

Feature . . .

The Personal Side of Counseling . . .

"The Personal Side of Counseling" highlights feelings, opinions, and attitudes within and about the counseling profession.

As Long as There Are Katrinas, It's Still Not Enough

Trish Hatch

This touching story describes the unique and vital role of an elementary school counselor as she struggles to obtain necessary services for a chronically ill student. Through determination the counselor was able to assist. The author reminds us all of the incredible opportunity the counselor has to impact a child's life in a positive and lasting way.

Last year I realized my dream of 7 years as a counselor. I was finally a full-time elementary counselor at a school with a manageable caseload of 580 students. After years of splitting my time between two schools with caseloads of 1,500-1,900, I had one school site that was dedicated to supporting, through Title I funding, a full-time elementary school counseling program. I had visions of counseling every student scheduled and of ending each day with an uncluttered desk.

I have a model elementary counseling program. I teach classroom guidance lessons weekly to over 200 fourth and fifth grade students. I lead counseling groups for children with behavioral problems, with Attention Deficit Disorder, whose parents are drug addicts, whose parents are separating or divorcing, and whose relatives are dying or deceased. I train and implement fourth and fifth grade conflict managers to assist younger students on the playground during recess. I counsel pupils individually, present in-service education for staff, meet with parents, attend School Attendance Review Board hearings and Student Study Team meetings, and teach Active Teaching programs and parenting classes. I have designed a classroom-sized multi-use Guidance Center with 50 children's guidance books and 25 videos available for teachers to check out and use. I work with a tremendous staff and principal that are supportive and believe in counseling, and you know what? It's not enough; *it's still not enough.*

Each day brings an unexpected crisis that needs immediate intervention—immediate total committed "stop-everything-and-help" crisis intervention. It seems that elementary campuses are becoming places where learning is secondary to survival — physical, emotional, and academic. Last week is a good example. I had planned for weeks to set aside 2 days to go through the mountain of paper work on my desk. "They're doing yearly testing," I thought. "I'll get something done." While welcoming students to school on that chilly and damp morning, I saw what I still believe was one of the saddest sights of my career. About 200 yards from me shuffled a tiny waif. Her hair hung in front of her face so that her eyes were not visible. She moved very slowly, about 2 inches at a time as she struggled to make her way toward school. I watched in disbelief. "What was wrong with

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her? Was she hurt?" As a counselor I wondered, "Has she been beaten? Molested? Raped? Why is she walking so slowly and in what seems to be such pain?" I approached and asked her what was wrong. "My legs hurt," she responded in a low shallow voice. What's wrong with your legs?" I inquired. "I have arthritis," she told me. "Does it hurt a lot today?" I asked, trying to remember that I was a professional and trying not to overreact. What I really wanted to say was, "How could your mother let you walk to school in this condition?" "Yes," she said.

I picked her up as gently as I could and carried her to my office as she grimaced. I placed her on my table and lifted her pant leg to see her knee. It was all I could do to keep from gasping. Her tiny toothpick legs had knees swollen to the size of grapefruits. As I looked in horror, I questioned her about her condition. She told me that she hurt all the time and that she had no medication for the problem. I asked when she had last seen a doctor. It had been long enough for her not to remember. I questioned the teacher as to her condition. The teacher told me she knew Katrina¹ had arthritis, that the mother had told her she was getting medical help, and that nothing else could be done. The teacher seemed to feel that walking to school was good for Katrina. Later we were to learn that this is true under normal circumstances. The teacher was unaware, however, that Katrina had walked all the way to and from school, which was about a mile, and that she had been doing this for several days. As a school counselor, a mother of three, and a human being, I was wrenched emotionally. Something had to be done immediately. This child could not walk to school again in this condition. I took the wheelchair from the nurse's office and rolled her to class. I then called the mother, who cried as she told me her story. She explained to me that she had taken Katrina to the doctor twice in the last 3 months and that Katrina could not tolerate the medication that had been prescribed. In addition, mom felt the doctors "wouldn't listen to her" and that she was "treated badly because she is on Medi-Cal." Although referred to University Hospital, Katrina had not been accepted because she was a Medi-Cal patient signed with a Primary Care Case Management Program (PCCMP).²

I questioned the mother about having her daughter walk to school. She said that the family car had broken down, that there was no other way for her to get there, that Katrina wanted to go to school, and that she (80 lbs. herself) could not carry her. I explained to mom that this child needed a doctor—now. I began to wonder whether there were other issues surrounding the lack of treatment. I obtained the phone number of the PCCMP doctor and called him. He was impatient with me, but I persisted to persist and scheduled an appointment for the next day. Next came transportation. I arranged to borrow a school district vehicle for the following morning and told the mom that I'd pick them up for the doctor's appointment in the morning. In the meantime I loaned the school's extra wheelchair to Katrina and her mom so Katrina could be wheeled home from school. I also obtained paper work to be filled out by the doctor so that the school district could have a bus pick her up at the door and return her home each day, a service that the parent did not know was available.

1. Katrina is a fictitious name. Names of people and places were changed in this article to preserve anonymity and confidentiality.

2. Eligible patients have the choice of registering with straight Medi-Cal or with a state-contracted Primary Care Case Management Program. According to the private company I contacted, managed care providers go door-to-door soliciting clients for private coverage which is state paid. The advantage, they say, is that patients have local primary care physicians who know them. The drawback, according to the general hospital eligibility worker, is that services can be limited and controlled by the primary physician or the care provider. The patient has to get approval for medications and special services, which can be, and in this case was, impossible for this patient.

Later that same morning three girls from the school came to see me to explain that a man on their street had been molesting several girls at the school for months. There went the rest of the day. After 4 hours with forms, Child Protective Services workers, and parents, I had added to the pile on my desk. "Friday," I sighed, "after Katrina's appointment, I'll finally get something done." And I did—perhaps the most important thing I've done in 8 years as a counselor.

I picked Katrina and her mom up at 8:30 a.m. for her appointment with the doctor. After our hour-long wait, the physician asked why we were there. Mom and I explained. The entire examination consisted of lifting one pant leg and looking at her knee. He then signed the form for transportation and was about to leave. "What about her condition?" I asked. He suggested mom take her to a specialist at University Hospital." I can't," explained mom. "The last time you referred me there I waited 8 hours only to be told that they don't take my coverage and that I had to come back here to see you again." The doctor explained, "She needs to be in physical therapy. She needs more specialized treatment than I can give her. I'll give you a referral to University Hospital." He said there was nothing else he could do. I intervened. "You don't understand," I said. "This child can't go on like this. She can hardly walk. It could be days or weeks before she can see the specialist."

He had seen us carry Katrina into the room, as she was barely ambulatory and in tremendous pain. "She needs therapeutic intervention for her symptoms of depression, a wheelchair, and a complete physical evaluation by someone who understands this condition," I pleaded. He prescribed Motrin (large pills) and left the room. I said to the nurses, "Isn't there something you can do?" Here was a child who couldn't walk, who appeared depressed, whose face was ashen with pain, and who weighed 40 lbs. as an 8-year old. All the physician could do was give her pills, a referral to a hospital that already refused to see her and sign a transportation sheet! I was getting angry—polite, assertive, but furious inside. It seemed as though no one cared, that our appointment was over, and that we were supposed to leave. But I didn't. "This is the way they always treat you," said mom. "Well not today," I told her.

I went back to the nurses and inquired, "Can't something be done? The mother has no idea how to get her child into University Hospital to see a specialist since she was turned down before. She has no transportation, does not know how to get her daughter through the system, and may not have the strength right now to fight the fight necessary to get her child in the door. You know people. Can't you call someone? Anyone? Won't someone see this child?" I walked out and got Katrina. I carried her back into the nurses' station, placed her on the counter in front of them, and lifted her pant legs—to the gasps of the three nurses. One of them picked up the phone. She was an obstetrics nurse who visited the location once a month to do patient checks, and she saw Katrina's legs and she understood my concern. "I have the district car only today," I told her. "I'll take all day if I need to, but I don't know when I'll be able to get the time or the car again. Mom has no transportation, and I'm afraid she won't follow through; she can't even take a bus unless she carries the child." The nurse made several phone calls and managed to reach a pediatric rheumatologist, Dr. T. from University Hospital, who also sees patients at General Hospital. He remembered Katrina from several years back when he had seen her, and said that he would make room for her that day. "What a relief!! She was going to see a specialist who could really help her," I thought. I was, and am, so grateful to that nurse.

I took Katrina to eat a hamburger while mom dropped off the prescription. We then drove to the General Hospital and went to the registration room. There we were told that since Katrina was signed up with PCCMP that they could not allow Katrina to be seen

by the doctor. I began to explain the whole story. I told them that Dr. T. had said that he wanted to see her, and that he remembered Katrina and would set up a special time to see her because he was concerned. I was told that none of that would matter (including what the doctor said) unless they got PCCMP approval. Katrina's mom said, "See, I told you. This is what happens. No one really cares." I was beginning to believe her. I stood my ground, and explained that I had taken a day from work to do this, and that I was not leaving until Katrina was seen by Dr. T. I must have made an impression because the receptionist checked with her supervisor, and we were told it was approved.

We then started the long wait for her to be seen. It was worth it. Dr. T. and his resident spent 2 hours with us. They both examined her thoroughly and found that her chronic condition, Juvenile Rheumatoid Arthritis (JRA), had seriously flared up in her knees, elbows, wrist, and even her back. He almost hospitalized her right then but decided not to because Katrina was able to stand and walk although still with great struggle. Hospitalization would have removed her from her emotional support system and from school, which she really enjoyed. Instead, he gave her a prescription for liquid Motrin (a better choice for the child than the large pills), took blood and urine specimens, scheduled physical therapy, instructed mom and Katrina on exercises she should do every morning, and scheduled an appointment with an ophthalmologist because Katrina was also having trouble with vision. He also consulted with the social worker regarding Katrina's need for counseling and mom's need to get her medical coverage changed back to straight Medi-Cal so that Katrina could be seen again without all the red tape. By the time I carried Katrina the half-mile trip to the lab and back to the car, drove everyone home, and returned the district car, it was 5:30 p.m. Friday's day for organizing paper work became Katrina's day, one of the most productive days I've had in my career.

The hours of wait had been productive as well. The time gave me a chance to get to know Katrina's mom better. Seems I had been right. She had some other unresolved issues. Katrina had been diagnosed as a baby with JRA, and Dr. T. had been her primary physician. Two years ago, however, mom was divorced, and her life fell apart. That's when Dr. T. last saw Katrina. He told me that he had tried to keep in contact, but that mom's address kept changing. Mom related to me details of her misfortune which she referred to as "tough times." She struggled through the ramifications of her admittedly poor choices and the toll it had taken on their life style. Mom's continued problems resulted in a strained relationship with her extended family, transiency, and homelessness. Mom insisted, however, that hard times were over and that her choices now were positive. As I listened, I wondered if her lack of assertiveness in gaining assistance for her child's medical condition was an indicator of continued personal problems, ignorance of the system, a nonassertive temperament, or a lack of concern for her child's well-being. I wanted to know about mom because I couldn't understand how any human being could allow a child to walk to school a mile each way in Katrina's condition. Yet I knew that mom had tried to get Katrina help but had hit the bureaucratic brick wall and *stopped trying*. I thought, "Here is a woman with little education and less self-confidence who is attempting a life-style change, but with symptoms of continuing concern. She feels rejected by her family, has no job, and little money. She lives in a small rented house with her sister who is also struggling with a 2-year-old child of her own." Meanwhile, I'm questioning her actions toward her chronically ill child as I sit in my large home with our joint professional incomes, my three healthy children, an intact nuclear and extended family, and full health benefits, and I ask: "Who am I to judge?"

I watched Katrina and her mom interact with genuine love. Mom would caress her, kiss her, talk softly to her, and cry. She apologized to Katrina for not getting help sooner, and thanked me more times than I can count for what I did because "No one ever helped me like this before."

On Monday Katrina returned to school in her wheelchair with a smile. She was glad to be back but I could still see that she was still in pain. "Did you do your exercises today?" "No." "Did mom give you medication?" "No." "Ugh!" I told myself. "What happened?" At the end of the school day the bus arrived to take her home. Tuesday Katrina was not at home when the bus came to pick her up. Where was she?? I paid a home visit to the sister who informed me that they went to the boyfriend's home, and that the car "blew a rod." I became impatient and questioned my investment in this case. I told her that I had spent too much time on this to let it drop, that Katrina was to be in school every day with her medication, that Katrina must do her exercises, that we weren't going to go away, and that I would be at their house every day if I had to. Wednesday, Katrina came to school. The school nurse called mom to inquire about medication. The pharmacist was unable to fill the prescription because the PCCMP only covered Naprosyn, which Katrina couldn't tolerate because it upset her stomach. It took some doing, but a pharmacy in another city finally gave her the prescribed medication. The pharmacy would give her only a week's dosage at a time, and, of course, then mom had to get there—and she did.

Once on the medication Katrina seemed fine for a week. The following week, however, things changed. The medication ran out, mom hadn't refilled the prescription yet, and Katrina was in such pain that she had to be carried on and off the bus. She couldn't stand for the flag salute at all. The teacher was helping Katrina daily with exercises because they weren't being done consistently at home. I was becoming more and more concerned about mom's ability to care for her.

I called a colleague at social services and discussed placement outside the home. "This is a tough one. Yes, it's neglect to me, but does it meet state criteria? Was she in danger? She isn't going to die. JRA is a painful disease and it's more comfortable with medication and physical therapy, but it doesn't kill you to go without those things. Katrina had food in the home, and a loving though struggling mom, but her condition appeared to be worsening." I decided that I would check back in with Dr. T. I explained the situation, and he confirmed that indeed originally mom had tried to get the medication but had had difficulty and that they were trying to register the family with straight Medi-Cal, and that the social worker was looking into Crippled Children's Services (CCS). I told him that I thought Katrina needed to be hospitalized so that treatment could take place, and mom could get the paper work arranged. He agreed that, if she was indeed nonambulatory, that it was time to admit her to residential care. He called Katrina's mom to schedule a time to bring in Katrina the next day.

As I walked from the staff room to the front office that Friday, I saw mom. She was returning the wheelchair. "She's in the hospital," she said through her tears. "I know, it's the best place for her now, until she's stabilized. Are you going to see her?" I asked. "I'm staying with her. They'll let me be in her room and spend the night," said mom. I was so relieved. It wasn't just that she was staying with Katrina but that she wanted to. Katrina wouldn't be alone, and mom didn't abandon her.

Today I called the hospital to talk to Katrina, and mom was there. She told me that Katrina's paper work was done, that her CCS plan was being developed, and that she had an appointment to gain disability certification for Katrina so she could afford transportation to physical therapy and pay for her other needs. Katrina, I could tell, was smiling as I spoke to her on the phone. Her delicate voice was the most cheerful I had heard. She told me of the playroom and her new friends, and that she would be there one more week. Mom said she was grateful. At the end of the conversation she asked, "Will you be at work tomorrow?" "I'm in training," I said, "but I'll be there Tuesday. Why?" She replied, "Well, our family talked about it, and me and my dad want to send you flowers for all you've

done to help me and Katrina." I thought "And dad? Her dad? Grandpa? This is great! Maybe they'll re-enter the family and help. For Katrina's sake, I hope so."³

I hung up the phone and looked at my desk—what a mess. I came to the office on a Sunday to clean up my desk and felt compelled to start writing this story about Katrina—her bravery, her pain, her needs, and her suffering. As a school counselor, I see so many Katrinas out there in this world who walk to school every day carrying physical and emotional burdens. There are so many moms and dads who don't have the confidence or tenacity to get what they need from the system to help their kids. These parents may risk their child's health or even removal by social services because of their apathy, ignorance, or lifestyle choices. I could be angry at mom, but mom is not my client—Katrina is. Whatever it takes to help that little sweetheart is what I need to do.

Seven years ago I wouldn't have believed that a full-time counselor at an elementary school with 580 students would not have enough time to serve all the children with needs. It seems the lower my caseload the greater the individual need, and I realize how superficial and limited my services were before. The proactive approach to counseling has created a realization by staff, students, and parents that *professional school counselors are a necessary and integral part of advocating for children's needs*. Now, when the time comes to decide how to spend Title I monies at my school, counseling is assumed, not debated. Two more counselors could be employed at our school and still not fulfill all of the counseling and guidance needs.

I'll keep dreaming that some day my caseload will be low enough to leave on a Friday with a clean desk. Until then the paper work can sit there—because another Katrina is shuffling through the door.

3. Katrina still struggles with the disease, sees the doctor regularly, and receives physical therapy. When asked for permission to print this article, mom was tearful as she reminisced, but steadfast in her decision to have this article printed so that other children, parents, and counselors could profit.

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