

# Utah's School Behavioral Health Services Implementation Manual



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# School Behavioral Health Services Implementation Manual

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## **Table of Contents**

### **I. Introduction**

A. Definition / Vision / Purpose	1
B. Utah's History of School Behavioral Health Services	1
C. Utah's Guiding Principles	3
D. Utah's Framework for School Behavioral Health Services	5
E. Utah State Office of Education Implementation System Framework	7

### **II. School Behavioral Health Services Components**

A. Readiness and Implementation	8
1. Community Readiness	8
2. Utah Behavioral Initiative	8
3. Funding	8
4. Management Capacity/Staffing Pattern	9
5. Facility Design	10
B. School, Local Authority, and Tribal Policies	10
C. Staff Development	11
1. Staff Roles, Functions and Training Requirements	11
2. Supervision and Consultation	12
D. Program Awareness	12
1. Marketing your SBH Services to Stakeholders	12
2. Outreach to Students, Family	13
E. Internal Referral Process	13
1. Referral	13
2. Screening and Assessment	13
3. Student Eligibility/Admission Criteria	14
4. Parental Consent	14
5. Pathway Into Care	14

F. Inter-disciplinary Team	17
G. Direct Services to Children and Students	17
1. Behavioral Health Assessment	17
2. Treatment Planning	18
3. Treatment Intervention	20
H. Integration with Other School-based Programs	21
I. Cooperation and Collaboration with Other Agencies and Resources	21
1. Community Partnership Development	21
2. Collaboration with Behavioral Health Service Providers	22
3. Collaboration with Non-Behavioral Health Service Providers	22
4. State and Local Collaboration	22
5. Tribal Collaboration	22
J. Program Evaluation/Sustainability	22
1. Evaluation Design	22
2. Outcome Measures	23
3. Client Satisfaction	23
4. Quality Improvement	23
5. Sustainability, including funding	24
<b>Note to All Readers</b>	25
<b>References</b>	26

## Appendices

1. System of Care Principles	28
2. Medicaid School-based Skills Development Services	30
3. Mental Health Parity Act	47
4. Sample Staff Performance Evaluations from Wasatch Mental Health	50
o Case Manager	
o Therapist	
5. School District and Local Authority Substance Abuse & Mental Health Providers	56
6. Sample Tribal MOU	60
7. FERPA and HIPAA	64
8. Excerpt from NAMI's <i>Choosing the Right Treatment: What Families Need to Know About Evidence-Based Practices</i> available at <a href="http://www.nami.org/Template.cfm?Section=Child_and_Teen_Support&amp;template=/ContentManagement/ContentDisplay.cfm&amp;ContentID=47656">http://www.nami.org/Template.cfm?Section=Child_and_Teen_Support&amp;template=/ContentManagement/ContentDisplay.cfm&amp;ContentID=47656</a>	66
9. Sample Flyer from Davis Behavioral Health	69
10. Sample Internal Referral Forms	72
o Davis Behavioral Health	
o Weber Human Services	
11. Children's Mental Health Disorder Fact Sheets for the Classroom	75
12. SSBD Info	96
13. "Mental Health Screening in Schools" - Mark Weist's 2007 article	104
14. Sample Parental Permission forms	111
o Davis Behavioral Health	
o Weber Human Services	
15. What Utah School Employees Can and Cannot Do	114
16. "My Profile"	116
17. Components of a Person-Centered Plan	127
18. Sample Crisis / Safety Plans	129
o New Frontiers for Families	
o Wasatch Mental Health	
19. Youth Outcome Questionnaire (YOQ)	136
20. Student Outcome Tracker II	138
21. Client Satisfaction Questionnaires	141
o YSS (Youth Satisfaction Survey)	
o YSS-F (Youth Satisfaction Survey, Parent/Caregiver Version)	
22. "Examples of Behavioral Health Funding to Purchase Mental Health Services for Children and Their Families"	149
23. "10 Critical Factors to Advancing School Mental Health: What Early Adopters Say"	151

# I. Introduction

## A. *Definition/Vision/Purpose*

It has come to our attention that the term "behavioral health" may not be widely used within the education community. Therefore, a definition at the start of this document will provide clarification: **behavioral health is an umbrella term which includes both substance abuse and mental health services.** It is our goal ultimately to offer in schools a continuum of services from prevention through treatment, for both substance abuse and mental illness.

Why provide behavioral health services in schools? We believe that addressing physical health concerns is doing only part of the job of serving the whole child. We must also address issues of mental health and substance abuse to ensure that our children succeed within today's school system. When done well, school behavioral health (SBH) promotes health and wellness, reduces barriers to learning, increases the likelihood that youth will graduate from high school, and decreases the likelihood that they will become involved with the criminal justice system.

## B. *Utah's History of School Behavioral Health Services*

Several Community Mental Health Centers in Utah initiated collaboration with schools to provide school behavioral health services. They include:

1. Valley Mental Health (VMH): Through its Children's Behavior Therapy Unit (CBTU), VMH has provided school mental health services since the early 1970s. By partnering with Salt Lake City's two largest school districts, Granite and Salt Lake, VMH has been able to provide supportive mental health services to children and youth in school settings. Over the years, these school services have expanded their reach from special education programs, to the whole student population and, most recently, to the community at large.
  - a. Special education programs: At four elementary and junior high schools, VMH provides full-time licensed mental health professionals to support school district staff in seven special education classrooms.
  - b. Whole student population: As of January 2010, VMH employs full-time mental health professionals in three elementary schools. They are integrated into the Student Support Teams and accept referrals from the teams for at-risk students needing mental health support. The mental health professionals can provide indicated individual, family, and group therapy services as needed to most of the student population, with some exceptions due to insurance plans and funding sources.
  - c. Community at large: In 2009, VMH collaborated with an elementary school and Intermountain Health Care (IHC) to provide mental health services in the school health clinic. At present, the mental health services are available to students and parents with *SelectHealth* insurance. Eventually, VMH hopes to expand mental health service availability and accessibility to the residents of the community through the school health clinic.
2. Wasatch Mental Health (WMH): WMH started providing school services in Utah County in 1994. In 2009, WMH operates school programs in three school districts (Alpine, Provo, and

Nebo): 26 elementary schools, four junior high/middle schools, and four high schools. These programs serve children and youth, ages three through 22, with special behavioral and emotional challenges, in their own schools. Services provided include assessment; individual, group, and family therapy; parent support and training; case management; skills development; and case consultation. WMH has contracts with Alpine and Provo School Districts to formalize these school services.

3. Four Corners Community Behavioral Health (FCCBH): FCCBH serves Carbon, Emery and Grand Counties. We would like to give credit to FCCBH's Bob Greenberg and Grand County School District Special Education Director Annette Greenberg, who formed a mental health-school partnership which continues today. This process enables special education students to have immediate access to mental health services in the school setting with parents' agreement. This also helps parents break through the stigma of the traditional mental health setting, and feel comfortable with services provided in a more natural environment for the child.

In 2004, Utah Division of Substance Abuse and Mental Health (DSAMH) received the Child and Adolescent State Infrastructure Grant from the federal Substance Abuse and Mental Health Services Administration/Center for Mental Health Services (SAMHSA/CMHS) to improve the way mental health and substance abuse services are delivered to children, youth, and their families. Several Utah communities identified school behavioral health services as their priority and applied funding from the DSAMH to plan, implement, and evaluate school services. DSAMH collaborated with the Utah State Office of Education to ensure that Positive Behavioral Interventions and Supports (PBIS) works well with other school-based programs.

In 2006, the Utah State Office of Education (USOE) was awarded a grant through the U.S. Department of Education to improve the mental health of children. The purpose of this grant was to integrate schools and mental health systems in Utah so that students had increased access to high-quality mental health care. The specific goal and objectives were to develop an integrated and collaborative infrastructure within participating schools that offers students access to a continuum of mental health services including education, prevention, health promotion, screening, referral, crisis intervention, treatment and recovery.

1. Northeastern Counseling Center (NCC): NCC serves Daggett, Duchesne, and Uintah Counties. NCC's school services focused on mental health and substance abuse prevention and early intervention. Services included:
  - a. School-day prevention education
  - b. Problem-solving team and case management
  - c. *Positive Action* family classes
  - d. School mental health prevention and early intervention services (e.g., early childhood psychosocial/emotional development services); also school referrals meeting the needs of each school district and follow-up with local public mental health agency (Student Assistance Program).
  - e. Training and consultation with school personnel and the Ute Indian Tribe

NCC braided funding from the Northeastern Counseling Center, Division of Substance Abuse and Mental Health, and the Ute Indian Tribe to implement the service array. The priority population for the nominated practice is students with no access to public or private insurance. The project serves elementary, middle, and high school age children and youth.

Approximately 75-80 students are served annually, with the majority being Caucasian, 20% American Indians, and a small number of Hispanics.

2. Bear River (serving Box Elder, Cache, and Rich Counties): A partnership was formed among Bear River Health Department, Bear River Mental Health, and Cache and Logan School Districts to provide school mental health and substance abuse services. Mental health providers are placed weekly at two after-school program sites to provide group counseling and individual counseling. Families receive information about the prevalence of mental illness and substance abuse and they receive assistance in accessing community resources.
3. Davis Behavioral Health (DBH): DBH provides school behavioral health services within multiple areas of Davis County/Davis School District.
  - a. DBH has a therapist assigned to the Davis Community Learning Center at Wasatch Elementary. The therapist provides individual, family, and group therapy and well as coordinating services for all ages. This is for both mental health treatment and substance abuse referral/treatment. The therapist has access to multi-disciplinary consultation.
  - b. A therapist is assigned to North Davis Junior High who provides individual, family, and group therapy with access to multi-disciplinary consultation.
  - c. A therapist is assigned to Canyon Heights High School (young parents) to provide individual, family, and group therapy. The therapist has access to multi-disciplinary consultation.
  - d. Therapists are mobile to clients in most Title I schools across Davis County to provide individual and family therapy.
  - e. DBH is part of the Davis School District Crisis Response Team for all school crises across the county.
4. Wasatch County: Through Heber Valley Counseling's (HVC) school mental health program, students are referred through elementary school counselors. HVC provides after-school social skills groups at two of the five elementary schools. Students needing services from the other schools are transported to one of the site-based schools for group. Individual counseling is also available on an as-needed basis. Project personnel include: Project Coordinator/School Liaison, Child Psychologist, Social Worker/MSW and a Social Services Aide.
5. Utah County: In Utah County, Wasatch Mental Health collaborated with school districts to implement youth suicide prevention programs. The program educates students and school staff, parents and other community members about the warning signs of suicide, what to do with at-risk youth, and available community resources including crisis lines.
6. Weber County: In Weber County, Weber Human Services (WHS) has Memoranda of Understanding with schools to formalize the collaboration. Liaisons at WHS and schools are identified and trained on best practices. There are teams at the district and school levels to coordinate mental health and substance abuse services for students. Screening and assessment instruments are used to identify students in need of mental health and substance abuse services.

### ***C. Utah's Guiding Principles***

Utah's school behavioral health services are guided by following principles:

1. The services are child-centered, youth-driven, and family-focused—with the needs of the students and their families dictating the types and mix of services provided.
2. The services are culturally competent—responsive to the linguistic and cultural diversity of the students and their families.
3. Mental health and substance abuse services are well integrated into planning, delivery and evaluation.
4. Seamless transition of behavioral health (mental health and substance abuse) services is expected as students exit schools and enter into new schools, post secondary education, or employment.

These principles are in keeping with the ten foundational principles of SAMHSA's system of care philosophy, which can be found in Appendix 1.

### ***D. Utah's Framework for School Behavioral Health Services***

Utah's Framework for school behavioral health services was developed by consensus in a statewide conference in 2008. Educators, mental health and substance abuse professionals, community stakeholders, and youth and family advocates attended the conference and developed the following framework.

<b>COMPONENT</b>	<b>RECOMMENDATIONS</b>
<b>Readiness and Implementation</b>	<ol style="list-style-type: none"> <li>1. Stakeholders (business, elected officials, providers, families, schools) have ownership of "mental healthiness" as part of what should be received at school.</li> <li>2. The community is involved in Identifying gaps in resources, staff, and services.</li> <li>3. The community understands that early identification and follow-through is preferable to allowing problems to grow and result in dropout, criminal activity, substance abuse, etc.</li> <li>4. The community expects a school environment conducive to learning and to mental health.</li> <li>5. The community believes that ALL students are eligible to receive ALL services.</li> <li>6. The community's culture (e.g., religious, ethnic, and political) is valued at every step of the process.</li> <li>7. There is a champion in the school to facilitate implementation.</li> </ol>
<b>School &amp; Local Authority Policies</b>	<ol style="list-style-type: none"> <li>1. There are integrated policies among stakeholders in children's behavioral health that discuss early identification using a team approach and systems of care principles.</li> <li>2. The integrated policies among stakeholders in children's behavioral health support the use of staff from collaborating agencies in assessment and treatment.</li> </ol>
<b>Staff Development</b>	<ol style="list-style-type: none"> <li>1. There is regular cross and interdisciplinary training that includes parents and family advocates.</li> <li>2. Training is followed by coaching.</li> <li>3. Training is focused on topics that reach the maximum number of students (e.g., Antecedent Monitoring, Precision Commands).</li> <li>4. Training topics may include, but are not limited to:               <ol style="list-style-type: none"> <li>a. Safety and crisis issues,</li> <li>b. Positive Behavior Intervention and Supports (PBIS),</li> <li>c. Cultural issues, and</li> <li>d. Staff wellness issues.</li> </ol> </li> <li>5. Support the development of a core curriculum to integrate behavioral health and teacher education.</li> </ol>
<b>Program Awareness</b>	<ol style="list-style-type: none"> <li>1. Staff is educated about existing services.</li> <li>2. Staff understands each other's roles and confidentiality/privacy issues.</li> <li>3. MH and SA staff considers entire school their "client," not just individual students.</li> <li>4. The school values family input and uses family-friendly methods in EVERY step of process.</li> <li>5. The school understands the "whole child" and wellness concepts and there is no stigma about MH/SA.</li> <li>6. The issue of schools paying for services for the referrals they make is addressed.</li> </ol>
<b>Internal Referral Process</b>	<ol style="list-style-type: none"> <li>1. Referral process is user friendly.</li> <li>2. There is a standard referral form.</li> <li>3. The referral process allows for quick response to parent request.</li> <li>4. The student is assessed for risks for safe school violation.</li> <li>5. Universal screening is available and procedures are clearly described.</li> <li>6. Assessments are strength-based and correspond to the identified needs.</li> </ol>
<b>Inter-disciplinary Team</b>	<ol style="list-style-type: none"> <li>1. The team adopts the child-centered and family-driven approach.</li> <li>2. The team membership is appropriate for the needs and reflects the characteristics of the community.</li> <li>3. There may be teams at different levels (e.g., county, school). They have clearly defined roles and communicate with each other.</li> <li>4. The team has team leader and co-leaders.</li> <li>5. Team meeting norms (agendas, meeting expectations, etc.) are clearly established.</li> <li>6. Team members assess their strengths and weaknesses, and know what they need from the team.</li> <li>7. The team values and regularly reviews outcomes.</li> <li>8. Establish trust among members of team.</li> </ol>
<b>Direct Services to Children and Students</b>	<ol style="list-style-type: none"> <li>1. Service plans are individualized and based on the needs of the students and their families.</li> <li>2. The skills development should be generalized into natural environments.</li> <li>3. Service plans are outcome-based and the selection of intervention is based on its effectiveness.</li> <li>4. Families receive necessary support.</li> <li>5. Relationship building is critical.</li> <li>6. Continuity of care is important and Individual service plans should follow the student and family when the child changes schools.</li> <li>7. Recovery support is available.</li> <li>8. Children and families are referred to community resources.</li> </ol>
<b>Integration with School-Based Programs</b>	<ol style="list-style-type: none"> <li>1. School-based programs use a team approach and systems of care principles to early identify, refer, and treat students in need of holistic services, including behavioral health.</li> <li>2. School-based programs commit their staff in collaboration efforts.</li> </ol>

COMPONENT	RECOMMENDATIONS
<p><b>Cooperation and Collaboration with Other Agencies and Resources</b></p>	<ol style="list-style-type: none"> <li>1. There are regular meetings with public and private agencies, businesses, faith-based community, cultural groups, elected officials, etc.</li> <li>2. Collaboration meetings are multi-layered:               <ol style="list-style-type: none"> <li>a. Direct Services: Members include hands-on staff, family and youth. Recommended meeting frequency is monthly.</li> <li>b. Organizational Problem Solving: Members include middle managers, family and youth. Recommended meeting frequency is quarterly.</li> <li>c. Policy and Financing Collaboration: Members include policy makers, executive staff, family and youth. Recommended meeting frequency is semi-annually.</li> </ol> </li> <li>3. There is a broad system collaboration which includes:               <ol style="list-style-type: none"> <li>a. Common language and vocabulary,</li> <li>b. Well-defined roles,</li> <li>c. Common philosophy on the good will of collaboration.</li> </ol> </li> <li>4. Family, youth and cultural groups must be involved at all levels of policy making, implementation and evaluation.</li> </ol>
<p><b>Program Evaluation and Sustainability</b></p>	<p style="text-align: center;">Evaluation</p> <ol style="list-style-type: none"> <li>1. Outcome evaluation is conducted. Possible data sources are:               <ol style="list-style-type: none"> <li>a. Individual level: YOQ, grades, school attendance, disciplinary referrals, CRT score, access/retention/service completion, satisfaction (parents, youth and staff).</li> <li>b. School level: grades, disciplinary referrals, CRT score, SHARP, Safe and Drug Free School report, AYP, etc.</li> </ol> </li> <li>2. Process evaluation is conducted on:               <ol style="list-style-type: none"> <li>a. Lessons learned</li> <li>b. Procedures and protocols used</li> <li>c. Other qualitative measures</li> </ol> </li> <li>3. Evaluation results are disseminated via web and reports, etc.</li> <li>4. Evaluation results are used for sustainability.</li> <li>5. If possible, there is evaluation on the economic model.</li> <li>6. Evaluation is focused on sites with strong implementation with fidelity.</li> </ol> <p style="text-align: center;">Sustainability</p> <ol style="list-style-type: none"> <li>1. Funding is braided. Possible funding sources include: MH, SA, DCFS, JJS, education, business, and private insurance, etc.</li> <li>2. Evaluation results are used to argue for sustainability.</li> </ol>

**E. Utah State Office of Education Implementation System Framework**

**Phases of Implementation for Utah's School Behavioral Health** (Adapted from ABC-UBI Training Initiative)

<p><b>Consensus Building</b></p>	<p><b>Infrastructure Developing</b></p>	<p><b>Implementation Doing</b></p>	<p><b>Continuous Improvement Refining</b></p>
<ul style="list-style-type: none"> <li>• Establish System Team</li> <li>• Provide working knowledge &amp; understanding of:                             <ul style="list-style-type: none"> <li>- RUIPBIS</li> <li>- School Based Mental Health</li> <li>- Substance Abuse</li> <li>- Evidence-Based Interventions</li> <li>- Assessment</li> </ul> </li> <li>• Set vision &amp; define beliefs</li> <li>• Gather data                             <ul style="list-style-type: none"> <li>- Outcome data</li> <li>- Student behavior data</li> <li>- Professional learning</li> </ul> </li> <li>• Assess current practices:                             <ul style="list-style-type: none"> <li>- funding</li> <li>- data systems</li> <li>- training</li> <li>- delivery of instruction in prevention, intervention and treatment</li> </ul> </li> <li>• Determine priorities</li> <li>• Commitment to change initiative</li> <li>• Develop action plan</li> </ul>	<ul style="list-style-type: none"> <li>• Create or access problem-solving team</li> <li>• Develop procedures and processes for: Education, Prevention, Health Promotion, Screening, Referral, Crisis Intervention, Treatment, Recovery</li> <li>• Address logistics (time, place, scheduling)</li> <li>• Examine effectiveness of universal (core) prevention</li> <li>• Examine effectiveness of selected (supplemental) and indicated (intensive) interventions</li> <li>• Align policies and practices</li> <li>• Build schedule, based on needs and outcomes</li> <li>• Resource mapping: Identify resources and personnel available</li> <li>• Establish on-site technical assistance, coaching, mentoring, and feedback opportunities</li> <li>• Provide systematic training on practices</li> </ul>	<ul style="list-style-type: none"> <li>• Execute procedures and processes for: Education, Prevention, Health Promotion, Screening, Referral, Crisis Intervention, Treatment, Recovery</li> <li>• Evaluate fidelity of implementation</li> <li>• Data are systematically collected &amp; used for problem-solving</li> <li>• Evaluate efficiency of data system</li> <li>• Engaged in full scale application of delivering universal (core), selected (supplemental), and indicated (intensive) services</li> <li>• Evaluation of intervention effectiveness for all tiers at least quarterly</li> <li>• Establish &amp; execute methods for ensuring intervention integrity</li> <li>• Evidence of implementation of priorities</li> </ul>	<ul style="list-style-type: none"> <li>• Re-examine priorities and plan for sustainability</li> <li>• Sustain teaming</li> <li>• Sustain problem-solving at multiple levels</li> <li>• Continue training and evaluation of interventions at each tier</li> <li>• Maintain systematic evaluation to monitor implementation</li> <li>• Adjust system, based on ongoing analysis of implementation integrity and other data.</li> <li>• Maintain ongoing professional development for practices and staff</li> </ul>
<p>Ongoing communication with all stakeholders to maintain consensus and commitment</p>			<p>Ongoing systems evaluation of implementation fidelity</p>
<p>Ongoing professional development &amp; celebration of successes</p>			

## II. School Behavioral Health Services Components

### A. *Readiness and Implementation*

#### 1. Community Readiness

It has been Utah's experience that the best way to promote and develop school behavioral health programs in the beginning is to adopt a bottom-up approach. After the community becomes more engaged in the development of these services, the top-down approach can be introduced to institutionalize and formalize the program through funding and policy development. Many of the successful school behavioral health programs in Utah are results of a well-thought-out community needs assessment and strategic planning process. All of them were initiated by champions who saw the benefit of providing behavioral health services at school settings. The initial champions could be from school districts, schools, or behavioral health providers. These initial champions found and/or nurtured the development of other champions from other collaborating systems. These champions form powerful teams to advance the school-based behavioral health agenda.

#### 2. Utah Behavioral Initiative

The Utah State Office of Education (USOE) receives funding from the Individuals with Disabilities Educational Improvement Act (IDEA) to develop and move forward Utah's Behavioral Initiative/Academics, Behavior, Coaching (UBI/ABC) to implement Positive Behavioral Interventions and Supports (PBIS) in Utah schools. UBI/ABC is a training platform that gives technical assistance with regards to the implementation of effective behavioral support systems in Utah schools. Adhering to behavioral research, UBI/ABC follows a school-wide model of prevention of problem behaviors and support of positive behaviors (PBIS). PBIS is a system approach designed to enhance the capacity of schools to educate all students by developing research-based, school-wide positive behavior supports to promote both increased academic and behavioral outcomes. An additional focus of UBI/ABC is to provide increased access to high-quality mental health care for Utah students struggling with mental and behavioral issues. This educational project UBI/ABC has worked to enhance the infrastructure at multiple levels: state, districts, and individual schools, to achieve integration of schools and mental health systems.

#### 3. Funding

Funding is a critical issue for the success and sustainability of school behavioral health services. It determines not just if the school services will be implemented and the scope of the services, but also which students will receive them. Medicaid covered school-based skills development services include:

- Evaluation and Assessment
- Motor Skills Development
- Communication Skills Development
- Nursing and Personal Services
- Behavioral Health Services
- Vision and Hearing Adaptation Services
- Information and Skills Training to Families

For additional detail, see Appendix 2.

Currently, Medicaid is the major funder of Utah's public mental health system and non-Medicaid-eligible populations have limited access to services. Although Utah's Legislature provides funding to expand services to non-Medicaid-eligible populations, the funding is very limited and the service slots are few compared to the community's needs. It is advised that the community examine existing funding streams and identify innovative strategies to braid funding or access other funding not traditionally tapped into by the public mental health system.

For those who are not covered by Medicaid, it may be possible to make arrangements with the local community mental health center to accept private insurance. If you have a private plan, it's important to understand the concept of parity. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was passed by Congress in October 2008. The measure requires covered employers that provide health plans to cover mental illness and substance abuse on the same basis as physical conditions. President George W. Bush signed it on October 3, 2008.

Originally, the mental health parity law was set to go into effect one year after enactment, with a different effective date for collective bargaining agreements. Congress deferred the effective date of the Act to January 2010 for plans that otherwise would have been covered in 2009. A more complete summary of the Mental Health Parity Act is in Appendix 3.

- a. Braided funding with school districts: Valley Mental Health partners with schools to establish school behavioral health services. The majority of the services are provided to Medicaid students. A couple of slots are set aside for non-Medicaid students in exchange for in-kind contributions from schools (e.g., office space, internet connection, phone usage, and other incidentals).
- b. Partnership with Intermountain Healthcare (IHC): VMH has established an agreement with IHC, a regional non-profit system of health care providers, to provide mental health services at approved school health clinics. IHC will reimburse VMH for mental health services provided at the school health clinics to students and their families with an IHC-approved insurance plan.

#### 4. Management Capacity/Staffing Pattern

For optimal effectiveness in service collaboration and delivery, it is recommended that liaisons be identified from school districts, schools, and behavioral health providers. School districts or school liaisons may come from Student Services or Special Education. The level of liaison's time dedicated to coordinating the school behavioral health program varies. It depends on the size and scope of the program and available resources. The larger or more complex the program, the more staff time is required for coordination. The coordination of the school behavioral health program should be an integral part of the functioning of the liaisons. Please see Appendix 4 for sample job descriptions/performance evaluations. (See also [www.mentalhealth.org](http://www.mentalhealth.org) for additional examples of documents ready for you to adapt to your program.)

For mental health providers, the liaisons can come from different disciplines: social worker, supervisor, team leader, clinician, case manager, etc. Most of Utah's community mental health/substance abuse centers employ family members or consumers as Family Resource Facilitators (FRFs) to assist families to navigate mental health and substance abuse systems and to access services. Many Centers have had success in assigning liaison duties to Family Resource Facilitators. Such arrangements greatly enhance the integration of family perspectives into the service planning and delivery.

## 5. Facility Design

In the initial development stage of school behavioral health programs, most schools contribute by providing office space, phone usage, and other incidentals for the program. It is critical to ensure that the area is private, secured for client privacy, and has a locked cabinet for records per HIPAA regulations. As the program becomes more advanced, there may be additional requirements for the facility, e.g., separate classroom, separate entrance to the classroom, etc. It is important to be flexible and work with the schools on the facility design with the provision that students and family privacy is protected. We need to be mindful that too much stipulation on the facility design may unnecessarily discourage schools and school districts from participating in the project.

### ***B. School, Local Authority, and Tribal Policies***

#### 1. School and Local Authority policies (See Appendix 5 to match school districts, including charter schools, with Local Authority Provider districts.)

Most of the school behavioral health programs in Utah are supported by collaborations at the local level. A few of them have contracts to formalize service mechanisms and funding streams. There are several rules and policies that influence the provision of school behavioral health services:

- a. The Utah State Office of Education (USOE) has Board Rule R277-609 that stipulates the four basic components of PBIS be incorporated into discipline policies for all districts, schools, and charter schools. This rule helped institutionalize the integration of behavioral health concepts into the school setting.
- b. The State Board of Education Special Education Rule 330-174 bans requiring a student to take any medication as a condition for attending school.
- c. The Utah Legislature passed House Bill 286 in 2007. HB 286, "School Discipline and Conduct," amended provisions of the State System of Public Education with regard to school discipline and conduct. This bill makes it unlawful for a school-age minor to engage in disruptive student behavior, and provides that a school-age minor who receives a habitual disruptive behavior citation is subject to the jurisdiction of the juvenile court. The bill also establishes the standards, procedures and administrative penalties for disruptive student behavior and makes it clear that the provisions apply to all schools, including charter schools<sup>1</sup>.
- d. The Utah Legislature passed House Bill 202 (also called the "Ritalin Bill") in 2007. The bill provided medical recommendations for children. Specifically,

**School personnel MAY:**

- Provide information and observations to a student’s parent about the student, including observations and concerns about the following:
  - Progress
  - Health and wellness
  - Social interactions
  - Behavior
  - Situations which exist that “present a serious threat to the well being of a student” [Section 53A-13-302(6)]
- Communicate information/observations between school personnel about a child.
- Refer students to appropriate school personnel/agents, consistent with local school board/charter school policy, including to a school counselor or other mental health professionals within the school system.
- Consult or use appropriate health care and mental health care professionals in emergency situations while students are at school, consistent with student emergency information provided at student enrollment.
- Complete a behavioral health evaluation form if requested by a student’s parent to provide information to a physician.

**School personnel SHALL:**

- Report suspected child abuse consistent with state law
- Comply with state and local health department laws, rules and policies
- Conduct student evaluations/assessments consistent with IDEA

Additional provisions can be found in Appendix 15.

2. Tribal Policy

Collaboration with tribes is critical in areas that have reservations and/or a significant American Indian population. It is important to recognize the sovereign status of tribes and develop collaboration accordingly. A consultation process or protocol can help formalize the communication with tribal entities. (See sample MOU in Appendix 6.)

***C. Staff Development***

1. Staff Roles, Functions and Training Requirements

In most cases, licensed mental health/substance abuse professionals and case managers are core staff for school behavioral health services. They must adhere to the state licensure requirements and code of ethics.

Basic professional competencies include:

- a. Knowledge of childhood behavioral disorders;
- b. Familiarity with children’s mental health and substance abuse systems;
- c. Knowledge of consumer rights and confidentiality\*, especially for minors;
- d. Understanding of basic psychiatric social work concepts and values;

- e. Knowledge of community resources;
- f. Ability to assess needs;
- g. Ability to craft and implement a service plan;
- h. Ability to accurately maintain records;
- i. Appropriate problem-solving skills;
- j. Ability to work cooperatively with other service providers, school personnel, other key stakeholders, and families;
- k. Ability to communicate well verbally and in written form; and
- l. Basic computer skills.

\* See also USOE document "FERPA and HIPAA" in Appendix 7 for additional guidance concerning confidentiality.

However, there are additional desirable staff competencies that will help promote program excellence:

- a. Working knowledge of Systems of Care philosophy and principles, including family-driven and youth-guided care, and cultural competency;
- b. Knowledge in early identification and early intervention of behavioral disorders;
- c. Knowledge of transition-into-adulthood issues when working in a high school setting;
- d. Familiarity with contemporary youth and family cultures;
- e. Working knowledge of special education classifications and disabilities;
- f. Ability to advocate for consumer rights; and
- g. Ability to assist consumers in developing a range of social supports in the community.
- h. Knowledge, understanding and implementation of Evidence-Based Practices (See Appendix 8 for excerpt from NAMI publication "Choosing the Right Treatment: What Families Need to Know About Evidence-Based Practices.")

## 2. Supervision and Consultation

It is recommended that the therapists and case managers working in SBH programs receive regular supervision. If one-on-one supervision is not possible, group supervision is a viable alternative. SBH staff should have access to consultation from various disciplines, including psychiatrists, psychologists, physicians, social workers, educators, family advocates and youth advocates. Family and youth advocates assist SBH to be sensitive to family and youth cultures, and to be grounded in family and youth development approaches. The State SBH TA Team is also available to provide coaching / implementation support upon request.

### ***D. Program Awareness***

#### 1. Marketing your SBH services to stakeholders

Marketing is critical in garnering community and school support in SBH programs. Community and schools thus engage in actions that support, strengthen, and expand SBH programs. It is recommended that in the beginning of the school year, behavioral health liaisons meet with school faculty members to explain about the SBH services and the benefits they have on school environments and student learning. The behavioral health liaison may approach individual teachers to assist them to better understand the SBH program.

Important community stakeholders should be briefed as well. These include school boards, leaders of youth-serving agencies, the faith community, and the media. Making them aware of the SBH services and the rationale behind them will decrease stigma and increase support. Marketing techniques may include flyers about SBH programs at different community events such as fairs and community gatherings, newsletter/newspaper articles, short presentations at meetings of sister agencies, etc.

## 2. Outreach to students, family

Outreach helps educate families on SBH services and encourages them to utilize the services appropriately. However, the SBH program needs to be aware of the different laws and rules that impact the discussion of medication and mental health issues in school or classroom settings. Please refer to Section II-B for specific laws and rules that are relevant to SBH services. If the behavioral health liaison is part of the school team and attends staff meeting, he/she can receive information about the specific student and/or family. However, there should be no individualized outreach unless families or guardians provide their consent.

It is appropriate to send flyers home regarding the availability of SBH services. Flyers should be sensitive to the different cultural and linguistic backgrounds of the students and their families. See sample flyer in Appendix 9. Other outreach strategies may include working with FRFs, holding meetings (with food) about the program at school and other settings.

### ***E. Internal Referral Process***

#### 1. Referral

Referrals usually come in through several sources: 1) self referral from students or families; 2) teachers or school personnel; 3) pediatricians; 4) court or law enforcement; and 5) school-wide screening. The School Team convenes to assess the reason for referrals and the next step for action. Actions may include: 1) enhancing existing school support services; 2) with parental consent, referral for evaluation for special education; 3) referral to Family Resource Facilitators to access community supports; and 4) with parental consent, referral for mental health and/or substance abuse assessment. It is recommended that a liaison from the behavioral health provider be part of the school support team to ensure that behavioral health issues receive adequate attention. Sample referral forms can be found in Appendix 10.

#### 2. Screening and Assessment

School behavioral health (SBH) helps students who struggle behaviorally, emotionally, or academically and who might benefit from mental health or substance abuse treatment. It is effective when the student is identified early and intervention is provided. Screening is essential to ensure that SBH services are *preventative and proactive*.

**BASIC:** Brief faculty training on some of the signs and symptoms of common child behavioral health issues can be extremely helpful in identifying students who may be in need of services. Fact sheets produced by the Minnesota Association for Children's Mental Health can be an important part of such training. The sheets summarize 10 common issues in childhood mental health which school personnel may encounter. They include a summary of each condition, signs/symptoms which teachers may observe in the classroom, possible

intervention strategies, how to document concerns, and suggested next steps. A complete set of these fact sheets can be found in Appendix 11.

**ADVANCED:** The most well-known and researched multiple-gating system is Walker and Severson's (1990) Systematic Screening for Behavioral Disorders (SSBD). It has been found to be particularly helpful in identifying students with internalizing disorders such as depression, anxiety, or suicidal ideation. Utah Behavioral Initiative pilot schools defined a process for screening all students using the SSBD. (See additional detail on the SSBD in Appendix 12.) Many other fields have well-established universal screening practices to identify problems early on that provide effective treatment or supports before the problems develop into more serious conditions or disorders. Utah law mandates that parental consent be obtained if screening is provided to selected students. If the initial screening reveals elevated behavioral health risk for certain students, secondary assessment can be conducted with parental consent. Additionally, students will receive evaluation for special Education and an Individualized Education Plan (IEP) will be developed.

A more in-depth discussion of the ramifications of screening can be found in the article "Mental Health Screening in Schools" in Appendix 13. (An additional resource: "Screening and Assessing Immigrant and Refugee Youth in School-Based Mental Health Programs" by Birman, D. and Chan, W.Y. published May 2008 by The Center for Health and Health Care in Schools, The George Washington University.)

### 3. Student Eligibility/Admission Criteria

Utah's Community Mental Health/Substance Abuse Centers are Medicaid providers and provide Medicaid-eligible behavioral health services to students and families with Medicaid coverage. (See Appendix 2 for covered services.) Services for the non-Medicaid students (including those with private insurance or no insurance at all) are more limited due to the limited funding sources. Case managers and/or Family Resource Facilitators can help students and their families to apply for Medicaid. Non-Medicaid families can access SBH services through school-funded slots, in-kind slots from behavioral health providers, or other local funding. At a minimum, it is strongly recommended that behavioral health providers provide consultation and referral services for non-Medicaid students and their families.

### 4. Parental Consent

As minors, students under 18 years of age need parental consent for individualized screening, assessment, and treatment. When school staff identifies students in need of behavioral health services, it is recommended that the school social worker or other student services personnel make outreach to the parent or guardian of the student, inform them of school's concerns for the student, and request their consent for further screening and assessment. Sample parental permission forms can be found in Appendix 14.

### 5. Pathway Into Care

Based on the System of Care principles listed in Appendix 1, the process outlined below would be the optimal way for services to be delivered. However, we realize that circumstances may dictate other processes for collaboration and communication in your local area.

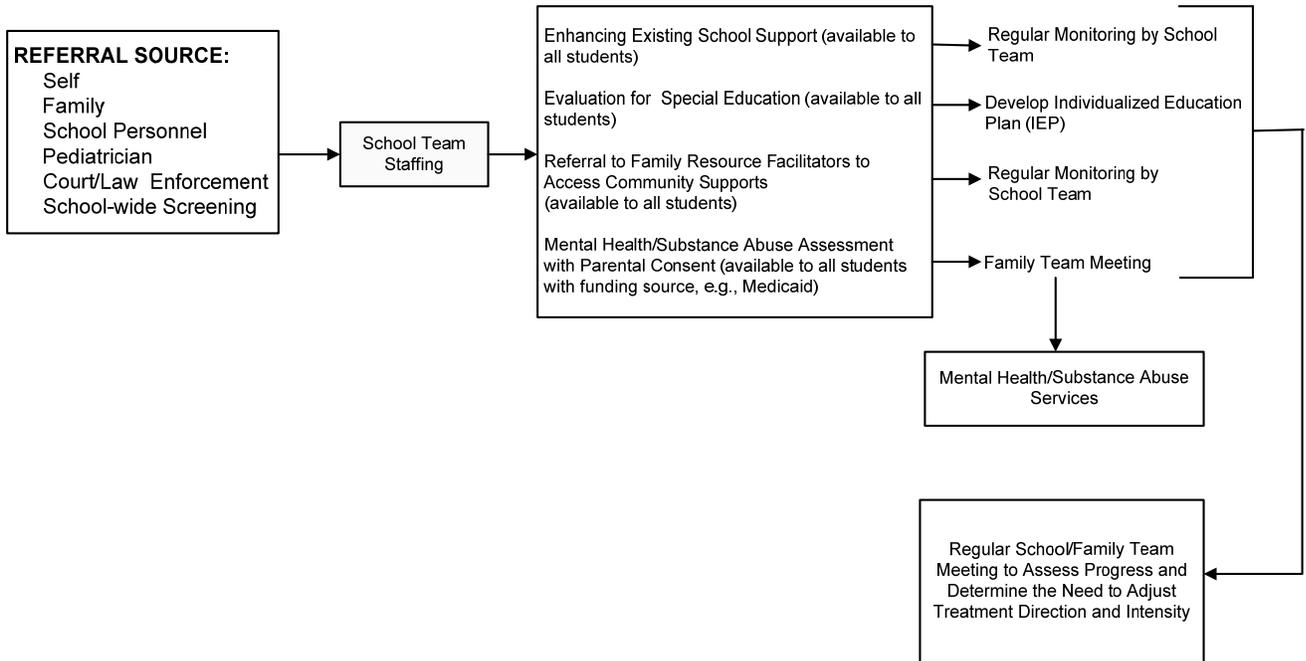
If the mental health and/or substance abuse assessment indicates a need for behavioral health interventions, a student team meeting will be convened. The family identifies and invites the people they feel important to be involved in their child's services to attend the family team meeting. They may include family members, friends, informal support, school personnel, health provider, and other child-serving systems. In family team meetings, the family is an active partner in the shared decision-making process. Families are engaged and supported in the case planning and service delivery process. A treatment plan will be developed during the family team meetings, and the meeting will be held regularly to assess student progress and reassess treatment direction. It is critical to ensure that the level of treatment is appropriate for the student and family's needs and they are not over- or under-treated. (See "Pathway Into Care" diagram below.)

Again, we think the Systems of Care Model is the ideal, and is worth recommending even though practical considerations may not allow for it in all areas of the state. But we encourage as similar a process as is feasible.

If additional structure and support is indicated, students may be referred to a higher level of behavioral health services. They include day treatment, residential, treatment program, respite, medication management, and intensive case management. Medication Management must be done by a qualified professional such as an MD (psychiatrist, pediatrician, etc.), a physician's assistant, or an APRN (Advanced Practice Registered Nurse).

See also USOE document "Medical And Mental Health Recommendations: What School Employees Can and Cannot Do" in Appendix 15 for more detailed guidance at each stage of this process.

**Pathway Into Care  
School-based Behavioral Health Services**



## ***F. Interdisciplinary Teams***

An Interdisciplinary Team brings expertise from various sectors and professional disciplines to help formulate the best recommendation for students who will receive behavioral health services in a schools. Additional benefits of the team approach include determining the funding source of the recommended services and the sharing of the responsibilities and the risks. If the recommendation originates from the team, no single agency can be held responsible for the cost of services.

School district teams *could* include:

1. Special Ed
2. Regular Ed
3. Student Services
4. Title I
5. Principal
6. PBIS representative, if appropriate
7. Safe & Drug-Free Schools Coordinator
8. SBH Coordinator, if there is one
9. School Social Worker, if there is one (probably only in large districts)
10. Title VII, where appropriate
11. Local community mental health/substance abuse center Prevention Coordinator, Children's Services Director, or designee
12. Division of Child & Family Services, where appropriate
13. Division of Juvenile Justice Services, where appropriate
14. Family Resource Facilitator or other family advocate

Local school team *should* include:

1. Special Ed
2. Student Services provider (school counselor, school psychologist, or school social worker)
3. Principal
4. Resource Officer
5. Family representative, such as Family Resource Facilitator, who has been invited by parent
6. Interpreter, where appropriate

## ***G. Direct Services to Children and Students***

1. Behavioral Health Assessment
  - a. Assessment should be done by the licensed behavioral health professionals, who usually are from the local community mental health/substance abuse centers.
  - b. Assessment should incorporate information from previous testing and/or assessment to avoid duplication. It is critical that the teams at the school district and local school levels develop a process to share testing and assessment information to avoid unnecessary retesting and reassessment.
  - c. It is highly recommended that each student and family receiving SBH services be trained to create their own behavioral health file. "My Profile" is a record of information that students and their families deem important and relevant for their mental health and substance abuse care. The information is provided by the consumer, written in the

- language that reflects the consumer preference, and genuinely owned by consumer (see Appendix 16). “My Profile” ensures family and youth engagement in the assessment process and provides authentic consumer input. It should be regularly updated by consumers.
- d. The Medical Home website has on-line tutorials and resources to help students and families to organize the student’s health information and developmental history. This will help students and their families become more effective partners with service providers. The tutorial is available from <http://medicalhome.org/families/paperwork.cfm>.

## 2. Treatment Planning

### a. Person-Centered Planning

Since 2007, Utah Division of Substance Abuse and Mental Health (DSAMH) has actively promoted a person-centered planning process. Person-centered planning is driven by the hopes and dreams of students and their families. Barriers to their goals and the interventions are identified and spelled out in the written plan to facilitate actions by the behavioral health providers, students and their families. Person-centered planning empowers students and their families to direct treatment efforts in achieving their own goals. DSAMH has chosen to promote the Adams/Grieder model (endorsed by federal Substance Abuse and Mental Health Services Administration) as described in the book *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery*.<sup>2</sup> Components of the person-centered plan can be found in Appendix 17.

### b. Crisis and Safety Planning

Most of the time, one can predict and prevent crisis; however, crisis does happen. The best service plan still cannot prevent some crises from happening. One can begin crisis management by predicting the worst-case scenario. This should be done with the student's team, including family, participating.

Purposes of the crisis plan are:

- i. Mitigation and Prevention – The plan first identifies what to do to reduce or eliminate risk for a crisis situation.
- ii. Preparedness and Advance Planning – Everyone knows what he/she and others will do to manage crisis.
- iii. Response – Response should be given quickly and efficiently.
- iv. Recovery – The plan addresses how to restore the normal environment, and the possibility for growth after a crisis.

A good crisis plan should:

- i. Be regularly reviewed, updated, and practiced.
- ii. Determine what crisis the plan will address.
- iii. Identify risk and protective factors.
- iv. Describe intervention, identify rules and management strategies (including self management).
- v. Teach skills to implement the plan.

- vi. Use a team approach and be developed in partnership.
- vii. Establish clear lines of communication.
- viii. Define roles and responsibilities.
- ix. Use terminology that is understood by all involved, including students and their families.
- x. Identify necessary resources needed.
- xi. Allow for flexibility.

Sample crisis plans can be found in Appendix 18.

### c. Transition Planning

Mental health and substance abuse intervention should consider two types of transition issues:

- i. Transition between placements/settings:
  - This includes students advancing from elementary to junior high, junior high to senior high, and transitioning between specialized and general classrooms. Special attention should be paid to ensure that the receiving school / placement is ready to receive and the local school team is in place. As much as possible, the therapist should be kept the same through transitioning. This helps reduce the stresses often associated with transitioning experiences.
  - It would also include transitions back and forth, e.g., between outpatient care, juvenile services and foster care, hospitalization etc. While critical, these are frequently handled very poorly. Improved communication and increased collaboration with all involved can make a huge difference. A joint release of information may be necessary to allow appropriate parties to have access to needed data about the student to ensure seamless services.
- ii. Transition from School to Post School / Transition-into-Adulthood: Individuals with Disability Education Act (IDEA) defines “transition services” as a coordinated set of activities for a child with a disability that<sup>3</sup>:
  - Is designed to be within a results-oriented process, that is focused on improving the academic and functional achievement of the child with a disability to facilitate the child’s movement from school to post-school activities, including postsecondary education, vocational education, integrated employment (including supported employment); continuing and adult education, adult services, independent living, or community participation;
  - Is based on the individual child’s needs, taking into account the child’s strengths, preferences, and interests; and
  - Includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, if appropriate, acquisition of daily living skills and functional vocational evaluation.

For the student who is 16 and over, the behavioral health treatment planning should integrate the transition goals in the student/child’s Individualized Education Plan (IEP). An SEOP (Student Education/Occupation Plan) is in place for all students from junior high onward.

### 3. Treatment Intervention

#### a. Strength-Based Approach

Rather than focusing on "what's wrong," a strength-based approach identifies the talents, knowledge, and abilities that children and families have, in addition to their unmet needs. Strengths are a family's source of power, will, character, purpose, values, and toughness that give them the capability of generating a reaction of effect and change<sup>4</sup>. The approach recognizes that students and families are active participants in the helping process. Strengths can be internal (e.g., talents) or environmental (e.g., resources). Professionals and other team members partner with students and their families to identify desired outcomes and a plan of action to reach those outcomes.

#### b. Family and Peer Support

Treatment plan should identify natural and informal supports that are important to students and families. As much as possible, utilize allied youth-serving agencies and other community resources. These may include organizations such as Boys & Girls Club or local YWCA.

#### c. Cultural Competency

All services must take into account the student and family's language preference, cultural backgrounds, values and beliefs, and other socioeconomic diversities including disability, sexual orientation, age, gender, and socio-economic status. Professional linguistic assistance should be provided at no cost to the family. Other family members, especially the children, should not be used to interpret, unless it is preferred by students and the families and is deemed appropriate for the intervention.

The school team should be aware of the student and family's immigration status (e.g., refugees). Some families may be reluctant to request/receive services for fear of deportation or losing welfare benefits. For example, current immigration policy gives the federal government the right to detain or deport aliens (immigrants or refugees) when they violate certain immigration or criminal laws. Once deported, an alien may lose the right to ever return to the United States, even as a visitor. The concern for deportation may discourage immigrants/refugees from reporting crimes, e.g., domestic violence. Additionally, immigrants or refugees may experience the types of trauma that are not common for America-born children and youth. The trauma they experience may include war, fleeing home, and refugee camps, etc. The local school team should examine the trauma issue in depth so an appropriate treatment plan can be developed. Treatment intervention should also incorporate culturally appropriate and specific natural support systems.

Each public community mental health center has a designated Cultural Competency Coordinator. Some of these coordinators have received training in the *California Brief Multicultural Competence Scale* (CBMCS), which is an evidence-based practice. More information can be obtained by contacting your local coordinator.

## ***H. Integration with Other School-based Programs***

School programs should use a team approach and Systems of Care principles to early identify, refer, and treat students in need of holistic services, including behavioral health. A system of care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations to design behavioral health services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. A system of care helps children, youth and families function better at home, in school, in the community and throughout life<sup>5</sup>. In 2003, the President's New Freedom Commission on Mental Health further recommended that schools should have the ability to play a larger role in mental health care for children and that such programs improve educational outcomes<sup>6</sup>.

Adopting the team approach and the Systems of Care principles, school behavioral health programs should collaborate with other school programs including:

- a. UBI/ABC (Positive Behavioral Interventions and Supports)
- b. Community of Caring
- c. Character Ed
- d. Prevention Dimensions
- e. Youth in Custody
- f. Peer Court/Drug Court/Mental Health Court
- g. Truancy Mediation
- h. School Primary Care Clinic
- i. School Afterschool/Childcare Programs

The benefits of collaboration are significant. It can help improve awareness on behavioral health issues, enhance communication with program staff, resolve turf issues, prevent unnecessary duplication, increase referrals, and provide additional supports or resources.

## ***I. Cooperation and Collaboration with Other Agencies and Resources***

### **1. Community Partnership Development**

To reduce the redundancy of existing efforts, the program should identify community groups that are already meeting (e.g., Local Interagency Council, Prevention Advisory Council). Usually, these community partnerships already involve other child-serving agencies, such as DCFS, JJS, DSPD, USOE. Special attention should be paid to youth and family representation. Youth and family representation can come from:

- a. Family Advocacy Organizations (e.g., Allies with Families, NAMI, New Frontiers for Families, and Utah Parent Center)
- b. Faith-based Organizations (e.g., Catholic Community Services, LDS Family Services, and Local Interfaith Councils)

- c. Charitable Organizations (e.g., United Way)
- d. Boys & Girls Clubs
- e. Business Community
- f. Healthcare Providers

## 2. Collaboration with Behavioral Health Service Providers

Providers include local community mental health and substance abuse centers and private providers. Many community mental health center providers only accept Medicaid-eligible cases. This limitation may present a barrier to collaboration. However, most community mental health centers can provide consultation and facilitate referrals for non-Medicaid students/families. All Utah community mental health centers employ Family Resource Facilitators (FRF) to assist with referrals to a variety of community supports. If families are Medicaid-eligible, but have not previously applied for services, FRFs can assist in the application process. They can also provide information about other appropriate community services.

## 3. Collaboration with Non-Mental Health Service Providers

The non-mental health providers include:

- a. Children's Justice Centers
- b. Employment
- c. Housing
- d. Social/recreational service providers
- e. Boys & Girls Clubs
- f. Big Brothers/Big Sisters.

## 4. State and Local Collaboration

The State can play a supportive role to facilitate the development of local services. It can also provide technical assistance and monitoring for quality improvement. The State may also be able to provide "the big picture" and identify how local programs fit into it. Local programs can inform the state of any implementation barriers and possible policy issues which need to be addressed.

## 5. Tribal Collaboration

Collaboration with tribes is critical in areas that have reservations and/or significant American Indian population. It is important to recognize the sovereign status of tribes and develop collaboration accordingly. A consultation process or protocol can help formalize the communication with tribal entities.

# **J. *Program Evaluation/Sustainability***

## 1. Evaluation Design

As with any new initiative, we strongly encourage evaluation to learn what is working well, and what might be improved within your particular school setting. Those schools that are implementing UBI/PBIS have access to SET (School Evaluation Tool.) For others, evaluations may be designed by the team based on the information that they deem most valuable to collect.

The National Assembly on School-Based Health Care has identified "10 Critical Factors to Advancing School Mental Health: What Early Adopters Say." This article can be found in Appendix 23, and suggests several areas of infrastructure, policies, and supports which could be measured in your own SBH program process.

For more sophisticated evaluation schemes, we recommend Part III: Policy and Evaluation in Transforming School Mental Health Services by Doll & Cummings. Chapters 10-12 contain a thorough explanation of *Comprehensive Mixed Methods Participatory Evaluation (CMMPE)*. Table 10.3 suggests evaluation questions to measure the dimensions of acceptability, social validity, integrity, outcomes, sustainability, and institutionalization.

## 2. Outcome Measures

Evaluation data can help schools and behavioral health providers to determine the effectiveness of their services, modify them if indicated, and enhance community support for the program. However, the evaluation data should be meaningful to the schools, behavioral health providers and the community; and not be a burden to staff, students and families.

Utah's community mental health/substance abuse centers use the YOQ (Youth Outcome Questionnaire) -- see information in Appendix 19 -- to track treatment progress and individual functioning outcomes. Some schools use Student Outcome Trackers (see Appendix 20). Other relevant outcome measures include individual student educational outcome data, such as GPA (Grade Point Average), ODR (Office Disciplinary Referrals), Safe School violations, attendance/suspensions, CBM (Curriculum-Based Measures), CRT (Criteria Reference Test), and IDEA (Individuals with Disability Education Act) qualification.

## 3. Client Satisfaction

Utah's community mental health/substance abuse centers use the Youth Satisfaction Survey and the Family Satisfaction Survey to assess levels of satisfaction with the services they provide. Copies of these may be found in Appendix 21.

## 4. Quality Improvement

Quality improvement is a systematic process for determining whether services are meeting customer needs and expectations. The process includes the implementation of ongoing program evaluation and appropriate outcome measures.

A number of very useful quality assessment and quality improvement resources have been developed by the University of Maryland Center for School Mental Health (CSMH) as part of a federally funded, practice-based research project. The following materials can be accessed at <http://www.schoolmentalhealth.org/Resources/Clin/QAIRsrc/QAI>

- a. World Health Organization has created a school environment inventory: The Psycho-Social Environment Profile (World Health Organization, 2003).
- b. Enhancing Quality in Expanded School Mental Health: A Resource Guide  
This guide provides a literature review and includes a listing of resources and references for each of 40 quality indicators for SBH programs. It can be utilized to enhance understanding of each of the indicators.
- c. Helping America's Youth (HAY) Program Tool:  
Helping America's Youth is national initiative which aims to raise awareness about the challenges facing our youth, particularly at-risk boys, and to motivate caring adults to connect with youth in three key areas: family, school, and community.
- d. Mental Health Planning and Evaluation Template (MHPET):  
The MHPET was developed to systematically assess and improve the quality of mental health services delivered within school-based settings.
- e. The School Mental Health Quality Assessment Questionnaire (Weist et al., 2006) is a research-based measure designed to help clinicians, administrators, and others invested in school mental health to assess strengths and weaknesses within their school mental health services and programming. Findings from the SMHQAQ can assist in identifying priority areas for improving school mental health services.
- f. The SMHQAQ Quality Indicator PowerPoints accompany the SMHQAQ, providing the following resources for each indicator: background, menu of suggested activities, helpful hints, web resources, and references.
- g. Ten-Step Action Planning Guide for Quality Improvement in School Mental Health provides a step-by-step framework for effectively advancing the quality of mental health services and programming within a school or district.
- h. The School Mental Health Quality Improvement Action Plan Worksheet complements the Ten-Step Action Planning Guide and can be used by teams to develop mental health action plans for their school.

## 5. Sustainability, including funding

Outcome measure data is critical to maintaining current funding and securing additional funding. With good data demonstrating clinical improvement, increased academic achievement, and cost effectiveness, several financing strategies are viable.

- Identify financing structures\*/*Waivers using existing organizations*
  - Braiding, blending, or fund pools: Breaking the lock of agency ownership of funds
  - Fiscal incentives: Rewarding community-based services
- Refinancing/*Generating new money by increasing federal claims*
  - The commitment to reinvest funds for families and children
  - Medicaid (Title XIX), Foster Care and Adoption Assistance (Title IV-E)
- Redeployment/*Using the money you already have*
  - Shifting funds from residential or hospital care to community-based care
  - Shifting funds from treatment to prevention
- Raising New Funds/*New targeted taxes*
  - "Millionaire's Tax": California's Proposition 63 (Mental Health Services Act) was a 2004 initiative that levied an additional 1 percent state tax on incomes

of \$1 million or greater to fund a range of prevention, early intervention and other service needs.<sup>7</sup>

\*See Appendix 22 – "Examples of Behavioral Health Funding to Purchase Mental Health Services for Children and their Families."

In addition to the examples in Appendix 22, it's also important to explore local funding sources, such as:

- a. County discretionary funds for non-funded populations
- b. Safe and Drug-Free School Coordinators
- c. Title I
- d. Monies from At-Risk and Safe Schools Violation Assessments

**Note to all readers:**

This manual was conceived and developed to provide a starting point for those schools and community mental health and substance abuse centers who are interested in initiating school-based services. We see the manual as a work in progress. We encourage you to provide your input. Lessons learned from implementation in the field will help improve the quality of Utah's school behavioral health services. Please email your input (corrections/suggestions/lessons learned) to [dsamhwebmaster@utah.gov](mailto:dsamhwebmaster@utah.gov) or (USOE equivalent here).

## References

- Doll, B., & Cummings, J. (2008). *Transforming School Mental Health Services*. Thousand Oaks: Sage Publications.
- Evans, S., Weist, M., & and Serpell, Z. N. (2007). *Advances in School Based Mental Health Interventions Vol. 2*. New York: Civic Research Press.
- Fox, L., & Smith, B. (2007). *Promoting Social, Emotional and Behavioral Outcomes of Young Children Served Under IDEA*. Center on the Social and Emotional Foundations for Early Learning Technical Assistance Center: [www.vanderbilt.edu/csefel/](http://www.vanderbilt.edu/csefel/) ; [www.challengingbehavior.org](http://www.challengingbehavior.org) .
- Judge David L. Bazelon Center for Mental Health Law. (2006). *Way To Go: School Success for Children With Mental Health Care Needs*. Washington, DC.
- Kutash, K., Duchnowski, A. J., & Lynn, N. (2006). *School mental health: An empirical guide for decision-makers*. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Dept of Child & Family Studies, Research & Training Center for Children's Mental Health.
- Rapport, L. J., & Robinson, K. E. (2002). Outcomes of a School mental health program for referred youth. *Psychology in the Schools* .
- Robinson, K. E. (2004). *Advances in School Mental Health: Best Practices & Program Models*. New York: Civic Research Institute.
- Robinson, K. E., & Rapport, L. J. (2002). Outcomes of a School mental health program for referred youth. *Psychology in the Schools* .
- Robinson, K. (2008). Providing mental health services in public schools: A model in Salt Lake County. *The Utah Special Educator*, vol 29(2) , 68-69.
- Sopko, K. (2009). *Early Childhood Mental Health Services: Four State Case Studies*. Alexandria, VA: National Association of State Directors of Special Education.
- Sprague, J., Cook, C. R., Wright, D. B., & Sadler, C. (2008). *RTI and Behavior: A Guide to Integrating Behavioral and Academic Supports*. Horsham, PA: LRP.
- Utah State Office of Education. (2008). *Least Restrictive Behavioral Interventions (LRBI) Guidelines*. Salt Lake City: Utah State Office of Education.
- Utah State Office of Education. (2007). *Utah Special Education Rules*. Salt Lake City: Utah State Office of Education.

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<sup>1</sup> Retrieved from [http://webster.utahbar.org/barjournal/2007/07/noteworthy\\_laws\\_passed\\_during.html](http://webster.utahbar.org/barjournal/2007/07/noteworthy_laws_passed_during.html) on February 21, 2010

<sup>2</sup> 2007 Annual Report, Utah Division of Substance Abuse and Mental Health, p. 1, retrieved from [http://www.dsamh.utah.gov/docs/2007\\_annual\\_report\\_for\\_web.pdf](http://www.dsamh.utah.gov/docs/2007_annual_report_for_web.pdf) on February 10, 2010.

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<sup>3</sup> U.S. Department of Education, retrieved from <http://idea.ed.gov/explore/view/p/%2Croot%2Cdynamic%2CTopicalBrief%2C17%2C> on February 10, 2010

<sup>4</sup> 2007 Annual Report, Utah Division of Substance Abuse and Mental Health, p. 2, retrieved from [http://www.dsamh.utah.gov/docs/2007\\_annual\\_report\\_for\\_web.pdf](http://www.dsamh.utah.gov/docs/2007_annual_report_for_web.pdf) on February 10, 2010.

<sup>5</sup> Substance Abuse and Mental Health Services Administration (SAMHSA) Systems of Care website, retrieved from <http://systemsofcare.samhsa.gov/> on February 16, 2010

<sup>6</sup> 2003, The President's New Freedom Commissioner on Mental Health, p. 62

<sup>7</sup> Wotring, Jim; Brown, Claudia; Ingoglia, Charles; "Strategic Financing for Sustainability"; presented at SAMHSA's Healthy Transitions Initiative Grant Community Policy Meeting; April 13, 2010.

Appendix 1.  
**System of Care Principles**

## Guiding Principles Systems of Care \*

**The following represent the ten foundational principles of the system of care philosophy<sup>1</sup>:**

1. Children with emotional disturbances should have access to a comprehensive array of services that address their physical, emotional, social, and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potential of each child and guided by an individualized service plan.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult services system as they reach maturity.
9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and adolescents with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

<sup>1</sup> Stroul, B., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (Rev. ed.) Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. Reprinted.

\* Downloaded 4-1-10 from <http://www.tapartnership.org/SOC/SOCprinciples.php>

Appendix 2.  
**Medicaid School-based Skills Development Services**

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996 Updated December 1996</b>

## Section 2

### School-Based Skills Development Services

#### Table of Contents

1	SERVICES .....	2
	1 - 1 Authority .....	2
	1 - 2 Definitions .....	2
	1 - 3 Target Group .....	4
	1 - 4 Provider Qualifications .....	4
	1 - 5 Individual Qualifications by Service Setting .....	4
	1 - 6 Service Standards .....	6
	1 - 7 Client Rights .....	6
2	SCOPE OF SERVICES .....	6
	2 - 1 Covered Services .....	6
	2 - 2 Non-Covered Services/Activities .....	8
	2 - 3 Service Coordination .....	8
3	SERVICE PAYMENT .....	9
	3 - 1 Standards Applicable to All School District Providers .....	9
	3 - 2 Required Information for Rate Setting .....	9
	3 - 3 Claims Processing .....	10
4	RECORD KEEPING .....	11
	4 - 1 Required Documentation; Self-Contained Settings .....	11
	4 - 2 Required Documentation; Itinerant Settings .....	11

#### TIME STUDY FOR SELF-CONTAINED SETTINGS

Instructions for Completing the School-Based Skills Development Time Study

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996 Updated December 1996</b>

## 1 SERVICES

School-based skills development services are *medically necessary* diagnostic, preventive and treatment services identified as "related services" in an eligible student's Individualized Educational Plan (IEP) and include therapeutic interventions designed to ameliorate motor impairments, sensory loss, communication deficits or psycho-social impairments. The goal of school-based skills development services is to improve and enhance a student's health and functional abilities and/or to prevent further deterioration.

### 1 - 1 Authority

The Medicare Catastrophic Coverage Act of 1988, Section 411(k)(12) permits Medicaid to pay for related services included in a Medicaid eligible recipient's IEP when the services are medically necessary and are covered in the Medicaid State Plan. Effective August 1, 1993, with the approval of the federal Health Care Financing Administration, Utah's Medicaid State Plan was amended to allow coverage of medically necessary services included in the IEPs of Medicaid eligible children ages 2 through 20.

### 1 - 2 Definitions

The following definitions apply to this program:

**CHEC:** Child Health Evaluation and Care; Utah's version of the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program designed to ensure Medicaid eligible recipients from birth through age twenty access needed medical care.

**Consortium of School Districts:** Multiple school districts enrolled with the Division of Health Care Financing (the Medicaid agency) under a single provider application/agreement and reimbursed under a single contract for the provision of school-based skills development services.

**Individualized Education Program (IEP):** A written program for a student with a disability, developed and implemented in accordance with the Utah State Board of Education *Special Education Rules*.

**Qualified Mental Retardation Professional (QMRP):** As defined at 42CFR 483.430, Qualified Mental Retardation Professional (QMRP) means a person who has at least one year of experience working **directly** with persons with mental retardation or other developmental disabilities and is one of the following:

- A. A doctor of medicine or osteopathy.
- B. A registered nurse.
- C. An individual who holds at least a bachelor's degree in one of the following professional categories and is licensed, certified or registered, as applicable, to provide professional services by the State in which he or she practices. Professional program staff who do not fall under the jurisdiction of State licensure, certification, or registration requirements must meet the following qualifications:
  1. To be designated as an occupational therapist, an individual must be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996 Updated December 1996</b>

2. To be designated as an occupational therapy assistant, an individual must be eligible for certification as a certified occupational therapy assistant by the American Occupational Therapy Association or another comparable body.
3. To be designated as a physical therapist, an individual must be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
4. To be designated a psychologist, an individual must have at least a master's degree in psychology from an accredited school.
5. To be designated as a social worker, an individual must meet one of the following two criteria:
  - a. Hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or
  - b. Hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.
6. To be designated as a speech language pathologist or audiologist, an individual must meet one of the following two criteria:
  - a. Be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American-Speech-Language-Hearing Association or another comparable body; or
  - b. Meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996 Updated December 1996</b>

7. To be designated as a professional recreation staff member, an individual must have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.
8. To be designated as a professional dietician, an individual must be eligible for registration by the American Dietetics Association.
9. To be designated as a human services professional an individual must have at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

**Providers:** In this manual, providers are enrolled school districts.

**Related Services:** Developmental, corrective and other supportive services required to assist a student with a disability to benefit from special education. Not all related services identified in the Individuals with Disabilities Education Act (IDEA), Part B Regulations, Section 300.16 are considered "medically necessary services."

**Special Education:** Instruction which is specially designed to meet the unique needs of a student with a disability.

**1 - 5 Individual Qualifications by Service Setting**

- A. Enrolled school districts (hereafter referred to as providers) must employ or contract with qualified

**1 - 3 Target Group**

Medicaid coverage of school-based skills development services is limited to CHEC eligible students ages 2 through 20 who receive medically necessary services under an IEP from a qualified provider.

**1 - 4 Provider Qualifications**

School districts or consortiums of school districts that provide special education and related services under Part B of the Individuals with Disabilities Education Act (IDEA) may request enrollment through the Division of Health Care Financing to receive Medicaid funding for school-based skills development services.

individuals to directly deliver or supervise the delivery of school-based skills development services. Individual qualifications vary according to the type of setting where services are delivered.

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996 Updated December 1996</b>

- B. Medicaid reimbursement is available for school-based skills development services provided in:
1. *Self-contained settings* designed to meet the unique needs of a specific population of students with significant disabilities. Students in such settings receive one or more skills development services on a daily basis. For purposes of this program, self-contained settings include special purpose day schools, self-contained classrooms in regular schools (including preschool programs) and self-contained resource rooms; and/or
  2. *Itinerant settings* including, but not limited to, regular classrooms, non-self-contained resource rooms, the child's residence or other non-self-contained settings where school districts provide special education and related services. Students in these settings do not necessarily receive skills development services on a daily basis.
- C. The matrix on the following page shows, by service setting, the licensure, certification or other credentials required to deliver or to supervise the delivery of Medicaid covered school-based skills development services described in Chapter 2 - 1, Covered Services, of this manual.

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996 Updated December 1996</b>

**Licensure, Certification or Other Credentials Required**

<b>** LICENSED ↓</b>	<b>SETTING</b>				<b>* AUTHORIZED TO DELIVER AND SUPERVISE ↓</b>
	<b>Itinerant Settings</b>	<b>All Self Contained Settings</b>	<b>Self Cont. Settings for Individuals with Devel. Disabilities/ Mental Retardation</b>	<b>Preschools</b>	
physician	x	x	x	x	all services
R. N.	x	x	x	x	motor, nursing
mental health practitioner	x	x	x	x	behavioral health
speech/language pathologist	x	x	x	x	communication
audiologist	x	x	x	x	vision & hearing. adaptation services
physical therapist	x	x	x	x	motor
occupational therapist	x	x	x	x	motor, personal
<b>***CERTIFIED ↓</b>					
educational psych.	x	x	x	x	behavioral health
school psychologist	x	x	x	x	
school social worker	x	x	x	x	
school counselor	x	x	x	x	
school speech/ language therapist	x	x	x	x	communication
school vision & hearing specialist	x	x	x	x	vision & hearing adaptation services
<b>**** OTHER ↓</b>					
<b>Qualified Mental Retardation Professional (QMRP)</b>			x	x	motor, communication, personal, vision and hearing

- \* Authorization also covers evaluation, assessment and provision of information and skills training to families.
- \*\* Practicing within the scope of their license in accordance with Title 58, Occupational and Professional Licensing, Utah Code Annotated, 1953 as amended.
- \*\*\* Practicing in accordance with the Utah State Office of Education Requirements for Certification, revised 7/1/93 as amended; or (as applicable) practicing in accordance with the Utah State Office of Education Rules, Appendix D, State Certification and Endorsements, May 1993.
- \*\*\*\* See Chapter 1 - 2 for definition of Qualified Mental Retardation Professional.

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996 Updated December 1996</b>

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996 Updated December 1996</b>

## 1 - 6 Service Standards

In addition to specific program standards described in this Manual, a provider will be held accountable to provisions contained in its Provider Agreement and Contract with the Medicaid agency and the standards contained in the Utah State Board of Education *Special Education Rules*. A Provider Agreement and Contract must be on file with the Medicaid agency before a provider receives Medicaid reimbursement.

### 1 - 7 Client Rights

A. Providers will have a process in place to ensure that:

1. a student or a student's guardian has voluntarily chosen to receive Medicaid reimbursed skills development services; and
2. **all** students with similar needs and conditions are offered school-based skills development services and a student's Medicaid eligibility is not considered when developing or delivering needed services.

B. The Medicaid agency and the provider will jointly ensure that the billing and payment procedures utilized for this program do not jeopardize a student's right to a free and appropriate public education under 20 U.S.C. 1401(a)(18).

## 2 SCOPE OF SERVICES

### 2 - 1 Covered Services

A. School-based skills development services include:

1. Evaluation and Assessment for the purpose of identifying and documenting a special education student's skills development needs.
2. Motor Skills Development designed to enhance a student's fine and gross motor skills including muscle coordination and strength, ambulation, range of motion, grasp and release and oral motor functioning.
3. Communication Skills Development designed to enhance a student's ability to communicate through the development of functional expressive speech or sign language, functional use of adaptive equipment and devices or improved oral-motor functioning.
4. Nursing and Personal Services
  - a. Nursing services designed to enhance or maintain a student's health status including such services as medication administration, seizure control, treatment and repositioning to maintain skin integrity, tube feeding, catheterization and weight management.
  - b. Personal services designed to maintain or develop a student's functional abilities through training in daily living skills (ADL skills) including toileting, hand washing, oral motor, eating and bathing skills.
5. Behavioral Health Services designed to

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996 Updated December 1996</b>

mitigate behaviors such as aggression, self-abuse, property destruction, severe noncompliance or withdrawal when those behaviors significantly impact a student's ability to benefit from special education. Providers requesting Medicaid reimbursement for *behavioral health* skills development services must have a written agreement with the local mental health center(s) serving their school district. The agreement must clearly describe the respective roles of each agency, the services each provides and how referrals between agencies are handled.

6. Vision and Hearing Adaptation Services (necessitated by a student's absence or loss of vision and/or hearing) are specifically designed adaptation training services to develop/enhance a student's functional abilities to assist him or her to benefit from special education.
7. Information and Skills Training to Families includes face-to-face, telephone or written communication *for the purpose* of assisting parents or guardians in understanding and implementing the skills development programs their child needs. This service includes the time spent informing and training the parent or guardian at the formal IEP meeting.

B. Medicaid coverage is available for services identified in Chapter 2 - 1(A) only when these services are:

1. provided to a Medicaid eligible recipient through an enrolled provider;
2. identified as a related service in an eligible student's IEP;

3. supported by documented, professional evaluation(s);
4. specifically designed to enhance a student's health and functional abilities and/or to prevent further deterioration;
5. necessary to assist the student to benefit from special education;
6. provided as an individual or group therapeutic intervention by, or under the direct supervision of, qualified individuals; **and**
7. provided and billed in amounts that are reasonable given the documented needs and condition of a particular student.

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996 Updated December 1996</b>

## 2 - 2 Non-Covered Services/Activities

A. The following services and activities are outside the scope of school-based skills development services and are **not** reimbursable under this program:

1. durable and non-durable medical equipment (including adaptive equipment and assistive technology devices), appliances and supplies. When medically necessary, these items are available to a Medicaid eligible student through other programs and enrolled providers;
2. services provided prior to the implementation (or subsequent to the expiration) of a student's IEP;
3. services not identified in a student's IEP; or
4. services identified in a student's IEP, but the nature or purpose of the activity is:
  - a. academic or educational and covered under the State's educational "core curriculum" including addition, subtraction, multiplication, letter and sound identification, reading, history, science, and other services that do not meet the criteria of "medically necessary services" as described in Chapter 2 - 1, Covered Services;
  - b. to teach consumer and homemaker skills including, but not limited to, shopping, budgeting, bed making, table setting, vacuuming, dishwashing and laundry skills;
  - c. extracurricular, including training and participation in regular physical education,

recreational and cultural activities, athletics/sports, special interest/leisure activities; **or**

- d. vocational or job training, and is designed to prepare a student to obtain or maintain paid or unpaid employment (such as objectives written to address specific job skills and work habits, use of public transportation, community awareness and access, and following work related directions).

## 2 - 3 Service Coordination

A. The provider is responsible to coordinate the provision of school-based skills development services with students' primary and specialty care providers.

B. School-based skills development services are covered as "expanded benefits" available to eligible individuals under the CHEC program. Providers should be familiar with the CHEC program's coverage of preventive, diagnostic, treatment and outreach services in order to assist families to appropriately utilize the Medicaid benefits available to eligible children.

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996 Updated December 1996</b>

**3 SERVICE PAYMENT**

**3 - 1 Standards Applicable to All School District Providers**

- A. Medicaid regulations prohibit payments to governmental agencies in amounts which exceed an agency's costs to provide a service. School districts, as governmental entities, are not allowed to make a profit.
- B. Under the school-based skills development program:
  - 1. *Costs* are defined as the school district's total compensation (salaries and benefits) of employees and contractors providing "hands-on" special education and related services.
  - 2. *Allowable costs* are the percentage of costs directly incurred by the provider to deliver covered skills development services.

**3 - 2 Required Information for Rate Setting**

- A. Newly enrolled school districts may be offered an *interim rate* for services if the Medicaid agency has already established a rate for comparable services. In such cases, the provider's contract will indicate that Medicaid's payments are not cost-based and are subject to cost settlement to determine the provider's actual allowable costs and establish a final payment.
- B. The following information is required in order for the Medicaid agency to determine a provider's actual allowable costs:
  - 1. The specific skills development service(s) the

provider intends to cover under Medicaid;

- 2. The setting(s) in which the covered service(s) will be delivered;
- 3. The names of the individuals who will directly supervise and/or deliver the covered service(s); each of those individuals' total annual salary and benefits; and the time spent by each of those individuals in the covered setting (See item C. below).
- 4. The total number of school days available to students in the district; and
- 5. The total number of Medicaid and non-Medicaid eligible students receiving covered services (applies to self-contained settings only).
- C. Time studies are used to determine the time spent by qualified individuals in covered and non-covered activities. A facsimile time study and instructions are found at the end of this section (Section 2) in this manual. Providers will oversee and ensure that, during the reporting period, time study participants appropriately document their time in 15 minute increments to the categories listed below:
  - 1. direct allowable activities (columns 1, 2 and 3);
  - 2. direct non-allowable activities (columns 4 and 5);
  - 3. indirect activities (column 6); or
  - 4. unrelated activities (column 7).

NOTE: Time spent in indirect activities is allocated

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996 Updated December 1996</b>

based on the ratio of time spent in direct “allowable” activities versus direct “non-allowable” activities.

- D. Approved time study, cost allocation and time allocation reporting formats are available from the Medicaid agency.
- E. Providers must confer with the Medicaid agency prior to collecting cost information and conducting time studies to ensure both parties agree to the scope and content of required reporting.
- F. **Rates for services provided in self contained settings are based on the provider’s average daily allowable cost to deliver services.**
- G. **Rates for services provided in itinerant settings are based on the provider’s average allowable cost per 15 minutes of service.**

### 3 - 3 Claims Processing

- A. Providers must be able to submit claims using *the Medicaid agency’s prepackaged software which runs on an IBM compatible computer.*
- B. Upon enrollment in the Medicaid program, providers will receive instructions, software and assistance from the Medicaid agency to enable them to submit monthly claims containing the following required information:
  - 1. The names of **all** (Medicaid and non-Medicaid) students who received skills development services during the billing period;
  - 2. Each student’s date of birth and Social Security Number; and
  - 3. The number of units of covered service(s) each student received during the billing period.
- C. The Medicaid agency will match the provider’s billing tape against Medicaid’s eligibility file. Payment will be made to the provider for each student who:
  - 1. was Medicaid eligible during the billing period; **and**
  - 2. did not have third party insurance coverage during the billing period.

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996 Updated December 1996</b>

#### 4 RECORD KEEPING

##### 4-1 Required Documentation; Self-Contained Settings

- A. The school-based skills development provider must maintain sufficient records to document that, for each daily unit of service billed to Medicaid, the identified student met two conditions:
1. did, in fact, receive one or more covered skills development service(s); and
  2. received the service(s) pursuant to an IEP which met the requirements found in the Utah State Board of Education, Special Education Rules, Chapter IV, May 1993, or as hereafter amended.
- B. Each provider must also maintain records to document that the individual(s) who provided services billed to Medicaid met the required licensure, certification or other criteria described in Chapter 1 - 6 (B), Service Standards, of this manual, or were supervised by an individual who met the requirements.

##### 4-2 Required Documentation; Itinerant Settings

Providers delivering services in itinerant settings (non-self contained settings where services are reimbursed in 15 minute units) must meet the requirements outlined in Chapter 4 - 1 above **and** must *additionally* ensure that logs or contact notes specifically document the following information:

- A. the date of each billed service;
- B. the number of 15 minute units billed for each date of service;
- C. the nature or purpose of each billed service as it relates to the student's IEP; and
- D. the name of the individual(s) who provided the billed service.

**SCHOOL - BASED SKILLS DEVELOPMENT PROGRAM  
TIME STUDY FOR SELF-CONTAINED SETTINGS**



**SCHOOL:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Name of Staff Member:** \_\_\_\_\_

TIME ↓	1	2	3	4	5	6	7
	Evaluation & Written Assessment	Covered Individual & Group Skills Development	Information & Skills Training to Families & IEP	Academic PE -Recreation Job Training Domestic	Activities & Training not on IEP	In service Paperwork/ prep Travel Supervision	Unrelated time/Personal Time/Unpaid lunch
7:30-7:45							
7:45-8:00							
8:00-8:15							
8:15-8:30							
8:30-8:45							
8:45-9:00							
9:00-9:15							
9:15-9:30							
9:30-9:45							
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1:45-2:00							
2:00-2:15							
2:15-2:30							
2:30-2:45							
2:45-3:00							
3:00-3:15							
3:15-3:30							
3:30-3:45							
3:45-4:00							
<b>Total Minutes</b>							

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996</b>

**INSTRUCTIONS FOR COMPLETING THE SCHOOL-BASED SKILLS DEVELOPMENT TIME STUDY**

**SCHOOL DISTRICT INSTRUCTIONS:** Prior to implementing a time study, a school district must do four things:

1. identify the specific skills development services it wishes to cover under the Medicaid program. Refer to the Medicaid Provider Manual for School-Based Skills Development Services, Chapter 2 - 1 for Medicaid-covered services;
2. identify the setting(s) where the service(s) will be delivered and the individuals who will deliver or directly supervise the delivery of the covered services. Refer to Chapter 1 - 5 of the Medicaid Manual for approved settings and supervisor qualifications;
3. contact the Medicaid agency to determine if the district's proposed service plan (as identified above) will require a time study, and if so, to jointly determine scope of the study (the individuals and settings to be studied) and the time period to be studied; and
4. ensure that all participants have received instruction as necessary to accurately complete the required time study.

**INSTRUCTIONS FOR INDIVIDUALS PARTICIPATING IN THE TIME STUDY**

1. During the agreed upon time period, each time study participant must carefully document his or her daily activities in one-quarter (.25) hour time increments to the categories described below.
2. When the time study participant is involved in more than one activity during a 15 minute time period, he or she should indicate the activity which required the majority of the time.
3. If a time study participant is unable to determine how to log an activity, he or she may contact the Medicaid agency for assistance.

**DOCUMENTING DIRECT and INDIRECT SERVICES and ACTIVITIES**

**Column 1: Evaluation and Written Assessment**

Includes time spent by qualified individuals conducting and documenting evaluations / assessments for the purpose of identifying the skills development needs of students receiving services under an IEP.

**Column 2: Individual and Group Skills Development Services**

Includes time spent by qualified individuals, or by individuals under their direct supervision, directly providing or monitoring one or more students' *covered skills development services* (those described in the Medicaid Provider Manual for School-Based Skills Development Services, Chapter 2 - 1, Covered Services).

**Column 3: Information and Skills Training to Families**

Includes time spent assisting and training a student's parent or guardian to implement the student's skill's development program as outlined in the IEP. This category also includes time spent at IEP meetings reviewing a student's progress in Medicaid covered, IEP services, and discussing modifications and revisions to the student's IEP objectives.

**Column 4: Academics / PE / Recreation / Job Training etc.**

Includes time spent on goals, objectives or other activities, *whether included in the IEP or not*, which are:

- a. part of the educational "core curriculum" and/or have an academic focus (for example, addition, subtraction, letter and sound identification, reading, history, science or other activities that do not meet the related service/medical necessity skills development criteria); or
- b. for the purpose of training or participating in sports, recreation, leisure, community integration, socialization, or are directed at training in vocational, job or housekeeping skills.

**Column 5: Activities and Training not Specified in the IEP**

Includes time spent in activities prior to the development of a student's IEP, time spent after the expiration of an IEP, time spent on "informal" activities or objectives not specifically included in the student's IEP. *Also include here the time spent in skills development services that do not meet the requirements for Medicaid coverage.*

**Column 6: Indirect Activities**

Include in column 6, time spent in any of the following:

- staffings; consultations with administrators or direct care staff;
- service planning / preparation / curriculum development;
- "routine" documentation and paperwork (*show time spent documenting evaluations / assessments in column 1*);
- staff development activities such as workshops and in services;
- breaks
- travel and transportation (all time spent traveling to and from a site where services are to be provided).

<b>Utah Medicaid Provider Manual</b>	<b>School-based Skills Development Services</b>
<b>Division of Health Care Financing</b>	<b>April 1996</b>

**Column 7: Unrelated Tasks and Activities/Unpaid Time**

Include in this column all time spent in programs, classrooms and other settings not covered in the scope of the time study; any unpaid time, including unpaid lunch breaks; "personal time," "down time" and time spent on general administrative or personnel requirements, etc.

Appendix 3.  
**Mental Health Parity Act**

# **Summary**

## **Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008**

**Purpose.** The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (The Wellstone-Domenici Parity Act), enacted into law on October 3, 2008, will end health insurance benefits inequity between mental health/substance use disorders and medical/surgical benefits for group health plans with more than 50 employees. The law becomes effective on January 1st, 2010. Under this new law, 113 million people across the country will have the right to non-discriminatory mental health coverage, including 82 million individuals enrolled in self-funded plans (regulated under ERISA), who cannot be assisted by State parity laws.

**The Parity Requirement.** The new law amends the Mental Health Parity Act of 1996 to require that a group health plan of 50 or more employees (or coverage offered in connection with such a plan)—that provides both medical and surgical benefits and mental health or substance use benefits—to ensure that financial requirements and treatment limitations applicable to mental health/substance use disorder benefits are no more restrictive than those requirements and limitations placed on medical/surgical benefits.

- Equity coverage will apply to all financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses, and to all treatment limitations, including frequency of treatment, number of visits, days of coverage, or other similar limits.
- This new law builds on the current 1996 parity law, which already requires parity coverage for annual and lifetime dollar limits.
- Mental health and substance use disorder benefits are defined broadly to mean benefits with respect to services for mental health conditions and substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.
- A plan may not apply separate cost sharing requirements or treatment limitations to mental health and substance use disorder benefits.
- If a plan offers two or more benefit packages, the requirements of this Act will be applied separately to each package.
- As under the current federal parity law, mental health or substance use benefit coverage is not mandated. However, if a plan offers such coverage, it must be provided at parity in accordance with this Act.

**Out-Of-Network Benefits.** A group health plan (or coverage) that provides out-of-network coverage for medical/surgical benefits must also provide out-of-network coverage, at parity, for mental health/substance use disorder benefits.

**Benefits Management and Transparency.** As under the 1996 Mental Health Parity Act, a group health plan (or coverage) may manage the benefits under the terms and conditions of the plan. A plan will make mental health/substance use disorder medical necessity criteria available to current or potential participants, beneficiaries or providers upon request. A plan must also make reasons for payment denials available to participants or beneficiaries on request or as otherwise required.

**Preservation of State Law.** The current HIPAA preemption standard applies. This standard is extremely protective of State law. Only a State law that “prevents the application” of this Act will be preempted which means that stronger State parity and other consumer protection laws remain in place.

**Small Employer Exemption.** As with the current 1996 Federal parity law, small employers of 50 or fewer employees are exempt from the requirements of the Act. State parity laws will continue to apply to these employers, as well as to individual plans.

**Cost Exemption.** If a group health plan (or coverage) experiences an increase in actual total costs with respect to medical/surgical and mental health/substance use benefits of 1% (2% in the first plan year that this Act is applicable), the plan can be exempted from the law.

- An employer may elect to continue parity coverage regardless of this cost increase.
- The exemption shall apply for one plan year.
- A qualified actuary (member of American Academy of Actuaries) shall determine and prepare a written report regarding a plan's cost increase after a plan has complied with the Act for the first six months of the plan year involved.
- A plan shall promptly and timely notify the Department of Labor (if self-funded) or the Department of Health and Human Services (if fully-insured), the appropriate State agencies, and participants and beneficiaries when it elects an exemption. Plan notification to Labor or HHS is confidential and will provide a description of covered lives in the plan and the actual costs for which the exemption is sought.
- Labor or HHS (as appropriate) and State agencies may audit a plan to determine compliance with the Act when the plan has elected an exemption.

**Compliance Report.** By 2012 and every two years after, the Labor Secretary shall submit to Congress a report on group health plan (or coverage) compliance with this Act. The report will include the results of any compliance audits or surveys, and if necessary, an analysis of reasons for any failures to comply with the law.

**GAO Study.** GAO will conduct a study that analyzes the specific rates, patterns and trends in coverage, any exclusion of specific mental health and substance use diagnoses by health plans, and the impact of this Act on such coverage and costs. GAO will provide a report to Congress within three years (and an additional report after five years) on the results of the study.

**Consumer Assistance.** The Labor Secretary, in cooperation with the HHS and Treasury Secretaries, shall publish and disseminate guidance and information for plans, participants and beneficiaries, applicable State agencies, and the National Association of Insurance Commissioners concerning the requirements of this Act. This information will include assistance with questions and how participants and beneficiaries can obtain assistance from State consumer and insurance agencies.

**Enforcement.** As under the 1996 law, Labor, HHS, and Treasury will continue to coordinate enforcement of the Federal mental health parity requirements and are required to issue regulations to carry out changes made in this Act not later than one year after the enactment date. Treasury may continue to impose an excise tax on any plan for failure to comply with the requirements of the Act.

**Effective Date.** The Act will apply to plans beginning in the first plan coverage year that is one year after the date of enactment. For most plans, this will mean the effective date begins on January 1, 2010. Plans maintained under collective bargaining agreements ratified before the enactment date are not subject to the Act until they terminate (or until January 1, 2009, if this is a later date). The current 1996 parity act requirements for annual and lifetime dollar limits remain in effect for all plans, while the annual sunset in the 1996 parity act is eliminated, effective January 1, 2009.

This information received from the American Psychological Association (APA), in Washington, DC.

Appendix 4.  
**Sample Staff Performance Evaluations  
from Wasatch Mental Health**

- Case Manager
- Therapist

POSITION DESCRIPTION FOR:

<b>1. Position Identification</b> Present Job Classification: <u>Case Manager</u> Proposed Job Classification: _____ <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time    _____ hrs/wk <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary    _____ months		<b>2. Position Location</b> Department: _____ Division: _____ Cost Center: _____	
<b>3. Action Requested</b> <input type="checkbox"/> Initial Allocation (New position to describe and classify) <input type="checkbox"/> Reallocation (Change in duties and responsibilities) <input type="checkbox"/> Additional Allocation (Already existing classification) <input type="checkbox"/> Review (No major change in job responsibilities)		<b>4. OPM Office Use Only</b> Title: _____ Job Code _____ EE04# Effective Date: _____ Supervised by: _____	

Anniversary Date: \_\_\_\_\_ Beginning Date: \_\_\_\_\_ Due Date: \_\_\_\_\_

5. Certification of Job Description

I certify that the objectives and tasks described below, and on any attached pages, accurately reflect the duties and responsibilities of this job.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Program Manager's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Division Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

6. Objectives and Tasks of Position Describe all important objectives of the position and the tasks that are performed to achieve those objectives. Important knowledge, skills and abilities should also be included at the end. The position description must be written in accordance with the "Position Description Guidelines."		Percent of Time	IMPORTANCE	
			Entry Level	Working Level
Objective A:	Provide Direct and Indirect Case Management Services			
Task 1:	Develop and implement individualized service plans for each consumer based on their strengths and needs.			
Task 2:	Monitor the service plan and coordinate services to ensure the needs are being met.			
Task 3:	Coordinate services provided to the consumer with their parents/guardians, the school, DCFS, DWS, UCHD, and other agencies as appropriate.			
Task 4:	Monitor patient behaviors and reactions to medications and treatment methods as needed to avoid adverse side effects.			
Task 5:	Assist consumer and his/her family in advocating for his/her own needs			
Task 6:	Manage personal case load; Is available at or to the schools assigned each of the 180 days school is in session.			
Task 7:	Travel to schools and homes to provide clinical services			

Task 8:	Make available to clients outcome questionnaires where clinically appropriate			
Task 9:	Make available to clients consumer satisfaction surveys where clinically appropriate			
Task 10:	Teach social skills and behavior management lessons			
Objective B:	Maintain and Comply with Case Documentation			
Task 1:	Complete request for service and initial paperwork with consumer			
Task 2:	Complete initial service plan			
Task 3:	Service and service plan reviews are completed with specific goals and objectives			
Task 4:	Case Management and/or Progress notes are completed daily			
Task 5:	Discharge summary is completed in a timely manner			
Task 6:	Develops behavior management and social skills lessons			
Objective C:	Time Sheets and Weekly Reports are completed in a timely manner			
Task 1:	Time sheets and weekly activity reports are turned in by Friday at 5:00 p.m.			
Task 2:	Time sheets and weekly activity reports are completed accurately			
Task 3:				
Task 4:				
Task 5:				
Task 6:				
Objective D:	Attendance at All Assigned Meetings			
Task 1:	Attendance at regular school district meetings is consistent			

Task 2:	Consultation with school district team members occurs regularly			
Task 3:	Attendance at monthly SBS staff meetings			
Task 4:	Regular attendance at weekly team meetings			
Task 5:	Documentation of meetings and consultations occurs in a timely manner			
Task 6:				
Objective E:	Attend and Utilize Appropriate Training			
Task 1:	Attend continuing education, training, workshops as available up to 40 hours per year			
Task 2:	Maintain appropriate license for providing mental health treatment			
Task 3:	Maintain professional ethics			
Task 4:	Provide services within the realm of licensure			
Task 5:	Participate in supervision as needed for licensure or to insure quality services			
Task 6:				
Objective F:	Positive Work Attitude			
Task 1:	Communicate effectively			
Task 2:	Uses work time effectively			
Task 3:	Works cooperatively with others			
Task 4:	Works cooperatively with supervisor			
Task 5:				
Task 6:				

**MINIMUM QUALIFICATIONS (FROM THE JOB DESCRIPTION)**

**1. Education and Experience:**

A. Graduation from a college or university with a bachelor degree in social work, psychology, or a related field.

AND

B. Utah State certification as a case manager

OR

C. An equivalent combination of education and experience.

**2. Knowledge, Skills, and Abilities:**

Working knowledge of special education classifications and disabilities, behavior disorders, legal environment related to client rights and confidentiality; appropriate problem solving skills and procedures; basic psychiatric social work concepts and values; resources available for linking of client needs; ability to assess needs; how to write and implement a service plan; how to accurately maintain daily log records of activities; basic computer skills; Ability to assist consumers in developing a range of social supports in the community; to advocate for consumer rights; design behavioral plans; use emergency medical procedures; communicate well verbally and in written form; assist consumer parents in monitoring consumer medications; link consumers with funding agencies and service providers; work cooperatively with a variety of agency service providers, parents, educators, and significant others;

**3. Special Qualifications:**

Must be a Certified Case Manager. Must possess a valid drivers license and a driving record acceptable to the Center's insurance carrier.

**4. Work Environment:**

An office will be provided to complete paperwork. All other services will be provided in schools in the \_\_\_\_\_ School District and/or in individual homes.



Wasatch Mental Health

WASATCH MENTAL HEALTH EMPLOYEE PERFORMANCE EVALUATION  
FOR PERIOD ENDING \_\_\_\_\_  
DUB IN HUMAN RESOURCE DEPARTMENT ON \_\_\_\_\_

\_\_\_\_ PROBATIONARY  
\_\_\_\_ ANNUAL  
\_\_\_\_ OTHER

NAME \_\_\_\_\_  
TITLE Masters Therapist  
PROGRAM School Behavioral Health

BEGINNING DATE \_\_\_\_\_  
DUE DATE \_\_\_\_\_

PERFORMANCE FOR THIS RATING PERIOD			RATING			PERFORMANCE FOR NEXT PERIOD	
PERCENT OF TIME	OBJECTIVES		1	2	3	JUSTIFICATION/ EXPECTATION	IMPORTANCE
0.6	Objective A: Provide direct and indirect clinical services						
0.1	Objective B: Maintain and comply with Case Documentation						
0.025	Objective C: Submit time sheets and reports weekly						
0.175	Objective D: Attend all assigned meetings						
0.05	Objective E: Maintain licensure						
0.05	Objective F: Work attitude						
1	WEIGHT MUST EQUAL 100 OVERALL EVALUATION SCORE: 0						

TRAINING AND DEVELOPMENT NEEDS OF EMPLOYEE

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SUPERVISOR COMMENTS:

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EMPLOYEE COMMENTS:

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THIS REPORT IS BASED ON MY OBSERVATION. IT REPRESENTS MY BEST JUDGMENT OF THE EMPLOYEE'S PERFORMANCE BASED ON MONITORING THE EMPLOYEE'S JOB DESCRIPTION AND WRITTEN PERFORMANCE EXPECTATIONS WHICH ARE ON FILE IN THE AGENCY.

\_\_\_\_ IMMEDIATE SUPERVISOR \_\_\_\_\_ DATE

THIS REPORT WAS DISCUSSED WITH ME

\_\_\_\_ EMPLOYEE \_\_\_\_\_ DATE

\_\_\_\_ PROGRAM MANAGER \_\_\_\_\_ DATE

\_\_\_\_ DIVISION DIRECTOR \_\_\_\_\_ DATE

ADDITIONAL COMMENTS ATTACHED \_\_\_\_ YES \_\_\_\_ NO

Appendix 5.  
**School District  
and  
Local Authority Substance Abuse and Mental Health Providers  
List**



**Division of Substance Abuse & Mental Health and State Office of Education**

Local Authority Substance Abuse and Mental Health Centers	School District	Charter Schools
Bear River Health Dept. (SA) 435-792-6420 Bear River Mental Health 435-752-0750	Box Elder 435-734-4800 or 435-279-8716 Cache 435-752-3925 Logan 435-755-2300 Rich 435-793-2135 or 435-793-2234	Edith Bowen Lab School Fast Forward High School InTech Collegiate HS Thomas Edison CS –North Thomas Edison CS - South
Central Utah Counseling 435-462-2416	Juab 435-623-1940 Millard 435-864-1000 North Sanpete 435-462-2485 Piute 435-577-2912 Sevier 435-896-8214 South Sanpete 435-835-2261 Tintic 435-433-6363 Wayne 435-425-3813	
Davis Behavioral Health 801-544-0585	Davis 801-402-5261 801-525-7000 (if calling from Ogden)	Legacy Prep North Davis Prep NUAMES Oquirrh Mountain Charter School Spectrum Academy Syracuse Arts Academy Wasatch Peak Academy
Four Corners Community Behavioral Health 435-637-7200	Carbon 435-637-1732 Emery 435-687-9846 Grand 435-259-5317	Moab Charter School Pinnacle Canyon Academy
Heber Valley Counseling 435-654-3003 (Wasatch County)	Wasatch 435-654-0280	Soldier Hollow Charter School
Northeastern Counseling Center 435-789-6300	Daggett 435-784-3174 Duchesne 435-738-1240 Uintah 435-781-3100	Uintah River High School
Salt Lake County Division of Behavioral Health 801-468-2009  Valley Mental Health – SL 801-263-7100	Canyons 801-256-5000 Granite 385-646-5000 Jordan 801-567-8100 Murray 801-264-7400 Salt Lake 801-578-8599	American Prep Academy American Prep Academy Accelerated School Channing Hall Summit Academy AMES American Prep Academy – School for New Americans BSTA Canyon Rim City Academy Dual Immersion Early Light Academy East Hollywood Entheos Guadalupe Hawthorn

		Itineris Monticello Academy Navigator Point North Star Academy Open Classroom Paradigm Providence Hall Salt Lake Arts Academy Salt Lake Center for Science Salt Lake School for the Performing Arts Success School North Star Academy
San Juan Counseling Center 435-678-2992	San Juan 435-678-1200	
Southwest Behavioral Health Center 435-634-5600	Beaver 435-438-2291 Garfield 435-676-8821 Iron 435-586-2804 Kane 435-644-2555 Washington 435-673-3553	Gateway Prep George Washington Academy Success Academy Tuacahn HS Vista at Entrada
Valley Mental Health – Summit 435-649-8347	North Summit 435-336-5654 Park City 435-645-5600 South Summit 435-783-4301	
Valley Mental Health – Tooele 435-843-3520	Tooele 435-833-1900	Excelsior Academy
Utah County Health Dept (SA) 801-851-7128  Wasatch Mental Health 801-373-4760	Alpine 801-756-8400 Nebo 801-354-7400 Provo 801-374-4800	John Hancock Karl Maeser Prep Lakeview Academy Mountainville Academy Noah Webster Odyssey Charter School Ranches Academy Renaissance Academy Rockwell Charter Timpanogos Academy UCAS American Leadership CS Lewis Liberty Academy Merit College Prep Regan Academy Freedom Academy Walden School Lincoln Academy
Weber Human Services 801-625-3700	Morgan 801-829-3411 Ogden 801-737-8250 Weber 801-476-7800	DaVinci Academy Ogden Prep Quest Academy Venture Academy

Appendix 6.  
**Sample Tribal MOU**

## Memorandum of Agreement

This Memorandum of Agreement (MOA) is entered between Northeastern Counseling Center and Ute Indian Tribe Alcohol/Substance Abuse Prevention Program.

### **Mission Statement:**

It is the mission of the Ute Indian Tribe Alcohol/Substance Abuse Prevention Program to provide services to all Native Americans who are struggling with the emotional and mental health challenges and substance abuse problems & to provide support efforts toward sobriety and a healthy beginning.

### **Vision Statement:**

It is the vision of the Ute Indian Tribe Alcohol/Substance Abuse Prevention Program to help individuals gain the knowledge, understanding and skills to strengthen the quality of personal, family and community life through treatment services and prevention programs.

### **Purpose:**

The purpose of the MOA is to establish a collaborative relationship between above-stated agencies to provide substance abuse services to the Native American population.

### **Deliverables:**

Ute Indian Tribe Alcohol/Substance Abuse Prevention Program (UIT A/SAPP) agrees to:

1. Provide intake and referral for substance abuse treatment to Northeastern Counseling Center (NCC).
2. Work collaboratively with NCC staff to coordinate and provide care to clients. (UIT A/SAPP will call NCC directly to schedule an appointment for services.)
3. Adhere to the mandatory HIPAA and CFR 42 Part 2 requirements.
4. Ensure culturally sensitive/appropriate substance abuse services.
5. Participate in case staffing.
6. Participate in discharge planning per referrals.
7. Prepare documents for admission & make necessary arrangements for clients referred back to UIT A/SAPP for in-patient treatment.
8. Participate in aftercare/continuum of care as per treatment plan.
9. UIT A/SAPP will pay for substance abuse treatment services provided by NCC for Native Americans recommended for outpatient treatment as agreed upon by both agencies per fee schedule.

Northeastern Counseling Center (NCC) agrees to:

1. Provide treatment services to referred UIT A/SAPP clients.
2. Work collaboratively with UIT A/SAPP staff to coordinate and provide substance abuse treatment services to clients.
3. Adhere to the mandatory Federal and State reporting of adult and child abuse and neglect procedures when clinically indicated.
4. Adhere to the mandatory HIPAA and CFR 42 Part 2 requirements.
5. Provide culturally sensitive/appropriate substance abuse services to Native Americans referred by UIT A/SAPP.

1/9/08

6. Ensure A/SAPP to include the status of each referral made, assessment results and treatment recommendations for level of care.
7. Provide discharge planning per referrals for A/SAPP.
8. Provide aftercare services as recommended by therapist.
9. NCC will provide treatment for substance abuse treatment services for Native Americans recommended for out-patient treatment for fees as agreed upon by both agencies per fee schedule.

**Management:**

Each agency will be acting as independent agencies at all times. All parties will not be considered employees of any other agency other than their own.

**Liability:**

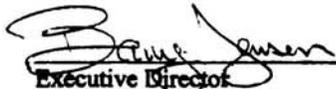
Each agency will maintain separate Liability insurance and/or TORT Claims that cover the activities proposed for this collaboration. Each organization will insure their staff is covered by respective organizations liability insurance and coverage.

**Duration:**

The period of the MOA will commence immediately per fiscal year from signing and will be reviewed half way through the contract. This MOA can be terminated by any party at any time with prior notice of 30 days in writing to ensure appropriate and ethical care of clients for substance abuse services.

**Agreement and Certification:**

As specified above, the undersigned agree to the terms, conditions, policies and procedural clauses of the MOA.

  
\_\_\_\_\_  
Executive Director  
Ute Indian Tribe  
1/17/08  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Director  
Northeastern Counseling Center  
1/17/08  
\_\_\_\_\_  
Date

Northeastern Counseling Center (NCC) Fee Schedule per Memorandum of Agreement

<b>Ute Tribe Adult Slots for treatment services for outpatient/intensive outpatient</b> <b>Summary of all three phases of Roosevelt NCC Substance Abuse Treatment</b>		
Phases of Substance Abuse Treatment		
Phase I	*Assessment 5.5 hours of group a week Individual every other 6 weeks or 30 minutes a week	Early Recovery Group Relapse Prevention Group
Phase II	5.0 hours of group a week Individual every other week 12 week or 30 minute a week	Relapse Prevention Group Group Family Education
Phase III	2.0 hours of group a week Individual every month One hour or two 30 minute a week 36 sessions a year	Social Support Group
Per consumer (slot) for the Fiscal Year 2007-2008 (review at mid point of MOA) 15 slots @ \$40,000.00		
<b>Ute Tribe Adolescent Slots treatment services for outpatient/intensive outpatient</b> <b>Summary of services provided from Roosevelt NCC Substance Abuse Treatment</b>		
Phases of Substance Abuse Treatment		
Clinical Evaluation with Therapist	*SASSI -A2 Screening Measure & Youth Outcome Questionnaire Parent /Guardian asked to participate	Parent /Guardian asked to participate
Individual/Family Therapy	6 Sessions (are arbitrary and not a set program). Some youth and parents may only participate in one or two sessions while others may be willing and are recommended to participate in a longer program that includes more than 6 sessions: determined on a case-by-case basis with a therapist, parent/guardian, and youth.	
Excel Class	6 to 8 hours of classes - frequently ordered by the juvenile court - one hour psycho-education class for 8 weeks or 4 weeks of 1.5 to 2 hours (not treatment/therapy) - closed group- starts when at least 5 clients are enrolled and at time there is a 30 to 60 day waiting period. - Class is education on avoiding abuser of drugs/alcohol which can lead to addiction. Examples of skills taught: - effects of alcohol on teen brain - skills to deal with peer pressure, etc. - educational DVD(s) Summary: For 5 slots with this program the program cost is approximately \$1,000 per slot or \$5,000 for 5 slots. However, youth over the five slots that only need excel class may be admitted at no additional cost provided the numbers are not too large. Many you referred by juvenile courts are only ordered to take the class and are required to have a clinical assessment and therapy. The determination should be made based on the youth's problem level with input from the court and tribe A/SAPP Program.	6 TO 8 HOURS OF EDUCATION *DEPENDING ON GROUP 4; 1.5 OR 4 - 2 HOUR CLASSES MAY BE TAUGHT OVER 4 WEEKS INSTEAD OF 8 WEEKS OF ONE HOUR A WEEK. SCHEDULE EXAMPLE: 3:30 p.m. to 5:30 p.m. for 4 weeks
Per consumer (slot) for the Fiscal Year 2007-2008 (review at mid point of MOA) 5 slots @ 5,000.00		<b>Total Cost : \$45,000.00</b>
UIT Executive Director	Date	 NCC Director
		 Date

Appendix 7.  
**FERPA and HIPAA**

## **FERPA and HIPAA**

**FERPA** is the Family Educational Rights and Privacy Act. The Ed.gov website states the following, “The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. §1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education *records*. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education” (italics added).

It is important to note that FERPA applies only to records. It is not a violation of FERPA to discuss specific students in a consultation relationship so long as records are not shared. The US Department of Education provides the following guidelines for “Education Records”:

- (a) The term means those records that are:
  - (1) Directly related to a student; and
  - (2) Maintained by an educational agency or institution or by a party acting for the agency or institution.
- (b) The term does not include:
  - (1) Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record.
  - (2) Records of the law enforcement unit of an educational agency or institution, subject to the provisions of §99.8.

**HIPAA** is the Health Insurance Portability and Accountability Act of 1996. It applies to health plans, health care providers and health care clearinghouses. HIPAA prescribes the conditions under which medical and psychiatric/psychological information can be shared. It states that without written permission health and mental health care professionals cannot provide any “individually identifiable health information”.

### **RECOMMENDATIONS FOR COLLABORATION BETWEEN SCHOOLS AND MENTAL HEALTH AGENCIES**

- Educate school staff and faculty about mental health and mental illness, including prevalence rates and prognoses.
- Conduct class-wide mental/behavioral health screening (this can be done without parent permission as long as it is a class-wide screening).
- Obtain parent permission to further evaluate students flagged for mental health concerns.
- Conduct further evaluations under the direction of school mental health personnel.
- Consult with mental health professionals regarding treatment options for students in need of mental health services.
- Allow mental health professionals to make recommendations to parents regarding treatment options.
- Have parents sign a release of information allowing school personnel and mental health personnel to communicate about pertinent aspects of a student’s treatment and school performance.

*Developed by UBI-Links School Mental Health Grant, Utah State Office of Education*

Appendix 8.

**Excerpt from NAMI's *Choosing the Right Treatment:  
What Families Need to Know About Evidence-Based Practices***

available at

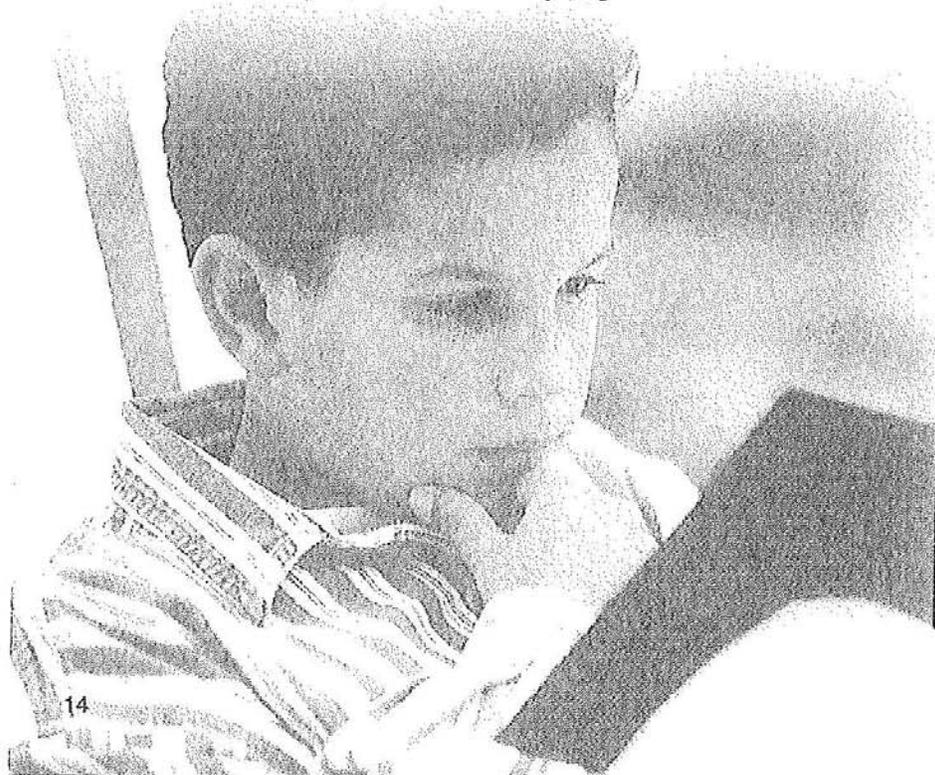
[http://www.nami.org/Template.cfm?Section=Child and Teen Support&template=/ContentManagement/ContentDisplay.cfm&ContentID=47656](http://www.nami.org/Template.cfm?Section=Child_and_Teen_Support&template=/ContentManagement/ContentDisplay.cfm&ContentID=47656)

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### **What Are Current Evidence-Based Practices in Children's Mental Health?**

There are a number of psychosocial interventions that have been shown to be effective for children and their families. There are also medications, often used in combination with psychosocial interventions, which are commonly prescribed for children and adolescents with mental illnesses. This guide includes a partial list of psychosocial EBPs in children's mental health that have a solid research base. The appropriateness of an evidence-based practice for a child depends on the child's age and unique needs.

The chart that follows provides families with a quick reference for evidence-based psychosocial interventions by diagnosis for children and adolescents. It also lists the medications commonly prescribed for children and adolescents with mental illness by diagnosis.



## Child & Adolescent Mental Health Treatments

Diagnosis	Evidence-Based Psychosocial Interventions	*Psychopharmacology
Anxiety	<ul style="list-style-type: none"> <li>• Cognitive Behavioral Therapy (CBT)</li> <li>• Exposure Therapy</li> <li>• Modeling Therapy</li> </ul>	**Antidepressant medication (Selective Serotonin Reuptake Inhibitors—SSRIs); Benzodiazepines (no controlled evidence, but used in clinical practice).
Attention Deficit Hyperactivity Disorder (ADHD)	<ul style="list-style-type: none"> <li>• Behavior Therapy (in home and in school)</li> <li>• Parent Management Training</li> </ul>	Stimulant and non-stimulant (Strattera) medications. (FDA requires a patient medication guide alerting consumers of possible serious side effects.)
Autism	The combination of behavior therapy and medication is often most effective in treating ADHD. <ul style="list-style-type: none"> <li>• Behavior Therapy</li> <li>• Individual and family therapies that target communication skills, interaction skills, and behavior modification.</li> </ul>	Antipsychotic medication: has been shown to reduce aggression.
Bipolar Disorder	No controlled studies of psychosocial interventions for youth with bipolar disorder have been done. However behavior therapy, family education, and support benefit youth and families and improve relationships, communication, and coping skills.	Mood stabilizers (Lithium and Valproate—an anti-convulsant medication); Atypical antipsychotic medication; and other medications may be appropriate.
Conduct Disorder/Oppositional Defiant Disorder (CD/ODD)	<ul style="list-style-type: none"> <li>• Parent Training (multiple EBPs for different age groups)</li> <li>• Anger Coping Therapy (targets skill development in school)</li> <li>• Brief Strategic Family Therapy (BSFT)</li> <li>• Functional Family Therapy (FFT)</li> <li>• Treatment Foster Care (TFC)</li> <li>• Multisystemic Therapy (MST)</li> <li>• Mentoring</li> </ul>	Antipsychotic medication & mood stabilizers. (CD and ODD often co-occur with other mental illnesses so other medications may be appropriate.)
Depression	<ul style="list-style-type: none"> <li>• CBT</li> <li>• Relaxation Therapy</li> <li>• Interpersonal Therapy (IPT)</li> <li>• Family Education and Support</li> </ul>	**Antidepressant medication (SSRIs)
Schizophrenia	The combination of CBT and medication is often most effective in treating major depression. No controlled studies of psychosocial interventions for youth with schizophrenia have been done. However behavior therapy, family education, and support benefit youth and families and improve relationships, communication, and coping skills.	Antipsychotic medication

Information in the chart is based on reviews by Burns, Chorpita, Chambers and Halloran, Hoagwood, Jensen, Weisz, and the authors of the Guide.  
 \* Generally, there is limited research on children's medication use, but more research exists on the utilization of ADHD medication.  
 \*\* The Food and Drug Administration (FDA) has issued a "black box" warning about the increased risk of suicidal thoughts and behaviors in youth being treated with antidepressant medications.

Appendix 9.  
**Sample Flyer from Davis Behavioral Health**

# Building a Brighter TOMORROW for Our CHILDREN, SCHOOLS, and COMMUNITY



## Davis County School District (Davis Community Learning Center @ Wasatch Elementary)

Davis County School District (DSD) and Davis Behavioral Health (DBH) are committed to the education of our students as well as the well-being of the students. DBH has committed to a therapist to provide services for the Davis Community Learning Center @ Wasatch Elementary to provide collaborative services to students. DBH at the DCLC @ WE can provide the following:

- |                                |                                        |
|--------------------------------|----------------------------------------|
| * Assessment                   | * Individual Counseling                |
| * Family Counseling            | * Group Counseling                     |
| * Teacher/Staff Consultation   | * Home Visits                          |
| * Crisis Intervention Services | * Multi-disciplinary Team Consultation |

### Types of Referral May Include:

- Disruptive behaviors at school/home
- Attention Deficit/Hyperactivity
- Decreased grades/Attendance
- Anxiety
- Grief/Loss
- Family Problems
- Lack of Social Support
- Stress
- Depression
- Anger/Aggression Behaviors
- Oppositional Behaviors

Often these concerns have a negative impact on the child's academic and social functioning.



## Our Mission

Prevent, Identify Early, and Intervene in social/emotional concerns of school-aged children and their families that may be experiencing these types of concerns. To assist in the development of comprehensive resources to enhance positive growth and learning in our students.

## Our Goals



- ⇒ Provide early identification, intervention, and preventative mental health services.
- ⇒ Decrease Stigma associated with accessing mental health services.
- ⇒ Enhance student attendance, academic performance, social development, and decrease suspensions and disciplinary referrals
- ⇒ Increase parental support and involvement in the child's academic and social development
- ⇒ Provide mental health informational and educational trainings for school staff, families, and community.



## Student/ Family Services

With parental permission, students can have access to school based mental health services. Parents are strongly encouraged to be included in the therapeutic process for their children. With parental involvement, the likelihood of the student and family having a successful counseling and academic experience greatly increases.

If there are questions you may contact the Therapist and/or the Program Manager.

Donna Raby, CPC-I  
270 East Center St.  
Clearfield, UT 84015  
(801) 402-8395

**Therapist**

Deborah Gold, LCSW  
934 So. Main St.  
Layton, UT 84041  
(801) 546-1168

**Program Manager**

Appendix 10.  
**Sample Internal Referral Forms**

- Davis Behavioral Health
- Weber Human Services

**Davis Behavioral Health**  
**FAMILY ADVOCATE PROJECT**  
**Referral Form**

Name of Person Filling Out Form: \_\_\_\_\_ School: \_\_\_\_\_

**Demographics of Student Being Referred:**

Name of Student: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Grade of Student: \_\_\_\_\_ Age of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Phone number: \_\_\_\_\_ Cell number: \_\_\_\_\_ Work Number: \_\_\_\_\_

**Reason for Referral:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please circle only those that apply:**

Depression                      Anxiety                      Disruptive Behaviors                      Grief/Loss

Grades                      Attendance                      Family Problems                      Attention

Hyperactive                      Substance Abuse                      Out of home placement                      Aggression

Other: (please specify) \_\_\_\_\_

**History:**

Has contact been made with the parent/guardian about the student? If yes, what was the outcome?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Weber Human Services  
School Based Mental Health  
**REFERRAL**

Student \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_

School \_\_\_\_\_ Teacher \_\_\_\_\_ Date \_\_\_\_\_

Grade \_\_\_\_\_ Parent/s \_\_\_\_\_ Telephone # \_\_\_\_\_

Referred by \_\_\_\_\_ Primary Language \_\_\_\_\_

Authorization to contact WHS liaison: Yes ( ) No ( )

Agency and Staff referred to: Weber Human Services Liaison, Jackie Coahran

General Information

1) Classroom Performance: ( ) above ( ) at ( ) below ( ) markedly below grade level.

2) Student's strengths and interests: \_\_\_\_\_

3) Student's needs: \_\_\_\_\_

School Adjustment

1) Daily behaviors are interfering with education. Yes ( ) No ( )

2) Peer relationships affect daily learning. Yes ( ) No ( )

3) Attendance issues are a problem. Yes ( ) No ( )

Has student been previously referred for counseling?

Yes ( ) No ( ) Don't Know ( )

If yes, do you know where? \_\_\_\_\_

Funding Source: Medicaid ( ) Private Insurance ( ) Uninsured ( )

Your concerns for this student (Be as lengthy as you wish; attach another paper if you need more space.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent contact made regarding referral: Yes ( ) No ( ) Date \_\_\_\_\_

Brief summary of contact: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Approved for WHS referral: Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Principal Signature

\_\_\_\_\_  
Counselor/Teacher Signature

\_\_\_\_\_  
Mental Health Liaison

\_\_\_\_\_  
Date

Appendix 11.  
**Children's Mental Health Disorder  
Fact Sheets for the Classroom**

# Adjustment Disorder

## Early Childhood Mental Health Fact Sheet

### *About the Disorder*

Adjustment disorder is a change or regression in behavior or emotions in response to a specific environmental change in a child's life. A child struggling with this disorder will respond to the stress of change in a way that is excessive when compared to what is considered normal for that child. This disorder may also appear in children who are going through a change in placement. For example, a child who moves to a new foster home or is adopted into a new home—even the most wonderful, loving home ever imagined—may experience an adjustment disorder. Adjustment Disorder can manifest itself as anxiety, depression, or it may be indicated by behavior that is uncharacteristic for specific a child.

There is not a specific type of event that will necessarily lead to an adjustment disorder, and not all children will respond to unsettling events in the same way. For example, an unsettling event could happen to several children—even children in the same family—but only one of the children may experience an adjustment disorder. The way a child responds to an unsettling event may also be affected by a child's cultural background and everyday experience. Adjustment disorders occur in both males and females and can occur in children of all ages.

### *What You May See*

Children who are fussy and act out for a week when their parent returns to work are not showing signs of an adjustment disorder. They are experiencing new rules, new hours, and possibly a new feeding schedule and may, predictably, seem unsettled. A child who develops intense separation anxiety or is noticeably sad and/or withdrawn for an extended period of time after a significant family change, however, may be experiencing an adjustment disorder.

Infants and young children have little control over many aspects of their daily life. They do not, for example, decide where to live, which childcare they will attend, or how long they will stay at childcare. Changes in these areas, as well as stressors such as major illness, parental divorce, birth of a sibling, and excessive marital conflict, can lead children to develop an adjustment disorder. In response to these changes, a child who usually plays happily may become aggressive; a child who often plays alone may begin to engage other children in a negative way; a child who typically is very good natured may become upset easily and begin to have tantrums; and a child who has mastered a developmental milestone, such as toileting, may regress.

Children are wonderful observers of their world, however, they are not always accurate interpreters. When a child begins to appear stressed, parents and caregivers often find clues to the child's behavior when they are able to see the world from their child's perspective. Events that may not seem disturbing to adults, such as the birth of a new child, may affect children differently. It is often not the change itself but the child's perception of the environmental change that causes the stress and, sometimes, a subsequent adjustment disorder.

### *Symptoms*

A child with Adjustment Disorder may exhibit one or all of the following:

- Appear subdued, irritable, anxious, or withdrawn
- Resist going to sleep
- Have frequent tantrums
- Regress in the ability to toilet independently
- Have increased separation anxiety
- Exhibit acting-out behaviors that are uncharacteristic for the child such as hitting or biting

#### IMPORTANT

This fact sheet is not intended to be used as a diagnostic tool. It is meant to be used only as a reference for your own understanding and to provide information about the different kinds of behaviors and mental health issues you may encounter.

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.



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## Adjustment Disorder

(continued)

### Strategies

Life can, at times, present unavoidable conflicts and difficulties. Although we cannot always control our children's environment, we do need to be attuned to when environmental changes begin to negatively affect the children in our care. Whenever possible, anticipating upheaval and preparing a child for changes in routines can often help a child to maintain a sense of security. Mentioning an anticipated change in a calm, relaxed way several times before the actual change takes place can reassure a child that although change may feel unsettling, their world will remain safe and secure.

Some changes in a child's environment are completely unexpected and may even cause the child's caregivers to have difficulty adjusting to the new circumstance. When unanticipated events disrupt a child's environment, allow the child time to get used to whatever has changed. For example, a preschool teacher may suddenly come down with a serious illness and be unable to return to the classroom for several months. In this case, take time to introduce any new teachers to the children and explain that the previous teacher may not be coming in for a while. Be sure to use a calm and self-assured manner. Children are pretty good at sensing when an adult is unsettled. Avoid lengthy explanations about what has occurred—children don't usually need in-depth explanations; they usually just need to be reassured that someone is in control and that their life will go on with as little disruption as possible.

### Documenting Your Concerns and Next Steps

When documenting behavior, avoid generalizations such as "the child appears depressed or anxious"; instead, record specific behaviors you are seeing or not seeing. For example, "Caleb did not want to participate in art time; we were using finger paints today, which is typically one of Caleb's favorite activities" or "When we went outside, Caleb sat in the sandbox but did not climb or slide as he has done almost every day since joining our group" or "This is the third day in a row that Caleb has had trouble falling asleep at nap time." Also note what happened before and after the behavior. For example, did Caleb have a disagreement over a toy before art time.

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH's *A Guide to Early Childhood Mental Health*, available for order at [www.macmh.org](http://www.macmh.org).

### Ready Resources

- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- National Institute of Mental Health at [www.nimh.nih.gov](http://www.nimh.nih.gov)
- SAMHSA's National Mental Health Information Center at [www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov)
- ZERO TO THREE at [www.zerotothree.org](http://www.zerotothree.org)

*Information included in this fact sheet comes primarily from the DC:0-3R (Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood: Revised Edition).*

*Funding for the development and publication of this fact sheet was sponsored in part by a grant from the Minnesota Department of Education using federal dollars from CFDA 84.323A, Special Education - Program Improvement Grants.*

# Anxiety Disorders

## Early Childhood Mental Health Fact Sheet

### *About the Disorder*

All young children feel anxious at times. Many infants and toddlers, for example, show great distress when separated from their parents, and preschoolers are often frightened of strangers, thunderstorms, or the dark. These anxieties are normal and are usually short-lived.

An anxiety disorder occurs, however, when a child experiences excessive worry, concern, or fear while involved in developmentally appropriate tasks, ordinary interactions, and everyday routines. Anxiety disorders in children are characterized by worry, concern, or fear that is exaggerated, pervasive, disproportionate to the situation at hand, and inappropriate for the child's age or developmental level. There are many types of anxiety disorders—here are the most common.

- **Generalized Anxiety Disorder**

Children experience excessive anxiety and worry more days than not for a period of more than six months. These children may have difficulty concentrating and/or difficulty falling or staying asleep. They often appear on edge or irritable and may have a more difficult time maintaining emotional stability. The child's anxiety and worry will interfere significantly with their functioning and/or development.

- **Separation Anxiety Disorder**

Separation from the caregiver causes the child excessive anxiety and distress that has intensity and duration beyond that of typical development and lasts more than one month; children experiencing this disorder often refuse to be held or comforted by a substitute caregiver. These children are also

often preoccupied with fears that their primary caregiver will have an accident or become sick; the child may also fear that they might have an accident or illness while separated from their primary caregiver. Children may also worry about getting lost or kidnapped. Physical complaints such as headaches, stomachaches, nausea, or vomiting are also common when separation from the caregiver occurs or is anticipated.

- **Specific Phobia**

Children experience excessive fear when they are in the presence of specific objects or exposed to certain situations; the fear may even occur when the child is just anticipating such experiences. The fear must last at least four months. Exposure to the object or situation will cause an immediate reaction by the child—usually crying, a tantrum, becoming immobile, or becoming “clingy.” The child will attempt to severely limit their own activities and their family's activities to avoid possible exposure to the feared object or situation.

- **Social Anxiety Disorder (Social Phobia)**

A child will have a persistent fear of social or performance situations that include people unfamiliar to the child or the child will be in a situation where they are under the scrutiny of others; this typically includes such things as play dates, large family gatherings, birthday parties, religious ceremonies, and/or collective sharing times at childcare or preschool; the fear must last at least four months. These situations may cause reactions such as crying, having a tantrum, becoming immobile, becoming clingy, or strongly resisting being involved in social situations. The child will avoid the feared social situation and may have anticipatory anxiety that interferes with their normal functioning and development.

- **Anxiety Disorder NOS (Not Otherwise Specified)**

Although not often used, this category may be used when a child exhibits some symptoms of an anxiety disorder but, taken together, the symptoms do not fulfill the diagnostic criteria of a specific anxiety disorder. A parent or caregiver may see uncontrollable crying or screaming, agitation and/or irritability, sleeping and/or eating disturbances, separation distress, or social anxiety. Caregivers should be careful to notice if the onset of the symptoms occurred after the child endured a trauma; in that case, the child may be at risk for posttraumatic stress disorder.

### IMPORTANT

This fact sheet is not intended to be used as a diagnostic tool. It is meant to be used only as a reference for your own understanding and to provide information about the different kinds of behaviors and mental health issues you may encounter.

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult “Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters,” available from the Minnesota Department of Human Services.



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# Anxiety Disorders

(continued)

## What You May See When

Children with anxiety disorders usually exhibit an excessive level of fear toward normal challenges and/or when learning new skills. Infants may display anxiety by crying inconsolably or screaming; sleeping and eating disturbances may also indicate a higher level of anxiety. Toddlers and preschoolers experiencing an anxiety disorder may exhibit recklessness and aggression directed toward themselves or others. For example, a toddler may be so afraid of the dark that the lights being turned down at nap time cause him to aggressively run from the room, or a child may become aggressive and run reckless when confronted with a new but developmentally appropriate activity such as finger painting.

It is also common for children to react with somatic complaints such as stomachaches or headaches.

## Symptoms

- Multiple fears
- Specific fears
- Limited play repertory
- Difficulty with transitions between activities
- Reckless and defiant behavior
- Excessive stranger anxiety
- Excessive separation anxiety
- Excessive inhibition due to anxiety
- Lack of impulse control

## Strategies

- Avoid belittling the fear or anxiety; instead, validate the concern without confirming that the fear is real. For example, "You are worried about your dad leaving—that can be scary to think about."
- Use and teach positive self-talk; listen to what the child says and help them to replace negative thoughts with positive ones. For example, if your child says "I can't go outside because their might be a dog and dogs are scary," you can say "Some dogs outside are mean and may be scary, but not all dogs are. I'll help you figure out which ones aren't mean so you can feel okay outside."
- If the anxiety is around learning or mastering new skills, teach building-block skills. For example, if a child seems overwhelmed at the thought of getting dressed by themselves, teach them to zipper or button first, then work toward the goal of independent dressing over time.

- For separation anxiety, try using a transitional object—something the child receives from their caregiver to hold while the caregiver is gone.
- Help the child verbalize their feelings and fears. With young children, help them to distinguish between a little bit scared and a whole lot scared.
- Teach relaxation and deep-breathing exercises to children who are able to understand and participate in these activities. Blowing bubbles and pretending to blow bubbles, learning to whistle, or actively trying to move their bellies in and out are all fun ways for children to learn deep breathing.

## Documenting Your Concerns and Next Steps

When documenting behavior, be as specific as possible and avoid generalizations such as "Shayla looked anxious." Instead, record specific behaviors you are seeing or not seeing and provide as much detail as seems relevant. Also include the context in which the behavior occurred. For example, noting that "Shayla held her blanket tight and got teary-eyed as the children lined up to go outside" is more informative than "Shayla wouldn't line up to go outside."

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH's *A Guide to Early Childhood Mental Health*, available for order at [www.macmh.org](http://www.macmh.org).

## Ready Resources

- Anxiety Disorder Association of America at [www.adaa.org](http://www.adaa.org)
- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- National Institute of Mental Health at [www.nimh.nih.gov](http://www.nimh.nih.gov)
- SAMHSA's National Mental Health Information Center at [www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov)
- ZERO TO THREE at [www.zerotothree.org](http://www.zerotothree.org)

*Information included in this fact sheet comes primarily from the DC:0-3R (Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood: Revised Edition).*

*Funding for the development and publication of this fact sheet was sponsored in part by a grant from the Minnesota Department of Education using federal dollars from CFDA 84.323A, Special Education - Program Improvement Grants.*

# Attention-Deficit/ Hyperactivity Disorder (AD/HD)

## Early Childhood Mental Health Fact Sheet

### *About the Disorder*

Although the symptoms of Attention-Deficit/Hyperactivity Disorder (AD/HD) can sometimes appear in preschoolers, the diagnosis of AD/HD in preschoolers is very difficult. Many of the symptoms required for an AD/HD diagnosis—difficulty sustaining attention and effort, lack of attention to detail, seeming not to listen, difficulty following through on tasks and instructions, disorganization, distractibility, talking excessively, difficulty waiting one's turn, and interrupting others—are actually developmentally appropriate behaviors for young children who are in the process of learning impulse control and self-regulation. To further complicate matters, language delays, developmental problems, anxiety, depression, and adjustment disorders are all things that can imitate AD/HD.

Of course, some preschool children actually do have AD/HD, and they need treatment and intervention. For these children there will likely be a qualitative difference in the way they exhibit the behaviors listed above. Because the symptoms of AD/HD are similar to developmentally appropriate behaviors and can be imitated by other health concerns, it is exceedingly important that qualified and skilled professionals conduct the assessment of very young children. In fact, preschoolers suspected of having AD/HD may need to be evaluated by a pediatrician, psychologist or psychiatrist, neurologist, speech pathologist, and/or developmental pediatrician to develop a full understanding of a child's behaviors.

Although pinpointing an actual diagnosis may be a difficult and complex task, helping a child develop proper social and

academic skills during early childhood can be crucial to their future success.

### *What You May See*

Most children have more energy than adults—they can play hard all day long and still not seem tired. Some children do have a naturally higher energy level than others, but a preschooler with AD/HD will likely have more difficulty sitting and listening to a story, they may behave more aggressively toward other children when they get distracted or bored, or they will interrupt much more often than other children. And although the early years are a time when children naturally struggle to learn impulse control, children with AD/HD will have a more difficult time learning to control their impulses.

### AD/HD in the Early Childhood Years

Although the revised *Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood* (DC:03R) does not list diagnostic criteria for AD/HD, we are providing a fact sheet about it because of the increase in the number of children younger than age 5 who are being diagnosed and treated for the disorder.

The American Academy of Pediatrics recognizes that AD/HD is difficult to diagnose in this population because young children are developing so rapidly and because many children display symptoms of AD/HD as part of their typical development in their early years. Despite this acknowledged difficulty, epidemiological data suggests that approximately 2 percent of children aged 3–5 years meet diagnostic criteria for AD/HD.

In fact, a 1990 review showed that 34 percent of pediatricians and 15 percent of family physicians had prescribed psychostimulant medications to preschoolers with AD/HD. Other studies indicate the growing use of stimulants in preschoolers during the 1990s. Stimulant medication treatment in preschoolers increased approximately three-fold in the early 1990s.

### IMPORTANT

This fact sheet is not intended to be used as a diagnostic tool. It is meant to be used only as a reference for your own understanding and to provide information about the different kinds of behaviors and mental health issues you may encounter.

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.



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## Attention-Deficit/Hyperactivity Disorder (AD/HD)

(continued)

### Symptoms

- Difficulty sustaining attention and effort
- Lack of attention to detail
- Seemingly unable to listen
- Difficulty following through on tasks and instructions
- Disorganized
- Easily distracted
- Talks excessively
- Has difficulty waiting one's turn
- Interrupts others
- Lacks impulse control

### Strategies

- Be patient and stay calm if the child is acting out.
- Teach the behaviors you would like the child to exhibit. Understand that the child may be practicing new skills and have patience.
- Teach calming skills such as deep breathing exercises. Blowing bubbles and pretending to blow bubbles, learning to whistle, or actively trying to move their bellies in and out are all fun ways for children to learn deep breathing.
- Teach strategies for impulse control—for example, say “I know you are excited to take a turn, why don't you march in place until your turn.”
- Play games that teach the child to anticipate what may happen next.
- Give the child plenty of time to respond when working to solve a problem.
- Provide structure and clearly define expectations.
- Give one direction at a time, for example, say “Let's put the toys away” instead of “Pick up your toys, get your boots, and then we will go outside to play.”
- Sharing books like *Jumpin' Johnny Get Back to Work! A Child's Guide to ADHD/Hyperactivity* by Gordan Michael can sometimes be helpful.

### Documenting Your Concerns and Next Steps

When documenting behavior, be as specific as possible and avoid generalizations like “Pete is always hyperactive”; instead, record specific occurrences. Here's an example: “At lunch time, Pete was reminded three times of the clean-up chores that follow lunchtime. When Pete finished his lunch, he left the table and began playing without washing his hands, busing his dishes, or taking off his bib. When I redirected him to do the clean-up chores, he threw his plate on the floor and then sat down and screamed.” That is a much more complete picture than, “Pete can't stay focused on tasks he is asked to do.” When noting worrisome behaviors, also look for patterns and areas of development where the child may need additional teaching. Does the child need different teaching methods or to learn skills in a different order than other children?

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH's *A Guide to Early Childhood Mental Health*, available for order at [www.macmh.org](http://www.macmh.org).

### Ready Resources

- Children and Adults with Attention-Deficit/Hyperactivity Disorder at [www.chadd.org](http://www.chadd.org)
- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- SAMHSA's National Mental Health Information Center at [www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov)
- National Institute of Mental Health at [www.nimh.nih.gov](http://www.nimh.nih.gov)
- ZERO TO THREE at [www.zerotothree.org](http://www.zerotothree.org)

Information included in this fact sheet came primarily from the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision).

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# Depression

## Early Childhood Mental Health Fact Sheet

### *About the Disorder*

Most children will, at some time, show signs of sadness, be whiny, or engage in their play halfheartedly. These times are usually short-lived and can often be linked to an oncoming illness, boredom with an activity, or a minor disruption in their routine. However, when these feelings or behaviors are consistently evident for longer than two weeks, the child may be suffering from depression.

Depression in children can be experienced in different ways. Some children may experience a low-grade feeling of sadness and/or lethargy nearly all the time, while others will experience intense periods of sadness that come and go. Regardless of the type of depression, research findings suggest that depression in preschool-aged children is typically characterized by symptoms of sadness and/or irritability. The symptoms, however, can look different—one child may appear sad and withdraw from activities, while another child may appear irritated and aggressive. In addition, children may exhibit joylessness—even though they may be engaging in playful activities, they will not be having fun.

In young children, these symptoms may be somewhat difficult to recognize because infants and toddlers don't always have clear ways to indicate these somewhat complex feelings. Actually depression can be especially difficult to recognize because some of its symptoms are similar to some of the cues infants use to get their everyday needs met. For example, an infant who is fussy or whiny may be getting in their first tooth and may need extra comforting. However, as a child's skills develop and their personality emerges, caregivers may be able to gain a clearer understanding of the

child's usual temperament. Therefore, as a child matures, the ability to recognize depression as a change from the child's normal behavior may become easier.

### *What You May See When*

In very young children depression may appear as irritability, isolation, consistently aggressive or destructive play, or being accident prone. Extreme anxiety may also be noted. These indicators must be a change from the child's usual emotional state. With depression, the depressed mood or sadness will occur across settings and activities and impede the child's development or impair their functioning.

#### **When – Infancy**

**What –** A baby experiencing depression may be whiny, lethargic, show signs of sadness, or play half-heartedly; their sleep patterns may be disrupted and they may lose weight. These children may either sleep more than usual or be more wakeful than is normal; they may also lose interest in their favorite toys.

#### **When – Toddlers & Preschoolers**

**What –** Toddlers and preschoolers, along with the indications above, may express feelings of sadness verbally and tend to be socially withdrawn. They may also complain of headaches or stomachaches, seem apathetic, have trouble concentrating and /or regress in some skill areas. For example, they may have trouble paying attention, have trouble solving problems, or they may even engage in creative play that offers clues about their feelings.

### *Symptoms*

- Depressed or irritable mood
- Diminished interest or pleasure in developmentally appropriate activities
- Reduced capacity to protest (may seem apathetic)
- Emotional withdrawal
- Lethargic
- Sad facial expression
- Regression in skills
- Regression in developmental milestones
- Excessive whining
- Reduced repertory of social interactions
- Change in sleep patterns
- Weight loss

#### **IMPORTANT**

This fact sheet is not intended to be used as a diagnostic tool. It is meant to be used only as a reference for your own understanding and to provide information about the different kinds of behaviors and mental health issues you may encounter.

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.



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## Depression (continued)

### Strategies

- When developing strategies for a child who is exhibiting symptoms of depression, remember that acknowledging feelings is critical to emotional development.
- Allow the child to initiate play, then be sure to show interest in the objects they select for play.
- Allow the child time to express their needs and wants—then relay back to them what they said and ask the child if you have accurately identified how they feel.
- Verbalize emotional expression with the child (for example, “Your face looks happy, are you enjoying this story? Your body looks frustrated, do you need help?”)

### Helping Children Express Their Feelings

Because all children—even those who never experience depression—will have feelings of sadness at some point, it is critical to engage in activities designed to help them recognize and express their feelings and emotions appropriately.

By about age 3 children are able to verbally label their own emotions, identify emotional states from pictures, and link emotions to social situations (The birthday party made me feel excited!). Preschool children may also begin to understand the experience of more than one feeling at a time, including the experience of conflicting emotions. The capacity to understand and experience emotions continues to increase during the preschool period. By age 5, children are learning to verbalize rather than act upon feelings, and they are gaining important insights into self-regulation.

Caregivers and others involved in children’s lives can help support this development. For example, when a caregiver acknowledges that a child is feeling mad, sad, frustrated, or tired, the caregiver can offer the child the support they need to be able to release tension and begin to problem solve.

Trusted adults can also help children focus on positive thoughts and actions rather than negative ones by teaching positive self-talk and coping strategies. Another excellent way to teach about emotions is to regularly express your own feelings of anger and frustration (“I’m feeling frustrated right now”) as well as feelings of joy and happiness (I’m feeling happy about going outside to play) in very simple and easy-to-understand language. This will help them be better able to deal with a wide range of emotional experiences.

- For infants who seem sad or depressed, be sure to hold, comfort, rock, and soothe them.
- In group situations, avoid games that may be socially isolating, such as one that requires picking teams.
- Openly give encouragement and positive reinforcement.

### Documenting Your Concerns and Next Steps

When documenting behavior, always be specific. Avoid generalizations such as “Grace looked depressed” or “Kyle seems really sad this week”; instead, record specific behaviors you are seeing or are not seeing. For example, “Kyle looked away when I held his favorite sparkly keys this morning. He did not appear to want to play with any of the toys; he fussed and looked away with each one I offered him. I held him and rocked him, but he made very little eye contact with me and did not seem soothed by my singing. This is the 5th day that Kyle has exhibited this very uncharacteristic behavior.”

If a child’s behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child’s behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH’s *A Guide to Early Childhood Mental Health*, available for order at [www.macmh.org](http://www.macmh.org).

### Ready Resources

- iFred—the International Foundation for Research and Education on Depression at [www.ifred.org](http://www.ifred.org) (formerly [www.depression.org](http://www.depression.org))
- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- National Institute of Mental Health at [www.nimh.nih.gov](http://www.nimh.nih.gov)
- SAMHSA’s National Mental Health Information Center at [www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov)
- ZERO TO THREE at [www.zerotothree.org](http://www.zerotothree.org)

*Information included in this fact sheet comes primarily from the DC:0-3R (Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood: Revised Edition).*

*Funding for the development and publication of this fact sheet was sponsored in part by a grant from the Minnesota Department of Education using federal dollars from CFDA 84.323A, Special Education - Program Improvement Grants.*

# Deprivation/Maltreatment Disorder of Infancy and Reactive Attachment Disorder

## Early Childhood Mental Health Fact Sheet

### *About the Disorder*

Deprivation or maltreatment disorder of infancy is characterized by disturbed and developmentally inappropriate attachment behaviors in which a child rarely or minimally turns to a specific attachment figure for comfort, support, protection, and nurturance. This disorder may develop when a child has a limited chance to form a primary attachment. Circumstances that can result in a child developing this disorder include frequent changes in caregivers, child abuse and neglect, or the unavailability of an attachment figure—for example, if the child is in an institution or if the attachment figure has a substance abuse problem or is experiencing severe depression.

A change or improvement in the caregiving situation will usually lead to some remission of the symptoms.

### *What You May See When*

A young child with a deprivation, maltreatment, or attachment disorder will usually follow one of three patterns of behavior. At times a child's behavior may fit one of the patterns listed below, but the behavior may be due to a delay or disorder of relating and communicating rather than to deprivation or maltreatment.

#### • **Emotionally withdrawn or inhibited pattern**

A child with the emotionally withdrawn or inhibited type will rarely seek comfort when feeling stress. Whether the disorder becomes apparent in infancy or during the toddler years, these children will not respond to efforts made to comfort or reduce stress. The child may show excessive levels of irritability, sadness, or fear, and typically will not

participate in social and emotional turn-taking or sharing. The child may appear depressed or emotionally withdrawn.

#### • **Indiscriminate or disinhibited pattern**

The indiscriminate or disinhibited child will not form selective attachments but will seemingly attach to relative strangers. The child may behave in an overly familiar way with any adult. For toddlers and preschoolers, the absence of checking in with a caregiver when exploring unfamiliar play spaces and a willingness to go off with unfamiliar adults are both characteristic of this pattern.

#### • **Combination of the two**

This child will exhibit characteristics consistent with both the emotionally withdrawn/inhibited pattern and the indiscriminate or disinhibited pattern.

### *Symptoms*

*Note: A child may exhibit some but not all the symptoms listed here.*

**Emotionally Withdrawn or Inhibited**—This may look like a depressive disorder and is difficult to distinguish, but remember the child will lack an attachment figure.

- Does not seek comfort when feeling stress
- Attachment behaviors, such as cooperation, showing affection, and reliance on others for help seem to be missing or very restricted
- Appears emotionally blunted
- Frozen watchfulness
- Avoids or fails to respond to social cues
- Does not initiate social interactions
- May resist comforting

#### **Indiscriminate or Disinhibited**

- Lacks the typical social shyness around unfamiliar adults that is typical of 2 to 4 year olds
- May resist comforting by primary caregiver
- May seek proximity and comfort indiscriminately, even with strangers
- Lacks the ability to protect themselves (willingness to go with strangers)

**Mixed Deprivation/Maltreatment Disorder**—This will have symptoms from both patterns of behavior.

### IMPORTANT

This fact sheet is not intended to be used as a diagnostic tool. It is meant to be used only as a reference for your own understanding and to provide information about the different kinds of behaviors and mental health issues you may encounter.

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.



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## Deprivation/Maltreatment Disorder of Infancy and Reactive Attachment Disorder (continued)

### Strategies

- Make sure the child has a sense of security and receives consistent nurturing while they are in your care.
- Empathize with the child and understand the child's reluctance to form an attachment; try not to take it personally and continue to engage the child.
- Provide a secure and trusting relationship—for example, tell the child that you are there for them and that you care about them. And follow up your words with acts of caring. Take advantage of every opportunity to comfort the child when they are experiencing difficulty by being their ally when they are faced with stressful situations. Whenever possible, give the child loving attention—for example, read to them, tell them stories, or sing to them.
- Avoid distancing strategies—use “time with” or “time in” instead of “time out.”
- Show sensitive responses to the child's invitations for social interactions, no matter how small the invitation appears. Even though you may feel rejected by the child, continue to respond to any invitations by the child to engage you. If a baby coos, offer a verbal response as well as a warm smile. When an older child offers to show you their toy, take a keen interest and make sure the child sees how much you appreciate their effort to relate to you.
- Be emotionally available to the child—for example, respond to the child's expressions of emotion, no matter how small. When the child talks of something that frightened them or something that made them happy, let the child know that you understand their feelings—share in their joy and comfort them when they are frightened.

### Child Abuse and Neglect

Abuse and/or neglect is characterized by a caregiver's persistent disregard for their child's basic physical needs, their emotional needs, and their need for comfort, stimulation, and affection. When a caregiver neglects or abuses a child in a physical or psychological way long enough to undermine their basic sense of security and attachment, the child may develop an attachment disorder. This neglect can essentially stop the emotional development of a young child. However, because all children have a unique temperament and internal resiliency, not every child who has been neglected or abused will experience this disorder.

Note: The presence of neglect or abuse alone does not create this diagnosis.

### Documenting Your Concerns and Next Steps

When a caregiver does become concerned about a child's behavior, it is important to record in as much detail as possible the frequency and intensity of the behavioral difficulties so that there is a greater chance of understanding the problem and arriving at workable solutions. A caregiver may worry about the care a child is receiving. Often it helps to write out a list of concerns and keep a log of behavior concerns or behavior changes in the child.

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH's *A Guide to Early Childhood Mental Health*, available for order at [www.macmh.org](http://www.macmh.org).

### Ready Resources

- Family Attachment Counseling Center at [www.familyattachment.com](http://www.familyattachment.com)
- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- National Institute of Mental Health at [www.nimh.nih.gov](http://www.nimh.nih.gov)
- SAMHSA's National Mental Health Information Center at [www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov)
- ZERO TO THREE at [www.zerotothree.org](http://www.zerotothree.org)

Information included in this fact sheet comes primarily from the DC:0-3R (*Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood: Revised Edition*).

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# Fetal Alcohol Spectrum Disorders (FASD)

## Early Childhood Mental Health Fact Sheet

### *About the Disorder*

Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term that describes a wide range of effects that can occur in a child whose mother drank alcohol during pregnancy. Prenatal alcohol exposure can cause significant brain damage. The effects of FASD typically include physical, mental, and learning disabilities as well as behavioral deficits and problems with socialization.

FASD includes the following categories:

- Fetal alcohol syndrome (FAS)—This is indicated by a pattern of neurological, behavioral, and cognitive deficits along with specific facial features.
- Alcohol-related neurodevelopmental disorder (ARND)—This term is used when only central nervous system abnormalities are present as a result of the fetal alcohol exposure. ARND is characterized by problems with memory and motor skills.
- Alcohol-related birth defects (ARBD)—This is indicated by defects in the growth of skeletal and major organ systems.
- Fetal alcohol effects (FAE)—This term is sometimes used to describe children who had prenatal exposure to alcohol but do not have all the symptoms (particularly the facial features) associated with FAS.

Some children will have no physical symptoms of FAS. If it is certain that a child was exposed to alcohol before birth but there are no physical symptoms and the child's early childhood screening appears to be within normal development, a follow-up screening may be necessary when the child is older if behavioral or learning deficits become apparent.

### IMPORTANT

This fact sheet is not intended to be used as a diagnostic tool. It is meant to be used only as a reference for your own understanding and to provide information about the different kinds of behaviors and mental health issues you may encounter.

While it is important to respect a child's need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters," available from the Minnesota Department of Human Services.

### *What You May See*

An infant with FASD may be very irritable, fussy, and/or cry a lot for no apparent reason. As a child with FASD grows, parents and caregivers may begin to notice that the child's development of gross motor skills is delayed—for example the child may walk or run with an awkward gait, have difficulty tossing and catching a ball, and/or struggle to be able to hop on one foot. The child may also exhibit cognitive deficits—for example the child may have trouble problem solving, difficulty planning future actions, and problems taking in, storing, and recalling information. Because of damage to the brain, a child with FASD is sometimes overly sensitive to sensory input—for example they may be upset by bright lights, loud noises, and tags on their clothes.

As the child's development continues, parents and caregivers may notice that the child has verbal skills that exceed their level of understanding, which will sometimes lead a child to say they understand something when they don't. They are also likely to have difficulty following multiple directions. These challenges are frustrating and can lead the child to emotional outbursts. Along with auditory processing problems, parents may also see a child develop oppositional behaviors and a pattern of not completing tasks or chores they are asked to do.

As a child with FASD has more social interactions, parents and caregivers may notice that the disorder can cause the child to misinterpret others' words, actions, or body movements, which can make it harder for the child to determine how to respond to different situations. It is also typical for children with FASD to miss social cues and be unable to entertain themselves. This too can lead to social problems and acting out.

### *Symptoms*

- May cry a lot and be irritable as an infant
- May have tremors
- Sensitive to sights, sounds, and touch
- Easily over-stimulated, then hard to soothe
- Problems with bonding
- Inappropriate social interactions (for example willingness to leave with a stranger or hugging strangers—strangers can be either child or adult)
- Unable to comprehend danger and does not respond well to verbal warnings
- Prone to temper tantrums and noncompliance



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# Fetal Alcohol Spectrum Disorders (FASD)

(continued)

## Symptoms (continued)

- Difficulty handling changes in routine
- Motor skills lag behind children of the same age
- May be disinterested in food
- May have disrupted sleep
- Distractible, unable to concentrate, poor memory
- Inconsistent behaviors, skill levels from day to day
- May be able to state a rule but not follow it
- No recognizable play themes or organization
- Has difficulty with requests or instructions that have more than two steps

## Strategies

Because damage to the developing brain varies, each child's development will be different; however, the following strategies work well with many children who have FASD:

- Speak simply and concretely. Avoid words with double meanings, sarcasm, and irony.
- Give only one-step or two-step directions.
- Simplify the child's environment and take steps to avoid sensory triggers.
- Be consistent and structure the day so there are predictable routines.
- Repeat and re-teach frequently. Rules, expectations, and directions may not be remembered from day to day. Review behavioral expectations with the child before each event.
- Use pictures, charts, and demonstrations. Allow children to find their own way of performing a task when possible.
- Provide skills training and use a lot of role playing.
- Supervise all activities—children with FASD can be socially naïve and are easily victimized.
- Use direct teaching of skills that are missing. Materials similar to those designed for students with autism are

## FASD

It is important to approach parents supportively and non-judgmentally. Although parental confirmation of prenatal drinking can be vital in obtaining services for a child, it is sometimes necessary to treat the symptoms (such as oversensitivity to stimuli or social delays), without raising the question or needing confirmation of a FASD.

often helpful in teaching behaviors like social interactions, waiting in line, and asking for help.

- Use teaching strategies that focus on the child's strengths; whenever possible give the child jobs to do that require the child's strengths.

## Documenting Your Concerns and Next Steps

When documenting behavior, avoid generalizations such as "Roberto never remembers the rules for circle time." Instead, provide observations such as "Each day this week I have had to remind Roberto that when another child is speaking during circle time he must raise his hand and wait until the other child is done." Often it helps to write out a list of concerns or keep a log of the situations where the child appears to have difficulty. Recording the frequency of the behavior and what the child said and did as well as what the caregiver said and did can help to identify specific triggers and/or learning deficits.

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH's *A Guide to Early Childhood Mental Health*, available for order at [www.macmh.org](http://www.macmh.org).

## Ready Resources

- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- National Institute of Mental Health at [www.nimh.nih.gov](http://www.nimh.nih.gov)
- National Organization on Fetal Alcohol Syndrome at [www.nofas.org](http://www.nofas.org)
- SAMHSA's National Mental Health Information Center at [www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov)
- ZERO TO THREE at [www.zerotothree.org](http://www.zerotothree.org)

*This fact sheet is based on information from SAMHSA'S (U.S. Department of Health and Human Services Substance Abuse and Mental Health Services) FASD Center for Excellence and NOFAS (National Organization on Fetal Alcohol Syndrome).*

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# Pervasive Developmental Disorders (PDD)

## Early Childhood Mental Health Fact Sheet

### About the Disorder

*\*For children younger than 24 months, "Multi-System Development Disorder" (MSDD) is preferred. For more on MSDD, see box on the back of this fact sheet.*

Pervasive developmental disorders (PDD) include autistic disorder, Rett's disorder, childhood disintegrative disorder, Asperger's syndrome, and PDD-NOS (not otherwise specified). For children with autism, the disorder will progress continually; children with other disorders in this category may develop normally and then experience a regression. For all disorders of this type, however, the onset will occur in early childhood, and except for Rett's Disorder, which has been seen only in females, the rates of occurrence are higher in males than in females. This category of disorders involves a delay in a child's development of basic social, communicative, and learning skills.

Children with this diagnosis may have impairments in the use of several nonverbal behaviors such as eye contact, facial expressions, body posture, as well as other gestures used in social interactions and to communicate. Because every child is unique and PDD covers a wide spectrum of symptoms and behaviors, no two children with this diagnosis will behave the same. In general, however, children with a PDD diagnosis have difficulty establishing social relationships, resist change, and need consistent structure and routine.

### What You May See

In children for whom the onset of the disorder occurs during infancy, parents and caregivers may notice a lack of socially directed smiles and that the child does not respond to their caregiver's voice. This sometimes leads caregivers to be concerned that their child may be deaf. Infants may also exhibit sensory sensitivities, avoid direct eye contact, be inflexible with regard to routines, and/or they may seem

clumsy. They may also have an aversion to affection and/or physical contact—during infancy this may mean the child seems uncomfortable when being cuddled.

As the child matures and begins to play with toys, they may tend to relate to the inanimate environment better than they relate to people. For example, a child with autism may be clearly enamored with a certain toy, but will not likely rush to share the special toy with their primary caregiver. The child may also seem to have little understanding of the needs of others and may even seem not to notice another person's distress. It is these behaviors that lead to difficulty in developing friendships and problems with social skills.

It may seem that young children with PDD have little or no interest in establishing friendships. They may even seem as though they have not formed a secure bond or attachment to a particular caregiver. As children with a PDD diagnosis get older, they often desire friendships and express sadness or depression as they gain understanding of being different. Early intervention, therefore, is especially important because it can help them to develop necessary and useful social skills, communication skills, and cognitive skills. With intense behavioral intervention, some preschoolers with autism have achieved higher IQ scores, more expressive speech, and a reduction in behavior problems.

### What You May See – At a Glance

*The spectrum of PDD is broad—some of these characteristics may be more indicative of autism than Asperger's.*

#### When – Infancy

**What** – May exhibit sensory sensitivities, avoid direct eye contact, be inflexible with regard to routines, and/or may seem clumsy; may reject cuddling.

#### When – Toddler

**What** – As a child with PDD matures, the initial indications may become more pronounced. Beyond avoiding eye contact, they will avoid direct interactions; language problems may become more apparent or a regression in language development may occur; inflexibility with regard to routine will be more fixed; difficulties in processing visual, auditory, and tactile sensations may appear; and problems with vestibular (sense of balance and equilibrium) and proprioceptive (sense of one's body in space) sensations may occur.

#### When – Preschooler

**What** – Children at this age may not engage in socially imitative play or they may engage in limited types of play; they may also begin to have more pronounced difficulties with peer relationships.

### IMPORTANT

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# Pervasive Developmental Disorders (PDD)

(continued)

## Symptoms and Behaviors

- Inflexible adherence to routines or rituals
- Avoidance of eye contact
- Impairment in non-verbal communication
- Abnormally intense focus or interest in a specific area (for example, may be intensely focused on vehicle wheels or may insist that every toy is a guitar)
- Language problems may be apparent—the child may rarely speak, may be unable to initiate or sustain a conversation, or may repeat phrases over and over
- Lack of varied play
- Lack of social imitative play typical of developmental level (for example, will not have tea parties or play store)
- May lack sensitivity to or be highly sensitive to sounds, lights, smells, touch, and/or the taste and texture of foods

## Strategies

- Provide a highly structured environment.
- Use graphic or visual schedules.
- Prepare the child for changes and transitions.

- Teach basic skills such as responding to their name, sitting with a group, and following directions.
- Teach social skills like taking turns and looking at the person you are talking to; if eye contact is too intense, teach the child to look at a person's forehead or nose instead.
- Structure playtime to help the child interact with peers (for example, assign peer buddies or establish cooperative groups to ensure inclusion).
- Find a creative way to show affection—although some children with PDD do not like to be touched, some do enjoy firm hugs.
- Ask the child's primary caregiver if there are any strategies (such as language games the child plays at speech therapy) that could be incorporated into the child's play.

## Documenting Your Concerns and Next Steps

When documenting behavior, avoid generalizations such as "Katie appears to have autistic tendencies or difficulty communicating." Instead, record specific behavior, for example, "This afternoon we did not go outside because it was raining—Katie threw the blocks and laid on the floor crying for 30 minutes and no amount of redirecting or consoling seemed to help. I think I am beginning to see a pattern with Katie; she has exhibited similar difficulty with changes in the schedule at other times as well."

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH's *A Guide to Early Childhood Mental Health*, available for order at [www.macmh.org](http://www.macmh.org).

## Multi-System Developmental Disorder (MSDD)

For children younger than 24 months, Multi-System Developmental Disorder (MSDD) is preferred.

A child with MSDD does not totally lack the ability to develop a social/emotional relationship with a primary caregiver but will have impairment in developing this relationship. The child may avoid contact with caregivers, but will give slight cues that show attachment. These children have difficulty forming, maintaining, and/or developing communication, including pre-verbal gestures. For many toddlers with MSDD, language does not serve a communicative intent. They may memorize parts of songs or dialogue but they do not use speech to communicate.

A child with MSDD may have major difficulty processing visual, auditory, tactile, proprioceptive (spatial awareness of one's body), and vestibular sensations. Most have poor motor planning—they lack the ability to sequence their movements to create a desired outcome—and may appear very clumsy when learning a new skill. Infants and toddlers diagnosed with MSDD also show impairments in processing sensations. For example, they may be extremely sensitive to touch (startling or even having a tantrum when touched lightly), or they may show great pleasure in heavy pressure (being sat on or wedging themselves in small spaces behind furniture).

Early interventions can be very successful in helping a child with MSDD develop processing tools and coping strategies. An assessment and intervention plan that utilizes a speech therapist, occupational therapist, family psychologist, and other professionals as necessary is crucial.

## Ready Resources

- Autism Society of America at [www.autism-society.org](http://www.autism-society.org)
- Kami M. Talley Reading and Resource Center at the University of Minnesota offers a bibliography of resources at <http://education.umn.edu/ChildCareCenter/Kamihealingthroughbooks/>
- National Institute of Mental Health at [www.nimh.nih.gov](http://www.nimh.nih.gov)
- SAMHSA's National Mental Health Information Center at [www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov)
- ZERO TO THREE at [www.zerotothree.org](http://www.zerotothree.org)

Information included in this fact sheet comes from the DSM-IV-TR (*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*) and DC:0-3R (*Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition*).

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## Posttraumatic Stress Disorder (PTSD)

## Early Childhood Mental Health Fact Sheet

### *About the Disorder*

Young children who have been exposed to an event that is life threatening (threatened death or serious injury), that is perceived as life threatening, or that threatens the physical safety of a caregiver can develop Posttraumatic Stress Disorder (PTSD). The trauma may be a sudden unexpected event, a series of connected events, or an enduring situation. Typically, the traumatic experience is so overwhelming and out of the ordinary compared to one's usual experience that one's ability to cope is overpowered. A child with PTSD will likely experience recurrent and intrusive thoughts and memories of the traumatic event, they may have flashbacks (a child may freeze or stare into space for a time), or they may suffer physical stress when reminded of the event (pounding heart, upset stomach). A child who has persistent symptoms that interfere with daily functioning requires immediate intervention.

### *What You May See*

After experiencing or re-experiencing a traumatic event, young children will often appear very disorganized and overwhelmed. Although infants do not have the ability to communicate their distress verbally or through play, it doesn't mean they can't experience PTSD. (See box for more on emotional development.) For infants, the symptoms of the disorder may be a difficulty in going to sleep or a pattern of disrupted sleep, an exaggerated startle response, increased irritability or fussiness, and/or intense separation anxiety.

A parent or caregiver may notice that the child sometimes engages in post-traumatic play by reenacting the trauma; unfortunately this type of play does not reduce their anxiety

about the trauma because they do not incorporate solutions or alternative endings during their play. Also, the play will be less imaginative than the child's usual play. In addition, some children may ask repeated questions about the subject of the trauma. For example, a child who has been bitten by a dog may ask numerous questions about dogs and may want to look at pictures of dogs. These children will be distressed but will still obsess about the topic of the trauma.

Symptoms of PTSD can sometimes be difficult to differentiate from age-appropriate behaviors such as temper tantrums. Frequency can also be difficult to determine because of varying developmental levels—for example, how many tantrums do 2 year olds usually have per week? Also be aware that as the child processes the trauma, their memories of the event may change because they are trying to make sense of the events; as this processing continues and the child begins to heal, allow for change in the story.

### Emotional Development During Early Childhood

Observable emotions develop throughout the first year of life. Some emotions that are critical to the diagnosis of PTSD are sadness, which develops around 3 months; recognizing fear in others, which develops around 5 months; anger and surprise, which develop around 6 months; and fear, which develops around 9 months.

By the age of 9 months, infants are able to reproduce events (behaviorally) from the day before, which indicates the development of explicit memory. Though traumatic events can be visualized with varying degrees of clarity and depth perception depending on visual abilities developed during the first 6 months, infants don't have the developmental abilities to express observable symptoms of PTSD until around 9 months of age.

Full verbal recollection (further development of explicit memory) of a traumatic event is likely if the trauma occurs after 28 to 36 months of age. A child will be able to give a full narrative of what they understand/remember about trauma event around that age. The behavioral expression of trauma is also dependent on each child's motor development.

### IMPORTANT

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## Posttraumatic Stress Disorder (PTSD)

(continued)

### Symptoms

- Preoccupied with the event
- Compulsively reenacting the event in play
- Exaggerated startle response
- Flashbacks
- Temporary loss of previously acquired developmental skills, such as talking or toileting
- Increased irritability, outbursts of anger or extreme fussiness, or temper tantrums
- Increased social withdrawal
- Aggression toward peers, adults, or animals
- Diminished interest in significant activities, including play, social interactions, and daily routines
- Protest going to bed
- Repeated nightmares; night terrors
- Fear of the dark, fear of toileting alone, and other new fears
- Constriction in play

### Strategies

- Create a space of trust, safety, and acceptance; build trust with the child.
- Be warm and welcoming.
- Use plenty of soothing techniques, holding, rocking, and/or gentle talking (take into account the child's temperament when using these techniques).
- Give the child a lot of verbal empathy and support.
- Physical proximity of a trusted person may be necessary.
- Assist the child in developing an accurate narrative of the traumatic event; correct misconceptions and distortions. Use storytelling to help develop alternative endings.
- Avoid circumstances that are upsetting or re-traumatizing for the child.
- If the child has an emotional response to a reminder of the event or if the child appears to be re-living the event, help the child to recognize that the emotion belongs to the past and that it is not what is happening at the present time.
- Respond empathetically when a child loses a skill that they had mastered before the traumatic event. Toilet training is the most common in this category. Return to teaching the skill to the child just as you had done the first time.

- Paints, clay, dolls, and water play provide some children with outlets for their feelings; incorporate this type of play into your day.

### Documenting your Concerns and Next Steps

When documenting behavior, avoid generalizations such as "Trevor seems anxious about loud noises." Instead write down what situations cause a child to have increased anxiety. Recording the frequency of the behavior and what the child said and did as well as what happened right before and after the change in behavior can help identify areas of concern. Also assess if there have been any traumatic events in the child's life. A parent may confide in you that the child witnessed domestic abuse—if so, provide the parent with resources in the community that can offer support and guidance. It is also a good idea to have resources and fact sheets on domestic abuse, substance abuse, and maternal depression available for parents.

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH's *A Guide to Early Childhood Mental Health*, available for order at [www.macmh.org](http://www.macmh.org).

### Ready Resources

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- National Institute of Mental Health at [www.nimh.nih.gov](http://www.nimh.nih.gov)
- The Posttraumatic Stress Disorder Alliance at [www.ptsdalliance.org](http://www.ptsdalliance.org)
- SAMHSA's National Mental Health Information Center at [www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov)
- ZERO TO THREE at [www.zerotothree.org](http://www.zerotothree.org)

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# Regulation Disorder of Sensory Processing

## Early Childhood Mental Health Fact Sheet

### *About the Disorder*

Young children with this disorder struggle to regulate their emotions and behaviors as well as their motor abilities in response to sensory stimulation. The sensory stimulation can include touch, sight, sound, taste, smell, sensation of movement in space, and awareness of the position of one's body in space. A child's struggle with these sensory inputs leads to impairment in their development and functioning. These children have trouble maintaining a calm, alert, or affectedly positive state. The three types of regulation disorder of sensory processing are:

- hypersensitive, which has two subcategories—fearful/cautious and negative/defiant;
- hyposensitive/under-responsive; and
- sensory stimulation-seeking/impulsive.

For all types of this disorder, parents report that their children get upset easily, often lose their temper, have difficulty adapting to change, are overly sensitive, and/or have a difficult temperament.

### *What You May See*

#### • **Hypersensitive**

These children experience sensory stimulation such as light touch, loud noises, bright lights, and rough textures as distressing. They may show an excessive startle reaction, aggression, increased distractibility, and they may attempt to escape from the stimulus. Infants may respond by being irritable or fussy. They may not be comforted easily being cuddled or sung to. In fact, these types of responses could be what the child is reacting against. Parents and caregivers may also notice hypersensitivity when trying to introduce new foods to the child because of the child's very low tolerance for a variety of textures, tastes, and smells. As children with the hypersensitive pattern mature, they typically display limited interest in sensory motor play, engage in exploration less often

than is expected for their age, and exhibit difficulty in fine motor coordination. All of this is usually due to the fact that they self-limit activities because of their sensitivity.

Children with a hypersensitive sensory processing disorder fall into one of two sub-categories, either fearful/cautious or negative/defiant. Children who show signs of the fearful/cautious pattern will show stress when routines change, are very shy and clingy in new situations, have a limited ability to self-soothe, and express excessive fears and worries. These children are very cautious, inhibited, and fearful. The negative/defiant hypersensitive child may appear negativistic, stubborn, controlling, and will often do the opposite of what is asked or expected. The child may be slow to engage in new experiences, is aggressive when provoked, and exhibits compulsiveness and perfectionism.

#### • **Hyposensitive/Under-Responsive**

These children require high-intensity sensory input before they are able to respond. They are quiet and watchful at times and may appear withdrawn and difficult to engage. Infants may appear delayed or depressed and lack the desire to explore their environment. As preschoolers, they often have fewer words for dialogue and show a limited range of behaviors, ideas, and fantasies. These children will seek out activities that they know will provide them with adequate sensory stimulus—they may spin on a sit-n-spin, swing for long periods of time, or jump up and down on a bed. They tend to show disinterest in exploring relationships, have poor-quality motor skills, engage in limited exploratory activity, and have limited flexibility when involved in activities.

#### • **Sensory Stimulation-Seeking/Impulsive**

Infants with this pattern will crave and seek sensory stimulation. Preschoolers will appear excitable, have intrusive behaviors, and exhibit a daredevil style. The motor activities of these children are often unfocused so they may appear clumsy due to poor motor planning.

These children may seem aggressive and fearless or impulsive and disorganized. Their behavior patterns involve high activity—for example, they will shriek with joy if you sit on them because they seek contact and stimulation through deep pressure. At times, this desire for contact coupled with poor motor planning and disorganized motor skills can lead to things being broken, unintended intrusions into others' physical space, and unprovoked hitting. These actions are often misinterpreted as aggressive, so other children may respond with aggression, which may then lead the child with the sensory stimulation-seeking/impulsive disorder to develop aggressive behaviors.

### IMPORTANT

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# Regulation Disorder of Sensory Processing

(continued)

## Symptoms

Children who have difficulty regulating and processing sensory input typically exhibit three features: 1) sensory processing difficulties, 2) motor difficulties, and 3) a specific behavioral pattern. A child with this disorder will be sensitive (either over or under) to touch, sights, sounds, smells, and sensations of movement in space.

- A child may be irritated by some types of clothes and shoes
- Bright, florescent lights may cause irritability or a meltdown
- A child may have a very limited diet and strongly resist foods because of the texture
- Routine tasks, such as brushing teeth and combing and/or cutting hair, may be nearly impossible to accomplish
- Toddlers may love or hate rough and tumble play
- A child may appear annoyed when touched too gently—in infants, this may mean they won't want to be cuddled or they may prefer firm swaddling
- A child may have difficulty sleeping if a room isn't completely dark

## Strategies

*For all children:*

- Show soothing and empathetic support of the child's individual needs.
- Announce transitions to the child who needs extra time to adjust; when significant changes are happening (such as moving to a new room), a slow and gradual change with plenty of emotional support can help a child adjust.
- Show the child empathy and love. A caregiver who can manage warmth even in the face of negativism or rejection will help the child's emotional development—it may take time, but don't give up!
- Help the child engage, attend to, interact with, and explore the environment.

*For hypersensitive children:*

- Provide quiet, calm spaces when possible.
- Watch for cues from the child that the environment is overly stimulating (for example, some children love loud noises, but a hypersensitive child may cover their ears).
- Find out the best way to show comfort, and help the child's peers to show comfort in similar ways (for example, let the child's peers know how close is too close).

*For under-responsive children:*

- Provide interactive input and exaggerated gestures.
- Reach out to the child; use animated expressions.

- Give robust responses to the child's cues, however slight the cues may be.

*For sensory stimulation-seeking/impulsive children:*

- Provide the child with constructive opportunities for sensory and affective involvement.
- Encourage and teach the child to recognize their own limits, especially with regard to issues of safety.
- Encourage the use of imagination and support exploration of the external environment.

## Documenting your Concerns and Next Steps

When documenting a child's sensory sensitivities being very observant and specific is especially important. For example, noting that "Jonah rarely eats all his lunch" is not as informative as "Jonah didn't have yogurt at snack today, and I noticed he rarely eats pudding when it's packed in his lunch." Or saying that "Michelle washes her hands a lot" is not as descriptive as "Michelle washes her hands immediately after activities that involve paint or anything gooey—even silly putty, which doesn't stay on your hands." Keeping close tabs on when a child has an unusual response to sensory stimuli may help to discover a pattern that will help determine which sensory stimuli trigger a response.

If a child's behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child's behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

For more information about early childhood mental health, see MACMH's *A Guide to Early Childhood Mental Health*, available for order at [www.macmh.org](http://www.macmh.org).

## Ready Resources

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# Tourette Syndrome

## Early Childhood Mental Health Fact Sheet

### *About the Disorder*

Tourette Syndrome (TS) is a neurological disorder characterized by tics—involuntary, rapid, sudden movements and vocalizations (though they may not occur simultaneously) that occur repeatedly in the same way. For children with Tourette Syndrome (also known as Tourette's Disorder), onset typically occurs before 7 years of age, and the disorder is usually recognized two to three years after onset. In most children, the severity peaks at 9 to 11 years of age. About 5 to 10 percent of children have an intensifying course with little or no improvement. In about 85 percent of children, symptoms diminish during and after adolescence.

The symptoms include:

- Both multiple motor and one or more vocal tic(s) present at some time during the illness; however, the motor and vocal tics may not necessarily occur simultaneously;
- The occurrence of tics many times a day (usually in bouts) nearly every day or intermittently throughout a span of more than one year; and
- Periodic changes in the number, frequency, type (vocal or motor), and location of the tics; severity of the tics will wax and wane; symptoms can sometimes disappear for weeks or months at a time.

Research at the National Institute of Mental Health suggests that some cases of TS (and related Obsessive Compulsive Disorder) may be an auto-immune response triggered by antibodies produced to counter strep infection. This phenomenon is known as PANDAS. There is also a confirmed genetic basis for TS; therefore, parents seeking medical assistance for possible tic behavior in their children

should mention to their medical professionals any similar tic-like behaviors observed in other family members. Both psychiatrists and neurologists are qualified to diagnose a case of Tourette Syndrome.

### *What You May See*

During infancy, symptoms of Tourette Syndrome are usually not evident. Around age 3, a child may begin to show motor or vocal tics. The most common first symptom in children with Tourette Syndrome is a facial tic, such as rapidly blinking eyes or twitches of the mouth. Tics of the limbs as well as involuntary sounds such as throat clearing and sniffing may also be initial signs. The tics, however, may be somewhat difficult to recognize because speech patterns and motor skills are still developing. By about age 4 when speech patterns and motor development are well established, vocal and motor tics may become more apparent. Vocal tics may include vocal outbursts, imitating or echoing the words of others, throat clearing, coughing, or snorting. Motor tics may be as simple as blinking, wrinkling the nose, or lip licking; or they may be as complex as arm or leg jerks, kicking, twirling, or fist clenching. You may also see that a child who is experiencing tics may be teased by others who don't realize that the tics are involuntary.

The complexity of some symptoms is often perplexing to family members, friends, and others who may find it hard to believe that the actions or vocal utterances are involuntary. Tics do, over time, change and vary in severity. For example, tics typically increase as a result of tension or stress, and decrease with relaxation or when focusing on an absorbing task. And although they can often be controlled or suppressed for brief periods of time, they are experienced as irresistible and, as with the urge to sneeze, eventually must be expressed.

### *Symptoms*

- Repetitive eye blinking
- Repetitive clearing of the throat
- Repetitive coughing
- Repetitive lip licking
- Repetitive fist clenching
- Imitating or echoing the words of others
- Imitating or echoing the motions of others
- Leg jerks
- Vocal outbursts

### IMPORTANT

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# Tourette Syndrome

(continued)

## Strategies

- Interventions for a child with Tourette Syndrome should emphasize teaching the child to successfully navigate developmentally appropriate tasks. The goals should be to help the child develop friendships, experience trust, and feel competent completing activities—not stopping the tics.
- Teach relaxation and deep breathing exercises to children who are able to understand and participate in these techniques. Blowing bubbles and pretending to blow bubbles, learning to whistle, or actively trying to move their bellies in and out are all fun ways for children to learn deep breathing.
- Teach the child to tune into and identify their emotions and levels of frustration—increased frustration or anxiety can cause an increase in tic behaviors.

## Common Co-Occurring Disorders with Tourette Syndrome • (adapted from [www.tsa-usa.org](http://www.tsa-usa.org))

Some children who have Tourette Syndrome (TS) may also have other mental health concerns.

### Obsessive Compulsive Disorder (OCD)

Children may have repetitive thoughts that can become unwanted or bothersome, or they may feel compelled to do something over and over and/or in a certain way. Examples include touching an object with one hand after touching it with the other hand to “even things up” or begging for a sentence to be repeated many times until it “sounds right.”

### Attention-Deficit/Hyperactivity Disorder (AD/HD)

AD/HD occurs in many people with TS. Children may show signs of hyperactivity before TS symptoms appear. Indications of AD/HD may include difficulty with concentration, failing to finish what is started, not listening, acting before thinking, shifting constantly from one activity to another, needing a great deal of supervision, and general fidgeting. AD/HD without hyperactivity includes all of the above symptoms except for the high level of activity.

**Difficulties with impulse control** may result, in rare instances, in overly aggressive behaviors or socially inappropriate acts. Also, defiant and angry behaviors can occur.

**Sleep Disorders** are fairly common among people with TS. These include difficulty getting to sleep, frequent awakenings, or walking or talking in one’s sleep.

- Do not punish the child for engaging in tics or what may appear to be strange habits such as lip licking or excessive blinking.
- Because stress can cause a child’s tics to increase, simplify the child’s environment and take steps to avoid sensory triggers such as bright lights, loud noises, or chaotic activity.

## Documenting Your Concerns and Next Steps

When recording information about a child who appears to have tics, being very observant and specific is especially important. Because tics can be related to frustration and anxiety, it is also helpful to record what was happening just before the tics occurred. Avoid generalizations such as “It seems like Stephan licks his lips all day.” Instead try to associate specific events with tic behavior. For example, noting that “Stephan seemed to lick his lips when he couldn’t find the last piece to the puzzle” may give more information about what triggers tics in Stephan. Recording the frequency of the tics as well as what the caregiver said and did can help to identify areas of concern.

If a child’s behaviors are causing concern, you may want to suggest to the parents that they take their child to their primary care provider who may refer the parents to a mental health professional, an early childhood behavior specialist, or a developmental pediatrician. When discussing your concerns, focus on the child’s behaviors and avoid drawing conclusions about whether the behaviors are indicative of a mental health problem.

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Appendix 12.  
**SSBD Info**

## Systematic Screening for Behavioral Disorders

Primary prevention systems of behavior support in schools require a systematic process for screening and identifying students who may be at risk for developing behavioral disorders. One valid and efficient approach to screening and identification being practiced in PBIS-NH schools is the use of teacher nominations and tracking of office discipline referrals (ODRs). There is evidence that teacher nomination and the use of ODRs are effective at identifying students with externalizing behaviors such as aggression, disruption and non-compliance. However, the evidence suggests that this approach is ineffective at detecting students with internalizing behaviors such as depression, withdrawal, social isolation and extreme shyness. Systematic Screening for Behavior Disorders (SSBD; Walker & Severson, 1992), used with elementary school-age children, is a more comprehensive approach that also identifies students with internalizing behaviors. The Early Screening Project is a similar instrument designed for children ages 3-5.

Results of recent research suggest that ODRs in combination with the SSBD is effective at identifying both types of students for supports before problems become more intense and chronic.

The SSBD is proactive and incorporates three gates, or stages. The screening takes into consideration both teacher judgments and direct observations in order to identify students at-risk for developing ongoing internalizing and externalizing behavior concerns. Stage 1 of the SSBD involves teacher nomination. Stage 2 requires that teachers complete a Critical Events Inventory and a short adaptive and maladaptive behavior checklist for each of the nominated students. Students whose scores on these checklists exceed the established cut off are then candidates for Stage 3. This final stage involves a 15-minute interval observation in both the classroom and on the playground to determine a student's actual performance in social and classroom interactions.

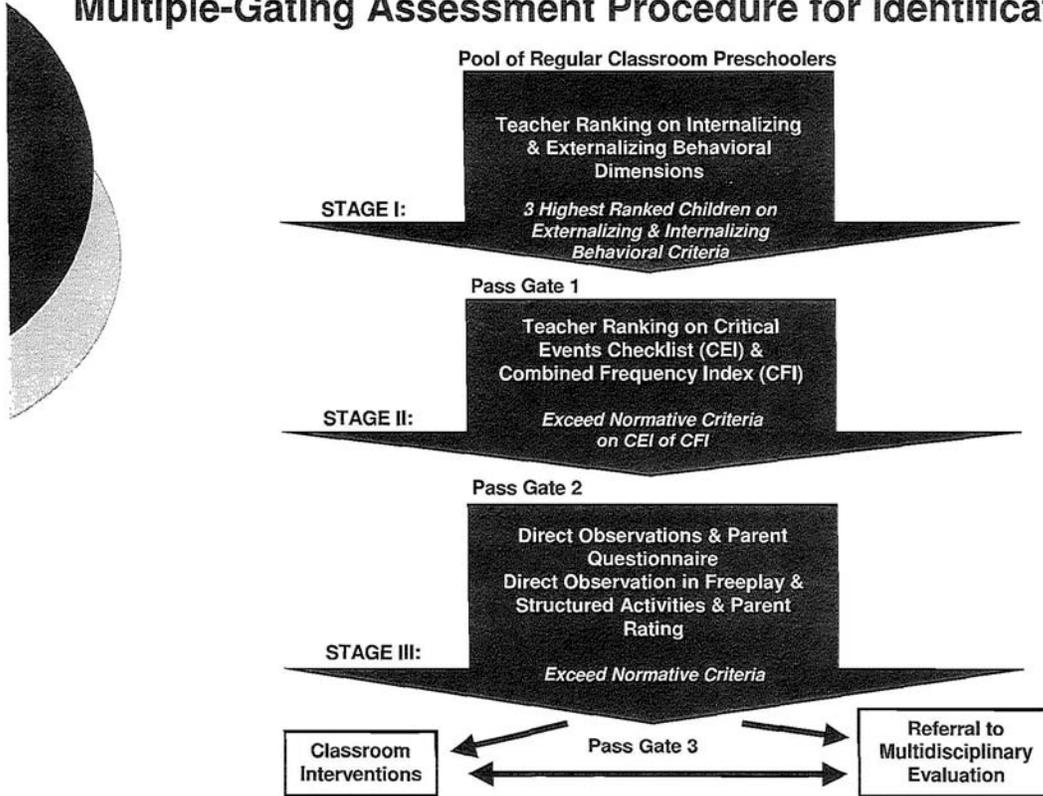
Systematic screening is not designed to make a definitive diagnosis about whether a student qualifies for special education services under the category of emotional disturbance (ED) under IDEA. It also should not be seen as a tool for making a mental health diagnosis or to replace other sources of data or professional expertise from other disciplines that should be taken into account in any assessment process.

We propose that an SAU-wide team take the lead in coordinating the SSBD process in order to address any policy, ethical or professional considerations unique to that school system. The result of this coordination should be an action plan which includes the individuals to be trained and the schedule of professional development activities. Technical assistance and training will be provided by the NH Center for Effective Behavioral Interventions and Supports (NH CEBIS).

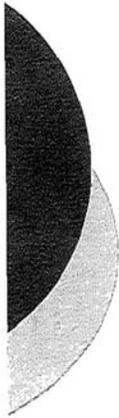
In the MAST-NH project, a minimum of 16 school or school-district members will be trained in Systematic Screening for Behavior Disorders (2 representing each school district). Once trained in SSBD, new 'trainers' will deliver a staff primer in SSBD. The staff primer will be followed by school-wide implementation of the SSBD within the context of primary prevention and in coordination with the PBIS universal team. An early identification of children at risk for development of behavior disorders emerging from the SSBD will connect to a plan for family engagement and /or referral to appropriate supports developed.

Early screening and identification of students at risk for internalizing and externalizing behavior disorders is a fundamental building block for a system of care and education. Research suggests that early identification followed by effective education and treatment improves the school, community and life outcomes for children and families.

# Multiple-Gating Assessment Procedure for Identification



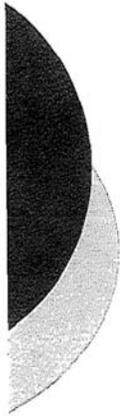
Adapted from: Feil, E., Severson, H., & Walker, H. (1994) Early screening project: Identifying preschool children with adjustment problems. *The Oregon Conference Monograph, Vol 6.*



## SSBD Measures

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- i Gate One
    - 1 Teacher nomination of Externalizing and Internalizing Students
    - 1 Rank ordering of Externalizing and Internalizing Dimensions
    - 1 Top 3 ranked students on each dimension move to screening stage 2
  - i Gate Two
    - 1 Teacher Ratings on:
      - i Critical Events Checklist (33 items)
      - i Adaptive Behavior Scale (12 items)
      - i Maladaptive Behavior Scale (11 items)
  - i Gate Three
    - 1 Direct Behavioral Observations Recorded in classroom and playground settings
      - i AET in the classroom
      - i PSB on the playground
-



## SSBD Norms

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Stage Two 4,500 Subjects

Adaptive Behavior

Maladaptive Behavior

Critical Events

Stage Three Observations 1,275 Subjects

Classroom

Playground

Six Census Zones

Eight States

Oregon

Washington

Utah

Illinois

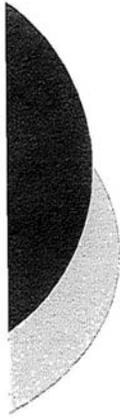
Wisconsin

Kentucky

Florida

Rhode Island

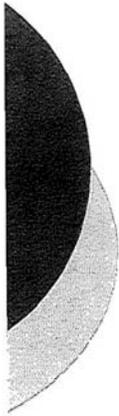
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## Internalizing Behavior

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- ; Excessively shy
  - ; Withdrawn
  - ; Not participating with peers
  - ; Unresponsive to social initiations
  - ; Unhappiness or depression
  - ; Inability to build or maintain relationships
  - ; Develop physical symptoms or fears
-



## Externalizing Behavior

---

- ; Aggressive behavior
  - ; Non-compliance
  - ; Rule breaking behavior
  - ; Hyperactivity
  - ; Extreme, distractibility
  - ; Defying the teacher
  - ; Not following school-imposed rules
  - ; Having tantrums
  - ; Stealing
-

Appendix 13.  
**“Mental Health Screening in Schools”**  
Mark Weist’s 2007 article

# Mental Health Screening in Schools

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## ABSTRACT

**BACKGROUND:** This article discusses the importance of screening students in schools for emotional/behavioral problems.

**METHODS:** Elements relevant to planning and implementing effective mental health screening in schools are considered. Screening in schools is linked to a broader national agenda to improve the mental health of children and adolescents. Strategies for systematic planning for mental health screening in schools are presented.

**RESULTS:** Mental health screening in schools is a very important, yet sensitive, agenda that is in its very early stages. Careful planning and implementation of mental health screening in schools offers a number of benefits including enhancing outreach and help to youth in need, and mobilizing school and community efforts to promote student mental health while reducing barriers to their learning.

**CONCLUSIONS:** When implemented with appropriate family, school, and community involvement, mental health screening in schools has the potential to be a cornerstone of a transformed mental health system. Screening, as part of a coordinated and comprehensive school mental health program, complements the mission of schools, identifies youth in need, links them to effective services, and contributes to positive educational outcomes valued by families, schools, and communities.

**Keywords:** mental health; health screening; counseling; school psychology.

**Citation:** Weist MD, Rubin M, Moore E, Adelsheim S, Wrobel G. Mental health screening in schools. *J Sch Health.* 2007; 77: 53-58.

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## BACKGROUND

A significant gap between the mental health needs of children and adolescents and the available services has been well documented. For example, between 12% and 27% of youth might have acting-out behavioral problems, depression, and anxiety; yet, as few as one sixth to one third of these youth receive any mental health treatment.<sup>1-3</sup> In this context, school mental health (SMH) programs have grown progressively.<sup>4</sup> This growth reflects increasing recognition of the need to address the mental health needs of children and youth and the many advantages of SMH programs. These include reducing barriers to student learning, unmatched access to youth, and ability to engage youth in an array of strategies that can simultaneously address their educational, emotional, behavioral, and developmental needs.<sup>5</sup> In fact, for youth who do receive mental health services, most receive them in schools.<sup>6-8</sup> In addition, SMH programs can reduce stigma,<sup>9</sup> enhance the generalization and maintenance of interventions,<sup>10</sup> increase opportunities for preventive services,<sup>11,12</sup> and promote efficiency and productivity of staff and programs.<sup>13</sup> Program evaluation data and early research suggest that *when done well*, SMH services are associated with satisfaction by a number of different stakeholder groups including students<sup>14</sup> and contribute to achieving outcomes valued by families and schools.<sup>9,15-18</sup>

Strong federal support for SMH programs and services is found in the US Surgeon General's reports on mental health<sup>7</sup> and child and adolescent mental health;<sup>19</sup> large federal initiatives such as the Safe Schools/Healthy Students Program and the Child and Adolescent Service System Program. *Achieving the Promise: Transforming Mental Health Care in America*, the report issued by the President's New Freedom Commission on Mental Health in 2003,<sup>20</sup> emphasized the large gap between needs and effective services and the lack of a national priority on child and adolescent mental health. The 6 goals and 19 recommendations of the report strongly support SMH, including recommendation 4.2 to "improve and expand school mental health programs" and a related recommendation 4.3 to "screen for co-occurring mental and substance use disorders and link with integrated treatment strategies" (Table 1).

*Achieving the Promise* calls for an approach that connects policy, training, practice, and research on mental health services and that improves behavioral, emotional, and academic functioning of youth. This approach is reflected in a pyramid of programs and services. The foundation aims to improve school environments and broadly promotes health as well as academic success. The second tier encompasses targeted prevention programs and early identification

Table 1. Goals and Selected Recommendations of the President's New Freedom Commission ([www.mentalhealthcommission.gov](http://www.mentalhealthcommission.gov))

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Goal 1: Americans understand that mental health is essential to overall health
Recommendation 1.1: Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention
Goal 2: Mental health care is consumer and family driven
Goal 3: Disparities in mental health services are eliminated
Goal 4: Early mental health screening, assessment, and referral to services are common practice
Recommendation 4.1: Improve the mental health of young children
Recommendation 4.2: Improve and expand school mental health programs
Recommendation 4.3: Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies
Recommendation 4.3: Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and supports
Goal 5: Excellent mental health care is delivered and research is accelerated
Goal 6: Technology is used to access mental health care and information

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practices that help recognize and refer students with unmet mental health needs. Providing access to effective treatment services for serious and/or chronic disorders occupies the top of the pyramid. This model is congruent with a public health approach to disease prevention and detection. It incorporates a continuum of educational messages that promote health and prevention and incorporates early identification practices that ensure cost-effective treatment for disabling health conditions. This pyramid model for health and mental health promotion has been embraced by the World Health Organization<sup>21</sup> and other groups but unfortunately does not reflect the way programs and services are delivered to children and youth in the United States.<sup>7,20</sup>

Although historically, school-based mental health services were provided primarily to students qualified for special education services, more recently, schools have expanded mental health and social services for all students as part of their coordinated school health program.<sup>22,23</sup> Today, there are a number of different models for offering these services in schools, with an array of service components ranging from alcohol and other drug use treatment, case management, individual and group counseling, and referrals to community mental health systems and providers. Despite this, there remain numerous barriers including:

- insufficient funding
- inadequate training and supervision of staff
- difficulty coordinating a full continuum of prevention and intervention services
- maintenance of quality and empirical support of services
- limited evaluation of outcomes of services to improve programs and contribute to policy improvement.<sup>24</sup>

Providing treatment services within school buildings is often challenging for additional reasons, including:

- environmental characteristics (poor office spaces, crowded classrooms)
- frequent changes in personnel (high teacher and administrator turnover)
- distinctive knowledge bases and cultures (education and mental health)
- difficulties in fully engaging families
- academic demands stemming from the No Child Left Behind educational reforms.

These issues are increasingly documented in the published literature, especially in relation to research-based interventions.<sup>25,26</sup>

### MENTAL HEALTH SCREENING IN SCHOOLS

Youth with internalizing disorders such as depression, anxiety, or suicide ideation are not as easily identified as those with acting-out or externalizing disorders. Individuals with internalizing conditions comprise a significant population; the 2003 Youth Risk Behavior Survey, a nationally representative sample of more than 15,000 high school students throughout the United States, found that in the 12-month period preceding the survey, 16.9% had seriously considered attempting suicide, 16.5% had made a plan for attempting suicide, 8.5% had attempted suicide 1 or more times, and 2.9% had made an attempt requiring medical attention.<sup>27</sup> In addition, studies have shown that students contemplating suicide or even those who had previous attempts were not known or detected by school personnel.<sup>28</sup> Furthermore, 90% of teens who commit suicide have a mental health issue at the time of their death but are usually not receiving treatment.<sup>28</sup>

For these reasons, formal screening programs that detect depression and suicide ideation are recommended. The New Freedom Commission on Mental Health recommended screening in multiple settings as a critical component of a public health approach to prevention and early intervention for mental health issues in youth.<sup>20</sup> The Commission went so far as to name the Columbia University TeenScreen program as a model program for identifying at-risk youth and linking them to critical intervention services. TeenScreen is currently implemented in 460 sites in 42 states and involves systematic and supported assessment of youth mental health needs in schools along with technical assistance and guidance on addressing identified needs.<sup>29</sup> Other effective programs such as *Dominic*<sup>30</sup> and the *Signs of Suicide* program<sup>31</sup> are also widely available. These recommendations have led to increasing discussion among

mental health providers of the need to advance mental health screening in schools. A few states, such as Ohio, Illinois, and New Mexico, have moved to expand screening in multiple settings as part of their efforts to transform their child's mental health system.

However, screening in schools is not without controversy. Some perceive screening as government intrusion, and others describe it as a violation of the family's right to privacy. These concerns appear to be based on the erroneous belief that screening programs in schools require all students to be screened against their wishes or against those of the parents.<sup>32</sup> In fact, "mandatory universal screening" for behavioral health issues does not exist anywhere and has never been recommended by any federal agency or community screening program. All existing mental health screening programs are voluntary and require active informed consent of the family and the assent of the student. It is likely that another factor contributing to the misunderstanding surrounding screening is stigma. The President's Commission acknowledged the pervasive nature of stigma and the need to actively address it.

While there are no currently agreed-upon national standards for mental health screening in schools, a number of federal agencies, professional organizations, and advocacy groups have issued helpful resources. Both the Substance Abuse and Mental Health Services Administration<sup>33</sup> and the National Alliance for the Mentally Ill<sup>34</sup> recently released documents confirming the importance of screening as part of a public health approach to early identification and intervention for behavioral health problems and offering guidelines for the appropriate use of screening. Well-established screening programs such as TeenScreen generally have experientially based recommendations for implementation and strongly recommend active parental consent for any screening in schools. Another helpful resource on screening and assessing mental health and substance use disorders was issued by the Office of Juvenile Justice and Delinquency Prevention of the US Department of Justice, which includes a set of criteria for selecting screening methods.<sup>35</sup> The American Medical Association's Guidelines for Adolescent Preventive Services includes recommendations for screening behavioral and emotional conditions, such as substance abuse, eating disorders, depression, suicide risk, and school or learning problems.<sup>36</sup> All these guidelines and criteria for mental health screening can provide a foundation for developing standards for the school setting.

### Other Issues

In trying to decide whether to implement a screening program, there are other factors that districts will need to consider. For example, strategic planning

should attempt to gauge the needs of individual schools in relation to the school/community's abilities to respond to those needs.<sup>37</sup> This will require a self-assessment process. In addition, prior to advancing the agenda related to mental health screening in schools, the community should consider:

1. Availability of trained staff and other resources to conduct screening.
2. Availability of mental health providers with training in evaluating and treating those children and youth identified by screening.
3. Need for technical assistance in system development for ensuring parental consent and student assent for participation in screening.
4. Selection of age-appropriate screening measures.
5. Logistics including when to do the screening, finding the right confidential space for screening, and provision of alternative activities for youth who do not have parental permission for screening.
6. Resolution of liability concerns.

#### First Steps

Once a district has addressed the issues outlined above and decided to move toward implementing a formal screening program, five additional elements will need to be considered: inclusive planning, collaborative relationships, logistics, training and supervision, and integration.

**Inclusive Planning.** Planning should involve all significant stakeholders including families, education professionals, primary care providers, mental health professionals, and other representatives from the community. Once configured, the planning body might begin with a policy review to ensure that sufficient safeguards are in place to protect privacy and confidentiality. Districts can also benefit from ongoing technical expertise from community agencies that respond to related mental health issues such as substance abuse, child welfare, law enforcement, or other specialty systems.

**Collaborative Relationships.** To promote collaboration, the sharing of resources, and to address liability concerns, memoranda of agreement should be established between schools and collaborating community agencies to ensure adequate clarification of responsibility. Ideally, local initiatives and agreements between child serving systems should be approved of and supported by state systems, such as state departments of education, mental health, juvenile justice, and child welfare.

**Logistics.** The time to conduct screening must be determined. Some have recommended transitional years such as sixth and seventh and ninth and 10th grades as critical times when clinical symptoms often linked to increased suicide risk sometimes

develop.<sup>29,37</sup> However, screening efforts at these ages should ideally be part of broader efforts within communities to promote wellness, mental health, and learning success for youth from preschool through young adulthood. Locally collected data such as emergency room data can assist in identifying age groups at particular risk. In the absence of locally available data, state and national data such as the Youth Risk Behavior Survey (<http://www.cdc.gov/HealthyYouth/yrbs>) can be helpful. However, if the planning group determines that there are inadequate resources to provide adequate follow up to the screen, the screening process should be delayed until adequate resources are marshaled and confidence of adequate follow up is increased.<sup>38</sup>

**Training, Supervision, and Support.** Staff that participate in screening will require adequate training and supervision. Personnel will be needed who can coordinate the work; select age-appropriate and culturally sensitive measurement tools; manage associated technology for administering, scoring, and interpreting the data; and establish and sustain relationships with school and community providers.

Regardless of whether a school implements a systematic screening program, all schools should enhance their capacity to identify youth who present signs of emotional/behavioral disturbance. These disturbances represent barriers to learning and are indicative of the development of serious mental health concerns. Schools should connect these youth to appropriate resources and services. Professional development will be required to raise awareness and increase knowledge of child and adolescent mental health needs, the factors that promote healthy youth development and those that contribute to mental health problems, specific signs of distress, and strategies to assist distressed youth in obtaining help.<sup>39,40</sup> All staff should have a clear understanding of referral procedures and know how to determine when a youth is in crisis and needs an immediate intervention.

**Integration.** Mental health screening should be one aspect of a full continuum of effective mental health programs and services in schools. Such programs can only exist when there is a full partnership between families, schools, and child serving systems, particularly the mental health system. There must be strong emphases on quality assessment and improvement, empirically supported practice, and evaluating outcomes of services.<sup>24</sup> Findings from outcome evaluations should be used to continuously improve services and should connect to advocacy and policy agendas.

#### CONCLUSION

The President's New Freedom Commission on Mental Health<sup>20</sup> provides specific recommendations

to improve and expand school mental health programs and to screen for co-occurring mental and substance use disorders and link with integrated treatment strategies. The New Freedom Initiative and its 19 specific recommendations represent a call to action for communities and states to move beyond fragmented and ineffective approaches to illness care for a small percentage of those in need toward a true public mental health promotion system that ensures quality and effectiveness along a full continuum of services. Consideration of the issues outlined in this article should help schools and communities determine whether they are ready to include screening in schools as part of their SMH program.

When implemented with appropriate family, school, and community involvement, mental health screening in schools has the potential to be a cornerstone of a transformed mental health system that identifies youth in need, links them to effective services, and contributes to positive health and educational outcomes valued by families, schools, and communities.

## REFERENCES

- Burns BJ, Costello EJ, Angold A, et al. Children's mental health service use across service sectors. *Health Aff.* 1995; 14:147-159.
- Leaf PJ, Alegria M, Cohen P, et al. Mental health services use in the community and schools: results from the four-community MECA study. *J Am Acad Child Adolesc Psychiatry.* 1996;35: 889-897.
- Weisz J. *Psychotherapy for Children and Adolescents: Evidence-Based Treatments and Case Examples.* New York, NY: Cambridge University Press; 2004.
- Flaherty LT, Osher D. History of school-based mental health services. In: Weist MD, Evans SW, Lever NA, eds. *Handbook of School Mental Health: Advancing Practice and Research.* New York, NY: Kluwer Academic/Plenum Publishers; 2003:11-22.
- Weist MD, Myers CP, Hastings E, Ghuman H, Han Y. Psychosocial functioning of youth receiving mental health services in the schools vs. community mental health centers. *Community Ment Health J.* 1999;35(5):69-81.
- Rones M, Hoagwood K. School-based mental health services: a research review. *Clin Child Fam Psychol Rev.* 2000;3(4): 223-241.
- U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary.* Rockville, Md: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health; 1999.
- U.S. Department of Health and Human Services. *Youth Violence: A Report of the Surgeon General.* Rockville, Md: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health; 2001.
- Nabors LA, Reynolds MW. Program evaluation activities: outcomes related to treatment for adolescents receiving school-based mental health services. *Child Serv: Soc Policy Res Pract.* 2000;3(3):175-189.
- Evans SW. Mental health services in schools: utilization, effectiveness and consent. *Clin Psychol Rev.* 1999;19:165-178.
- Elias MJ, Gager P, Leon S. Spreading a warm blanket of prevention over all children: guidelines for selecting substance abuse and related prevention curricula for use in the schools. *J Prim Prev.* 1997;18:41-69.
- Weare K. *Promoting Mental, Emotional and Social Health: A Whole School Approach.* London: Routledge; 2000.
- Flaherty LT, Weist MD. School-based mental health services: the Baltimore models. *Psychol Sch.* 1999;36(5):379-389.
- Nabors LA, Reynolds MW, Weist MD. Qualitative evaluation of a high school mental health program. *J Youth Adolesc.* 2000; 29:1-14.
- Sugai G, Horner RH, Dunlap G, et al. Applying positive behavior support and functional behavioral assessment in schools. *J Posit Behav Interv.* 2000;3:131-143.
- Zins JE, Weissberg RP, Wang MC, Walberg HJ, eds. *Building Academic Success on Social and Emotional Learning: What Does the Research Say?* New York, NY: Teachers College Press; 2004.
- Bruns EJ, Walrath C, Siegel MG, Weist MD. School-based mental health services in Baltimore: Association with school climate and special education referrals. *Behav Modif.* 2004;28:491-512.
- Schargel FP, Smink J. *Strategies to Help Solve Our School Dropout Problem.* Larchmont, NY: Eye on Education; 2001.
- U.S. Department of Health and Human Services. *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.* Rockville, Md: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health; 2000.
- President's New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, Md: U.S. Department of Health and Human Services; 2003.
- World Health Organization. *The World Health Report 2001, Mental Health: New Understanding, New Hope.* Geneva: World Health Organization; 2001.
- Foster S, Rollefson M, Doksum T, Noonan D, Robinson G. *School Mental Health Services in the United States, 2002-2003.* Rockville, Md: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; 2005.
- Brener ND, Martindale J, Weist MD. Mental health and social services: results from the School Health Policies and Programs Study 2000. *J Sch Health.* 2001;71:305-312.
- Weist MD, Evans SW, Lever NA. Advancing mental health practice and research in schools. In: Weist MD, Evans S, Lever N, eds. *Handbook of School Mental Health: Advancing Practice and Research.* New York, NY: Kluwer Academic/Plenum Publishers; 2003:1-8.
- Greenberg MT, Domitrovich C, Bumbarger B. *Preventing Mental Health Disorders in School-Age Children: A Review of the Effectiveness of Prevention Programs.* University Park: Prevention Research Center, Pennsylvania State University; 1999. Available at: www.prevention.psu.edu. Accessed December 31, 2004.
- Graczyk PA, Domitrovich CE, Zins JE. Facilitating the implementation of evidence-based prevention and mental health promotion efforts on schools. In: Weist MD, Evans SW, Lever NA, eds. *Handbook of School Mental Health Programs: Advancing Practice and Research.* New York, NY: Kluwer Academic/Plenum Publisher; 2003:301-318.
- Grunbaum JA, Kann L, Kinchen S, et al. Youth risk behavior surveillance—United States, 2003. *MMWR Morb Mortal Wkly Rep.* 2004;53:1-95.
- Shaffer D, Craft L. Methods of adolescent suicide prevention. *J Clin Psychiatry.* 1999;60(suppl 2):70-74.

29. Shaffer D, Scott M, Wilcox H, et al. The Columbia Suicide Screen: validity and reliability of a screen for youth suicide and depression. *J Am Acad Child Adolesc Psychiatry*. 2004;43(1):71-79.
30. Valla JP, Bergeron L, Smolla N. The Dominic-R: a pictorial interview for 6- to 11-year old children. *J Am Acad Child Adolesc Psychiatry*. 2000;39:85-93.
31. Aseltine RH, DeMartino R. An outcome evaluation of the SOS suicide prevention program. *Am J Public Health*. 2004; 94(3):446-451.
32. Ashford E. Screening aimed at preventing youth suicide. *School Board News* [serial online]. Available at: [www.nsba.org/site/doc\\_sbn\\_issue.asp?TRACKID=6&VID=556&CID=682&DID=36189](http://www.nsba.org/site/doc_sbn_issue.asp?TRACKID=6&VID=556&CID=682&DID=36189). Accessed June 28, 2005.
33. U.S. Department of Health and Human Services. *Screening, Assessment, and Treatment Planning for Persons with Co-Occurring Disorders*. Rockville, Md: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, Center for Mental Health Services; 2005.
34. National Alliance on Mental Illness. NAMI supports screening children and adolescents for mental illnesses in child servicing agencies and settings. Available at: [http://www.nami.org/Content/ContentGroups/CAAC/screening\\_statement.pdf](http://www.nami.org/Content/ContentGroups/CAAC/screening_statement.pdf). Accessed December 7, 2005.
35. U.S. Department of Justice. *Screening and Assessing Mental Health and Substance Use Disorders among Youth in the Juvenile Justice System: A Resource Guide for Practitioners*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention; 2004.
36. American Medical Association. *Guidelines for Adolescent Preventive Services (GAPS)*. Chicago, Ill: Department of Adolescent Health, American Medical Association; 1997.
37. Center for School Mental Health Assistance. *School Mental Health and the President's New Freedom Initiative*. Baltimore, Md: University of Maryland School of Medicine; 2004. Available at: <http://csmha.umaryland.edu>. Accessed November 25, 2005.
38. Gould MS, Greenberg T, Velting DM, Shaffer D. Youth suicide risk and preventive interventions: a review of the past 10 years. *J Am Acad Child Adolesc Psychiatry*. 2003;42(4): 386-405.
39. Paternite CE, Johnston TC. Rational and strategies for central involvement of educators in effective school-based mental health programs. *J Youth Adolesc*. 2005;34:41-49.
40. Weist MD, Paternite CE, Adelsheim S. *School-Based Mental Health Services*. Report to the Institute of Medicine, Board on Health Care Services, Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders Committee. Washington, DC: Institute of Medicine; 2005.

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Appendix 14.  
**Sample Parental Permission Forms**

- Davis Behavioral Health
- Weber Human Services

**Permission for Behavioral/Educational Interventions**  
**Davis School District Student Services Department**  
**Student Services/School Based Behavioral Health Services**

\*

I give permission for my son/daughter to participate in behavioral/educational interventions through Davis Behavioral Health. This may include individual, group or family counseling or education and skill building activities. Local school personnel may also be involved. Topics for discussion will be determined by the needs of the student, family and schools. Various instructional materials may be presented and the students may discuss their personal views, experiences and concerns as appropriate, including those areas covered by the Family Educational Rights and Privacy Act, Section 53A-13-301 and 302, Utah Code. For the purpose of improving services to the student, the counselor/teacher may discuss, share, send or receive information with the school system's Case Management Teams or outside consultants such as Davis Behavioral Health. Some of the data, without personally identifiable information, may be used for research. Your permission may be sought to record segments of the intervention sessions for training purposes. You and your student may also be asked to complete checklists, now and in the future, to evaluate areas of concern and to research the effectiveness of the interventions. Information will be kept confidential except where disclosure is required by state law, district policy, professional ethics or consultation needs. Under section 53A-13-301 and 302, Utah Code, parents have a two week waiting period before deciding about any interventions within the school system. **The School Based Behavioral Health services are NOT part of special education services.** **Special education services are identified on the student's Individual Education Plan. The local school should be contacted for Special Education information.** You may withdraw your son/daughter from the program at any time. Please discuss any concerns with the counselor/educator before signing this form, and please keep in contact with the counselor/educator throughout the intervention.

I give permission for my son/daughter, (student's name) \_\_\_\_\_ to participate in School Based Behavioral Health interventions.

Parent/Guardian Signature \_\_\_\_\_, Relation to student \_\_\_\_\_.

Date \_\_\_\_\_ I waive the two week waiting period (initial) \_\_\_\_\_.

Comment:



Appendix 15.  
**What Utah School Employees Can And Cannot Do**

## **MEDICAL AND MENTAL HEALTH RECOMMENDATIONS: WHAT UTAH SCHOOL EMPLOYEES CAN AND CANNOT DO**

### **School personnel MAY:**

- Provide information and observations to a student's parent about the student, including observations and concerns about the following:
  - Progress
  - Health and wellness
  - Social interactions
  - Behavior
  - Situations which exist that "present a serious threat to the well being of a student" [Section 53A-13-302(6)]
- Communicate information/observations between school personnel about a child.
- Refer students to appropriate school personnel/agents, consistent with local school board/charter school policy, including to a school counselor or other mental health professionals within the school system
- Consult or use appropriate health care and mental health care professionals in emergency situations while students are at school, consistent with student emergency information provided at student enrollment
- Complete a behavioral health evaluation form if requested by a student's parent to provide information to a physician

### **School personnel SHALL:**

- Report suspected child abuse consistent with state law
- Comply with state and local health department laws, rules and policies
- Conduct student evaluations/assessments consistent with IDEA

### **School personnel MAY NOT:**

- Require that a student take/continue to take psychotropic medication
- Recommend that parents seek or use a psychiatric/psychological treatment for a child
- Conduct psychiatric/behavioral health evaluation or mental health screening, test, evaluation, assessment of an individual child except where specifically required by IDEA
- Make a report of suspected child abuse only because a parent refuses to allow a psychiatric, psychological, behavioral treatment for a child UNLESS not doing so would "present serious, imminent risk to a child's safety or the safety of others."

### **School counselors and school psychologists MAY:**

- Recommend, but not require, psychiatric/behavioral health evaluation or treatment of a child
- Recommend, but not require, psychological treatment of a child
- Conduct a child psychiatric/ behavioral health evaluation or mental health screening, test, evaluation, assessment consistent with 53A-13-302
- Provide to parents, upon specific request, a list of three or more health care professionals/providers

Appendix 16.  
**“My Profile”**

My Profile Template

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Gender: \_\_\_\_\_

My Family:	
Parents: _____	
Brothers and Sisters (with dates of birth): _____	
_____	
_____	
Other family members who are involved with me on a regular basis: _____	
_____	
_____	
_____	
Who I Live With:	
Other regular caretakers:	
Immigration: What is your immigration status (citizen, undocumented, etc.), how long have you lived in U.S., etc.:	
Child:	Family:
Legal status of family: living with family of origin, blended family, custody information, guardianship, etc.	
Is child or family involved in any legal actions? (adoption proceedings, law suits, criminal prosecution, imprisonment, probation, paying legal judgments, etc.)	
Child:	Family:

## Community Life

Where do you live now?	
What kind of community do you live in (size, urban/rural, etc.): _____	
What is in your neighborhood (circle those that apply): <span style="margin-left: 20px;">Park/playground</span> <span style="margin-left: 20px;">Grocery store</span> <span style="margin-left: 20px;">Bus/train</span> <span style="margin-left: 20px;">sidewalks</span> <span style="margin-left: 40px;">School/college</span> <span style="margin-left: 20px;">place to worship</span> <span style="margin-left: 20px;">indoor mall</span> <span style="margin-left: 20px;">strip mall</span> <span style="margin-left: 20px;">restaurants</span>	
What do you LIKE about your community? _____ _____	
What do you DISLIKE about your community? _____ _____	
What are things you like to do in your spare time?	
Child:	Family:
What are things you like to do in your community? Where are places you go regularly in your community?	
Child:	Family:
Are there new things or groups you would like to become involved with in your community?	
Child:	Family:
How do you get around in your community? (walk, own a car, bus, etc.)	
Child:	Family:
Do you feel comfortable in your community? (Safety, how you fit in with the "norms", etc.)	
Child:	Family:

## Family Life

Living Situation		
What kind of home is it?	Single family house	Apartment in large complex      Apartment in small complex
	Other: _____	
What do you LIKE about your living situation?	_____	
	_____	
What do you DISLIKE about your living situation?	_____	
	_____	
What is your primary language?		
Child: _____	Family: _____	Extended family: _____ :
Who lives with you? How involved are they with you?		
Person: _____	How involved: _____	
Person: _____	How involved: _____	
Person: _____	How involved: _____	
Person: _____	How involved: _____	
Person: _____	How involved: _____	
Person: _____	How involved: _____	
Person: _____	How involved: _____	
Person: _____	How involved: _____	
Are there any basic needs that are not being met? (food, clothing, paying bills, medical care and prescriptions, etc.)		
Date: _____	Needs not being met: _____	
Date: _____	Needs not being met: _____	
Date: _____	Needs not being met: _____	
Date: _____	Needs not being met: _____	
Date: _____	Needs not being met: _____	
Date: _____	Needs not being met: _____	
What are your most important family values? What are the things most important to your family?		

### Child's Development

Summarize your child's development compared to other children of the same age:		
Age	Things my child does that are typical for this age:	Things my child CANNOT do that other children CAN do:
What kinds of services has your child received to help with developmental concerns?		
Date(s): _____ Type of program/help: _____		
Date(s): _____ Type of program/help: _____		
Date(s): _____ Type of program/help: _____		
Date(s): _____ Type of program/help: _____		



## Employment

What are the employment goals for the child?

Employment history – include job hunting efforts, how long in each job, reason job ended, etc.

Dates: \_\_\_\_\_ Type of Activity:  job search  employment at (company) \_\_\_\_\_

Describe job search or employment: \_\_\_\_\_

If employment ended, state when and why: \_\_\_\_\_

Dates: \_\_\_\_\_ Type of Activity:  job search  employment at (company) \_\_\_\_\_

Describe job search or employment: \_\_\_\_\_

If employment ended, state when and why: \_\_\_\_\_

Dates: \_\_\_\_\_ Type of Activity:  job search  employment at (company) \_\_\_\_\_

Describe job search or employment: \_\_\_\_\_

If employment ended, state when and why: \_\_\_\_\_

Dates: \_\_\_\_\_ Type of Activity:  job search  employment at (company) \_\_\_\_\_

Describe job search or employment: \_\_\_\_\_

If employment ended, state when and why: \_\_\_\_\_

Dates: \_\_\_\_\_ Type of Activity:  job search  employment at (company) \_\_\_\_\_

Describe job search or employment: \_\_\_\_\_

If employment ended, state when and why: \_\_\_\_\_

Dates: \_\_\_\_\_ Type of Activity:  job search  employment at (company) \_\_\_\_\_

Describe job search or employment: \_\_\_\_\_

If employment ended, state when and why: \_\_\_\_\_

(add more sheets for this section as needed)





**Substance Abuse and Family Violence**

Does any family member have CURRENT problems with substance abuse (legal or illegal) or violence?	
Child:	Other Family members:
Is the child or other family member CURRENTLY receiving treatment or any services related to substance abuse or violence?	
Child:	Other Family members:
Does the child or family have PAST HISTORY of problems with substance abuse or violence? Include any treatment or services received.	
Child:	Family:



Appendix 17.  
**Components of a Person-Centered Plan**

## **PERSON-CENTERED RECOVERY PLAN \***

**... a Person-Centered Recovery Plan ... will include the following components:**

- a. Identifying Information
- b. Diagnosis
  1. Do the treating diagnoses match the diagnoses in the current assessment?
  2. Document changes in diagnosis.
- c. Formulation
- d. Goals (Are the treatment goals stated in the consumers own words [for youth, when age and developmentally appropriate?])
- e. Strengths
- f. Barriers (Behaviors, symptoms or life situations)
- g. Objectives (Behavioral changes that are measurable, short term and tied to the goals)
- h. Interventions (List what modality is being used, the credentials of individuals who will furnish the services, and frequency and duration.)
- i. Anticipated Transition/Discharge Criteria
- j. Printed copies of the plans should available and copies should be offered to the consumer.
- k. Child and youth records must contain a safety/crisis plan when clinically indicated.

\* *Division of Substance Abuse & Mental Health, 2011 Division Directives, pp. 2-3*  
Downloaded 4-12-10 from [http://www.dsamh.utah.gov/docs/division\\_directives\\_fy11\\_final.pdf](http://www.dsamh.utah.gov/docs/division_directives_fy11_final.pdf)

Appendix 18.  
**Sample Crisis / Safety Plan**

- New Frontiers for Families
- Wasatch Mental Health



NEW FRONTIERS FOR FAMILIES  
EMPOWERING FAMILIES TO SUCCEED  
P.O. Box 207, Tropic, UT 84776  
1-866-897-7322

## **Wraparound Safety and Crisis Plan**

Basic procedure for safety crisis intervention in Wraparound planning:

- Anticipated crises are defined and clarified in the Family Team meeting with input from all members.
- Safety and Crisis Plan is developed with the child and family in the meeting (see below).
- Safety and Crisis Plans are proactive and reactive.
- Families and teams are instructed to practice with dry runs.

### **Crisis Definition and Clarification**

1. Each member of the team, including all cross-systems members, Social Worker, school personnel, etc, puts his or her concerns on the table regarding what could go wrong.
2. There is a review of history because most crises have happened before.
3. The team should identify where its plans seem most vulnerable and what the possible consequences would be if the plan does not function.
4. Alternative strategies will need to be thought through as "Plan Bs".
5. Proactive plans include tangible or intangible supports that are expected to prevent a targeted crisis from happening.
6. Reactive plans are developed by the team to prepare for what action they will take if the crisis actually occurs.
7. After each crisis occurs, the team should convene within 48-72 hours to review whether or not the plan worked: Was it effective? Does it need modification?
8. All changes to the plan need to be team-driven, and all members who are not present must be informed immediately so that everyone is on the same page.

## Family Safety Plan Form

<b>Child's Name:</b>	<b>Date of Birth:</b>
<b>Family Address:</b>	<b>Phone #</b>
<b>Referring agency and contact person:</b>	
<b>Facilitator Name and Number:</b>	

Team Members	Relationship	Phone #

Anticipated Crisis	Intervention Plan

Other Vital Info: (Medications, unusual circumstances, hints, tips, etc.)

Directions and Maps:

## EXAMPLE

\_\_\_\_\_ SHARP \_\_\_\_\_ Family Safety Plan

**Child's Name:** Kid Sharp **Date of Birth:** Age 10  
**Family Address:** \_\_\_\_\_ **Family Phone:** \_\_\_\_\_  
**Referring Agency and contact person:** \_\_\_\_\_  
**Facilitator Name:** Fanny Facilitator **Phone:** \_\_\_\_\_

Team member	Relationship	Phone
Mom and Dad Sharp	Parents	
Sister Sharp	Sister	
Grandma Sharp	Grandmother	
Nice Neighbor		
Patty Principal	Principal at the Kid's school	
Connie Counselor	Sister's school-based Therapist	
Medicine Man	MD Psychiatrist	
Thelma Therapist	Family Specialist	
Sammy Supportalist	Family specialist	
Susie Specialist	Family Specialist (sister)	

ANTICIPATED CRISIS	INTERVENTION PLAN
<p>Kid becomes upset because he feels he is not being heard and/or he is not being taken seriously. He begins to use foul language, escalating to Suicidal Ideation, and makes suicidal/hopeless statements.</p>	<ol style="list-style-type: none"> <li>1. Attempt to distract, divert attention to something he is interested in.</li> <li>2. Give attention, ask about his day.</li> <li>3. Try to get him to verbalize his feelings.</li> <li>4. Remind him of his successes and that he has learned how to express his feelings without making suicidal threats.</li> </ol>
<p>Kid continues to escalate and begins grabbing sharp objects and attempting to cut himself or tries running into the street.</p> <p>*Remember to check on Sister. Sometimes she</p>	<ol style="list-style-type: none"> <li>1. Knives, scissors and other sharp objects to be kept in secure box with padlock.</li> <li>2. When escalation begins, Mom to work with Kid and attempt to soothe, contain and restrain him if necessary for safety.</li> <li>3. A safety check will be made and all other potentially dangerous items will be quickly collected and placed in locked box.</li> <li>4. Mom will immediately call for backup if she is alone. If she feels she cannot keep situation safe until help arrives she will call 911.</li> </ol>
<p>Will be able to be helpful and sometimes her own issues will necessitate her being removed from the situation to avoid having both children in crisis at the same time. She can go to a neighbor's or Grandmother's. If these are not available, send staff to take her away from the situation.</p>	<ol style="list-style-type: none"> <li>5. Back ups are as follows according to expected response time: <ul style="list-style-type: none"> <li><input type="checkbox"/> Dad and/or Sister</li> <li><input type="checkbox"/> Next door neighbor- Jun</li> <li><input type="checkbox"/> Grandmother</li> <li><input type="checkbox"/> Wrap program</li> </ul> </li> </ol>

	<p>6. Back ups will support Mom by doing the safety check and locking the items away, making phone calls as the need arises and other tasks.</p> <p>7. If Kid does not de-escalate call MH Crisis to assess for hospitalization criteria. If safety cannot be maintained, call 911 first and call Wrap program when able.</p>
<p>Sister may feel suicidal, make veiled or direct suicidal threats, cut on herself or threaten to run away.</p> <p>(Remember to check on how Kid is doing when his sister is in crisis. Kid has been doing very well, but may need reminding that he has learned to manage his emotions safely and without resorting to suicidal threats.)</p>	<ol style="list-style-type: none"> <li>1. Knives, scissors and other sharp objects and pills to be kept in secure box with padlock. Other items will be secured as warranted.</li> <li>2. Encourage her to talk and help her identify her feelings.</li> <li>3. If she can't talk, give her some time and then try again.</li> <li>4. She can talk with therapist, Connie during school hours and Thelma after school hours.</li> <li>5. She can call Wrap program staff to talk.</li> <li>6. She can go to Grandmother's or a neighbor's. First ask Mom if it is appropriate.</li> <li>7. If crisis continues to escalate send staff to home and assess if MH crisis should be deployed or 24 hour watch be put in place.</li> <li>8. If she has made suicidal threat, veiled threat, superficial cuts on self, or behavior/mood warrants - call MH crisis or psychiatrist to assess. Exception: Non-bleeding scratches without accompanying Suicidal Ideation that she reports within 12 hours to appropriate adult (therapist, parent, specialist, etc.).</li> <li>9. If she has ingested pills or made bleeding cuts take to ER.</li> <li>10. If actively attempting to or has seriously cut self, call 911.</li> <li>11. Remember to support parents in keeping to plan and remind them not to take things Sister says personally.</li> </ol>

**Program On-Call Pager # 555-5555      Monday-Friday 5pm – 9am, 24 hours on Weekends**

**Other Vital Info: (Medications, unusual circumstances, hints, tips, etc.)**

- ◆ Medications: Kid - Tegretol 400mgs AM & PM; Trazodone 100 mgs PM; Seroquel 25 mgs PM; Prozac 20 mgs AM
- ◆ Kid is currently doing very well. However, he has severe separation anxiety. Be very cautious about saying things about going to the hospital, etc.
- ◆ Medications: Sister -- Tegretol XR 400 mgs AM & PM; Depakote 500 mgs PM; Wellbutrin SR 200 mgs AM, 150 mgs PM; Trazodone 100 mgs PM; Seroquel 25 mgs PM.
- ◆ Sister can be very dramatic and doesn't always say what she means.
- ◆ Large dog in home. He will bark, but is friendly.

**Map and Directions (Please include precise location of residence.)**

**WASATCH MENTAL HEALTH SAFETY/CRISIS PLAN**

**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Important phone numbers:** \_\_\_\_\_

**Caregiver(s):** \_\_\_\_\_

**Care Coordinator:** \_\_\_\_\_

**Other Service Providers:** \_\_\_\_\_

**Family/Community Supports:** \_\_\_\_\_

**Interests and Strengths of \_\_\_\_\_ relevant to the crisis situation:**

**Specific Effective Techniques in Resolving Crises** (What does the child/youth respond to?  
What should be avoided? Please use examples.): \_\_\_\_\_

**What helps the Caregiver?** (Please use examples.): \_\_\_\_\_

**Current Medications for \_\_\_\_\_:** \_\_\_\_\_

**Prescribed by:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Potential Support Resources:** \_\_\_\_\_

**Alternative Resources** (c.g., relatives and friends): \_\_\_\_\_

Steps for filling out the Crisis/Safety Plan form:

1. fill the attached crisis/safety plan out with the parents/guardian/youth input
2. have all parties sign the plan
3. make a copy of the plan
4. give the parents/guardian/youth the original plan
4. document in the progress note that the safety/crisis plan was completed
5. send a copy of the plan to be scanned in to the chart.

Appendix 19.  
**Youth Outcome Questionnaire (YOQ)**

## Youth Outcome Questionnaire (YOQ) ©

The Youth Outcome Questionnaire was developed by Gawain Wells, Ph.D.; Gary M. Burlingame, Ph.D.; Michael J. Lambert, Ph.D.; and Curtis W. Reisinger, Ph.D.

The YOQ describes a wide range of troublesome situations, behaviors, and moods that are common to youth. It is designed to detect treatment effectiveness regardless of treatment modality, diagnosis or discipline of the treating professional. It is available in several versions:

- Y-OQ<sup>®</sup> -30.2 (30-item questionnaire for youth 4-17 to be completed by parent)
- Y-OQ<sup>®</sup> -30.2SR (30-item questionnaire for youth 12-18 to be completed by them)
- Y-OQ<sup>®</sup> -2.01 (64-item questionnaire for youth 4-17 to be completed by parent)
- Y-OQ<sup>®</sup> -2.01SR (64-item questionnaire for youth 12-18 to be completed by them)

which can be administered as a paper/pencil form, at a kiosk, or on a PDA.

The Division of Substance Abuse and Mental Health requires its subcontractors to utilize the YOQ. *So the community mental health center in your area (see Appendix 4) is already familiar with and licensed to use this outcome tool.*

The YOQ has been used as a pre/post measure for students receiving behavioral health services at school, and has shown significant improvements.

### **For More Information, contact:**

- OQ Measures, LLC  
P.O. Box 521047  
Salt Lake City, UT 84152  
Toll-Free: 1-888-MH-SCORE (1-888-647-2673)  
Phone: 801-990-4235  
Fax: 801-990-4236  
Email: [INFO@OQMEASURES.COM](mailto:INFO@OQMEASURES.COM)
- Or visit <http://www.oqmeasures.com/>

Appendix 20.  
**Student Outcome Tracker II**

## Student Outcome Tracker

**Student name:** \_\_\_\_\_ **Teacher name:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **School:** \_\_\_\_\_

1. How many days of school has the student missed? \_\_\_\_\_ days in the last month
2. How many times has the student been tardy to class? \_\_\_\_\_ times in the last month
3. How many times has the student left school early? \_\_\_\_\_ times in the last month
4. Please list the student's grades.  
\_\_\_ Math \_\_\_ Reading \_\_\_ Science \_\_\_ Social Studies  
\_\_\_ Other (please specify): \_\_\_\_\_
5. How many office discipline referrals has the student received? \_\_\_\_\_ ODRs
6. How many in-class assignments is the student missing? \_\_\_\_\_ assignments
7. How many homework assignments is the student missing? \_\_\_\_\_ assignments
8. The student follows directions first time given (check one).  
\_\_\_ Always \_\_\_ Almost always \_\_\_ Sometimes \_\_\_ Rarely \_\_\_ Never
9. The student stays in seat when required (check one).  
\_\_\_ Always \_\_\_ Almost always \_\_\_ Sometimes \_\_\_ Rarely \_\_\_ Never
10. The student raises hand to speak in class (check one).  
\_\_\_ Always \_\_\_ Almost always \_\_\_ Sometimes \_\_\_ Rarely \_\_\_ Never
11. The student completes in-class assignments.  
\_\_\_ Always \_\_\_ Almost always \_\_\_ Sometimes \_\_\_ Rarely \_\_\_ Never
12. The student completes homework assignments.  
\_\_\_ Always \_\_\_ Almost always \_\_\_ Sometimes \_\_\_ Rarely \_\_\_ Never
13. The student pays attention in class.  
\_\_\_ Always \_\_\_ Almost always \_\_\_ Sometimes \_\_\_ Rarely \_\_\_ Never
14. The student interacts positively with peers.  
\_\_\_ Always \_\_\_ Almost always \_\_\_ Sometimes \_\_\_ Rarely \_\_\_ Never

15. The student interacts with age appropriate peers.  
 Always  Almost always  Sometimes  Rarely  Never
16. The student annoys other students.  
 Always  Almost always  Sometimes  Rarely  Never
17. The student interacts appropriately with teachers.  
 Always  Almost always  Sometimes  Rarely  Never
18. The student interacts appropriately with other adults (administrator, custodian, parents etc.).  
 Always  Almost always  Sometimes  Rarely  Never
19. The student appears happy at school.  
 Always  Almost always  Sometimes  Rarely  Never
20. The student appears frustrated at school.  
 Always  Almost always  Sometimes  Rarely  Never
21. The student seems to like school.  
 Always  Almost always  Sometimes  Rarely  Never
22. The student comes to school well groomed.  
 Always  Almost always  Sometimes  Rarely  Never
23. The student is awake and alert during school.  
 Always  Almost always  Sometimes  Rarely  Never
24. The student appears to be in good health.  
 Always  Almost always  Sometimes  Rarely  Never

**Comments:**

Appendix 21.  
**Client Satisfaction Questionnaires**

- YSS (Youth Satisfaction Survey)
- YSS-F (Youth Satisfaction Survey, Parent/Caregiver Version)

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## 2010 YOUTH SERVICES SURVEY – YOUTH VERSION

Please help our agency make services better by answering some questions about the services you have received. Your answers will be kept confidential. Please indicate if you **Strongly Agree, Agree, Are Undecided, Disagree, or Strongly Disagree** with each of the statements below. **Fill in the circle** that best describes your answer. Thank you!

<b>Gender:</b> <input type="radio"/> Male <input type="radio"/> Female	<b>Age:</b> ____ ____ <input type="radio"/> 0 <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 9	<b>Race:</b> <input type="radio"/> Alaska Native <input type="radio"/> American Indian <input type="radio"/> Asian <input type="radio"/> Native Hawaiian/Other Pacific Islander <input type="radio"/> Black or African American <input type="radio"/> White <input type="radio"/> Other Single Race <input type="radio"/> Two or More Races	<b>Ethnicity:</b> <input type="radio"/> Puerto Rican <input type="radio"/> Mexican <input type="radio"/> Cuban <input type="radio"/> Other Specific <input type="radio"/> Not of Hispanic Origin <input type="radio"/> Hispanic – Specific Origin Not Specified	<b>When did you start getting services <i>here</i> for your current problems?</b> <input type="radio"/> 3 months ago or less <input type="radio"/> 4-6 months ago <input type="radio"/> 7-9 months ago <input type="radio"/> 10-12 months ago <input type="radio"/> 1-2 years ago <input type="radio"/> 3-5 years ago <input type="radio"/> more than 5 years ago
------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Strongly Agree (1)	Agree (2)	Undecided (3)	Disagree (4)	Strongly Disagree (5)
-----------------------	--------------	------------------	-----------------	--------------------------

- |                                                          |   |   |   |   |   |
|----------------------------------------------------------|---|---|---|---|---|
| 1. Overall, I am satisfied with the services I received. | ① | ② | ③ | ④ | ⑤ |
| <b><u>As a result of the services I received:</u></b>    |   |   |   |   |   |
| 2. I am better at handling daily life.                   | ① | ② | ③ | ④ | ⑤ |
| 3. I get along better with family members.               | ① | ② | ③ | ④ | ⑤ |
| 4. I get along better with friends and other people.     | ① | ② | ③ | ④ | ⑤ |
| 5. I am doing better in school and/or work.              | ① | ② | ③ | ④ | ⑤ |
| 6. I am better able to cope when things go wrong.        | ① | ② | ③ | ④ | ⑤ |
| 7. I am satisfied with my family life right now.         | ① | ② | ③ | ④ | ⑤ |
| <b><u>Feedback about the services I received:</u></b>    |   |   |   |   |   |
| 8. I helped to choose my services.                       | ① | ② | ③ | ④ | ⑤ |
| 9. I helped to choose my treatment goals.                | ① | ② | ③ | ④ | ⑤ |
| 10. The people helping me stuck with me no matter what.  | ① | ② | ③ | ④ | ⑤ |
| 11. I felt I had someone to talk to when I was troubled. | ① | ② | ③ | ④ | ⑤ |

	Strongly Agree (1)	Agree (2)	Undecided (3)	Disagree (4)	Strongly Disagree (5)
12. I was actively involved in my treatment.	①	②	③	④	⑤
13. I received services that were right for me.	①	②	③	④	⑤
14. The location of services was convenient.	①	②	③	④	⑤
15. Services were available at times that were convenient to me.	①	②	③	④	⑤
16. I got the help I wanted.	①	②	③	④	⑤
17. I got as much help as I needed.	①	②	③	④	⑤
18. Staff treated me with respect.	①	②	③	④	⑤
19. Staff respected my family's religious/spiritual beliefs.	①	②	③	④	⑤
20. Staff spoke with me in a way that I understood.	①	②	③	④	⑤
21. Staff was sensitive to my cultural/ethnic background.	①	②	③	④	⑤
22. My therapist and/or psychiatrist discusses wellness related activities with me during my appointments.	①	②	③	④	⑤
23. Wellness activities are an important part of my recovery plan	①	②	③	④	⑤

	Yes	No
24. Were you arrested during the past 12 months?	Ⓨ	Ⓝ
25. Were you arrested during the 12 months prior to that?	Ⓨ	Ⓝ
26. Were you expelled or suspended during the past 12 months?	Ⓨ	Ⓝ
27. Were you expelled or suspended during the 12 months prior to that?	Ⓨ	Ⓝ

28. Since starting to receive services, the number of days I was in school is:

- greater
- about the same
- less
- does not apply

**Comments:**

What did you LIKE about our services?

What did you NOT LIKE about our services?

What could we do to IMPROVE our services?

*Thank you for taking the time to answer these questions!*

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## 2010 YOUTH SERVICES SURVEY – PARENT OR CAREGIVER VERSION

Please help our agency make services better by answering some questions about the services **your child** has received in the last 12 months. Your answers will be kept confidential. Please indicate if you **Strongly Agree, Agree, Are Undecided, Disagree, or Strongly Disagree** with each of the statements below. **Fill in the circle** that best describes your answer. Thank you!

<b>Gender of Child:</b> <input type="radio"/> Male <input type="radio"/> Female	<b>Age of child:</b> ____ ____ <input type="radio"/> 0 <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 9	<b>Race of Child:</b> <input type="radio"/> Alaska Native <input type="radio"/> American Indian <input type="radio"/> Asian <input type="radio"/> Native Hawaiian/Other Pacific Islander <input type="radio"/> Black or African American <input type="radio"/> White <input type="radio"/> Other Single Race <input type="radio"/> Two or More Races	<b>Ethnicity of Child:</b> <input type="radio"/> Puerto Rican <input type="radio"/> Mexican <input type="radio"/> Cuban <input type="radio"/> Other Specific <input type="radio"/> Not of Hispanic Origin <input type="radio"/> Hispanic – Specific Origin Not Specified
<b>How are you related to this child? (Fill in <i>one</i> only)</b>  Mother <input type="radio"/> Foster mother <input type="radio"/> Father <input type="radio"/> Foster father <input type="radio"/> Other relative <input type="radio"/>		<b>Does your child have Medicaid insurance?</b>  Yes <input type="radio"/> No <input type="radio"/>	

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
(1)	(2)	(3)	(4)	(5)

1. Overall, I am satisfied with the services my child received.

①                      ②                      ③                      ④                      ⑤

**As a result of the services my child and/or family received:**

2. My child is better at handling daily life.

①                      ②                      ③                      ④                      ⑤

3. My child gets along better with family members.

①                      ②                      ③                      ④                      ⑤

4. My child gets along better with friends and other people.

①                      ②                      ③                      ④                      ⑤

5. My child is doing better in school and/or work.

①                      ②                      ③                      ④                      ⑤

6. My child is better able to cope when things go wrong.

①                      ②                      ③                      ④                      ⑤

7. I am satisfied with our family life right now.

①                      ②                      ③                      ④                      ⑤

8. My child is better able to do things he or she wants to do.

①                      ②                      ③                      ④                      ⑤

Strongly Agree (1)	Agree (2)	Undecided (3)	Disagree (4)	Strongly Disagree (5)
-----------------------	--------------	------------------	-----------------	--------------------------

**Feedback about the services my child and/or family received:**

9. I helped to choose my child's services.	①	②	③	④	⑤
10. I helped to choose my child's treatment goals.	①	②	③	④	⑤
11. The people helping my child stuck with us no matter what.	①	②	③	④	⑤
12. I felt my child had someone to talk to when he/she was troubled.	①	②	③	④	⑤
13. I was frequently involved in my child's treatment.	①	②	③	④	⑤
14. The services my child and/or family received were right for us.	①	②	③	④	⑤
15. The location of services was convenient for us.	①	②	③	④	⑤
16. Services were available at times that were convenient for us.	①	②	③	④	⑤
17. If I need services for my child in the future, I would use these services again.	①	②	③	④	⑤
18. My family received the help we wanted for my child.	①	②	③	④	⑤
19. My family received as much help as we needed for my child.	①	②	③	④	⑤
20. My therapist and/or psychiatrist discuss wellness related activities with me/or my child during my appointments.	①	②	③	④	⑤
21. Wellness activities are an important part of my child's recovery plan	①	②	③	④	⑤
22. Staff treated me with respect.	①	②	③	④	⑤
23. Staff understood my family's cultural traditions.	①	②	③	④	⑤
24. Staff respected my family's religious/spiritual beliefs.	①	②	③	④	⑤
25. Staff spoke with me in a way that I understood.	①	②	③	④	⑤
26. Staff was sensitive to my cultural/ethnic background.	①	②	③	④	⑤

**Other than my child's service providers:**

27. I know people who will listen and understand me when I need to talk.	①	②	③	④	⑤
28. In a crisis, I would have the support I need from family or friends.	①	②	③	④	⑤
29. I have people that I am comfortable talking with about my child's problems.	①	②	③	④	⑤
30. I have people that I am comfortable talking to about private things.	①	②	③	④	⑤

**Please answer the following questions to let us know how your child is doing.**

31. Is your child currently living with you?                      Yes        No   

32. Has your child lived in any of the following places in the last 6 months? (FILL IN ALL THAT APPLY)

- |                                                  |                                                    |                                                        |
|--------------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
| <input type="radio"/> With one or both parents   | <input type="radio"/> Crisis Shelter               | <input type="radio"/> Hospital                         |
| <input type="radio"/> With another family member | <input type="radio"/> Homeless shelter             | <input type="radio"/> Local jail or detention facility |
| <input type="radio"/> Foster home                | <input type="radio"/> Group home                   | <input type="radio"/> State correctional facility      |
| <input type="radio"/> Therapeutic foster home    | <input type="radio"/> Residential treatment center | <input type="radio"/> Runaway/homeless/on the streets  |
|                                                  |                                                    | <input type="radio"/> Other (describe):                |

33. In the last year, did your child see a medical doctor (or nurse) for a health check up or because he/she was sick?  
(Check one)

- Yes, in a clinic or office     Yes, but only in a hospital emergency room     No     Do not remember

Yes	No
-----	----

34. Is your child on medication for emotional/behavioral problems?

Y     N

34a. If yes, did the doctor or nurse tell you and/or your child what side effects to watch for?

Y     N

35. When did your child start getting services here for his/her *current* problems?

- 3 months ago or less  
 4-6 months ago  
 7-9 months ago  
 10-12 months ago  
 1-2 years ago  
 3-5 years ago  
 more than 5 years ago

Yes	No
-----	----

36. Was your child arrested since beginning services?

Y     N

37. Was your child arrested during the 12 months prior to that?

Y     N

38. Since your child began to receive services, have their encounters with the police . . .

- Been reduced (for example, they have not been arrested, hassled by police, taken by police to a shelter or crisis program)  
 Stayed the same  
 Increased  
 Not applicable (they had no police encounters this year or last year)

39. Was your child expelled or suspended since beginning services?

Y     N

40. Was your child expelled or suspended during the 12 months prior to that?

Y     N

41. Since starting to receive services, the number of days my child was in school is

- Greater  
 About the same  
 Less  
 Does not apply (please select why this does not apply)  
 Child did not have a problem with attendance before starting services  
 Child is too young to be in school  
 Child was expelled from school  
 Child dropped out of school  
 Other: (please explain)

**Comments:**

What did you LIKE about our services?

What did you NOT LIKE about our services?

What could we do to IMPROVE our services?

*Thank you for taking the time to answer these questions!*

Appendix 22.  
**“Examples of Behavioral Health Funding  
to Purchase Mental Health Services  
for Children and their Families”**

**EXAMPLES OF BEHAVIORAL HEALTH FUNDING TO PURCHASE MENTAL  
HEALTH SERVICES FOR CHILDREN AND THEIR FAMILIES**

**MEDICAID**

Psychosocial Rehabilitation  
Inpatient and Psychiatric Residential  
EPSDT  
1915(b) & (c) Waivers  
Clinic Services

**CHILD WELFARE**

Federal Title IV-E (foster re/adoption)  
Federal Title IV-B (CW services)  
Federal Family Preservation  
State General Fund  
County Child Welfare General Fund

**HEALTH**

Medicaid/SCHIP  
State General Fund  
County General Fund  
Substance Abuse Block Grant  
Title V

**MENTAL HEALTH**

State Medicaid Match  
State General Fund  
County General Fund  
Federal MH Block Grant

**JUVENILE JUSTICE**

State General Fund  
Federal Grants  
County General Fund

**EDUCATION**

State/County General Fund  
Local General Fund  
Federal Education Funds (Spec Ed)

**OTHER**

County General Fund  
City General Fund  
Federal, state or local grant funds  
Foundation Revenue

Appendix 23.  
**“10 Critical Factors to Advancing School Mental Health:  
What Early Adopters Say”**

# 10 Critical Factors To Advancing School Mental Health:

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## *What Early Adopters Say*

In recognition of the critical role that schools play in addressing the social and emotional needs of students, there is a growing movement to build the capacity of education agencies to advance school mental health efforts in their states and districts. Rather than schools being a “de facto” mental health system, states and districts are increasingly interested in ensuring that schools are equipped with the necessary infrastructure, policies, and supports that allow them to adequately address the complex needs of their students. School mental health is complicated business; It crosses over multiple public systems and disciplines, involves complex partnerships and redistribution of resources, and covers a broad spectrum of services including prevention, promotion, early intervention, and treatment. It therefore looks different in every state, district and school building.

In 2006-07, NASBHC’s School Mental Health-Capacity Building Partnership (SMH-CBP)<sup>1</sup> set out to gain a deeper understanding of how school mental health activities are operationalized at the state and local levels. The SMH-CBP held site visits in four states -- Maryland, Missouri, Ohio, and Oregon – that were considered to be “early adopters” based on their innovation and achievement in school mental health policy and practice. In each state, the SMH-CBP conducted four stakeholder discussion groups with representatives from the fields of mental health, education, health, family and youth advocacy, and social service. Participants in the discussion groups shared their successes and challenges in advancing agendas related to mental health in schools as well as strategies used to implement school mental health policies, programs, and services. Separate discussion groups were held with youth and summarized in the document *What Students Have to Say about Mental Health*.

Using findings from these site visits, *Ten Critical Factors to Advancing School Mental Health: What Early Adopters Say* summarizes key themes and strategies that emerged across the four states. While strategies may be implemented differently across states and districts, and the roles and functions of stakeholders may vary, these ten factors and their accompanying strategies can guide the work of education agencies and their partners in advancing school mental health in their states and districts.

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<sup>1</sup> The SMH-CBP is a national initiative made possible through a cooperative agreement between the National Assembly on School-Based Health Care (NASBHC) and the Centers for Disease Control and Prevention, Division of Adolescent and School Health (CDC-DASH). For more information on the SMH-CBP, contact Laura Hurwitz, Director of School Mental Health Programs at [LHurwitz@nasbhc.org](mailto:LHurwitz@nasbhc.org).

# 1 State leaders across child-serving public sectors must establish a cohesive and compelling vision and shared school mental health agenda that inspires localities to act.

A unified vision for school mental health, jointly held by key state political and policy stakeholders, is essential for providing clarity and consensus around the "what" of school mental health. A compelling vision for school mental health should attract state public sector leaders and staff representing mental health, public health, education, family advocates, and social service -- all who have vested interests in the same outcomes: healthy, safe, and successful school-aged youth. A vision and agenda developed at the state level, when thoughtfully and comprehensively marketed, can inspire and motivate local jurisdictions to adopt that vision and create opportunities for implementation in school districts and buildings.

## ***Strategies to develop a unified vision and shared agenda in school mental health:***

- a. Identify and establish state level champions, leaders, and decision makers who are supportive and are invested in school mental health.
- b. Build a coalition consisting of an articulate and aggressive constituency of influential local systems and organizations that demand policies for funding and implementation of school mental health.
- c. Document areas of integration and mutual support and convey these connections to system leaders.
- d. Develop and/or update a state policy or legislative agenda in which all school mental health stakeholders have an investment. This agenda should be informed by:
  - existing initiatives across child serving systems that support school mental health,
  - individual state agency agendas (e.g., departments of mental health, education, health) that complement and support school mental health,
  - state and local legislation and financing supports,
  - federal school mental health mandates and priorities (e.g. No Child Left Behind, Response to Intervention),and
  - lessons learned from local sites that have been successful at implementing school mental health efforts.
- e. Use social marketing strategies to extend lessons learned at the local level to develop and convey compelling messages related to a school mental health vision.

## 2 State public agencies need a centralized organizational infrastructure and accountability mechanisms to ensure the vision's implementation across sectors.

Organizational infrastructure and accountability mechanisms are essential for developing effective and sustainable school mental health programs and services. This is particularly important when a "champion" leaves his/her post, when grant funded programs end, or when there is a lack of shared investment in school mental health efforts. While the ownership of a school mental health agenda must be shared among stakeholders and agencies, one entity must ultimately be accountable for the planning, implementation, and evaluation of statewide programs and services. States can benefit from a central entity that has recognition, authority, accountability, and capacity for statewide dissemination of school mental health efforts, optimally in partnership with all invested state agencies.

### *Strategies to build accountability across state agencies:*

- a. Establish and sustain a state level body (e.g., partnership, task force, committee) through executive or legislative order that meets regularly and is inclusive of all school mental health stakeholders (e.g., mental health, education, health, youth, family members).
- b. Engage the state level body in a strategic planning process to develop school mental health goals and action steps that are consistent with an established school mental health vision and agenda.
- c. Establish roles and responsibilities for each state agency in implementing a comprehensive school mental health effort that includes planning, implementation, and evaluation.
- d. Create an organizational infrastructure and staff positions to carry out these roles.
- e. Establish a funded, central entity that has recognition, authority, accountability, and the capacity to disseminate information statewide.
- f. Establish formal partnerships with universities and/or research institutions to assist in data collection and management and outcomes monitoring.
- g. Establish results-oriented grant-making and contracting processes (e.g., assure that funding is linked to defined outcomes).

### **3 State policymakers and leaders need to create feasible and sustainable funding models that maximize use of revenue and provide categorical grants for *comprehensive* school mental health services, including prevention and early intervention.**

In order to achieve success and longevity, school mental health services require sustainable funding mechanisms that support the full continuum of mental health care, including prevention, promotion, early intervention, and treatment.

Traditionally, school mental health programs have had to rely on limited funding from multiple sources, often without opportunities for sustainability. Programs that have relied on fee-for-service delivery models, in particular, have experienced challenges in providing comprehensive, quality care for all students, regardless of insurance status or provider type/setting.

#### ***Strategies to develop funding that is sufficient to sustain quality school mental health services include:***

- a. Identify existing and new dedicated funding sources for school mental health (e.g., Medicaid, private insurance, philanthropy, federal grants, state budget).
- b. Identify funding sources that support:
  - establishment of infrastructure and program development
  - sustainability of programs and services
  - prevention and early intervention efforts
  - quality care and evidence-based practice
- c. Advocate for legislation (e.g., Elementary and Secondary Education Act, America's Health Care Choices Act) that mandates use of federal funds for implementation and evaluation of the full continuum of mental health in schools.
- d. Advocate for expansion of public and private insurance to cover school mental health services.
- e. Extend funding periods for state agency grants to support school mental health and establish requirements for state agency grants to support infrastructure development and sustainability.
- f. Develop relationships with foundations in order to increase philanthropic investment in school mental health.
- g. Explore creative use of current public funding streams, including tax levies, pooling, or redirecting funds for school mental health.

## **4 State and district education leaders must understand the connection between school mental health programs and students' academic enrichment and success in school.**

While schools have become a de facto mental health system for many children, they are not universally eager to embrace a mental health agenda as part of their academic mission. Schools are increasingly faced with many competing priorities and mandates to raise academic standards and administrators do not feel adequately resourced to provide mental health care in the school building. Furthermore, stigma around mental health can be a barrier to providing programs and services in schools. In order for mental health to be fully integrated into schools, school mental health stakeholders must communicate about the connection between mental health and academic achievement, and demonstrate how school mental health programs can reduce the demands on overburdened school systems.

### ***Strategies where school mental health programs can support the academic mission of schools include:***

- a. Promote dialogue around solutions that address the growing pressure on schools to achieve academic results.
- b. Jointly develop education-centered strategies to reduce the burden on schools by implementing school mental health programs.
- c. Identify and use existing national, state, and local data demonstrating the link between school mental health and academic success (e.g., grades, discipline, and attendance).
- d. Reduce fear associated with addressing mental health in the school setting by addressing legal (e.g., consent and confidentiality) and accountability issues.
- e. Partner with entities that have the capacity and interest in expanding research that demonstrates the link between school mental health and educational outcomes.
- f. Implement statewide and local initiatives/campaigns that reduce stigma around mental health.
- g. Develop a social marketing plan that includes a common message about the importance of school mental health, tailored messages to target audience(s), and strategies for delivering the message.

## **5 Youth and families from a diversity of backgrounds must be engaged in all aspects of school mental health policy and program development.**

As recipients of the services, family members and youth are a critical voice in the establishment, implementation, and evaluation of school mental health programs and policies. As such, schools and mental health providers must adopt policies and practices that encourage full and meaningful partnerships with families and youth. While engaging families and youth can be challenging due to a variety of logistical and social factors, the process is worth it. These stakeholders offer a unique and invaluable perspective that ensures that services are designed to meet the needs of those for whom they are developed.

### ***Strategies to engage family members and youth as partners include:***

- a. Engage culturally diverse family and youth organizations as key partners in state- and district-wide school mental health efforts.
- b. Expand family roles in schools to promote families as partners in their children's education.
- c. Establish culturally and linguistically competent guidelines to ensure family and youth representation.
- d. Invite youth and family members to participate in all aspects of school mental health efforts (e.g., planning, needs assessments, evaluation, social marketing).
- e. Offer incentives (e.g., food, social activities, money) when inviting youth and families to participate in school mental health activities.
- f. Accommodate family needs by establishing convenient meeting times, and reimbursing for time, transportation, and child care.
- g. Assign family members and youth leadership decision-making roles to assure that their involvement is meaningful.
- h. Follow-up with family members and youth after their involvement and make appropriate adjustments/recommendations.
- i. Provide leadership training to family members, youth, school mental health stakeholders, and educators on the value and process of effectively engaging family members, youth, and communities.
- j. Increase youth participation through student mentorship programs, speakers' bureaus, and youth leadership activities.

## **6 School staff and school mental health providers must recognize the needs of students from diverse cultural backgrounds and offer programs that reduce disparities in services.**

Racial and ethnic minorities suffer disproportionately from particular mental health conditions. Factors such as income level and stigma can lead to disparities in accessing mental health services. Schools consistently struggle with how to meet the mental health needs of students from diverse backgrounds and are challenged by changing demographics and the lack of an available workforce that reflects the demographics of a community. Developing policies and practices that are inclusive of cultural variables (e.g., race, ethnicity, language, income, and gender orientation) is critical to the success of a school mental health program.

### ***Strategies to address the needs of students from diverse backgrounds include:***

- a. Expand the definition of "culture" beyond language and race to include: spiritual beliefs, economic levels, geographic area, living arrangements, family structures, and sexual orientation.
- b. Learn what mental health means to various cultures as a way to address mental health stigma within each cultural group.
- c. Encourage school districts to conduct needs assessments and/or focus groups to identify the unique needs of each group being served.
- d. Encourage schools to offer services in the native language of the population by hiring linguistically competent providers, providing interpreters, translating resources, and/or establishing access to language translation phone lines.
- e. Support emerging research on cultural competence and reducing disparities in school mental health.
- f. Encourage schools to collaborate with non-traditional providers (e.g. immigrant organizations, ethnic organizations, faith-based institutions) when providing comprehensive school mental health services.
- g. Provide ongoing training and supervision on cultural competence, disparities, and the "culture of poverty" to mental health providers and all school staff.
- h. Analyze program outcome data in terms of disparities (e.g., populations that are affected at disproportionate rates).

## **7 Pre- and in-service training should prepare educators on child and adolescent mental health as well as factors related to providing mental health services in a school setting.**

Despite efforts to prepare educators and mental health providers for work in schools, professionals are often challenged by the demands of the school setting, particularly with respect to children's mental health needs. Training and professional development can be expanded across the board – at the pre-service level for undergraduate and graduate mental health and education programs as well as for school personnel and school mental health professionals. Developing competencies and establishing clear roles and responsibilities for all adults interacting with youth is essential to providing high quality and effective school mental health programs and services.

### ***Strategies to enhance competencies of education and mental health students and professionals include:***

- a. Advocate for legislation at the state level that mandates mental health training for educators.
- b. Introduce training on school mental health in undergraduate and graduate education programs.
- c. Implement school-wide mental health programs that provide all school staff (including teachers, administrators, custodial staff, cafeteria staff, security) with training and resources on mental health.
- d. Provide required and on-going training to school personnel on school mental health issues that emphasize role clarification, early identification, referral, and crisis intervention.
- e. Utilize school-based mental health providers for consultation and training for staff.
- f. Explore multiple methods for training educators including on-site mental health providers, expert consultants, train-the-trainer, and online opportunities.
- g. Create standards and core competencies for professional certification for school mental health providers.
- h. Promote interdisciplinary training across multiple professions including school mental health, early childhood, pediatrics, social services, juvenile justice, and foster care.

## **8 State and community stakeholders should support practitioners in utilizing and monitoring best practice models.**

Despite efforts to advance evidence-based practices in school mental health, the identification and implementation of evidence-based practices has been difficult to achieve. This is due in part to a lack of consensus on the definition of "evidence-based practices" and the limited accountability and monitoring of such practices. School mental health efforts should implement practices that have demonstrated effectiveness, are easy to implement, are appropriate for the school setting, and where outcomes can be monitored.

### ***Strategies to enhance use of quality effective practice include:***

- a. Adopt a consensus definition of empirically supported promotion and intervention in school mental health, with guidance from federal and national leaders.
- b. Support mandates, initiatives, and models that encourage implementation and evaluation of evidenced-based school mental health activities.
- c. Support development of local organizational capacities related to planning, implementation, evaluation, and sustainability of evidence-based programs.
- d. Adopt common, systematic protocols that use "best practice processes" (i.e., systematic processes supporting planning, implementation, evaluation, sustainability, and continuous improvement of evidence-based programs).
- e. Carefully consider context of implementation including cultural appropriateness and geographic location when selecting specific prevention or intervention programs and/or curricula.
- f. Provide infrastructure support at the program level for implementing empirically supported school mental health interventions with fidelity, including intensive and ongoing training and onsite coaching and support for providers.
- g. Ensure reliable implementation of empirically supported school mental health intervention.
- h. Provide information to providers on national registries of specific evidence-based programs (e.g. [www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov)).

## **9 State and community stakeholders should coordinate the myriad of resources dedicated to students' academic success, mental health, and well-being to assure full integration and equitable distribution across schools.**

Lack of coordination of services, at all levels, leads to fragmentation and duplication of services and, consequently, inequity in school mental health services. At the state level, school mental health is often managed and funded by multiple state and federal agencies. Schools may have a range of programs and collaborations with outside agencies as well as within the school itself. Increased coordination between all child-serving programs and systems can maximize resources and efficiency.

### ***Strategies to enhance coordination at all levels include:***

- a. Identify or develop a structure (e.g., advisory board, committee) at both the state and district levels to assist in the planning, oversight, coordination, and evaluation of school mental health efforts.
- b. Hold intra- and inter-agency meetings at state and district levels to ensure successful coordination of services and understanding of roles and responsibilities.
- c. Develop and maintain local structures (e.g., management boards with local coordinating councils) for coordinating and supporting school mental health services within jurisdictions.
- d. Develop and regularly review and update memoranda of understanding (MOU) between schools and mental health service providers stipulating services, space, supervision, and confidentiality.
- e. Designate a resource/service case coordinator in each school to coordinate referrals and services and to link youth and families to school and community resources.
- f. Establish guidelines that ensure the participation of school mental health providers in school teams (e.g., student support teams).
- g. Assure that funding requires school-provider collaboration and provider participation on school teams.
- h. Integrate mental health into other coordinated school-based health efforts (e.g., school-based health centers; Coordinated School Health).

# 10 **State and community stakeholders should collect data that document the impact of school mental health on academic indicators and integrate these indicators into evaluation efforts at the school, district, and state levels.**

It is essential for school mental health programs to measure educational outcomes systematically in order to document effectiveness and justify continued funding. While schools and mental health programs are under increasing pressure to measure outcomes, limited resources and system burdens can hinder efforts to collect data successfully on the impact of school mental health efforts. Coordination, consistency, and uniformity between jurisdictions and states are important in developing effective and meaningful data collection efforts.

## ***Strategies to enhance data collection and evaluation efforts include:***

- a. Adopt policies that encourage schools and communities to define student and program level variables that can be collected through student/school records (e.g., grades, attendance, suspensions, referrals for special education).
- b. Ensure that program evaluation is compliant with federal laws [e.g., Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Family and Educational Rights and Privacy Act (FERPA)].
- c. Publish findings from evaluation efforts in nationally recognized education, mental health and public health journals.
- d. Consider using an independent evaluation team or university partnerships to limit the bias in assessing the effectiveness of programs.
- e. Include qualitative evaluation strategies (e.g., focus groups with students, families, and teachers) to help assess needs, program strengths and weaknesses, and recommendations for improvement.
- f. Provide school mental health providers with adequate resources and administrative support to facilitate ongoing student- and program-level evaluation.
- g. Enhance current data systems to assess school mental health needs and outcomes.
- h. Foster the development of data sharing agreements and support for centralized data collection and storage across state agencies (e.g., data warehouses).