SECTION 5 – SCHOOL BEHAVIORAL HEALTH SERVICES

Definition

Behavioral health services (which may be more generically referred to as mental health) refers to developmental, behavioral, cognitive, emotional, psychological and medical needs associated with optimal human functioning. Behavioral health typically addresses individual, family, social and environmental systems and their inter-relatedness. Services are provided by professionals with training in counseling, psychology, social work, nursing, medicine or, to a lesser extent, the social sciences and related programs. Staff may be exclusively school-based or may be associated with local community agencies.

Addressing behavioral health includes providing safe, supportive environments that encourage self-examination and inquiry, leading to growth as an individual and as a member of society. Although approaches to providing comprehensive behavioral health services to young people may differ, methods are likely to include individual or group counseling, student assistance or child study teams, and actions to positively affect the school climate. Although each of these program types has strengths and limitations, they can be most effective when combined within a coordinated plan of services and policies. To foster behavioral health schools need to be safe; ensure academic readiness, including appropriate nutrition, academic supports, health and mental health services, and intellectual challenge; support the validity of an individual's uniqueness; and respect differences.

Rationale

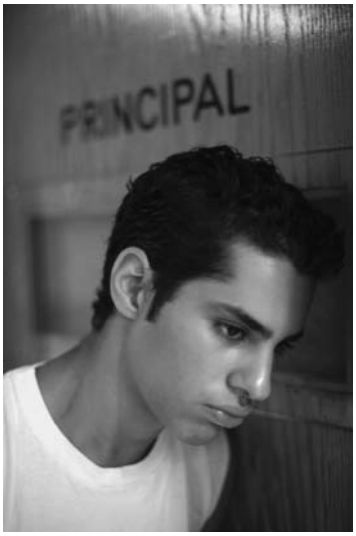
Mental health is an essential component of overall general health, and mental health disorders are genuine health conditions (President's New Freedom Commission on Mental Health, 2003; U.S. Public Health Service, 1999). Mental health treatment is efficacious, meaningful, and, when delivered consistently and comprehensively, reduces economic, social and psychological costs to individuals, their families and society. A study by the World Health Organization, in collaboration with the World Bank and Harvard University, of the impact of mental health disorders on established market economies during the 1990s found that mental health impairment is the second leading cause of disability and premature death (World Health Organization, 2001).

The costs of mental illness, both personal and economic, attest to the need for preventive services throughout the lifespan and targeted interventions as soon as issues emerge. Most schools provide some level of mental health-related service. These services commonly include referral (89 percent), assessment (80 percent), crisis intervention (78 percent), and screening (77 percent) (Lear, Isaacs, & Knickman, 2006). On any given school day, about 20 percent of the U.S. population is in a public school setting. Schools, therefore, have the unique potential to provide screening, prevention and early intervention services along with long-term oversight and follow up to a significant proportion of our society. Without investing in a significant number of additional resources, schools could extend these prevention and support services to their adult staff.

5 School Behavioral Health Services

The traditional approach to behavioral health services provision in schools is based on the assumptions that schools must (1) identify those students who may have emotional, social, behavioral or psychiatric conditions that will predispose them to ongoing vulnerability and incapacity; and (2) provide support services to address those issues identified to enable students to benefit from their educational program. The results of the 2005 Connecticut School Health Survey (Connecticut's version of the national Youth Risk Behavior Survey) clearly identify the hazards confronted by young people, as well as some factors that effectively reduce risk:

- More Connecticut students report dating violence than is reported nationally.
- More Connecticut students report attempting suicide than is reported nationally.
- 23 percent of high school students have smoked marijuana in the last 30 days.
- 45 percent of high school students drank alcohol in the last 30 days.
- Nearly 30 percent of students reported having ridden in an automobile where the driver had been drinking alcohol.
- Students who say that their parents usually know where they are, are about 30 percent less likely to attempt suicide, experience dating violence, have sexual intercourse, or smoke marijuana. They are also 50 percent less likely to drink alcohol or smoke cigarettes.



School behavioral health personnel can contribute to the reduction of these trends through carefully and consistently focusing prevention and intervention efforts on these and related risk factors. The No Child Left Behind Act has increased focus on academic achievement with pressures on schools to achieve adequate yearly progress. At the same time that schools, in response to NCLB, are moving from a deficit model of educational evaluation and toward assessments based on a student's capacity to respond to teaching interventions, schools are also moving away from identifying social, emotional and behavioral deficits toward models based on normative development. The New Freedom Commission's recommendations emphasize the need for mental health in schools to focus on the following:

- Promoting social-emotional development, preventing mental health and psychosocial problems, and enhancing resiliency and protective buffers.
- Intervening as early as feasible after the onset of emotional, behavior, and learning problems and addressing severe and chronic problems.
- Addressing systemic issues at schools that affect both student and staff well-being, such as practices that engender bullying, alienation, student disengagement from classroom learning, and staff burnout.
- Establishing equitable guidelines, standards, and accountability for mental health in schools.
- Building the capacity of all school staff to address emotional, behavioral, and learning problems and promote healthy social-emotional development, drawing on all empirical evidence as an aid to developing a comprehensive, multifaceted and cohesive continuum of school-community interventions (Center for Mental Health in Schools & Center for School Mental Health Assistance, 2004).

This section presents policy recommendations, policy rationale, implementation strategies and resources for school behavioral health services.

Policy Recommendations

Policy recommendations for school behavioral health services address the following ten areas.

1. ***Eliminate stigma.*** Stigma related to mental health disorders shall be eliminated.
2. ***Informed consent.*** The district shall develop protocols, policies, and procedures to obtain parental consent for children to participate in clinical assessment and treatment services.
3. ***Mental health screening.*** Early and ongoing screening shall be provided for existing and emerging conditions that affect social-emotional development, behavior and psychological functioning.
4. ***Community-based linkages.*** The district shall develop proactive linkages to local community services that provide supports for target conditions.
5. ***Economically disadvantaged families.*** The district shall, in collaboration with local community providers, develop and increase its capacity to provide appropriate services for young people whose family's economic circumstances may be a barrier to accessing best-practice services.
6. ***Crisis intervention.*** Capacity to provide crisis intervention and brief treatment services shall be strengthened.
7. ***Staff development.*** All school staff shall be informed about normative development, common potential stressors that may interfere with learning and behavioral health (e.g., bereavement, parental divorce), atypical emotional responses, classroom-based interventions that positively affect school climate, systems-based interventions that improve quality of life in school settings, and mechanisms for referring students for more extensive behavioral health services.
8. ***Parent-school linkages.*** Parent-school linkages related to the behavioral health needs of young people throughout childhood and adolescence shall be strengthened.
9. ***Reduce risk behaviors.*** Child and adolescent risk behaviors, including but not limited to tobacco use, unsafe sexual behaviors, drug and alcohol use, and suicide, shall be reduced.
10. ***School climate initiatives.*** Personal and systems-based programs to improve school climate shall be established.

Policy Rationale and Implementation Strategies

1. ***Eliminate stigma.*** Stigma related to mental health disorders shall be eliminated.

Most professionals agree that mental illness has historically been viewed with confusion, suspicion and judgmental bias. Lack of understanding and fears coupled with a desire to distance oneself from the harsh reality of affected persons' lives have led society to reject individuals suffering from common and debilitating mental health conditions. Current estimates of the incidence of mental health disorders indicate that about 20 percent of the adult population suffers from some form of mental illness at any given time (U.S. Department of Health and Human Services, 1999). Surveys among school-aged populations offer similar results.

Although 1 in 5 children, adolescents and adults experience some form of mental illness, stigma associated with such conditions results in secretiveness and a reluctance to seek treatment, which in turn reduces the ability of support systems to reach their target populations. Schools, whose principal mission is to inform and educate, are uniquely positioned within their communities to confront stigmatization and promote understanding through dissemination of age-appropriate and developmentally informed communication.

Schools, families and other societal systems have the responsibility to teach positive social values associated with optimal functioning. Literature suggests that historical ignorance concerning mental illness and behavioral health disorders has led to intergenerational misunderstanding and a continued prejudice against individuals with these conditions. School staff should proactively and consistently confront these misunderstandings and provide in their place compassion, understanding and empathy. Through these means, the next generation of unaffected individuals will be able to assist those with behavioral health disorders to engage more fully in society.

Implementation strategies include:

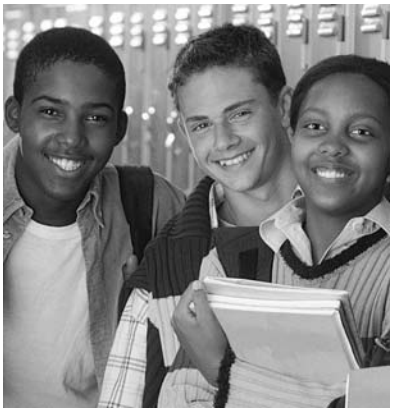
- ✧ Use considerate and respectful language when discussing mental health conditions.
- ✧ Focus on the abilities and capacities of individuals, rather than limitations.
- ✧ Avoid derogatory and inaccurate labels such as "crazy," "psycho," or "mental" when discussing these conditions or the individuals that suffer from them.
- ✧ Furnish information, available through SAMHSA, National Institute of Mental Health and the World Health Organization, among others that corrects mistaken impressions about mental illness in our society, i.e., provide evidence-based information to rectify misconceptions directly associating mental illness with violence.
- ✧ Provide to any parent whose child presents with a mental health disorder a copy of a "Consumer's Bill of Rights" (available from the Substance Abuse and Mental Health Services Administration (SAMHSA) website at http://www.hcqualitycommission.gov/final/append_a.html).
- ✧ Monitor local press reports regarding individuals with psychiatric disabilities and write letters to the editor to correct any misconceptions or negative portrayals of individuals with these conditions.
- ✧ Help the school community make the link between stigma and discrimination.

2. ***Informed consent.*** The district shall develop protocols, policies and procedures to obtain parental consent for children to participate in clinical assessment and treatment services.

Schools should attempt to obtain active parental consent for clinical evaluations and treatment services. In certain circumstances, crisis intervention services may be required before obtaining such consent; parents should be contacted as early as reasonably possible. Policies and procedures should clearly and completely address privacy and confidentiality issues before any conflicts arise.

Although there may be concern that a requirement for parental consent and involvement may create a barrier for serving adolescents, establishing these practices in the earliest grades can reduce this concern from the student's perspective and can promote understanding of behavioral health services as common practices from which many can benefit.

Implementation strategies include:



- ✧ Publish information about policies and procedures for obtaining parental consent, including privacy and confidentiality, in student and/or parent handbooks.
- ✧ Provide parental consent forms written in the parents' dominant language and avoid ambiguous, confusing or nonstandard terms. Forms should explain the purpose, intent and process in which the student will be participating, including alternative assessment or treatment options, procedures, risks, benefits and specifics of what will be maintained as confidential, as well as costs or compensation.
- ✧ Avoid technical terms whenever possible and provide clear, straightforward explanations of technical terms whenever they must be used.
- ✧ Frame the permission statement in the consent form as the parents themselves would state it.

3. ***Mental health screening.*** Early and ongoing screening shall be provided for existing and emerging conditions that affect social-emotional development, behavior and psychological functioning.

Schools have developed the capacity to identify early conditions that impede academic achievement, such as autism and other developmental and learning disabilities. Although school counselors, psychologists and social workers commonly participate in these assessments, their expertise has not always been incorporated into the broader structure to screen for conditions that may emerge later in a student's development.

When schools face more complex behavioral health issues, such as childhood disintegrative disorder, depression, schizophrenia or other dysfunctional conditions, they frequently address them on a case-by-case basis, which can result in a wide disparity in services provided to children and their families. Schools and districts must develop within their structures more comprehensive, cohesive systems of care to provide early detection and screening, as well as thorough evaluation of need and subsequent treatment.

Behavioral issues are often viewed from the perspective of how they disrupt school and classroom activities. School staff needs to distinguish between disciplining students for normative behaviors, such as sloppiness, competitiveness and risk-taking that may temporarily interfere with classroom management, and problematic behaviors that require professional assessment.
Implementation strategies include:

- ✧ Require principles of informed consent to guide administration of screening tools.
- ✧ Screen children, while planning collaboratively with their parents, at the first indication of poor academic adjustment in relation to social, emotional, developmental, cognitive or other peer-matched functional measures. Additional screening may be appropriate as children encounter significant developmental or chronological stressors that may affect their education, such as changing family or school circumstances.
- ✧ Use developmental norms, when appropriate, in screenings to establish thresholds for additional services.
- ✧ Use screening to identify functional areas that may benefit from additional supports, rather than establishing diagnostic data.
- ✧ When school personnel participate in statewide or national surveys, provide staff and administration with disaggregated data, when available and appropriate, to inform them of local trends.
- ✧ Use principles of Response to Intervention cited in the 2004 Individuals with Disabilities Education Act (IDEA) to address social-developmental-behavioral learning.

4. ***Community-based linkages.*** The district shall develop proactive linkages to local community services that provide supports for behavioral health conditions.

Schools need to improve the integration of services with outside community agencies through creative mechanisms that are not dependent on funding. For example, providing space for a local mental health agency to meet with children during the school day would eliminate scheduling and transportation barriers that often prevent children from receiving necessary services. Linkages should focus on early identification, referral and follow up. Collaboration between schools and local agencies should adhere to guidelines that address confidentiality, informed consent and the inclusion of parents as partners.

Implementation strategies include:

- ✧ Build linkages that accommodate the needs of individuals, their families and organizational systems.
- ✧ Consider providing space for local mental health agencies to meet with client children during the school day.
- ✧ Ensure that collaboration between schools and local agencies adheres to guidelines addressing confidentiality, informed consent and the inclusion of parents as partners.
- ✧ Ensure that any request for release of information clearly indicates what information will be shared, with whom, and for what period of time.
- ✧ Develop contractual relationships (memoranda of understanding or agreement) with outside agencies rather than collaborating on a case-by-case basis.
- ✧ Engage in coordinated, collaborative case planning that includes representation from multiple associated disciplines, e.g. nursing, social work, counseling, psychology.

5. ***Economically disadvantaged families.*** The district shall, in collaboration with local community providers, develop and increase its capacity to provide appropriate services for young people whose family's economic circumstances may be a barrier to accessing best-practice services.

Lack of funding and inadequate insurance coverage are among the most significant barriers to support for families and children who need it. Through the Health Insurance for Uninsured Kids and Youth (HUSKY) plan, children and their families who meet eligibility criteria can receive insurance coverage either free or at reduced cost. Although this plan meets the needs of some of the more vulnerable members of our society, the cost of mental health treatment is still prohibitive for a significant portion of the public. These families often also have incorrect information or the impression that mental health needs are less important than other health concerns.

Implementation strategies include:

- ✧ Work with parent groups and through information mechanisms, such as letters to the home, websites, and parent and student handbooks, to communicate the contributions that healthy social-emotional, developmental and psychiatric status make to academic and overall functioning.
- ✧ Help parents advocate for more expansive, coordinated services for children and families.
- ✧ Assist families with ensuring that their children have health insurance and provide appropriate application materials when needed.
- ✧ Review and catalogue, in collaboration with local health providers, free or reduced-cost services available in the community and develop protocols to ensure that those with greatest need receive priority.
- ✧ Establish formal relationships with providers in the *Community Collaborative System of Care* (http://www.ct.gov/dcf/lib/dcf/behavioral_health/pdf/ct_comm_coll_for_child_&_fam_directory.doc).
- ✧ Participate in the Mental Health Transformation activities administered by the Connecticut Department of Mental Health and Addiction Services (http://www.dmhas.state.ct.us/transformation.htm).

- ✧ Create and annually update a listing of all licensed providers in your community, along with any special instructions related to enrollment, application for services, types of treatment, etc.
- ✧ Develop resource packets for families that include listings of relevant community and state services with explanations of the services, intake mechanisms, approximate costs, and alternative resources for families with economic limitations that may affect students' access to necessary services.

6. ***Crisis intervention.*** Capacity to provide crisis intervention and brief treatment services shall be strengthened.

Childhood and adolescence is a period in human development when one experiences many changes in functioning within a short time frame. As a result of these ongoing, normative challenges, young people frequently require brief interventions to help them develop and improve their coping and problem-solving skills. Although many schools offer high-quality, meaningful supports for such intermittent crises in students' lives, many of these services are provided in a reactive mode. Schools will respond more effectively and strategically by developing protocols and procedures for addressing such predictable needs. Overarching philosophies related to the milestones, challenges and skills development that affect the healthy growth of young people should govern the provision of crisis-related and brief treatment services.

Implementation strategies include:

- ✧ Develop appropriate protocols with a decision tree that indicates how, when, and by whom services are to be delivered, what the follow-up plan will be, and how the family will be included in assisting students through transitional periods.
- ✧ Establish in each school a safety committee, as suggested by CGS 10-220f, to increase staff and student awareness of health and safety issues and to review the adequacy of emergency response procedures. Each school should have comprehensive emergency response plans that anticipate relocation, temporary isolation from other support services, and mental health triage and brief treatment, in addition to other challenges to typical school operations.
- ✧ As allowed by CGS 10-231, substitute every three months a crisis drill in place of the required fire drill. Use these opportunities to practice "lockdown" and evacuation drills.
- ✧ Establish a crisis team that considers the physical plant, the student and community population, capacity of external agencies, and their involvement with municipal emergency management services. This team should be able to respond to the individual and group needs of the student body.
- ✧ Establish proactive relationships and agreements with the regional agency overseeing Emergency Mobile Psychiatric Services (http://www.ct.gov/dcf/cwp/view.asp?a=2558&q=314354) for effective facilitation of urgent referrals for services.
- ✧ Gather and analyze data on urgent requests for support services to ensure that interventions, protocols and deployment of behavioral health staff are responsive to current and emerging trends in the student body.
- ✧ Ensure full implementation of the Connecticut Comprehensive School Counseling Program (http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/counseling.pdf).
- ✧ Ensure that mental health staff employed by the school applies evidence-based techniques and practices that address specific goals and outcomes.
- ✧ Facilitate transfer to community mental health specialists those youngsters who might benefit from more long-term interventions.

7. ***Staff development.*** All school staff shall be informed about normative development, common potential stressors that may interfere with learning and behavioral health (e.g., bereavement, parental divorce), atypical emotional responses, classroom-based interventions that positively affect school climate, systems-based interventions that improve quality of life in school settings, and mechanisms for referring students for more extensive behavioral health services.

Teachers' pre-service education includes little information about the normative development of young people and behaviors that might emerge throughout a student's educational career. Schools should ensure that each staff member has adequate information about normative development.

Implementation strategies include:

- ✧ Provide staff orientation and training that addresses the typical developmental milestones, emotional needs and activities that affect young people. Staff should be particularly knowledgeable about the age group with whom they interact but should also be familiar enough with general development to recognize how their students fit within the continuum of growth during the school years.
- ✧ Schedule regular in-service workshops provided by behavioral health services staff that address typical development, anomalous development, and strategies to assist students in their passage through the school system.
- ✧ Ensure that mental health personnel receive relevant professional training that increases their skills and capacity to meet the behavioral health needs of students.
- ✧ Collaborate with colleagues in higher education to incorporate more comprehensive education about child development and age-appropriate education into pre-service training.

8. ***Parent-school linkages.*** Parent-school linkages related to the behavioral health needs of young people throughout childhood and adolescence shall be strengthened.

The involvement of parents is essential for creating a supportive, social behavioral health program. Students who receive high quality support services in a school setting but return to a home with an uninformed or uninvolved environment will not benefit as fully as they might from supports that have been put into place. Moreover, parents as taxpayers may be the school's best ally in leveraging financial and municipal support for the expansion of behavioral health services. Involvement of parents in the overall planning for and oversight of behavioral health needs and programming can be another method for reducing stigmatization and encouraging socially informed curriculum and services. Although in some rare occasions parents may not be able to play a beneficial role in addressing a youngster's mental health needs, the inclusion of parents closes the loop on assisting students within all the environments that affect them.

Schools can be one of the most powerful and meaningful sources of information for successful parenting. School staff members receive constant exposure to emerging developments and policies affecting young people. Schools should become information centers for the families they serve using, along with other strategies, resource packets that include information about normative development, local resources, areas of concern and advocacy around emerging or existing needs.

Implementation strategies include:

- ✧ Ensure that all staff members and students use considerate and respectful language.
- ✧ Ensure that conversations are two-way, that each person is heard and understood, and that structures for these conversations remain flexible.
- ✧ Become an information center for the families you serve, using along with other strategies, resource packets that include information about normative development, local resources, areas of concern and advocacy around emerging or existing needs.
- ✧ Assist parents in becoming actively involved in their child's education.
- ✧ Create "action teams" that are made up of parents, school staff and administrators, and students to develop comprehensive plans to increase family and community involvement.
- ✧ Conduct regular, ongoing information and training sessions addressing childhood development, limit-setting, positive reinforcement, homework skills, new math, etc., for parents and other concerned adults.
- ✧ Create and annually update a listing of licensed providers in your community, along with any special instructions related to enrollment, application for services, types of treatment, etc.
- ✧ Develop resource packets for families that include listings of community and state services with explanations of the services, intake mechanisms, the approximate costs of services, and alternative resources for families with economic limitations that might affect students' access to necessary services.
- ✧ Develop scheduling that accommodates family schedules as well as organizational staff schedules.

9. ***Reduce risk behaviors.*** Child and adolescent risk behaviors, including but not limited to tobacco use, unsafe sexual behaviors, drug and alcohol use, and suicide, shall be reduced.

Young people need to test external boundaries and realize their own internal capacities as part of their normal development. Unfortunately, modern society offers innumerable risks and hazards that can have fatal consequences. Drugs, alcohol and violence remain the greatest threats to young people and their successful transition into adulthood. Schools need to work with the community to identify hazards and risks, offer alternatives and recommend strategies to reduce the hazards associated with risk-taking behaviors.

Implementation strategies include:

- ✧ Ensure that staff is familiar with the content and recommendations in *Guidelines for Suicide Prevention: Policy and Procedures*, 2nd Edition, 2004 published by the Connecticut State Department of Education (http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Student/PsychSocial/SP_Guidelines.pdf).
- ✧ Provide to all staff the most recent results of the Connecticut School Health Survey, which informs the public about the rates of risk-associated behaviors.

- ✧ Use curricular materials that are evidence-based and replicable between groups. For examples, see the CDC Registries of Programs Effective in Reducing Youth Risk Behaviors at http://www.cdc.gov/HealthyYouth/AdolescentHealth/registries.htm.

10. ***School climate initiatives.*** Personal and systems-based programs to improve school climate shall be established.

Schools themselves must become safer, more predictable, and increasingly responsive to the needs of young people and their families. Staff members need support to strengthen their capacity to support others. Systemic consideration must include the physical, emotional and humanistic needs of the school community. Violence must be reduced. Acceptance of differences should guide interpersonal interaction, pro-social and non-judgmental values should guide decision making, and responsibility should be taught and modeled.

Implementation strategies include:

- ✧ Develop structures that provide safety while encouraging the involvement of students, families and the community in school-based activities.
- ✧ Identify for each student an adult who will serve as mentor, aide, adviser and guide. Encourage the development of long-term relationships between students and staff that endure while the student attends the school.
- ✧ Use schoolwide contingency programs that provide reinforcement for positive behaviors and consistent consequences for errors. The State Education Resource Center, in collaboration with the University of Connecticut and the State Department of Education, provides training and consultation on incorporating schoolwide positive behavioral supports.
- ✧ Advise your school's student government to consider and respond to climate issues related to accountability and responsibility.
- ✧ Increase students' willingness to listen respectfully and responsively to one another.
- ✧ Encourage decision making by consensus instead of simple majority or administrative privilege.

Legislation Pertaining to School Behavioral Health Services

Connecticut General Statutes Section 10-16b. Prescribed courses of study. (a) In the public schools the program of instruction offered shall include at least the following subject matter, as taught by legally qualified teachers, the arts; career education; consumer education; health and safety, including, but not limited to, human growth and development, nutrition, first aid, disease prevention, community and consumer health, physical, mental and emotional health, including youth suicide prevention, substance abuse prevention, safety, which may include the dangers of gang membership, and accident prevention. http://www.cga.ct.gov/2007/pub/Chap164.htm#Sec10-16b.htm

Connecticut General Statutes Section 10-19. Teaching about alcohol, nicotine or tobacco, drugs and acquired immune deficiency syndrome. Training of personnel. (a) The knowledge, skills and attitudes required to understand and avoid the effects of alcohol, of nicotine or tobacco and of drugs, as defined in subdivision (17) of section 21a-240, on health, character, citizenship and personality development shall be taught every academic year to pupils in all grades in the public schools; and, in teaching such subjects, textbooks and such other materials as are necessary shall be used. Annually, at such time and in such manner as the Commissioner of Education shall request, each local and regional board of education shall attest to the State Board of Education that all pupils enrolled in its schools have been taught such subjects pursuant to this subsection and in accordance with a planned, ongoing and systematic program of instruction. The content and scheduling of instruction shall be within the discretion of the local or regional board of education. Institutions of higher education approved by the State Board of Education to train teachers shall give instruction on the subjects prescribed in this section and concerning the best methods of teaching the same. The State Board of Education and the Board of Governors of Higher Education in consultation with the Commissioner of Mental Health and Addiction Services and the Commissioner of Public Health shall develop health education or other programs for elementary and secondary schools and for the training of teachers, administrators and guidance personnel with reference to understanding and avoiding the effects of nicotine or tobacco, alcohol and drugs.

(b) Commencing July 1, 1989, each local and regional board of education shall offer during the regular school day planned, ongoing and systematic instruction on acquired immune deficiency syndrome, as taught by legally qualified teachers. The content and scheduling of the instruction shall be within the discretion of the local or regional board of education. Not later than July 1, 1989, each local and regional board of education shall adopt a policy, as the board deems appropriate, concerning the exemption of pupils from such instruction upon written request of the parent or guardian. The State Board of Education shall make materials available to assist local and regional boards of education in developing instruction pursuant to this subsection. http://www.cga.ct.gov/2007/pub/Chap164.htm#Sec10-19.htm

Connecticut General Statutes Section 10-19b. Advisory councils on drug abuse prevention. Advisory councils on drug abuse education and prevention established by municipalities pursuant to subsection (a) of Section 4126 of the Drug Free Schools and Communities Act of 1986 may serve as a resource for public schools in the field of substance abuse prevention and education and may assist in the development of out-of-school activity for students. http://www.cga.ct.gov/2007/pub/Chap164.htm#Sec10-19b.htm

Connecticut General Statutes Section 10-76ff. Procedures for determining if a child requires special education. (a) Each local and regional board of education shall follow the procedures outlined in this section in determining if a child requires special education and related services, as defined in section 10-76a. (1) In conducting an evaluation of the child, the local or regional board of education shall: (A) Use a variety of assessment tools and strategies to gather relevant functional and developmental information, including information provided by the child's parent or guardian, that may assist in determining (i) whether the child is a child, (I) who requires special education and related services pursuant to subparagraphs (A) and (C) of subdivision (5) of section 10-76a, (II) whose disability has an adverse effect on his educational performance, and (III) who, by reason of such adverse effect requires special education and related services, and (ii) the content of the child's individualized education program, including information related to enabling the child to be involved in and progress in the general curriculum or, for preschool children, to participate in appropriate activities; (B) not use any single procedure as the sole criterion for determining whether a child is a child with a disability or determining an appropriate educational program for the child; and (C) use technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors. (2) Each local and regional board of education shall ensure that: (A) Tests and other evaluation materials used to assess the child are (i) selected and administered so as not to be discriminatory on a racial or cultural basis, and (ii) provided and administered in the child's native language or other mode of communication, unless it is clearly not feasible to do so; (B) any standardized tests that are given to the child (i) were validated for the specific purpose for which they are used, (ii) are administered by trained and knowledgeable personnel, and (iii) are administered in accordance with any instructions provided by the producer of such tests; (C) the child is assessed in all areas of suspected disability; and (D) assessment tools and strategies that provide relevant information that directly assists persons in determining the educational needs of the child are provided. (3) In accordance with section 10-76d and applicable federal law and regulations, upon completion of administration of tests and other evaluation materials, the determination of whether the child is a child requiring special education and related services shall be made by a team consisting of qualified professionals and the parent or guardian of the child and a copy of the evaluation report and the documentation for such determination shall be given to the parent or guardian of the child. (4) The local or regional board of education shall not determine that a child requires special education and related services based solely on (A) a lack of instruction in reading or math or limited English proficiency, or (B) evidence that the child's behavior violates the school's disciplinary policies or evidence that is derived from the contents of discipline records. http://www.cga.ct.gov/2007/pub/Chap164.htm#Sec10-76ff.htm

Connecticut General Statutes Section 10-209. Records not to be public. Provision of reports to schools. (a) No record of any medical examination made or filed under the provisions of sections 10-205, 10-206, 10-207 and 10-214, or of any psychological examination made under the supervision or at the request of a board of education, shall be open to public inspection. http://www.cga.ct.gov/2007/pub/Chap169.htm#Sec10-209.htm

Connecticut General Statutes Section 10-212b. Policies prohibiting the recommendation of psychotropic drugs by school personnel. (a) For purposes of this section, (1) "psychotropic drugs" means prescription medications for behavioral or social-emotional concerns, such as attentional deficits, impulsivity, anxiety, depression and thought disorders, and includes, but is not limited to, stimulant medication and antidepressants, and (2) "school health or mental health personnel" means school nurses or nurse practitioners appointed pursuant to section 10-212, school medical advisors appointed pursuant to section 10-205, school psychologists, school social workers, school counselors and such other school personnel who have been identified as the person responsible for communication with a parent or guardian about a child's need for medical evaluation pursuant to a policy adopted by a

local or regional board of education as required by subsection (b) of this section. http://www.cga.ct.gov/2007/pub/Chap169.htm#Sec10-212b.htm

Connecticut General Statutes Section 10-220a. In-service training. Professional development. Institutes for educators. Cooperating and beginning teacher programs, regulations. (a) Each local or regional board of education shall provide an in-service training program for its teachers, administrators and pupil personnel who hold the initial educator, provisional educator or professional educator certificate. Such program shall provide such teachers, administrators and pupil personnel with information on (1) the nature and the relationship of drugs, as defined in subdivision (17) of section 21a-240, and alcohol to health and personality development, and procedures for discouraging their abuse, (2) health and mental health risk reduction education which includes, but need not be limited to, the prevention of risk-taking behavior by children and the relationship of such behavior to substance abuse, pregnancy, sexually transmitted diseases, including HIV-infection and AIDS, as defined in section 19a-581, violence, child abuse and youth suicide, (3) the growth and development of exceptional children, including handicapped and gifted and talented children and children who may require special education, including, but not limited to, children with attention-deficit hyperactivity disorder or learning disabilities, and methods for identifying, planning for and working effectively with special needs children in a regular classroom, (4) school violence prevention and conflict resolution, (5) cardiopulmonary resuscitation and other emergency life saving procedures, (6) computer and other information technology as applied to student learning and classroom instruction, communications and data management, (7) the teaching of the language arts, reading and reading readiness for teachers in grades kindergarten to three, inclusive, and (8) second language acquisition in districts required to provide a program of bilingual education pursuant to section 10-17f. The State Board of Education, within available appropriations and utilizing available materials, shall assist and encourage local and regional boards of education to include: (A) Holocaust education and awareness; (B) the historical events surrounding the Great Famine in Ireland; (C) African-American history; (D) Puerto Rican history; (E) Native American history; (F) personal financial management; and (G) topics approved by the state board upon the request of local or regional boards of education as part of in-service training programs pursuant to this subsection. http://www.cga.ct.gov/2007/pub/Chap170.htm#Sec10-220a.htm

Connecticut General Statutes Section 10-220f. Safety committee. Each local and regional board of education may establish a school district safety committee to increase staff and student awareness of safety and health issues and to review the adequacy of emergency response procedures at each school. Parents and high school students shall be included in the membership of such committees. http://www.cga.ct.gov/2007/pub/Chap170.htm#Sec10-220f.htm

Connecticut General Statutes Section 10-221. Boards of education to prescribe rules, policies and procedures. (d) Not later than July 1, 1991, each local and regional board of education shall develop, adopt and implement policies and procedures in conformity with section 10-154a for (1) dealing with the use, sale or possession of alcohol or controlled drugs, as defined in subsection (8) of section 21a-240, by public school students on school property, including a process for coordination with, and referral of such students to, appropriate agencies and (2) cooperating with law enforcement officials.

(e) Not later than July 1, 1990, each local and regional board of education shall adopt a written policy and procedures for dealing with youth suicide prevention and youth suicide attempts. Each such board of education may establish a student assistance program to identify risk factors for youth suicide, procedures to intervene with such youth, referral services and training for teachers and other school professionals and students who provide assistance in the program. http://www.cga.ct.gov/2007/pub/Chap170.htm#Sec10-221.htm

Connecticut General Statutes Section 10-222d. Policy on bullying behavior. Each local and regional board of education shall develop a policy, for use on and after February 1, 2003, to address the existence of bullying in its schools. Such policy shall: (1) Enable students to anonymously report acts of bullying to teachers and school administrators, (2) enable the parents or guardians of students to file written reports of suspected bullying, (3) require teachers and other school staff who witness acts of bullying or receive student reports of bullying to notify school administrators, (4) require school administrators to investigate any written reports filed pursuant to subdivision (2) of this section and to review any anonymous reports, (5) include an intervention strategy for school staff to deal with bullying, (6) provide for the inclusion of language in student codes of conduct concerning bullying, (7) require the parents or guardians of students who commit any verified acts of bullying and the parents or guardians of students against whom such acts were directed to be notified, and (8) require each school to maintain a list of the number of verified acts of bullying in such school and make such list available for public inspection. The notification required pursuant to subdivision (7) of this section shall include a description of the response of school staff to such acts and any consequences that may result from the commission of further acts of bullying. For purposes of this section, "bullying" means any overt acts by a student or a group of students directed against another student with the intent to ridicule, humiliate or intimidate the other student while on school grounds or at a school-sponsored activity which acts are repeated against the same student over time. http://www.cga.ct.gov/2007/pub/Chap170.htm#Sec10-222d.htm

Connecticut General Statutes Section 10-231. Fire drills. Crisis response drills. Each local and regional board of education shall provide for a fire drill to be held in the schools of such board at least once each month, except that once every three months a crisis response drill may be substituted for a fire drill. http://www.cga.ct.gov/2007/pub/Chap170.htm#Sec10-231.htm

Connecticut General Statutes Section 17a-101. (Formerly Sec. 17-38a). Protection of children from abuse. Mandated reporters. Educational and training programs. (a) The public policy of this state is: To protect children whose health and welfare may be adversely affected through injury and neglect; to strengthen the family and to make the home safe for children by enhancing the parental capacity for good child care; to provide a temporary or permanent nurturing and safe environment for children when necessary; and for these purposes to require the reporting of suspected child abuse, investigation of such reports by a social agency, and provision of services, where needed, to such child and family.

(b) The following persons shall be mandated reporters: Any physician or surgeon licensed under the provisions of chapter 370, any resident physician or intern in any hospital in this state, whether or not so licensed, any registered nurse, licensed practical nurse, medical examiner, dentist, dental hygienist, psychologist, coach of intramural or interscholastic athletics, school teacher, school principal, school guidance counselor, school paraprofessional, school coach, social worker, police officer, juvenile or adult probation officer, juvenile or adult parole officer, member of the clergy, pharmacist, physical therapist, optometrist, chiropractor, podiatrist, mental health professional or physician assistant, any person who is a licensed or certified emergency medical services provider, any person who is a licensed or certified alcohol and drug counselor, any person who is a licensed marital and family therapist, any person who is a sexual assault counselor or a battered women's counselor as defined in section 52-146k, any person who is a licensed professional counselor, any person paid to care for a child in any public or private facility, child day care center, group day care home or family day care home licensed by the state, any employee of the Department of Children and Families, any employee of the Department of Public

Health who is responsible for the licensing of child day care centers, group day care homes, family day care homes or youth camps, the Child Advocate and any employee of the Office of Child Advocate.

(c) The Commissioner of Children and Families shall develop an educational training program for the accurate and prompt identification and reporting of child abuse and neglect. Such training program shall be made available to all persons mandated to report child abuse and neglect at various times and locations throughout the state as determined by the Commissioner of Children and Families.

(d) Any mandated reporter, as defined in subsection (b) of this section, who fails to report to the Commissioner of Children and Families pursuant to section 17a-101a shall be required to participate in an educational and training program established by the commissioner. The program may be provided by one or more private organizations approved by the commissioner, provided the entire costs of the program shall be paid from fees charged to the participants, the amount of which shall be subject to the approval of the commissioner. http://www.cga.ct.gov/2007/pub/Chap319a.htm#Sec17a-101.htm

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World Health Organization. (2001). *Mental health: New understanding, new hope*. http://www.who.int/whr/2001/en/. Retrieved on January 25, 2007.

Resources

Community Collaborative System of Care: http://www.ct.gov/dcf/lib/dcf/behavioral_health/pdf/ct_comm_coll_for_child_&_fam_directory.doc

Connecticut Behavioral Health Plan: http://www.ctbhp.com/

Connecticut Mental Health Transformation State Incentive Grant: http://www.dmhas.state.ct.us/transformation.htm

Connecticut State Department of Education Coordinated School Health Partnerships: http://www.ct.gov/sde/healthyconneCTions

Connecticut State Department of Education Primary Mental Health Program: http://www.sde.ct.gov/sde/cwp/view.asp?a=2678&q=320752

Connecticut State Department of Education Special Education Resources: http://www.sde.ct.gov/sde/cwp/view.asp?a=2678&Q=320730#publications

Crisis Response – Creating Safe Schools: http://www.ed.gov/admins/lead/safety/training/responding/index.html

Developing Quality Programs for Pupil Services: A Self-Evaluative Guide: http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/QPPupilSrves.pdf

Healthcare for Uninsured Kids and Youth (HUSKY): http://www.huskyhealth.com/

Internet Mental Health: http://www.mentalhealth.com/

Internet Resource for Special Children: http://www.irsc.org/

MedLine Plus – School Health: http://www.nlm.nih.gov/medlineplus/schoolhealth.html

Model Special Education Policies and Procedures Manual, 2007: http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/PolicyProceduresManual.pdf

National Institute of Mental Health: http://www.nimh.nih.gov/

Practice Guidelines for Recovery-Oriented Behavioral Health Care: http://www.dmhas.state.ct.us/documents/practiceguidelines.pdf

Report on Attention-Deficit Hyperactivity Disorder (ADHD): http://www.ctserc.org/initiatives/teachandlearn/ADHD_report_5-2-05.pdf

School Mental Health Services in the United States, SAMHSA: http://mentalhealth.samhsa.gov/publications/allpubs/sma05%2D4068/

School-based Mental Health Services: A Selected Bibliography, The center for Health and Healthcare in Schools: http://www.healthinschools.org/sbhcs/biblio_mental.asp

The Collaborative for Academic, Social and Emotional Learning (CASEL): http://www.casel.org/home/index.php

The National Center for School Crisis and Bereavement: http://www.cincinnatichildrens.org/svc/alpha/s/school-crisis/default.htm

The World Health Organization – Mental Health: http://www.who.int/mental_health/en/index.html

UCLA School Mental Health Project: http://smhp.psych.ucla.edu/

University of Maryland School of Medicine Center for School Mental Health Analysis and Action: http://csmha.umaryland.edu/index.html