

Addressing Barriers

to Learning

New ways to think . . .

Better ways to link

Working in Schools: Q and A

*Anyone who knows all the answers
most likely misunderstood the questions*

A major focus at our Center is on facilitating continuous learning related to mental health and psychosocial concerns in schools. Among the ways we do this are providing technical assistance and encouraging networking among those working in and with schools.

The Center's weekly Practitioners Listserv contributes to both functions through a question and answer and sharing format. Participants send in requests, ideas, comments, and experiences. Center staff reply to each request and ask participants to share their views. Respondents include members of the Center's Consultation Cadre. For some particularly thorny matters, requests are sent to other colleagues whose expertise is needed.

All relevant and nonduplicative responses sent to the Center are included in the following week's listserv. We also post a broad range of responses on our *Net Exchange* at <http://smhp.psych.ucla.edu/netexch.htm>

Table 1 provides an indication of what practitioners have been asking about and asking for. It affords a glimpse into the concerns and needs encountered by practitioners in schools across the country.

Note in Table 1 that many requests ask about the research/science/knowledge base for practices and for data to make the case for student supports. Other common requests are for resources and strategies to

use in daily practice and to facilitate continuing education of school personnel. Practical, ethical, and relationship issues are frequently raised. And, there is increasing interest in school improvement planning as a context for enhancing how schools address mental health and psychosocial concerns.

To illustrate the type of responses that are shared, we have selected a few from a recent exchange about confidentiality. They have been edited for use below.

Must School MH Staff Tell the Principal if a Student is Suicidal?

A school based mental health practitioner asked:

"Do school-based mental health programs report to principals as a matter of course when students express suicidal ideation? Does the situation differ for school district employees and community providers?"

Embedded in these question are a variety of other issues and problems. For example:

- C How good are the criteria and clinical judgement that determined suicidal risk?
- C If confidentiality must be broken because of potential self-harm, who needs to be told (principal? other staff? parents?)?
- C Who is liable if things go wrong?

To assess what is current practice and policy, we contacted a range of school district support staff, school-based community agency providers, and national pupil service organization staff. As you will see, the responses are varied and thoughtful.

From the Perspective of District Staff

Response #1 – There is not a standard procedure for school-employed support service professionals vs agency co-located professionals in reporting suicidal ideation. Clearly, personnel employed by schools are required to follow district procedures. In my district, agency owned professionals who

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co-locate in the schools also must follow the district procedures. District policy requires that building based response teams intervene with the student, and the lead professional directly report student's status to the administrator. Parent notification and staff contact with mental health crisis services are required.

In some school districts, agency-owned providers at a school invoke confidentiality as a reason for not reporting to the school's administration. This results in liability issues for schools. When both systems work out how these high liability issues will be handled, staff and students are protected.

Response #2 – Potential self-harm is uppermost in the minds of school staff. We try to work collaboratively for the sake of the student. I would expect that community providers working in schools want the same, to protect the student, and would share info about such problems.

Reporting to school principals helps insure safety for the student as well as for the student body and faculty. That is, if there is a question or comment expressed to the principal by other students or staff about a troubled student, the principal is better prepared to respond if s/he knows some of the history. It also helps the principal to deal with concerns that parents have about their children and the level of supervision within the school.

From the Perspective of Community Agencies Working in Schools

Response #1 – It depends on the degree of suicidality. If it is something that comes up in a therapy session, the clinicians are asked to document it and inform the parents but do not have to tell the school principal. If there is imminent harm (plan, attempt) then they are asked to tell the principal, but it doesn't need to be in writing. The same goes for suicide screens – if it is very passive suicidality, we inform the parents but not necessarily the school. In some cases, we refer back to the school social worker or psych. We ask them to sign a confidentiality statement though, stating they will not share the information with teachers.

This actually came up yesterday. We respected the confidentiality and have not released information regarding prior suicidal thoughts, because the student's talk was vague and there was no plan. The principal really wants to know what students "she should be on the look-out for" and isn't particularly happy with our policy.

Response #2 – Legally, I do not believe that we have any responsibility to report to school personnel (unless the contract requires it). Ethically and

clinically, however, the potential dangerousness could effect the school campus, other students, and foster more unsafe situations in the milieu. I think that clinical best practice would suggest that this is an emergent care matter, requiring that the provider create a "safety net" for the child. Seeking the child's permission and working through his or her ambivalent resistance about sharing is the pathway to including others (e.g., school personnel) in the prevention/safety net team. In this way, the provider empowers the child to approve the disclosure of this most confidential subject and supports the child's taking personal responsibility.

Skilled experienced providers likely know how to do these things; however, typically they are not working on school campuses. Too often, it is inexperienced interns or beginning clinicians who are responding. Minimally, school-based workers should have written protocols and training to establish clear standards for practice.

From Associations

Response #1 – When there may be the potential for injury to the individual or to another student, the principal should be informed. If I understand the Family Educational Rights and Privacy Act (FERPA) correctly, the principal, as the building administrator, has a right to know information about any professional working relationship. It would be similar to the administrator in a hospital's right to confidential information for chart review purposes. But this answer becomes complicated and also may depend on the Minor Consent Law in the state in which one practices. In some settings a minor has the right to care from a health professional and no other person has the right to that information without the minor's consent.

Response #2 – School counselors, mental health counselors, and any other student service providers in a school really have an obligation to notify the administration of a student's suicidal ideation. Even more important is to notify the parents and to document and have a witness to this notification.

Relatedly, note the following from the book *School Counseling Principles: Ethics and Law*: "The law of negligence involves injury or damage to another through a breach of duty owed to that person. Duty owed means a legal responsibility one person has to another such as a legal

Table 1

Practitioner's Requests*What's being asked about? What's being asked for?***Assessment Instruments to**

- C Measure individuals (e.g., self-esteem, mental "health," behavior problems, anger management, psychosocial competence, parenting knowledge and skills, client satisfaction)
- C Screen problems (e.g., depression, suicide, at risk kindergarteners)
- C Assess violence prevention at school
- C Map and analyze systems

Available Research/Science/Knowledge-Base on

- C Best/effective practices for schools related to
 - >mental health >providing health and social services
 - >behavioral health >suicide prevention
 - >strengthening community mental health
 - >promoting parent/child communication
 - >anger management for high school students
 - >working with neighborhood vendettas
- C Empirically supported therapeutic relationships
- C Effects of dress codes on academic achievement and graduation rates
- C Effects of exposure to violence on learning
- C Cost-effectiveness
- C "Huffing" as gateway drug
- C Moving students with problems into special settings
- C Comparative efficacy of school & community services
- C Racial disproportionality in special education
- C Most common barriers to learning
- C "Knowledge-based Compensation System"
- C Connection between bullying and substance abuse
- C School based depression screening programs
- C Students living in poverty with a single parent
- C Homelessness and mental health
- C Prevalence and incidence of various problems
- C Student use of MH services in schools
- C Making the case for MH in schools
 - >need for MH in schools >effectiveness of school MH
 - >impact on school performance >effect on academics
 - >impact on suicide prevention
 - >implications of the "Plateau Effect"
 - >productivity of school-based MH clinicians
- C Social marketing
 - >the value of school-based student support
 - >the value of mental health at the school site

Confidentiality and Consent Concerns

- C Using email to share info about a student's problems
- C Do school mental health staff have to tell the principal if a student is suicidal?
- C Is a consent form needed for school counseling?
- C Can MH staff see a student under age 12 one time without parent consent?
- C Does writing therapy goals in an IEP violate confidentiality?
- C Conducting research on school-based MH practice

Evaluation of

- C School-based individual interventions
- C School-based programs
- C MH intervention outcomes in schools
- C Parent involvement
- C Family functioning before and after interventions
- C Systemic changes
- C School consultation teams
- C 8th grade transition program
- C School-community collaboration
- C MH workers in schools
- C Multiservice family centers

Funding for Doing and Enhancing the Work

- C Writing proposals
- C Leveraging grant funding
- C Coping with budget reductions
- C Resources for delivering mental health in schools
- C Funding for afterschool counseling
- C Strengthening a school-based student/family center

Inservice/CE Topics, Strategies, and Resources

(e.g., teaching teachers, support staff, administrators)

[Note: All of the other categories, of course, contain matters relevant to inservice and continuing education.]

- C Info for establishing ways to
 - >orient new support staff
 - >support for new teachers
 - >help teachers and other school staff learn more about school MH, about imparting MH info, and about being sensitive to student MH
 - >provide leadership training on mobilizing staff
 - >tell parents about a teacher's molestation conviction
- C Info to help in covering specific topics such as
 - >student transitions
 - >homework as a MH concern and barrier to learning
 - >engaging parents of middle school students
 - >resilience and high school students
 - >suicide prevention and referral guidelines
 - >dealing with the hurricane aftermath
 - >avoiding "triangulation"
- C Requests for resource materials
 - >powerpoint presentation for school staff on MH
 - >short but comprehensive MH handbook for teachers
 - >guides for behavioral management systems for schools
 - >protocols on school planning to respond to terrorism
 - >for planning/implementing disaster aftermath efforts
 - >lesson plans for conflict resolution for middle school
 - >curriculum materials on various MH issues
 - >guides for suicide prevention and aftermath
 - >to use with non-English speaking populations
 - >for use by special education assistants and aides
 - >on social-emotional learning
 - >on helping students cope with holiday stressors
 - >on helping students cope with grief and loss
 - >on paraeducator training

(cont.)

C Questions about dealing with the following specific types of student problems

- >bullying >teen depression >substance abuse
- >attention problems >fear of talking >grief
- >won't speak at school >communication disorders
- >verbally aggressive >cries at school every day
- >oppositional defiant disorder >suicide >huffing
- >extreme separation anxiety >bipolar disorders
- >choking game >cutters >bright, turned off student
- >those impacted because of family deployment to war
- >students on medication >exposure to domestic abuse
- >student who made false abuse accusation
- >classroom disruptors >residential school students
- >understand sibling with Asperger's Syndrome
- >avoidance behavior around homework
- >disaster victims >obesity as an eating disorder
- >computer game addiction >children living in poverty

Intervention Approaches (How to do it)

- C Mental health in schools "How do I start?"
- C Behavior supports
- C Dealing with behavioral outbursts
- C Guidelines on alternatives to corporal punishment
- C Addressing truancy and student attendance
- C Alternatives to suspension
- C Starting a counseling program at a school
- C Group counseling guidelines
- C MH interventions for 10-14 year olds
- C Helping to transition new students
- C Human sexuality curriculum for special populations
- C Curriculum for sexual abuse prevention
- C Developing a day treatment program
- C Promoting MH through classroom curriculum
- C Using interactive software (e.g., for MH education)
- C Strategies to minimize dependence and enhance independence in students
- C Using social-emotional themes in students' reading
- C Processes for triage, referral, tracking, session planning, care management, progress evaluation
- C Transition programs for ninth grade
- C Suicide prevention for 5th grade
- C Preventing violence among deaf adolescents
- C Resources for crisis response
- C Adventure-based counseling in schools
- C Strategies to support cultural & linguistic diversity
- C Introducing non-English speakers to MH concerns
- C Working with troubled kindergarten students
- C Working with a gifted but unmotivated student
- C Working with students concerned about death of friends/relatives
- C Working with families through a student "life map"
- C Family Systems Therapy in schools
- C Info on juvenile justice for "high risk" youth
- C Practices for keeping students out of jail
- C Rural school MH and teleconsultation
- C Helping grandparents who are raising grandchildren
- C Re-engaging disengaged students in learning
- C Strategies to keep kids engaged during the summer
- C Enhancing "self-discipline" through class projects
- C Enhancing student connectedness
- C Talking with students about motivation
- C Homework as "work at home"
- C What to do (and not to do) on the anniversary of a school shooting or other tragedy

Intervention Issues

- C Helping vs. socialization
- C School-wide screening for depression and suicide
- C Continuing counseling at school after graduation
- C How to account for diversity
- C First grade retention
- C Intervening at school vs. in a special setting
- C Medication refusal at school
- C Why don't classrooms account for emotional problems?
- C "Mental health" can be a scary term for students and families: What's a better term?
- C Does early drug abuse education increase curiosity about drugs?

Peer Programs

- C Youth council to address MH stigma
- C Peers imparting mental health info
- C Training 4th-6th graders as peer coaches for coping

Policy Information

- C Policy for a student/learning support system
- C Policies and procedures around drug testing
- C Substance abuse policies for athletes and afterschool
- C Policies that affect immigrant students
- C District social-emotional policy

School-Agency Relationships &

Bureaucratic Concerns

- C Difficulties between school staff and school-based community mental health providers
- C Reconciling differences in rules and regulations
- C Aligning record keeping and teacher consultation
- C Working as a case team at school
- C School-community collaborative agenda
- C Fingerprinting
- C Record keeping (e.g., decisions, tracking, review)
- C Sample forms (consent, release of info., etc.)
- C Computer-generated behavior report to parents

School Climate

- C Customer friendly schools
- C Student ratings
- C Improving school teamwork and climate

School Improvement Planning as Context for Enhancing How Schools Address MH and Psychosocial Concerns

- C Opportunities related to Title I
- C Opportunities related to IDEA
- C Including MH guidelines in School Wellness Plans
- C Using a unifying framework to pull together initiatives
- C Integrating an "enabling component"
- C Support staff playing a role in the school's restructuring
- C Formulating a plan for mental health in schools
- C Creating readiness for a comprehensive and integrated system of student support
- C Planning how to move in more effective new directions
- C Winning over district leaders and "fence sitter" staff
- C Enhancing learning supports in small schools
- C Forming charter school for students with MH problems
- C MH in schools: looking to the future – a chance to reshape the No Child Left Behind Act

School Staff Wellness

- Surveying staff overwork and stress
- Resources to support staff well-being
- Providing teacher support groups
- Supporting school staff reeling from accountability pressures

Selecting and Training New Professionals

- Starting a school counseling intern program
- Guidelines needed for supervision of school MH staff for licensing
- Interviewing to select school-based MH staff

Special Education Concerns

- Helping a new teacher in a special ed class
- Difference between a special day class and intensive day treatment

- Who provides what services in private schools?
- Timelines for evaluating and placing a new student who comes in with an IEP
- Backlash to excessive special ed referrals
- Does writing therapy goals into the IEP violate confidentiality?
- Focusing an IEP team on student engagement and positive goals
- Moving beyond a social control agenda
- Next steps for post secondary student with learning problems

Stakeholder Relationships at School

- Administrator-staff
- School-family connections
 - >enhancing communication
 - >working with families
- Teams

(continued from page 2)

responsibility to drive with care so that you do not injure another person.... Negligence requires the presence of four elements: 1) a duty is owed, 2) the duty owed was breached, 3) there is a causal connection between breach of duty and injury, and 4) an injury has occurred. Until the Eisel v. Montgomery County Board of Education court case in 1991, courts consistently found that school counselors did not 'owe a legal duty' to prevent a student's suicide. Eisel strengthened counselors' legal obligation to students by satisfying for the first time the primary element of negligence and declaring that school counselors have a special relationship with students, and owe a duty to try to prevent a student's suicide."

Response #3 – Suicide ideation is a situation in which usual confidentiality constraints do NOT apply (due to the potential for harm) and, for the safety of the student, the school principal should be informed. While the student is in the school building or on the grounds, it is the school that has legal responsibility for the student's safety.

The school should have a policy and uniform procedures for handling such situations, depending on what a community school-based provider or school district personnel determines after an assessment of the level of concern. There should be contractual language that spells out the responsibilities of both the community provider and school district staff (e.g., required communications and limitations – how much and with whom will information be shared). While the risk for suicide attempt should be shared, some or all details of the student's situation may not need to be shared.

Summary Analysis

The above responses and others sent in all stress that, more often than not, school employees do tell the principal about potentially suicidal students. They do so for a range of legal, ethical, and clinical reasons. In contrast, community providers working at a school decide whether to inform principals based first on the contractual agreement and second on the judgments they arrive at using their agencies ethical and clinical standards for practice.

School employees and their representatives tend to think all professionals working at a school should be governed by school policies. For a variety of reasons, providers from agencies tend not to agree. Indeed, they usually believe they can do a better job and are relieved when they can work at a school and still operate outside the school bureaucracy.

Schools and agencies both must balance institutional liability concerns with considerations about what is in the best interest of the youngster. And, both must live with the repercussions that arise from whatever course of action is chosen. For example, as the above responses clearly highlight, this situation is fraught with the type of institutional and interpersonal conflicts that can jeopardize helping relationships with students and parents and working relationships among professionals.

Ethically and practically, it is wise to take steps to minimize the repercussions. For example:

- A clear set of procedures should be developed to which all parties have contributed and agree

(cont. on p. 6)

to follow. Such procedures detail what information needs to be shared, with whom, and when.

C Contractual agreements between schools and agencies and informed consent agreements with parents and students need to encompass these matters.

C When disclosure is imminent, it is important clinically to determine whether the student agrees the information should be shared. When a student doesn't agree, the implications of not doing so should be explored with her or him (in a developmentally appropriate way). The point is to enhance understanding of the situation and why disclosure is necessary and to address feelings of betrayal.

Ultimately, of course, the focus must remain on the well-being of the student – as best we can fathom it.

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For more on confidentiality considerations and on the topic of suicide prevention, go to the Center Quick Find Online Clearinghouse and scan the resources under the following topics:

>Suicide Prevention
http://smhp.psych.ucla.edu/qf/p3002_02.htm

>Confidentiality
<http://smhp.psych.ucla.edu/qf/confid.htm>

Explore the Net Exchange & Join the Practitioners Listserv

>If you want to see responses to matters highlighted in Figure 1, go to the Net Exchange on the Center's website – <http://smhp.psych.ucla.edu/netexch.htm>

>If you want to join the Practitioners Listserv, sign up by email at smhp@ucla.edu or by phone toll free at (866) 846-4843

Isn't the human brain amazing! It sure is – mine is filled with great answers; unfortunately, nobody asks me the right questions.





Center News

**IMPACT EVALUATION

While we continuously seek and receive feedback, we also periodically conduct a more formal impact evaluation for our funders. One facet of this involves soliciting data from anyone who has come in contact with the Center.

Please consider filling out the survey inserted in this newsletter either in its hardcopy version or online.

**NEW DIRECTIONS FOR STUDENT SUPPORT

>Update on the national initiative:

Statewide Summits – As can be seen from the information on our website, Minnesota, Wisconsin, Texas, California, Indiana, New York, Connecticut, Iowa, and Pennsylvania already have convened their Summits and are exploring ways to take next steps. Minnesota and Texas have followed-up with Leadership Institutes. The date for New Jersey’s Summit is January 30, 2006. Other states have contacted us to begin the discussion.

In addition to all this, various states and districts across the country already are initiating significant changes. For example, Hawai`i has pioneering legislation for its statewide efforts to establish a Comprehensive Student Support System (CSSS), and Iowa has developed its design for systems of learning supports and is beginning implementation. In California, proposed legislation is calling for establishment of a Comprehensive Pupil Learning Supports System.

For info on the activity around the country, go to <http://smhp.psych.ucla.edu/summit2002/currentstatus.htm>

Leadership Institutes – The input we have received makes it clear that the next phase in states that have held statewide summits is to expand leadership capacity building and networking. Therefore, in August, we began conducting Leadership Institutes for New Directions for Student Support. The first was in Minneapolis/St. Paul, Minnesota; the second was in September in Dallas, Texas. While the original intent was to work specifically with teams from schools and education agencies in each state,

we have agreed to open the Leadership Institutes to individuals and teams from other states who are ready to move in new directions. We are now determining interest in future institutes.

Policy Recommendations to Date – At the 2002 National Summit, a set of recommendations were formulated calling for elevating policy to ensure development to full potential of student learning support systems (see online report). Support for each recommendation has been forthcoming at the ensuing regional and state summits.

Resources to Advance New Directions – The resource tool kit for the initiative continues to expand. It is available online (and in hardcopy). See <http://smhp.psych.ucla.edu/toolkit.htm>

Recently added to the tool kit:

>*Example of a Formal Proposal for Moving in New Directions* (e.g., proposal to a Superintendent, Student Support Director, Principal, Board, etc. about integrating a comprehensive system to address barriers to learning into school improvement planning)

>*Infrastructure for Learning Supports at District, Regional, and State Offices*

In general, things are moving along at a good clip. As always, we value your input on how to maximize the initiative’s impact, including info on upcoming events where there would be an opportunity to engage decision makers in exploring New Directions. Contact: ltaylor@ucla.edu

For ongoing updates about the initiative, see <http://smhp.psych.ucla.edu/summit2002/currentstatus.htm>

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For ready access to all Center materials go to

<http://smhp.psych.ucla.edu/selection.html>

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You can get there from here
Bumper sticker

Center Staff:
Howard Adelman, Co-Director
Linda Taylor, Co-Director
Perry Nelson, Coordinator
... and a host of graduate and undergraduate students

** POLICY ANALYSES

>New Center Report:

*Systemic Change for School Improvement:
Designing, Implementing, and Sustaining
Prototypes and Going to Scale*
[http://smhp.psych.ucla.edu/pdfdocs
/systemic/systemicreport.pdf](http://smhp.psych.ucla.edu/pdfdocs/systemic/systemicreport.pdf)

Based on analyses of school improvement planning guides, we previously highlighted the lack of emphasis on fundamentally transforming schools in ways that (a) enable all school staff to address barriers to learning in a comprehensive manner and (b) facilitate teacher ability to engage and re-engage students in classroom learning. Further analyses of such planning guides indicate that they also tend not to address how desired improvements will be accomplished. That is, we find little evidence of sophisticated strategic planning for how schools and districts intend to get from here to there with fidelity and in ways that sustain improvements and scale-up over time.

Moreover, a survey of the relevant literature suggests that the nation's research agenda does not include major initiatives to delineate and test models for widespread replication of education reforms. Little attention has been paid to the complexities of large scale diffusion. Leadership training for education policy makers and administrators has given short shrift to the topic of scale-up processes and problems. And, in our work, we find that most personnel who are expected to act as change agents in districts and schools have relatively little specific training in facilitating major systemic changes.

Major school improvements require substantive systemic change. And, if the intent is to leave no child behind, implementation of fundamental and essential improvements has to be replicated in all schools. However, effective change on a large scale cannot even be approximated as long as policy makers, education leaders, and researchers continue to treat systemic change as an after thought.

The analyses in the report referenced above are meant to encourage increased policy discussion about the complexities of large scale implementation of school improvement prototypes. It (a) discusses the need to expand school improvement planning to address *how* schools and districts will accomplish systemic changes, (b) outlines basic considerations related to systemic change, and (c) proposes a set of policy actions.

Want resources? Need technical assistance?

Contact us at:

E-mail: smhp@ucla.edu Ph: (310) 825-3634

Toll Free Ph: (866) 846-4843

Write: Center for Mental Health in Schools
Department of Psychology, UCLA
Los Angeles, CA 90095-1563

Or use our website: <http://smhp.psych.ucla.edu>

If you're not receiving our monthly electronic newsletter (ENEWS), send an E-mail request to:

smhp@ucla.edu

or subscribe online @ – <http://lists.ucla.edu/cgi-bin/mailman/listinfo/mentalhealth-L>

For access to the latest
Center developed resources, go to:

<http://smhp.psych.ucla.edu/whatsnew/JustPutOnline.htm>

<http://smhp.psych.ucla.edu/whatsnew/otherresources.htm>

**FOR THOSE WITHOUT INTERNET ACCESS,
ALL RESOURCES ARE AVAILABLE
BY CONTACTING THE CENTER.**

Exchange info on MH practices in school and network with colleagues across the country by joining (1) the **Weekly Listserv for School MH Practitioners** and/or (2) the **Center's Consultation Cadre**. Sign up by email at smhp@ucla.edu or by phone – Toll Free (866) 846-4843.

Also, if you want to submit comments and info for us to circulate, use the insert form in this newsletter or contact us directly by mail, phone, or E-mail.

Do you like going to school?



Going is fine;
having to stay is the problem!



Some Base Line Data on School Mental Health Services

(Excerpted from a national survey funded by the
Center for Mental Health Services, SAMHSA, U.S. Dept. of Health and Human Services)

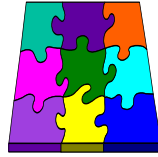
As reported in *School Mental Health Services in the United States, 2002–2003*,* survey topics included: types of MH problems encountered in schools; types of MH services schools deliver; numbers and qualifications of school staff providing MH services; types of arrangements for delivering the services, including collaborations with community; and major sources of funding for school MH services.

Key Findings as Reported in the Executive Summary

- C Nearly three quarters (73 percent) of the schools reported that “social, interpersonal, or family problems” were the most frequent mental health problems for both male and female students.
- C For males, aggression or disruptive behavior and behavior problems associated with neurological disorders were the second and third most frequent problems.
- C For females, anxiety and adjustment issues were the second and third most frequent problems.
- C All students, not just those in special education, were eligible to receive mental health services in the vast majority of schools (87 percent).
- C One fifth of students on average received some type of school-supported mental health services in the school year prior to the study.
- C Virtually all schools reported having at least one staff member whose responsibilities included providing mental health services to students.
- C The most common types of school mental health providers were school counselors, followed by nurses, school psychologists, and social workers. School nurses spent approximately a third of their time providing mental health services.
- C More than 80 percent of schools provided assessment for mental health problems, behavior management consultation, and crisis intervention, as well as referrals to specialized programs. A majority also provided individual and group counseling and case management.
- C Financial constraints of families and inadequate school mental health resources were the most frequently cited barriers to providing mental health services.
- C Almost half of school districts (49 percent) used contracts or other formal agreements with community-based individuals and/or organizations to provide mental health services to students. The most frequently reported community-based provider type was county mental health agencies.
- C Districts reported that the most common funding sources for mental health services or interventions were the Individuals with Disabilities Education Act (IDEA), State special education funds, and local funds. In 28 percent of districts, Medicaid was among the top five funding sources for mental health services.
- C One third of districts reported that funding for mental health services had decreased since the beginning of the 2000–2001 school year, while over two thirds of districts reported that the need for mental health services increased.
- C Sixty percent of districts reported that since the previous year, referrals to community-based providers had increased. One third reported that the availability of outside providers to deliver services to students had decreased.

While survey findings indicate that schools are responding to the mental health needs of their students, they also suggest increasing needs for mental health services and the multiple challenges faced by schools in addressing these needs. Further, more research is needed to explore issues identified by this study, including training of school staff delivering mental health services, adequacy of funding, and effectiveness of specific services delivered in the school setting.

*Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., Teich, J. (2005). *School Mental Health Services in the United States, 2002–2003*. DHHS Pub. No. (SMA) 05-4068. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
<http://www.mentalhealth.samhsa.gov/media/ken/pdf/SMA05-4068/SMA05-4068.pdf>



Policy & Program Analyses: Improving Schools: Some Fundamentals

Disaffection with progress in raising student achievement has resulted in institutionalization of school improvement planning.

No one doubts that significant school improvement requires rigorous planning and implementation. But, as too often has been the case in the past, current guides for school improvement planning are not adequately conceived. Analyses done by our Center and presented in various policy reports and two recent books published by Corwin Press continue to focus on this problem.*

Our analyses stress that a fundamental flaw in school improvement planning is the lack of attention given to how schools do and do not address barriers to learning and teaching.

We also emphasize the following matters as essential to improving schools:

- (1) The curriculum in every classroom, of course, must include a major emphasis on acquisition of basic knowledge and skills. However, such *basics* must be understood to involve more than the traditional “three Rs” and cognitive development. There are many important areas of human development and functioning, and each contains “basics” that individuals may need help in acquiring. Moreover, any student may require special accommodation in any of these areas.
- (2) Every classroom must address student motivation as an antecedent, process, and outcome concern.
- (3) Special assistance must be *added* to instructional programs for certain individuals, but only after the best nonspecialized procedures for facilitating learning have been tried. Moreover, such procedures must be designed to build on strengths and must not supplant continued emphasis on promoting healthy development.

- (4) Beyond the classroom, schools must have policy, leadership, and mechanisms for developing school-wide programs to address barriers to learning. Some of the work will need to be in partnership with other schools, some will require weaving school and community resources together. The aim is to evolve a comprehensive, multifaceted, and integrated continuum of programs and services ranging from primary prevention through early intervention to treatment of serious problems. Our work suggests that at a school this will require evolving programs to
 - enhance the ability of the classroom to enable learning
 - provide support for the many transitions experienced by students and their families
 - increase home involvement
 - respond to and prevent crises
 - offer special assistance to students and their families
 - expand community involvement (including volunteers).

- (5) Relatedly, decision makers at all levels must revisit current policy using the lens of addressing barriers to learning with the intent of both realigning existing policy to foster cohesive practices and enacting new policies to fill critical gaps.

- (6) Leaders for education reform at all levels are confronted with the need to foster effective scale-up of innovations. This means designing and implementing (a) efficacious school improvement prototypes and (b) effective systemic change strategies for replicating new approaches taking them to scale.

*See:

> *School Improvement Planning: What's Missing?*
<http://smhp.psych.ucla.edu/pdfdocs/schoolimprovement/whatmissing.pdf>

> *Addressing What's Missing in School Improvement Planning: Expanding Standards and Accountability to Encompass an Enabling or Learning Supports Component.*
<http://smhp.psych.ucla.edu/pdfdocs/enabling/standards.pdf>

> *The school leader's guide to student learning supports: New directions for addressing barriers to learning.* Thousand Oaks, CA: Corwin Press. (2006).

> *The implementation guide to student learning supports in the classroom and schoolwide: New directions for addressing barriers to learning.* Thousand Oaks, CA: Corwin (2006).

Where's the Money?

Examples of Provisions of Federal Law that Allow Districts
to Redeploy Federal Resources to Improve Systems
(e.g., to creating a cohesive *System of Learning Supports*)

***No Child Left Behind Act of 2001
(PL 107-110)***

This last reauthorization of the Elementary and Secondary Education Act continues to enable making the case for using a percentage of the allocated federal funds for enhancing how student/learning supports are coalesced. For example, under Title I (Improving The Academic Achievement of the Disadvantaged), the need for coordination and integration of student supports is highlighted in the statement of Purpose (Section 1001) # 11 which stresses “coordinating services under all parts of this title with each other, with other educational services, and, to the extent feasible, with other agencies providing services to youth, children, and families.” It is also underscored by the way school improvement is discussed (Section 1003) and in Part A, Section 1114 on schoolwide programs. Section 1114 (a) on use of funds for schoolwide programs indicates:

“(1) IN GENERAL- A local educational agency may consolidate and use funds under this part, together with other Federal, State, and local funds, in order to upgrade the entire educational program of a school that serves an eligible school attendance area in which not less than 40 percent of the children are from low income families, or not less than 40 percent of the children enrolled in the school are from such families

(J) Coordination and integration of Federal, State, and local services and programs, including programs supported under this Act, violence prevention programs, nutrition programs, housing programs, Head Start, adult education, vocational and technical education, and job training.”

<http://www.ed.gov/policy/elsec/leg/esea02/pg2.html#sec1114>

The need is also implicit in Part C on migratory children, Part D on prevention and intervention programs for neglected, delinquent, or at-risk students, and Part F on comprehensive school reform, and Part H on dropout prevention, in Title IV 21st Century Schools, and so on.

Mechanisms for moving in this direction stem from the provisions for flexible use of funds, coordination of programs, and waivers detailed in Titles VI and IX. – <http://www.ed.gov/policy/elsec/leg/esea02/index.html>

***Individuals with Disabilities Education
Improvement Act of 2004
Public Law No: 108-446***

Using IDEA funds to coalesce student/learning supports is emphasized in how Title I, Part B, Section 613 (Local Educational Agency Eligibility) discusses (f) Early Intervening Services:

“(1) IN GENERAL- A local educational agency may not use more than 15 percent of the amount such agency receives under this part for any fiscal year . . . , in combination with other amounts (which may include amounts other than education funds), to develop and implement coordinated, early intervening services, which may include interagency financing structures, for students in kindergarten through grade 12 (with a particular emphasis on students in kindergarten through grade 3) who have not been identified as needing special education or related services but who need additional academic and behavioral support to succeed in a general education environment.

(2) ACTIVITIES- In implementing coordinated, early intervening services under this subsection, a local educational agency may carry out activities that include–

(A) professional development (which may be provided by entities other than local educational agencies) for teachers and other school staff to enable such personnel to deliver scientifically based academic instruction and behavioral interventions, including scientifically based literacy instruction, and, where appropriate, instruction on the use of adaptive and instructional software; and

(B) providing educational and behavioral evaluations, services, and supports, including scientifically based literacy instruction.” ...

“(5) COORDINATION WITH ELEMENTARY AND SECONDARY EDUCATION ACT OF 1965- Funds made available to carry out this subsection may be used to carry out coordinated, early intervening services aligned with activities funded by, and carried out under, the Elementary and Secondary Education Act of 1965 if such funds are used to supplement, and not supplant, funds made available under the Elementary and Secondary Education Act of 1965 for the activities and services assisted under this subsection.”

<http://www.ed.gov/about/offices/list/osep/index.html?src=mr>

The Rewards Controversy

Ed Deci, Richard Ryan, and their colleagues have done fundamental work on the topic of *intrinsic motivation*. Their efforts have major applications for school and MH professionals. Below we draw your attention to their work on “the rewards controversy.”

[Edited excerpts from the University of Rochester website on *Self Determination Theory*
http://www.psych.rochester.edu/SDT/cont_reward.html]

“Over the past 20 years, nearly 100 published experiments have provided support for the initial finding of tangible extrinsic rewards undermining intrinsic motivation. The finding was very controversial when it first appeared because it seemed to contradict the prevailing behaviorist wisdom of that time, which maintained that the careful use of rewards (or reinforcements) was the most effective approach to motivation. Remarkably, three decades later, in spite of very convincing evidence ..., the controversy continues.”

But, the evidence is clear: “Tangible extrinsic rewards reliably undermine intrinsic motivation under most circumstances, and, interestingly the most detrimental reward contingency involves giving rewards as a direct function of people's performance. Those who perform best get the most rewards and those who perform less well get less (or no) rewards. This contingency, which is perhaps the one most often used in life, seems to be the one that is most detrimental to the motivation, performance, and well-being of the individuals subjected to it.”

Please see the insert and provide us with some evaluative feedback.

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 Center for Mental Health in Schools
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Both HRSA and SAMHSA are agencies of the U.S. Dept. of Health and Human Services.

USEFULNESS

How useful were any of these to you?	TA/ Consultation	Policy Reports	Other Resource Materials*	Electronic Newsletter (ENEWS)	Quarterly Hardcopy Newsletter	Practitioners Listserv	Work Related to New Directions for Student Support	Other Networking**	Support for Programs and/or Initiatives	Support for Systemic Changes
Quite a Bit										
Somewhat										
A Little										
Not at all										
Not Used										

IMPACT

Check, then rate any of the following functions that are part of the work you do.

DEGREE OF OUR CENTER'S IMPACT ON ANY OF YOUR JOB FUNCTIONS

	Quite a Bit	Somewhat	A Little	Not Yet	N/A
_____ TA/Consultation					
_____ Program Development					
_____ Direct Practice					
_____ Influencing Policy					
_____ Training					
_____ Research					
_____ Facilitating Networking					
_____ Initiating New Approaches & Ideas					
_____ Infrastructure Development					
_____ General Capacity Building					
Other? (Please specify)					

***Other Resource Materials** -- refers to resource packets and aids, fact sheets, practice notes, guidebooks, concept papers, statements of principles and guidelines, critical issue and policy reports, continuing education modules, special training aids, published articles, chapters, and books, products related to research and development

****Networking** -- refers to opportunities created by the Center for interacting at regional and national meetings, through participation in coalitions and special cadres, through Center operated listservs, through task workgroups and other collaborative connections, etc.

Ways in which you have had contact with the Center: *(check all that apply)*

- Website
- Listserv (e.g., Monthly ENEWS, Weekly Practitioners, Policy Makers)
- Received direct mail or email
- Had contact at a presentation or special meetings
- Center staff came to us
- Indirect contact through center materials, special reports, publications, etc.
(e.g., shared by a colleague)
- We visited Center and/or a site with which the Center works
- Other (specify) _____

Satisfaction with Center *(circle rating)*

How easy was it to access the Center's resources?	Not at all	Somewhat	Very	Extremely Easy
How timely and appropriate was the Center's response to your requests?	Not at all	Somewhat	Very	Extremely Responsive
How well did the Center meet your needs?	Not at all	Somewhat	Very	Extremely Well

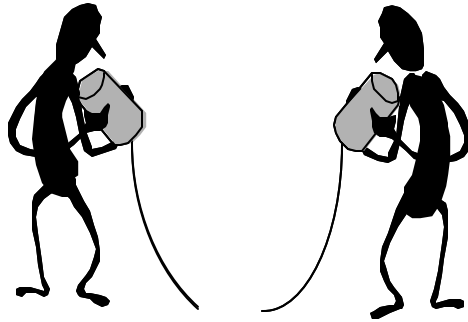
Based on your experience with the Center, would you use it again and/or recommend that others make contact?

Yes No

Other comments?

Why are you asking these questions?

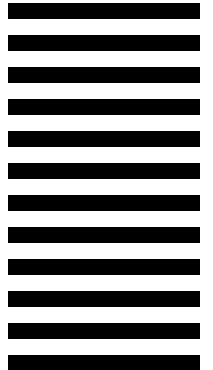
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