Chapter 48
Mission Possible:
A Private Practice SBFC Model

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OVERVIEW: *This chapter describes the history and progress of Mission Possible in the Sacramento Valley, where since 1994, it has been functioning in a private practice model, providing SBFC mental health services to youth and families in elementary and secondary schools throughout Sacramento and San Joaquin Counties.*

BACKGROUND

I first became aware of the likelihood that youth and families would be well served by having mental health services available within the school system when I was a graduate student in Social Work in the mid 1970's. When I became licensed as both a Licensed Clinical Social Worker and a Marriage and Family Therapist (in 1979 and 1980), I blended the skills to address family systems in work with clients in whatever constructs they formed. Shortly thereafter, AB 3632 passed in California, beginning an era of team building among educators, mental health providers, social service case managers and families to become "whole family helpers" for at-risk youth. At that time I was the Coordinator for Mental Health Services for Children and Adolescents for Sacramento County, so I felt honored to be in the position to implement this legislation and the challenges it presented.

I left that administrative position to become a parent myself, and soon entered the world of school-based interaction from three different viewpoints:

Therapist: Some of my clients were (and continue to be) students from preschool through college ages; as a result, collaboration and consultation have been part of my practice for decades.

Parent: From the time my son entered kindergarten until he graduated from eighth grade, I volunteered in his classroom as the "Tuesday mom," and thus became the example of the helper during the situations throughout the years.

Professor: When I began teaching at the University of San Francisco in 1992, at the Sacramento Campus, in the Marriage and Family Therapy Program, I began hearing about the wonderful work being done at the Mission Possible Program within the Center for Child and Family on the main campus under the direction of Dr. Brian Gerrard. Our students in Sacramento could certainly benefit from such a wonderful placement opportunity, and our local schools could certainly benefit from such a great resource for USF trainees to provide on-site help. However, I knew that the overhead expenses of having a Center to run were costly, and that the administrative cost of having a faculty member in place to oversee a center was prohibitive so…

I decided to create a local program with a very modest budget, to fit the harsh reality of the declining economy, and offer it to a district dear to my heart, to see if it could help meet some of the unmet needs of the community.

It remains true that approximately 10% of children and adolescents in the United States will meet criteria for a mental health disorder during their school years [National Institute of Mental Health, 2004], and, regardless of a formal diagnosis, 12% to 22% of youth under age 18 have a need for mental health intervention to address emotional or behavioral difficulties (Christner, 2009), I met with Dr. Brian Gerrard

and Dr. Steven Pomerantz, and obtained support to create *Mission Possible* as it has evolved in the Sacramento Valley. This model is a school based youth and family counseling program operating on elementary, middle and high school campuses with high risk students, to facilitate their success academically, socially, behaviorally and emotionally as they progress through the developmental stages of competency and identity discovery. The program brings trainees and interns from the University of San Francisco graduate program in Marriage and Family Therapy, at the Sacramento Campus, under the supervision of a private practitioner, and contracts with local school districts to provide mental health services on designated school sites.

More than 25% of school children experience moderate to severe school adjustment problems due to emotional difficulties, and children who do not experience early school success are at risk of school failure, dropping out, becoming drug addicted and delinquent, and developing serious emotional disorders, which result in costly burdens to society (Drewes, 2001a, in Christner, 2009); thus, after meeting with Brian Gerrard to learn about the Center for Child and Family in San Francisco, and interviewing with staff there to learn how the Center and school based services operated, I approached the Natomas Unified School District to begin this venture in 2004. I presented the well documented position that mental health providers might serve as mediators and facilitators between families and the schools (Boyd-Franklin, 2000). At that time, the school counselor/student ratio in California was 1:951, and the "recommended school counselor/student ratio was 1:250 (Counseling Today, 2005). In 2010-11 the school counselor student ratio was 1: 1,016 (see Figure 48.1).

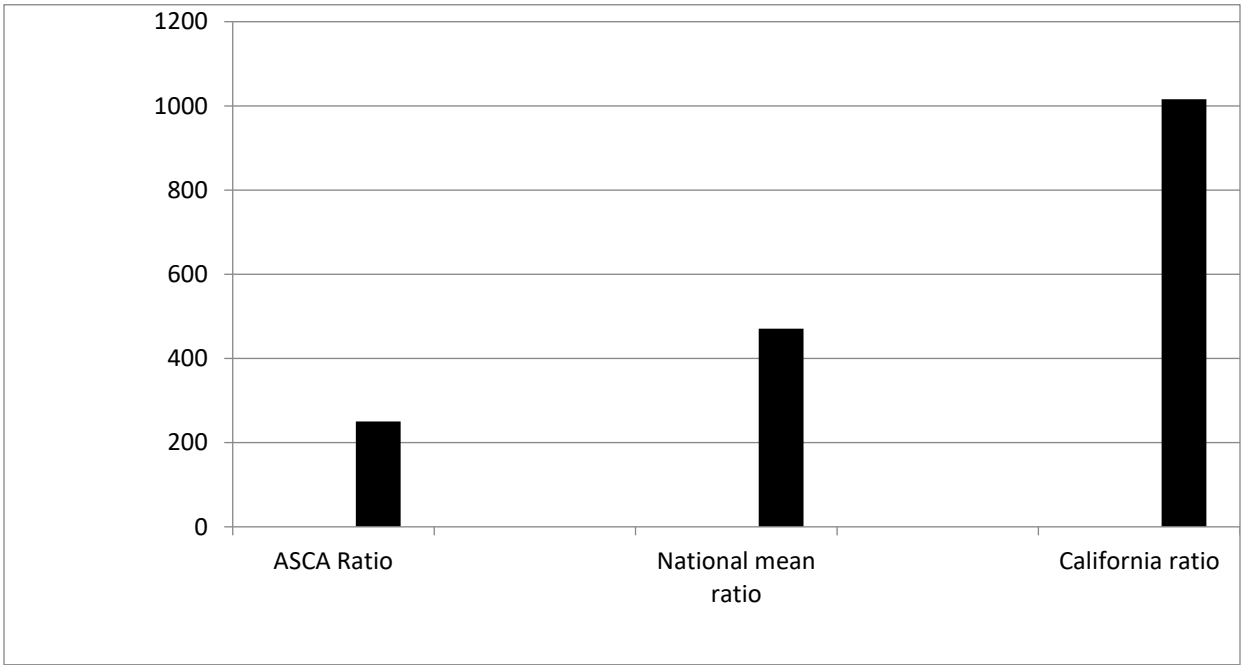

Figure 48.1 School Counselor/Student Ratios

In the Sacramento community, there are four Special Education Local Planning Areas, encompassing seventeen school districts, within which some overlapping charter schools operate. Each of these stakeholders understands that school is the equivalent of a workplace for children and adolescents. If the youth learn how to handle the challenges experienced while in school, they will be able to handle employment and further challenges later on (Boyd-Franklin, 2000). Further, mental health is directly related to children's learning and development. It intersects with interpersonal relationships, socio-emotional skills, behavior, academic motivation, learning, mental illness, crisis prevention and response, school safety and substance abuse. Each of these issues affects not only the success and well-being of the individual student but also the school climate and outcomes for all students (**www.counseling.org**, 2010). As Coordinator for Mental Health Services for Children and Adolescents, I had worked closely with the SELPA (Special Education Local Planning Area) Directors in implementing AB 3632 (later PL 26.5). This helped me understand the importance of teambuilding on school sites, and increased my desire to bring mental health services as an adjunct to the already overstressed academic counseling load that existed at those school sites.

PROGRAM DESCRIPTION

This model was proposed to the Natomas Unified School District, to be piloted in one elementary school, one middle school and one high school, in order to reach the K-12 range of student population. However, when presented to the District for initial consideration, with benefit for "at risk youth", the population that was identified fit with what has been researched by Christner & Rosemary (2009)

> …adolescents with mental health disorders are at increased risk for poor academic achievement as well as continued mental disability. Many youth who suffer from mental disorders also end up in the juvenile justice system, an outcome that could be prevented if they were treated while still in school. These young people are also at increased risk for substance abuse and failing to complete school.

While schools remain focused, as they should, on TEACHING students, they are becoming increasingly aware that, the 10-25% of the population of those being taught with emotional distress/disturbance will be better taught IF/WHEN their socio-emotional issues are addressed as part of their ongoing growth-promoting experience. Thus, when *Mission Possible* was presented to the Natomas Unified School District, as an opportunity to have a graduate level trainee at a school site two days each week, providing mental health services to youth and their families, freeing academic counselors to do the college prep work that was mandated by the State, and charging the district ONLY for the cost of supervising the trainees, the contract was approved, and the placements were selected to start at both middle schools and both high schools, to reach the most at risk youth first.

Learning supports have been shown to be directly effective in reducing barriers to learning and overall success. Resources, strategies, and practices that provide physical social and intellectual support to learning, teaching and emotional interaction can reengage disconnected students (**www.louisianaschools.net**). *Mission Possible* is helping the whole child succeed, by accepting referrals from the designated site link from each school, from teachers through that designee, from a referral box with a confidential slot so that youth may self refer, from administrators who may contact the trainee directly, from parents who may contact the school, or from other students who may request help with conflict resolution.

The SBFC approach requires volunteer time from the trainee counselors, who receive graduate school credit for their experience with *Mission Possible.* Over the years, some of them have devoted such

extraordinary effort to this project that they have stayed an additional year to share their skills with this community. In addition, this model requires a contract between each district or charter school and the supervising clinician, so that the contracted supervision will be compensated. The annual cost for supervising approximates $4500 (@$75.00 per hour). This cost is far less than would be charged for any agency overhead or for any third party billing or eligibility determination, so *Mission Possible* makes it possible for more youth to be served, more effectively, with more efficiency, more easily.

Since 2004, the program has served over 1200 youth and families, and saved several lives. The services that have been performed have varied, and the interventions have been flexible. The client issues have included:

self-injury
peer conflict (sometimes escalating to physical aggression/suspension
parental separation/divorce
foreclosure/homelessness
abuse (physical, sexual, emotional)
relational harassment
gang activity
bullying
serious emotional disturbance
cultural shock (transition to/from differing continents
grief (loss of significant caregiver)
chronic truancy
school failure (not turning in completed work)
substance use/abuse)
mood disturbance (depression, anxiety)

Empirical evidence shows that intervention with early adolescents with early warning signs, like those identified above, e.g., truancy, poor grades, behavioral problems, and difficulty getting along at home and/or school, will have an increased probability of developing *severe* problems later on (Boyd-Franklin, 2000). Further, middle school youth are seen as good targets for identification for help; if they begin to disengage, and then repeat a grade due to academic failure (e.g., not turning in completed work), poor attendance, discipline referrals or any of the other issues referenced above, then the more generalized problems can be anticipated (Boyd-Franklin, 2000).

RELATIONSHIP TO THE SBFC MODEL

Mission Possible in the Sacramento Valley relates to the SBFC model in a holistic manner, in that the program works to help the whole child succeed within his or her real world, which incorporates the ecosystem within which the child survives and grows. While doing this, the child is growing through either the developmental stage of industry or identity, so how much or how little the guardians are actually in attendance during the therapy sessions differs on a case by case basis. Nonetheless, the family is a crucial component of assessment and treatment. How this looks in terms of the SBFC model follows:

Promoting self esteem: *Family Prevention; School Prevention*
Improving attendance: *School Prevention*
Improving behavior: *School Prevention; School Intervention*
Increasing grades: *School Intervention; School Prevention*

Community employed or contracted mental health providers focus their work on a student's "global mental health" and how it impacts family, community, and school functioning

(www.counseling.org, 2010). The school setting, into which the *Mission Possible* volunteer trainees have entered for the past eight years, provides ample teachable moments to introduce and reinforce rational thinking concepts, which can be generalized to wide problem solving situations (Christner, 2009). Also called therapy moments, these examples from daily interactions are brought into sessions to process and facilitate growth.

Boyd-Franklin and Hafer-Bry, among others, have identified numerous socio-emotional learning competencies that can translate well from school based interventions to school, family, and community success: Self awareness: identification and recognition of one's own emotions, recognition of strengths in self and others, sense of self-efficacy and self confidence; Social awareness: empathy, respect for others, and perspective taking; Responsible decision making: evaluation and reflection and personal and ethical responsibility; Self management: impulse control, stress management, persistence, goal setting, and motivation; Relationship skills, cooperation, help seeking and providing, and communicating (Christner, 2009).

PROGRAM DESCRIPTION

The trainees I select for *Mission Possible* may come from a variety of backgrounds. They will be working in districts that serve clients from very diverse cultures; the original schools I approached for the pilot project had been known to serve students with 32 first languages on entry to first grade. All of the trainees and interns who have since worked with *Mission Possible* in its expansion through the Valley have been allowed the opportunity to learn and grow while providing a great benefit to the community. Because of their placement in schools away from the place where supervision occurs, they must possess the following skill set in addition to the knowledge, skills and abilities they are learning as part of their graduate training in marriage and family therapy, in order to succeed in this valuable work:

initiative
self confidence
willingness to work as a team member
ability to ask for help when needed
flexibility
self awareness

Trainees and/or interns commit to work at their designated schools for the duration of the school year; they may choose to extend on a yearly basis if the fit is mutually agreeable. However, for continuity of therapeutic benefit for students/clients being served onsite, the commitment goes from year to year, rather than changing throughout the year as much as possible. Teambuilding among staff and administration is enhanced by this practice; *Mission Possible* has come to be known as the favorite program of those who come in and out of the schools but who, unlike us, do not seem to maintain a consistent link with either students or staff.

This consistency, and the delivery of those socio-emotional supports which were referenced earlier, are thus shown to be linked to the development of a positive school climate (Christner, 2009) as the bond between *Mission Possible* and the school sites reveals. This was clearly evident during a very low economic point in 2009, when 48 of the 52 school counselors in the Natomas Unified School District were given pink slips. The School Board sadly had to withdraw funding from Mission Possible in order to retain the remaining 4 counselors and try to comply with the mandates for scheduling and college readiness with just 4 employees. Since the cost for *Mission Possible* had continued to be kept so skeletal, and the services were considered so crucial, each of the sites approached their site councils and secured school funding to keep the program onsite. Thus *Mission Possible* has remained intact through the Valley economic crisis, and has welcomed back the 48 academic counselors when they returned this Spring!

Those counselors kept the student/academic counselor ratio in the 1/850 range for academic readiness, and left *Mission Possible* available to help with socio-emotional issues.

CASE EXAMPLES

Confidentiality is the cornerstone of the psychotherapeutic relationship. This is basic knowledge for all allied health and mental health professionals. However, when counselors work with other professionals, the meaning of this standard, and the implications of violating it, can either strengthen alliances or create barriers to effective work with student/client/families. Thus, the standard that fits for school based mental health practitioners is that therapists should be careful to share *with informed consent only, unless in excepted circumstances* only information that benefits the client (Boyd-Franklin, 2000). The case examples included here have been disguised to preserve client anonymity, while retaining sufficient detail to alert the reader to the systemic collaboration exhibited in implementing the humanistic systems perspective in school based mental health intervention.

AMBROSE

One morning I was visiting one of the high schools, getting ready for the mid-term evaluation meeting. In order to make efficient use of the time away from my office, my trainee and I had scheduled her weekly supervision meeting to be held there, on campus, prior to the start of her time with students that day. One of her clients that year was Ambrose, an African American youth who had moved to California from Texas to live with his maternal aunt following the sad loss of his mother due to a brain aneurysm. He was feeling lost and without energy, and was not responding to the "tough love" approach his aunt was providing in an attempt to help him move forward in life. As a senior in high school, he had been doing well in Texas, was athletic and academically successful, and friendly; however, since moving to California, he noticed a change, with little energy for previous activities or interests. He was not interested in involving his aunt in counseling; for fear that she would consider him "weak" and be even more disappointed in him than she already appeared. The trainee and I devised a plan to work with the client and his aunt symbolically, in order to help him address his distress, reground, and decide his next steps. He wrote a practice dialogue with his aunt, and then role-played it with the trainee, playing both roles in succession. After expressing the feelings in session, he did this task at home, and returned with a greater sense of calm.

On the day I was at the high school, there was a quiet knock at the door; with my permission, the trainee opened the door. Standing outside was a very polite Ambrose, asking if she would be willing to write a letter on his behalf for admission to a university in Northern California! She arranged a meeting with him for later that day, and then we strategized. I encouraged her to talk with her site link and his academic counselor, sharing only the information that would be to his benefit, and with his informed consent, so that no one would think that collusion rather than collaboration occurred.

Then I encouraged her to think what she would like to ask him before she wrote the letter, and she said: "Why would you like to go to college most?" I supported her in posing this question, emphasizing the <u>most</u>, and she did just that. When they met, and he answered, "I want to learn to do something so that I can give back to the community. My mom would have liked that." She incorporated that into the letter, read it to him, and sent it to the university. A few months later, he received an early acceptance letter! He felt a return of his energy, and no longer felt like running back to Texas.

ANGER MANAGEMENT GROUP

One of the trainees was working with several youth at a middle school who had been referred for difficulty with anger management and/or defiant behavior. He noticed that they did well in individual counseling, but had difficulty managing interpersonal interaction. In supervision, we talked about the developmental challenge of identity growth through group diffusion, which eventually emerges into identity emergence later; I suggested that he create a peer group to simulate a slice of life, and use the situations that are brought into group to problem solve and then generalize therefrom. Very soon, an incident occurred that could not have been done by anyone other than peers → One student was describing his difficulty in getting to school on time; all of his "buddies" were commiserating, and saying things like, "Oh, man, that's hard, can you get a clock?...Or, can someone help you get up?...Or, how come no one helps you not get in trouble?" Then, when the 'victim' began berating his Mom, calling her a "****ing *****, who should just get the **** out of my room", the kids said, in the quietest voices heard ever thus far, "Oh, man, you can't talk to your Mom, that way. If I did that, I'd get smacked into the wall." Just hearing other kids say that garbage talk was not OK was enough to unstick a group member from his position; the trainee was able to facilitate by being present rather than lecturing or overcontrolling. During the course of the group, tools such as a hacky sack [a golf-sized, soft, pliable ball which feels soft yet is comforting to hold and comes in a variety of earth friendly colors],(to show who had the floor for talking), a thumb-ball [a round ball with words plastered all over it; whoever catches it selects the word covered by his "thumb" which elicits feedback on a topic], anger bingo [one of a series of bingo games used with youth to teach wider examples of triggers and options for affect management] and worksheets were used as needed, but the greatest gifts came from the mouths of the participants themselves.

JOSIE

This youth had been seen by a *Mission Possible* trainee in a prior year. When the next year began, he requested services again, because he was beginning to feel increasingly despondent, depressed and, eventually suicidal. The trainees are taught to assess for self harm and suicidality, and also to call for consultation as needed. A copy of the *Self Injury Contract* is shown as Box 48.1

When it became clear that this client could not remain safe from self harm, the trainee contacted me. We agreed that it was time to initiate a Welfare and Institutions Code§5150. WIC§5150 authorizes mental health persons in California to help clients who, as a result of serious emotional disturbance, pose evidence of grave, imminent, lethal danger to self or others, and thus require evaluation of need for care and custody in a facility designated to provide 24 hour services for no more than 72 hours before review, be taken to such facility for evaluation and possible detention and care. The following steps were taken:

1. The Sacramento County 911 5150 assistance operator was contacted;
2. The client's mother was contacted;
3. The trainee had the client come to the phone so that I could talk with him and let him know that the police would be coming to help him get to a place where people will be with him 24 hours a day until his feelings become manageable; the police will be coming to him to help him (not to arrest him; the phone is on speaker phone so that the trainee's messages matched my statements to this vulnerable client;
4. The trainee let the site link know just the emergent details so that when the police arrive on campus, there is no escalated drama;
5. I follow up with the trainee once the client has been transported from the school site, to debrief the process.

Box 48.1 Self Injury Contract

Self Injury Contract

This is my self-injury contract. I have agreed to carry it around with me and refer to it when I am upset and feel like hurting myself. I won't guarantee that I will never hurt myself, but I guarantee that I will read and do what I've agreed to do in this contract before I hurt myself.

I feel the impulse to hurt myself because:

I think it will help me to get through this moment, but it will cost me:

Before I hurt myself, I can:

Four people I can call before I hurt myself are:

Name: Phone #

Name: Phone #

Name: Phone #

Name: Phone #

One thing that I can try, that has worked before and is almost always comforting to me, is:

The most important reminder for me is:

_____ _____

Client Signature *Date* *Witness Signature* *Date*

In this case, the client was hospitalized, stabilized, and returned to school. The client and his mother have consistently worked toward success for the remainder of the school year, with collaboration from clinical, teaching and administrative support. This particular mom has requested input from me regarding a complicated third party entanglement (insurance billing for the hospital stay that started, lapsed, and then asked about "preexisting conditions" for a teen a with serious emotional disturbance warranted a consultation that no trainee should be expected to provide. The whole child is being considered in the nest of his high school environment, with such respect that he regularly refers his friends to "his *Mission Possible* counselor, and when a sticky ethical dilemma occurs for him, he asks her to check with "Miss Christine".

EVIDENCE-BASED SUPPORT

The USF trainees have worked at the schools as mental health providers, and become integral members of the helping community, for the past eight years. During one of our presentations to the Natomas

Unified School District School Board, the program was called “a Godsend”, to a resounding ovation of applause from appreciative community members. The services provided at each school include individual counseling, family counseling, group counseling, crisis intervention, community collaboration and referral, consultation with staff and administration, and program development. In addition, twice during each year, I visit each school to do program evaluation with the identified site link personnel and program administrator, to assure program effectiveness and plan for future success. The qualitative instruments utilized for feedback are shown below in Figure 48.2.

In addition, during 2011-12, a pilot research project has begun, to learn if there is a way to quantitatively measure those standards that were identified earlier in this chapter of whole child success. The tool for gathering this data has been given to each of the *Mission Possible* interns and trainees, with instructions to complete it (maintaining confidentiality and gathering it solely based on client interviews) on those clients they saw for three or more times during the past school year. The tool is shown below in Figure 48.3. Measuring success is difficult, because whole child success includes the student’s perspective on what constitutes success, and that may be very different from what might be desired by the referral source. However, we were very interested in gathering this information, to see what the results revealed. As can be seen from Figure 48.4, counselor ratings showed significant increases for self-esteem, attendance, pro-social behavior, and grades.

Figure 48.2 Mission Possible Qualitative Evaluations

Mission Possible Mid-Term Evaluation Tool

Site Visited:_____ Date:_____

Contact Person:_____

What is working well?	*What could we improve?*
{this goes on an 8 ½ x 11” sheet, and is used for note taking during a scheduled meeting at mid-year in the school calendar, to allow any possible change).	

Mission Possible End of Term Evaluation Tool

What worked well this year?	*What would you like to see next year?*
{as before, this goes on an 8 ½ " sheet, and forms the basis for discussion, with awareness of the limitations posed by the state of the economy and the priority given to socio-emotional needs of students and families within the school setting).	

Figure 48.3 Data Recording Sheet Mission Possible Pilot Project,2011-2012

Data Recording Sheet Mission Possible Pilot Project

Instructions: This year I would like to begin seeing how helpful we are at working to engage whole children in succeeding with various aspects of their functional lives. Without reducing their sense of selves to "what they can do for us" I just want to naturally capture aspects (on entry and discharge from service, as these issues become available to us in the course of clinical inquiry) of difficulty that would impinge on their ability to have ***happy healthy lives.***

Therefore, please record using a 0-5 rating scale (o=low, 5=high), for clients with whom you connect for the 3-session intake and make a treatment agreement (thus becoming an "entry"client), their functioning in the categories below. Similarly, note their functioning on end of treatment. We will then compare the ratings during this pilot, seeing within the entire *Mission Possible Program***,** the impact of our services with the clients we serve.

Client:_____

Characteristic Rated	Self Esteem	Attendance	Behavior (Antisocial-Prosocial)	Grades (e.g., one course or overall)
Entry rating				
Discharge rating				

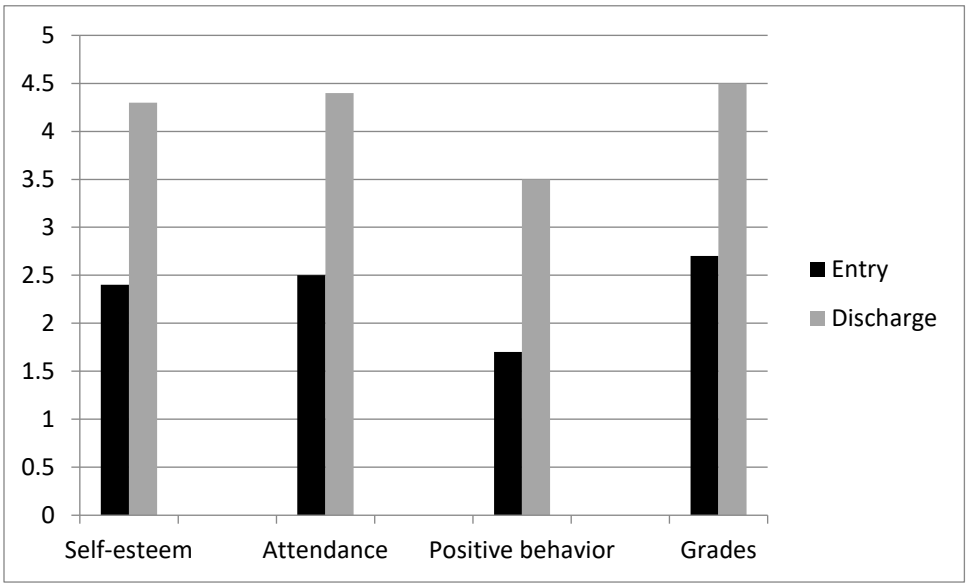

Figure 48.4 Pilot Project Results 2011-2012

difficulties, or pressure from others to leave the area. This break in services has created a mid-year shift each time it has occurred, and has taken some time to repair.

Mental health providers speak a language that is unique to our profession, and it sometimes comes across as though we consider ourselves better than other professions. I actually respect and appreciate the work that my colleagues do; otherwise I would neither have spent nine years helping in my son's classroom each week, all day, nor would I continue to work with children and go to their schools to work with their teachers (as I have done since 1980). However, the challenge remains to adhere to our standards while working at the setting where everyone else speaks educator-talk, and learn to understand that, just as we learn to adjust our communication to that of our clients from whatever background they honor us with their sharing. Similarly, we need to value the educational culture within which we are welcomed to provide our services.

The supervision is external to the actual practice, so I must select the trainees with care for the process for clients to go well, and for trainees to be effective. If I choose unwisely, *Mission Possible* may not be invited back for another year. If I supervise inattentively, the trainees will not learn and grow. If I do not help them learn new skills, the clients will not benefit.

As discussed earlier in this chapter, measuring success is difficult, because whole child success includes the student's perspective on what constitutes success, and that may be very different from what might be desired by the referral source. We will continue the data gathering methods referenced herein to monitor progress for three years, and assess our findings from 2004-2014.

Billing changes each year as staff at each school changes. Because I am in private practice, I do the billing for supervision on a monthly basis. At various times throughout the year, staffing changes occur; however, the way I learn this is that an invoice remains unpaid. The amount of time necessary to figure this out and correct this constitutes pro bono service to the community, because I do not want to create a financial burden for this very efficient program; yet it is challenging to offer a service and figure out how to be compensated for it.

Sometimes having a solo operation can be isolating. When asked why the concept isn't more widespread, a part of me responds, "I wish it was, because it certainly could be replicated, if only people would carry this dream into their community and start one district at a time." Yet another part understands that it requires perseverance, organization, and stamina to continue to pursue the dream when the details become cumbersome. Nonetheless, the benefits FAR outweigh the challenges, as can be seen by the case examples given. These were three of over 1,200. I hope that the program lasts for years to come.

REFERENCES

American Counseling Association (2010). *An overview of school-based mental health services.* **www.counseling.org**.

Boyd-Franklin, N. & Hafer-Bry, B. (2000). *Reaching out in family therapy: Home-based, school, and community Interventions.* The Guilford Press, New York.

Christner, R. & Christner, R. (Eds.) (2009). *School-based mental health: A practitioner's guide to comparative practices.* New York: Routledge.

Pastorek, P.(2009). *Louisiana's comprehensive learning supports system: The design document.* **www.louisianaschools.net.**

RESOURCES

http://smhp.psych.ucla.edu/pdfdocs

This is the link to H.S. Adelman & L. Taylor's wonderful website; once you are part of this network, you will receive well documented research about school based information from educators, clinicians and community members who work together for whole child success.

Rigby, K. (2011). *Bullying in Schools: Six Methods of Intervention.* Northampton,UK:Loggerhead Productions, Ltd.

This is a 45 minute DVD by Ken Rigby, with a comprehensive booklet which I have used with my interns and trainees in group supervision both in the field and at the University in traineeship courses.

Berman, A. , Jobes, D. & Silverman,M. (2006). *Adolescent Suicide: Assessment and Intervention.* New York: American Psychological Association**.**

This is a very informative text written by Berman, Jobes and Silverman which I rotate among the trainees when then enter *Mission Possible.* It helps prepare them for the *No Self Injury Contracts* that soon become part of our work.

Scaife, J. (2001).*Supervision in the mental health professions: A practitioner's guide*. New York:

Routledge.
As a private practitioner, I find it useful to be a lifelong learner about how to be the best nurturer I can be to the next generation of therapists. Joyce Scaifes' book helps with this.

Potter-Effron, R. (2007). *Rage: A Step by Step Guide to Overcoming Explosive Anger.*Oakland, CA: New Harbinger
This is a very readable guide to help introduce trainees to the work of affect management. Potter-Effron writes well and the book gets used regularly.

Huang, C. & Lynch, J. (1999). *TAO Mentoring: Cultivate Collaborative Relationships in All Areas of Your Life*. Cambridge, MA: Da Capo Press.
This is another example of a supervision book, which generalizes to wider use. Huang and Lynch are wonderful authors and examples.

Igoa, C. (1995).*The Inner World of the Immigrant Child*. New York: Routledge.
Cristina Igoa presented at Oxford in 2006. She shared this example of helping whole children learn and grow in her classroom in Hayward, CA. I share this with the trainees to help them join with their clients equally respectfully.

Pipher, M. & Ross, R. (2005). *Reviving Ophelia: Saving the Selves of Adolescent Girls.* New York: Riverhead.
Mary Pipher wrote with clarity and compassion about this painful, very prevalent treatment issue.

Anaya, R. (1999). *Bless Me, Ultima.* New York: Warner Books.
Rudolfo Anaya is one of the premier Hispanic authors. I regularly share his two novels so that the trainees can learn how a major population in the Natomas Unified School District are raised to dream. In that way, some of the messages that are shared have another layer of respect.

D'Ambrosio, R. (1970*). No Language But a Cry*. New York: Dell.
Trainees regularly want to know "what should I do when the door closes for the first time?" Dr. D'Ambrosio answers this perfectly, as he waits patiently for two years for his very abused client to find her way through abuse to him. This book has been well read and loved.

Many workbooks, handouts and articles are used for training and group enhancement throughout the year. Hopefully these resources will enhance your SBFC work as well.