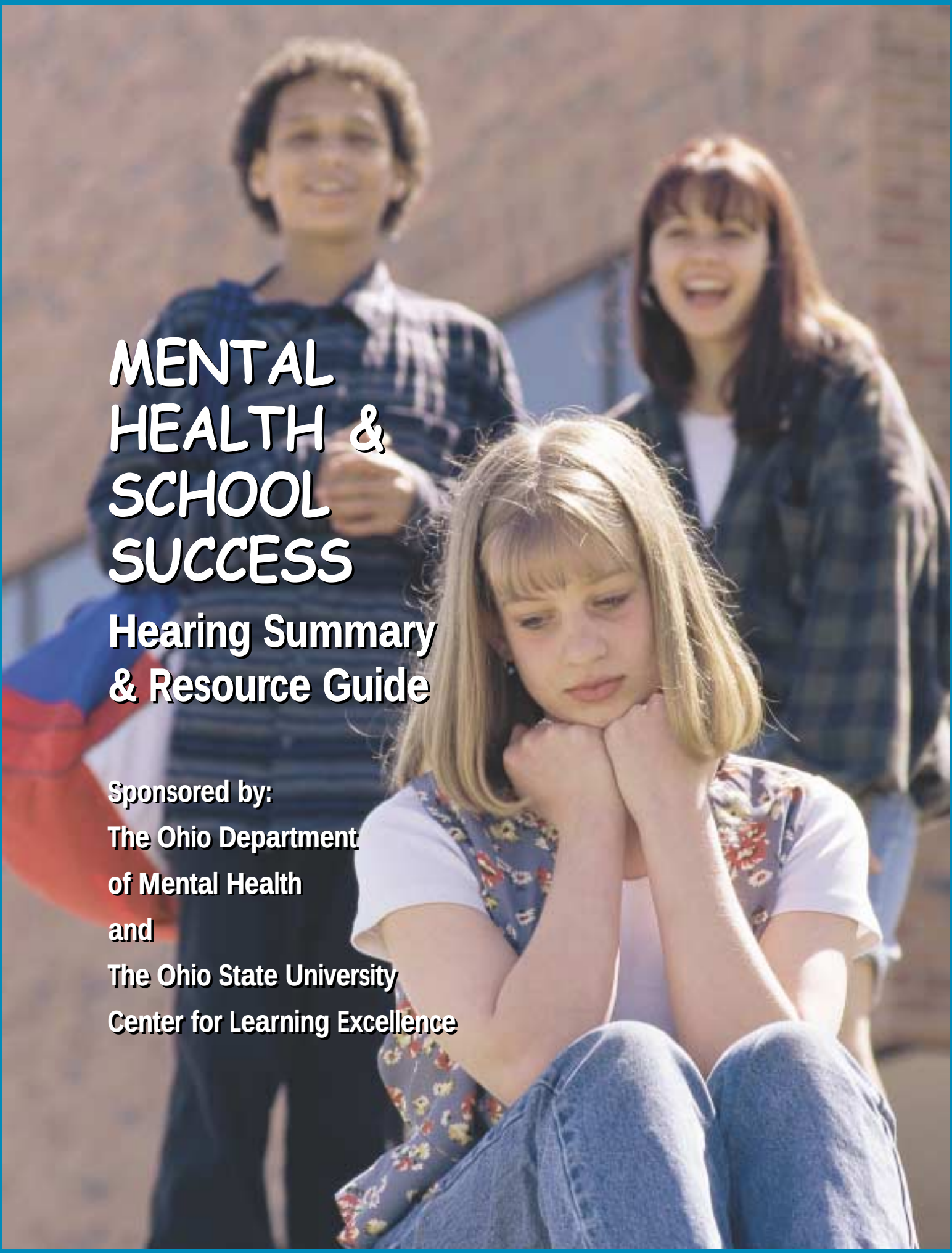

MENTAL HEALTH & SCHOOL SUCCESS

Hearing Summary & Resource Guide

Sponsored by:
The Ohio Department of Mental Health
and
The Ohio State University
Center for Learning Excellence

An Educator's Perspective

"In my 30 years of working in education, I've seen, unfortunately, a deterioration in the emotional support that children receive in their homes and communities. And schools are not doing that well either, so I must put us on that list as well.

Families are in crisis and don't even know it. They've come to believe that the turmoil that sometimes characterizes their lives is normal. They're afraid to admit that they need help and they don't see the value in changing their priorities to focus on emotional wellness and explore a new course for their family.

We stand ready to help. We would welcome suggestions, new ideas, and new approaches from anyone who can be of help to us."

Francine Toss
Oberlin City Schools

Needs in Mental Health

"We did find that we had increased the number of severely emotionally disturbed children that we were serving in our system by twofold over the last couple of years, so we really are finding more children that needed care, and that was one of the prime concerns.

When we look at the outcomes measured, we do find that kids who get into treatment are functioning better. We also find that parents are satisfied and the schools feel pretty good about the service they're getting."

Amy Levin
Lorain County Mental Health Board

TABLE OF CONTENTS

Introduction 1
Definition – Serious Emotional Disturbance 4
Hearing Testimony and Recommendations 5
Depression and Suicide in Children and Adolescents . . .7
A Family's Experience 33
Case Study – "One District's Needs" 35
Resource Guide 37
Ohio Mental Health/Alternative Education Network . . .48

Hope Taft, First Lady of Ohio (center), joined by Dr. Michael Hogan, Director, Ohio Department of Mental Health (to the right) and staff from The Ohio State University's Center for Learning Excellence, including (L-R) Dr. Al Neff, Associate Director, Dr. David W. Andrews, Director, and Dr. Diana Leigh, Program Manager at the Mental Health & School Success Hearing.

From Ohio's First Lady, Hope Taft

Governor Taft's strong commitment to helping every child succeed inspires us to evaluate our effort, share our successes and encourage more collaboration between families, schools and mental health agencies. Help for Ohio's children depends upon our willingness to do so.

"You can be a model for positive values. You can reveal paths of empowerment that enable young people to make a difference in their families, schools, and communities. You can set clear boundaries and high expectations, guiding young people toward good health and safety. You can provide any number of activities and opportunities for young people and adults to make constructive use of their time.

By all of us working together – no matter what role you have in your family, your community, or our society, you can keep children our number one priority. As you till the soil they grow in, you can enrich it with the nutrients they need. The seeds we plant today will blossom and brighten our future in a very dramatic way."

Hope Taft, from a speech to The Columbus Foundation

From the Ohio Department of Mental Health

Michael F. Hogan, Ph.D., *Director*
Ohio Department of Mental Health

This publication summarizes a hearing conducted in Columbus, Ohio, on February 8, 2001. We also hope to provide facts, resources, and ideas about the emerging link between good mental health and success in school—and what parents, educators, and mental health professionals can do.

At the Ohio Department of Mental Health, we are focused on mental health and school success for several reasons. First, Governor Bob Taft has made **"Helping Every Child to Succeed"** the top priority of his administration. For a large and growing number of children, emotional and behavioral problems are a major cause of school failure. With new evidence about the impact of mental illness and the effectiveness of treatment, it is time to make the link between positive mental health and success in school even stronger.

Second, despite positive reforms in mental health care, most children with mental illness never get needed treatment. Attorney, parent, and child advocate Jim Mauro describes in this publication how parenting challenges are multiplied when children have a brain disorder. The Mauro family—and most families of children with brain disorders—find that the care system is like a maze. As a result, less than one quarter of all children needing treatment ever see a mental health specialist. Since education is a universal experience and since behavioral problems have such a negative impact on learning, we believe schools can be the best place to identify children needing help. The challenges facing educators have multiplied dramatically in the 30 years since I was a classroom teacher. For schools to succeed, as Ohio Superintendent of Public Instruction Dr. Susan Zelman puts it, "we must open the schoolhouse doors" to mental health professionals and others who can support the mission of learning.

Finally, Ohio has many communities where truly excellent collaboration between educators and mental health professionals is making an impact on learning and the health of students. This publication highlights just a few of these "emerging best practices." Through collaboration with the Center for Learning Excellence at The Ohio State University, we are supporting and expanding these positive efforts.

We hope you find this resource useful and a call to action to improve mental health and school success. If you have feedback, questions, or ideas, we hope to hear from you.

Michael F. Hogan, Ph.D., *Director*
Ohio Department of Mental Health

Ohio Department of Mental Health

Bob Taft, Governor
Michael F. Hogan, Ph.D., Director

From the Center for Learning Excellence

David Andrews, Ph.D., *Dean*
OSU College of Human Ecology
and *Director*, Center for Learning Excellence

There is no question that mental health issues play a significant role in the levels of education ultimately achieved by our children. Children with untreated mental health problems experience multiple obstacles to learning that often make the difference between whether or not they lead positive, productive adult lives. The overall success of any educational reform is unquestionably tied to the creation of a more accessible, effective system of assessment and treatment of children with mental health problems.

Accessing mental health services can be greatly enhanced through the availability of these services in a wide range of educational settings. Children spend the majority of their waking hours in and around schools and are most easily accessed in school and at after-school programs. As a single point of contact for children and their families, schools are the natural choice as the focal point of community-building efforts. These efforts will be successful to the degree that they have a holistic impact on the lives of children and families.

Mental health services and other community support must be provided to our highest risk children in a coordinated, seamless system that can be delivered within the context of our educational system. Ohio took a major step forward in achieving this goal by creating the Alternative Education Challenge Grant Program. Under the direction of the Alternative Education Advisory Council, this program funded 127 different projects statewide, each designed for students demonstrating behaviors that put them at serious risk for school failure. A primary criteria for funding was whether provisions were made for students to receive mental health services.

In addition, the Center for Learning Excellence was created at the John Glenn Institute for Public Service and Public Policy at The Ohio State University to provide training and technical assistance to the Alternative Education Program schools in Ohio. With direct support from the Ohio Department of Mental Health, the Center established a network of mental health professionals to assist in the innovative delivery of mental health services to alternative school students. The Ohio Mental Health/Alternative Education Network is providing invaluable assistance to schools as they strive to meet the mental health needs of their students.

The programs outlined in this hearing, along with the pressing needs and concerns articulated by the participants, will become part of Ohio's roadmap for the future. I look forward to seeing increased collaboration between schools, mental health professionals, and other community partners. Ohio will reap the benefits of this collaboration with a healthier, happier, more educated and productive citizenry.

David Andrews, Ph.D., *Director*
Center for Learning Excellence

THE OHIO STATE UNIVERSITY

THE JOHN GLENN INSTITUTE
FOR
PUBLIC SERVICE & PUBLIC POLICY
CENTER FOR LEARNING EXCELLENCE

Serious Emotional Disturbance (SED) Definition

A significant number of children, and adolescents have serious emotional disturbances. Serious emotional disturbance in children is defined by the Center for Mental Health Services as follows:

Children with a serious emotional disturbance are persons: from birth up to age18; who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified with DSM-IV-R, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

These disorders include any mental disorder (including those of biological etiology) listed in DSM-IV-R or their ICD-9-CM equivalent (and subsequent revisions), with the exception of – R "V" codes, substance use, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious emotional disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.

Presenters

Parents and Families

James Mauro, Parent/Advocate
Franklin County

Marcy Dvorak, Parent/Advocate
Lucas County

Butler County Team

John Staup, Executive Director
Butler County Community Mental Health Board

Brian and Dustin Nesbitt
New Miami Elementary School

Dr. Carl Paternite
Department of Psychology, Miami University

Robert Bierly, Superintendent
New Miami Local School District

Melissa Kircher, Principal
New Miami Elementary School

Marian Grollmus, Teacher
New Miami Elementary School

Dr. David Turner
The Counseling Source

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Carol Lichtenwalter
Stark County Family Council

Joyce Lemke
Stark County Educational Service Center

Richard Hull
Fairless High School

Lorain County Team

Amy Levin, Executive Director
Lorain County ADAMH Board

Fannie Johnson-Baxter
Applewood Centers, Inc.

Francine Toss
Oberlin City Schools

Hearing Testimony & Recommendations

Mental Health & School Success: A Public Hearing and Call to Action

"Mental Health & School Success: A Hearing" took place on February 8, 2001. The report includes testimony and recommendations from:

- Parents and family members
- Representatives of Community Mental Health and ADAMH Boards
- Students
- Representatives of local school districts
- Representatives of provider agencies implementing successful school-based mental health programs and services.

The goal of this hearing was to identify "critical success factors" which will lead to improved school success for children with severe emotional disorders, as well as those children identified as "at risk" for school failure due to psychosocial difficulties.

Joining First Lady Hope Taft, ODMH Director Mike Hogan and OSU Dean David Andrews as hearing panelists were professionals from Ohio Family and Children First, The Ohio Department of Education and community mental health boards.

Surgeon General's Report:

Overview of Mental Disorder in Children

A mental disorder results from the interaction of a child and his or her environment. Thus, mental illness often does not lie within the child alone. Within the conceptual framework and language of integrative neuroscience, the mental disorder is an emergent property of the transaction with the environment. Proper assessment of a child's mood, thought, and behaviors demands a simultaneous consideration of nature and nurture, genes and environment, and biology and psychosocial influences. These relationships are reciprocal. **The brain shapes behavior, and learning shapes the brain.**

(Jenson & Hoagwood, 1997)

Chapter 3, Children and Mental Health, Page 136

Mrs. Hope Taft
Panel Member

I want to welcome you all to this hearing. Thank you for inviting me.

It's a great pleasure to be here with the experts — the families and children, and those of you who have been working year in and year out to make your part of Ohio the best place to live.

I want to thank the organizers for finding a way to draw attention to this very important issue: how schools and mental health programs can work with parents to help children. And I want to thank you for being a part of the Governor's top priority — enabling every child to succeed.

Through Ohio Children and Family First, the Governor has put forth six commitments for every child's well being.

- **Expecting parents and newborns thrive;**
- **Infants and toddlers thrive;**
- **Children are ready for school;**
- **Children and youth succeed in school;**
- **Youth choose healthy behaviors; and**
- **Youth successfully transition into adulthood.**

When I think about what will be discussed here, I realize that your work will impact all six of those commitments.

We must work together to make sure that all Ohio's children have the best chance to succeed. That probably means a large dose of preventive care, changing the way we operate between systems, and finding new ways to help youngsters get back on track.

I am honored to be included in this hearing and to be able to learn from you all. I consider it a privilege to listen to your stories of success, as well as your trials, and to work with you to make sure that Ohio really is the best place to live, work, go to school, play, and most of all, be a young person.

Dr. Michael Hogan, *Director*
Ohio Department of Mental Health
Panel Member

We think the record from our hearing today will show that behavioral and emotional challenges that some students face are major factors in school success, and some of these children who don't get the support from us that they need experience blocks and failures as a result. We think that, in fact, the record is going to show that there are profound and serious problems in how we adults respond to the needs of these children in our schools, in our mental health programs, in our collaboration, or too frequently our failure to collaborate, to provide a helping hand to kids and to parents. But we also think that the record for today is going to begin to show some very positive things.

In communities around Ohio, people are starting to take steps that I would describe as strong baby steps. Steps that are strong that involve collaboration, that involve commitment, that involve extending a helping hand. **I don't think anybody here will say that in their community there is yet enough support to help kids wrestling with these challenges to succeed.**

So, we want to listen and learn from those people who are taking those strong baby steps and understand how we can help other communities to learn from and to follow their examples.

We've chosen the format of a public hearing today, precisely because we want to listen — and to learn. This is an area of growing concern. It's not an area where there are really good answers yet about the best ways to respond. We think that some of the best ways to respond may be in what we hear today from communities that are grappling with these issues.

Mr. James Mauro
Parent/Advocate
Franklin County

Good morning. My name is Jim Mauro, I'm a resident of Franklin County, and the very first thing I'd like to do is to thank the members of this panel and the various agencies and institutions and offices that you represent for convening this session. This is extremely important work.

I'm here this morning primarily as a very concerned parent, but I am also a member of the NAMI board of directors, a member of the NAMI Ohio Children's Committee, and a member of the local NAMI affiliate here in Franklin County.

My wife and I are raising three great kids. We have a set of twins, a boy and girl, who are seniors in high school, and a fourth grader. We are experiencing all of the joys and pleasures and a lot of the heartache that goes along with raising kids who suffer from mental illness.

Our older son suffers from depression and our younger son is bipolar. We are, by most standards, I think, a middle class family. My wife and I both work outside the home. She has been a professional educator in the special education field for in excess of 25 years. I've worked in both state and local government, I've had positions in private industry, and for the last 18 years, I've been practicing law here in central Ohio. We also — it's almost frightening to think about — between the two of us, my wife and I, we have about 40 years of classroom education. I can't tell you how many continuing education hours we have. And we also have a relatively good health care plan.

I mention these things to you so that you will have some perspective within which to put my comments as you think about educating kids that have mental illnesses throughout the state, because I'm not so sure we are typical of the families that are dealing with these problems.

When we first learned that our sons were affected by mental illness some well over ten years ago, I thought that we were going to be able to call on this great expanse of education and background and experience that my wife and I had to deal with it, but the very first thing that we learned was that we were woefully and pitifully prepared to deal with this. We were very ignorant of the illnesses and very ignorant of what we were going to have to do to relieve these kids from their obvious miseries.

When we turned, first of all, to our family physicians, pediatricians, folks who had been providing excellent care for our kids for many years, the first thing we learned was that ignorance and misunderstanding of mental illness is probably the rule, rather than the exception.

Surgeon General's Report:

Depression and Suicide in Children and Adolescents

In children and adolescents, the most frequently diagnosed mood disorders are major depressive disorder, dysthymic disorder, and bipolar disorder. Because mood disorders such as depression substantially increase the risk of suicide, suicidal behavior is a matter of serious concern for clinicians who deal with the mental health problems of children and adolescents. The incidence of suicide attempts reaches a peak during the mid-adolescent years, and mortality from suicide, which increases steadily through the teens, is the third leading cause of death at that age (CDC, 1999; Hoyert et al., 1999). Although suicide cannot be defined as a mental disorder, the various risk factors—especially the presence of mood disorders—that predispose young people to such behavior are given special emphasis in this section, as is a discussion of the effectiveness of various forms of treatment. The evidence is strong that over 90 percent of children and adolescents who commit suicide have a mental disorder.

Chapter 3, Children and Mental Health, Page 150

PARENT/ ADVOCATE

We were faced with what seemed to be an almost universal reaction that, well, I think what we have here are some poor parenting skills and probably some pretty bad behavioral activity on the part of the kids, but we don't see any real illness. We were very fortunate, though. My wife undauntedly pressed on, researched the subject, the topics, and was looking desperately to find the medical and counseling help that we needed. And eventually we did find that, but in the interim period, we were subject to a considerable amount of misdiagnosis, poor application of medicines, and, quite frankly, some less than competent care.

On one occasion, our younger son, who was being treated by a psychiatrist, had the occasion to go in for a scheduled unrelated surgery, at which time we found out that the medications that were being given to our son had reached almost toxic levels. And had it not been for this intervening surgery, we may have had a tragedy of unimaginable proportions.

I don't think it's an exaggeration to say that there seems to be a tremendous lack of qualified professionals working in the field of pediatric psychiatry and therapy.

We did finally find the appropriate mix of medical assistance and medications after about two years of searching, finally got both of our boys pretty well-balanced out, at which time we learned the next lesson in dealing with mental illness, and that is that mental illness is a long-term condition. It is cyclical, pervasive, chronic, and you need to develop a set of skills and abilities as a person to deal with that that are very foreign to our normal, daily routines.

We also learned another very real truth, and it's something that haunts you every single day, and that is that mental illness is one of the leading killers of young people in this country. This is an issue that, as a parent, you need to be able to focus on but put away because it will drive you absolutely crazy if you face it every day when you look in the mirror.

Another thing that we learned about long-term dealing with this illness is that aside from there being a lack of qualified professionals, there seems to be a lack of qualified and readily available inpatient and even outpatient care centers.

But it's a very frightening thought to come to the understanding that whether or not your child may receive some required emergency care depends more on luck than just about anything else.

Keeping in contact with therapists is becoming an ever-increasing problem. There seems to be a revolving door that professionals in the field are moving through. Moving from location to location makes it very difficult for parents to find, first of all, the person that can make a connection with your child so that child gets the greatest benefit out of the therapy, and then, secondly, to continue that relationship on over a period of time, because there are so few that seem to be engaging in this field, and they move from time to time, I'm sure much to their credit, nonetheless, it creates a problem for us. And when you add to this problem the not too seldom issue of confidentiality, where health care providers will not disclose reports and other information, even to the custodial parent or guardian of the minor, you find yourself kind of probing to help your kids. You don't have all the information you need, you're moving from place to place to get assistance, it makes it extremely difficult to be effective. During periods of crisis, of course, you need care.

RECOMMENDATIONS

James Mauro's Recommendations from a parents perspective:

Educate parents and caregivers about mental health issues, what to look for and where to go for help if you suspect your child might have a mental illness.

Increase the economic incentives for professionals entering pediatric mental health care, including psychiatrists, clinicians and others.

Improve and reach parity between insurance coverage for physical and mental health treatment.

Hold parents teachers and administrators accountable for the mental health care children receive in school.

Develop home schooling curricula for parents who are attempting to home school children with mental illness.

Getting into available locations, finding the help that you need can be an extremely difficult proposition. Not only is there just generally a lack of professionals, but when you couple with that a need, under most insurance plans, to get a referral from a primary care physician and then to make sure that that referral is an approved supplier of medical assistance, you find out the numbers of available people are even that much smaller.

In fact, when we first started this — and we're with a fairly large insurance company — the book of approved suppliers, which must have been two inches thick, did not have one pediatric psychiatrist in it.

The time that you devote to your working life gets upside down. Now, we are very fortunate, both from an economic perspective, as well as flexibility perspective. I'm in private practice, so we have been able to establish our schedules so that either my wife or I are at home all the time if need be. I don't think most families have that opportunity.

And I've had the occasion to talk with a number of different families who have related some absolute horror stories that we need not go into now, but the bottom line is these families are made to face unconscionable choices between work and caring for their kids.

And with an almost nonexistent respite care and day care — qualified day care facilities, parents are faced with dealing with these problems virtually alone, with the exception of perhaps their psychiatrist and counselors.

The other kind of frightening issue about this is that you almost go full circle, and the disease that has caused this upheaval in your life that comes from your ill children comes back to visit in this case, because they not only have the illness, they have to live with the effects of that illness.

For example, at home, you would see the illness state of one of our kids exacerbating the illness state of the other child. Outside of home, most particularly at school, where these boys want to be regular kids, they're the kids that are taking medication, they are the kids that are leaving the classroom unexplained and at unusual times. They're the kids that might exhibit some very strange behavior, and they're certainly the kids that miss an awful lot of school. It becomes very difficult for them to find a sense of fitting, of belonging in that group. Now, both of our boys have demonstrated very good aptitudes at most of the subject matter they've encountered in school. And, in fact, in some areas, they've exhibited exceptional abilities. But getting them to school is a whole other issue.

Our younger son, for example, might belabor a pair of socks he's going to wear to get to school for an hour. Seems like a silly thing to have happen, but it's very important to him, and it's a difficult thing for him to overcome.

One of the net results of that, of course, is that schedules are things that you really can't focus on too seriously. So you can't ride a bus, which in our case is not a problem, but for most families, it would probably be devastating.

The time classes begin and the time classes ended become problematic. I'm sorry, we can't get there by 8:30, so our son ends up arriving midway through a class.

And the not too seldom condition of kids in these situations, particularly bipolar kids, is their night period is something that none of us want to go through. Our son really doesn't sleep well until the sun comes up. While he may go to bed, he's not getting much rest. So even if I could get him to school, his

RECOMMENDATIONS

Precipitators for arranging school-based services:

Recognition by a principal, parent group, teacher group, or guidance team that the existence of mental health problems among the student body carries a risk to student success.

A relationship of support among local schools, organizations and community agencies that create or foster an interdependence for identifying mental health problems faced by youth in schools.

A study, report or needs assessment that specifically addresses the intensity and the depth of mental health problems expressed in the schools.

Formalized discussion and planning between school and agency administrative teams as a precursor to mental health involvement. This discussion should include the following information gathering – identifying needs, reviewing the appropriateness of services, defining the scope of services, the population to be served, the location and access of services, the costs of services, differentiating the roles between agency staff and school staff.

An invitation to a mental health agency to partner with the school.

Get involved with the schools when a prevention model by mental health practitioners addresses schools in the areas of development and safety and other problems that face children and adolescents.

PARENT/ ADVOCATE

effectiveness, and alertness at school, until 2:00 in the afternoon, is probably not worth his time to be there, and certainly would be disruptive to the rest of the class.

Once we get to school, though, we have a whole other set of issues. Our younger son, for example, is one of those kids that stays within the lines. He wants to do things just exactly as they should be done. He wants to perform at a high level when he's feeling well, but any distraction in the classroom will begin to raise anxiety. He's almost certain he's going to get into trouble, and he won't be able to perform at the level he should.

As that anxiety builds, of course, he has the flight reaction; he's got to get out of that room. That requires that wherever he's going to school, they have a safe place for him to go that is staffed by a qualified person who's going to be able to deal with issues like giving medications, and be able to recognize and deal with some behaviors that might be somewhat extreme given the norm of proper day to day activities in the classrooms.

How we deal with excessive absences is another issue. What do we do with the class day if he's not going to be there? Do we find a tutor for him to complement the classroom activity? Do we home school him? Which, by the way, we are doing now for the first time this semester. And I suppose we've done that by choice, although we have a choice not to pursue doing an individual educational plan for him now. But I question whether that's really been a choice.

The practical matter is we have not run into any school administrator or teacher who I honestly believe wouldn't walk on fire to help these kids. They would do anything they can, but the reality is, there's very little they can do within the structure of their school setting.

An IEP, even if it were formulated and met all of the needs on paper that our son has, I don't know how we'd implement it. Where are we going to find the psychiatrist or the clinical psychologist or the case worker, and how do we prepare the teacher who's going to be responsible for implementing that program to deal with the needs of our son?

And I know that idea, as laid out, is just that, a wonderful idea, but I think we are a long way from being able to implement an IEP for even a portion of the kids in this state that need it.

If the statistics are correct, and I have no way of knowing this, I've heard estimates as much as 10 percent of all the students in our public schools are in need of mental health assistance, intervention. It's an enormous number.

We've got to do something about tolerance issues. Again, our experience has been wonderful, but I've had conferences with many, many families where issues of tolerating the behavior of these kids have come to life in the form of some very, very ugly stories.

And I don't mean just teachers and administrators, but we have people who work in cafeterias, people who drive buses, we have volunteer parents in the playgrounds and in the gymnasiums. All of these people need to have some sensitivity as to the needs and the condition of these kids if we're going to make schools a viable place for them to spend six or eight hours a day.

Now, I feel a little bit uncomfortable with a lot of these comments, because before this session started, out in the hall talking to people, it's apparent there's an awful lot going on. I've seen on the internet all kinds of reports, new National Institute of Health programs that are being brought to the forefront to do research and to better equip all of us to deal with these things. It's hard to be critical, but after all, we're here today to talk about problems, and I guess that's what I put out to you.

Aside from the fact that, with some rare exceptions, our experiences have been good, nonetheless, we do have some serious problems we have to deal with. And so what I'd like to do is offer a few thoughts of mine and recommendations on some things we should do.

RECOMMENDATIONS

I think the very first thing we need to do is to educate the most important person in this whole process other than the kids themselves, and that's the parent and the caregiver. With all of our education and broad base of experience, my wife and I were totally ill-prepared to deal with this, as I said.

We need to figure out a way we can get information to parents. I think that happens in two ways. First of all, we have to start before they're parents. We've got to begin educating all of our students about mental health, and what some of the odd behaviors, for example, are going to be that they may encounter during their typical school day if they have a child in their class that suffers from mental illness.

We need to increase the economic incentives for people to get into the practice of pediatric care. Both psychiatrists, therapists, the whole gamut. I get the sense that not only has it now kind of reached a plateau, but without some further economic incentive, I'm afraid we're going to find ourselves ten years down the road, five years down the road, even in a worse position than we are now, trying to find psychiatrists and therapists to deal with our kids.

We need to do something about insurance. It's rather difficult to believe at this point in the development of researching this illness that insurance companies aren't a little more in tune to the need to deal with this as a physical, biological condition that is treatable.

But, again, the number one problem in developing IEPs is the lack of understanding and exposure to the subject matter on the part of the parents. I think they have unrealistic expectations.

We need to hold teachers, administrators, and parents accountable for the care kids get in schools. And I think we need to do something in the interim to develop home schooling curriculums for parents. I know there are a lot of different programs out there, but our experience thus far has been there aren't very many that are designed for such parents who are trying to home school children with mental illness.

"My final comment would simply be that I don't think there is anything more daunting about the problem of improving education for kids with mental illness in the year 2001 than the problems that faced NASA when John Kennedy said, let's go to the moon. We just need to develop the collective will to do it."

Mr. James Mauro
Parent/Advocate
Franklin County

BUTLER COUNTY TEAM

Mr. John Staup, *Executive Director*
Butler County Mental Health Board
Butler County Team

Mrs. Taft and members of the panel, good morning. My name is John Staup, I'm the Executive Director of the Butler County Mental Health Board, and I'm pleased to be here today, and have been asked to assemble a team of collaborators to present you with testimony about the need and benefits of school-based mental health services.

We hope that our testimony will be persuasive in convincing you that school mental health services are both urgently needed, as well as a worthwhile investment of public resources.

The need for mental health services in schools is based on one single and indisputable fact: Students with unrecognized and untreated mental health problems cannot achieve their academic potential; many are severely disadvantaged by their disorders. Students who are identified by public schools as meeting the criteria for severely emotionally disturbed have the worst academic records. They account for the lowest graduation rates among all students with disabilities. Addressing barriers to learning is crucial to student success and in helping our youth to develop into healthy and well-educated adults.

Estimates of the number of school-aged children with emotional and behavioral problems vary. Incidence and prevalence figures are controversial, with estimates ranging from 2 to 3% to as high as 22%. The numbers increase when those referred to as "at risk" are included.

The connection between mental health problems and school attendance, discipline problems, and academic performance is real. As public schools in Ohio are expected to meet higher performance standards, expanding school mental health programs is vital to helping schools to carry out their mission to educate our young people.

Butler County, which is situated in southwestern Ohio, has a student population of about 55,000 children and youth served by ten public school districts, supported by a faculty of over 3,500 classroom teachers.

Butler County schools range from large to small, from urban to rural, from rich to poor. Yet, every school district in Butler County shares one thing in common. They all have students with mental health problems, from mild to severe, from acute to chronic.

The estimated need of children and youth with emotional and behavioral problems in Butler County ranges from 1,000 to 1,500, with serious emotional disturbance, to as many as 6,000 who are at risk or show signs of maladaptive behaviors warranting mental health intervention services. These are conservative estimates. According to some researchers, they would place the number of

students needing help to be much higher.

With me today are representatives from one of the smaller school districts in Butler County, with a student population of just under 1,000, the New Miami Local School District.

The Butler County Mental Health Board has been working with the New Miami schools for the past two years, building service capacity and trust in working collaboratively to address barriers to learning.

We believe New Miami schools serve as a good example of what can and should be done across Ohio's 600 plus public school districts in establishing an integrated, curriculum-based mental health prevention and early intervention program.

New Miami schools represent a model of collaboration and success which we are proud to showcase here today.

Let me introduce our team, starting with the New Miami Local School District superintendent, Robert Bierly; elementary school principal, Melissa Kircher; and fourth grade teacher, Marian Grollmus.

Also joining us is David Turner, Chief Executive Officer of The Counseling Source, which is a certified mental health provider and a contract agency of the Butler County Mental Health Board; Mr. Greg Rausch, who is a licensed independent social worker and clinical social worker assigned full time to the New Miami schools; and Dr. Carl Paternite, professor of psychology and director of the Center for School-Based Mental Health Programs at Miami University, Oxford.

Mrs. Taft, Mike Hogan and Jane Wiechel.

Mr. Robert Bierly, *Superintendent*
New Miami School District
Butler County Team

We're pleased to be here today and pleased to share the New Miami School District story. As John mentioned, New Miami is a small district of 900 students located in Butler County, southwestern Ohio. New Miami really is a low wealth district. We are limited financially in a lot of areas, and we're very fortunate to have had the opportunity to partner with Butler County Mental Health, and also with Miami University.

Until our involvement with them, because of limited financial resources, we really were not able to provide the type of counseling services that really we felt our students needed and were deserving of.

As a result of this partnership — I think it does speak to the value of partnerships within communities that can take place — we're now able to do some of the things that we're going to share with you today.

As we looked at our district needs, we found that our students were losing a lot of instructional time as a result of conflict resolutions. As we look back on some of our disciplinary issues, 75% of those were a result of our students not being able to handle conflicts and how to resolve those conflicts.

We've come up with a program that we think is effective. And as a result of the partnership we have with the Butler County Department of Health and Miami University, we have put together a program that addresses early intervention, getting kids early, working with them early, providing a forum which is curriculum-based, which we think is important and also the partnership with the

RECOMMENDATIONS

Butler County CMH Board
Butler County Recommendations:

Identify children with mental health needs early.

Provide interventions that are curriculum-based.

Partner with parents, teachers, school administrators and the community to design strategies that address early intervention.

BUTLER COUNTY TEAM

parents, with the teachers and with the community. We think it's been effective.

Mrs. Melissa Kircher, *Principal*
New Miami Elementary
Butler County Team

When I began my career over at New Miami, there were a few things that were crucial to my building. We had to develop a common vision, and that vision was that all of our children in our school were going to be literate. They were going to read and write and we were going to be successful in that area.

In order to do that, I had to increase time on task in the classroom and look at especially the language arts section as a very valuable component, where I wasn't going to give up one minute of instruction time unless I absolutely had to.

I looked at the discipline in that school, and we developed a building policy where discipline wasn't about punishment, it was about choices, and the choices we make and our consequences to those choices. So that became building-wide and in every room and everybody had the same system.

We began this model — in a traditional way. I said, we've got to look at when you're using your counseling sessions with these children and time in the classroom and where can we pull.

And then Greg and I talked one day and I said, Greg, wouldn't it be wonderful if all of our kids could have you, not just the ones that really have problems? But I have some there that don't come to light right away. I said, wouldn't it be great if you were in that classroom with them?

And we were talking about higher level thinking, writing, taking care of all my proficiency outcomes as well in that classroom, and he said, how can we do that?

I said, what if in that room where I have learning centers and listening centers and little group discussions in that group, that you were a group yourself and you took each child, four or five at a time, and you worked with them?

The staff love it, we love it, he is a key part to our success in our school district, and you'll see that it's made a dramatic effect on not just teachers and students but I think on our community.

I'd like to introduce Greg Rausch, our social worker.

Mr. Greg Rausch
The Counseling Source
Butler County Team

Good morning. Thank you for allowing us to be here. I'd like to support what you have heard in terms of my interactions with the students at New Miami School District.

I began operating in a much more traditional mental health type format where I was in the school and working individually with students, but it was not integrated. I happened to be under the same building and that was pretty much the extent of it. I might see a teacher in the hallway, or talk with people in the staff room, or things like that, but as you just heard Mrs. Kircher say, the learning needs of the students is prime. That's what schools are there for, and I very much want to support that, and our vision is very much in support of that.

With the fourth grade, I have been working each week with every single classroom in the fourth grade, working to help enhance their team building skills,

their cooperation, their communication, and their trust of each other. That spark showed us that there was a possibility of doing work within the classrooms. And from there, the principal and I talked and we came up with the idea —actually, she approached me with the idea of the conflict resolution centers in the classroom that operate much the same as the reading centers, as the writing centers.

The beauty of the program that we're in the process of implementing is that I reach every single student currently in the 6th grade once a week every week. So that instead of maybe meeting with 15 or 20 students individually within a week, I've got 70 students in the 6th grade, I've got another 60 some in the fourth grade that I'm able to work with and focus on these skills.

When I go into the classroom, I am able to work with them and enhance their reading skills, their writing skills, while also enhancing their conflict resolution skills. Because that's such a focus, I incorporate reading and writing into what I'm doing, and instead of them reading some novel, necessarily, they're reading about conflict resolution and things that they can do to make things better.

One of the beauties of what I can do in the school just happened this past week, where I came out of my office and was getting ready to go meet with students in this group of four to seven students that I meet with once a week, again, the whole class, and two of the students were coming out of gym, having just gotten in a fight. Yes, they're going to get in trouble when they go to see the principal and things, but ten minutes — literally ten minutes after this fight had happened, they were already in — in my group situation with the scheduled group and we sat down and the two kids who were in this fight, we were able to talk on a very real, very legitimate level about what happened, how did it get to be that way, where did the choices go wrong, what didn't go right.

The other beauty of it is that I do have the availability and the training and background to work with individual students who need them. They are certainly there in the school. I'd like to introduce Mr. Brian Nesbitt and Dustin, who's in the first grade.

Brian and Dustin Nesbitt

Mr. Brian Nesbitt
Parent/Advocate
Butler County Team

Ladies and gentlemen, my name is Brian Nesbitt. I am a former student and a proud parent of the New Miami Local School District.

Growing up, I have never had the experience of having counseling in school. Yes, we had a guidance counselor, but to us, that was considered a teacher. And to us, all teachers were evil. You go tell the teacher, you had the fear of them going to tell another teacher. We didn't want that.

But in the past two years, I've noticed a great change in the New Miami School District. My son, for example, he's been one of the worst students his first two years, kindergarten and first grade. He went from being one of the worst students to one of the best students in the New Miami school. As you can see on his shirt, he has been nominated as the January Student of the Month.

And thanks to the help of Mr. Rausch, the counseling center, and the students of Miami University, my son has made a dramatic change.

He has been diagnosed with attention deficit disorder, which is commonly known as hyperactivity or very low attention span.

BUTLER COUNTY TEAM

Well, since Mr. Rausch — he went, like I said, from the worst student to the best, and I am now able to be at home and talk with him on a level basis without him having the worries of getting mad, and losing his temper.

Our children are the future of this great country. I want them to grow up to be like Thomas Jefferson or Abraham Lincoln. I want them to be great leaders. The children are the future. We need to show the children that we care and that we love them and that no matter what it takes, whether it's counseling in school, whatever, but we need to show how much we care.

QUESTIONS/ANSWERS

MR. RAUSCH:
I just wanted to ask you a couple quick questions, Dustin. What was school like for you at the beginning of the school year?

Dustin Nesbitt
Student
Butler County Team

Dustin Nesbitt and Mrs. Taft

DUSTIN NESBITT: Bad.

MR. RAUSCH: What was bad about it?

DUSTIN NESBITT: The way I was hitting other kids.

MR. RAUSCH: Did you ever get sent to the principal's office?

DUSTIN NESBITT: Yes.

MR. RAUSCH:
I remember one time you got sent to the principal's office four times in one day. Do you remember that day?

DUSTIN NESBITT: Yes.

MR. RAUSCH: And since then, what is school like for you now?

DUSTIN NESBITT: Good.

MR. RAUSCH: What's better about it?

DUSTIN NESBITT: I'm not hitting anybody.

MR. RAUSCH:
That's right. And you just received an award recently; is that right?

DUSTIN NESBITT: Yes.

MR. RAUSCH: What was that award?

DUSTIN NESBITT: Getting to be Student of the Month.

MR. RAUSCH:
That's right. Thank you. And you brought your plaque here to show the members of the panel. Would you show the members of the panel, please.

Ms. Marian Grollmus, *Teacher*
New Miami Elementary
Butler County Team

I teach fourth grade at New Miami Elementary, and I can certainly attest to the fact that often classroom instruction is stopped or hampered by behaviors and actions of students who don't know how to manage their anger or resolve conflicts or to just have physical self-control, and the first reaction is often just to remove this student and get rid of the problem so teaching can go on. Yes, that's a temporary solution, but in the process, the student who's removed is losing class time, frustration is rebuilding, and nothing has really been permanently resolved. The cycle becomes self-perpetuating, becomes frustrating, becomes a problem, is removed, becomes frustrated, so it continues.

Mr. Rausch's Team Builders Program is tailored to benefit the student in many ways, and it's tailored to teach the students skills so this cycle can be broken. Team Builders includes all students.

To me this makes perfect sense, how can a student learn to get along with others if he's not with others, if he's secluded? He needs to be with others to learn these skills.

The program is directly related and integrated with the curriculum, so the participation in it is not at the sacrifice of our instructional time, which is so closely guarded.

And perhaps the most important benefit of acquiring these skills that Mr. Rausch is teaching is the fact that they will enable the child to react appropriately during the inevitable challenging times.

The acquisition of these skills has the potential of breaking the cycle that I spoke of earlier, and then teachers can concentrate on using this valuable time for teaching, educating our children.

Dr. Carl Paternite
Department of Psychology, Miami University
Butler County Team

I'm Carl Paternite, from the Department of Psychology at Miami University, and I sincerely appreciate the opportunity to join the Butler County panel and speak with you today.

We are involved in a variety of work in the area of school-based mental health. We provide intervention and/or prevention services and programming in five of the ten school districts in Butler County, as well as in one parochial school.

I'll offer just a few brief observations about our goals and about the key concepts, which guide our work. In our Center for School-Based Mental Health Programs, we have two primary goals. Our goals are to:

- Enhance healthy psychological development of school-age children, and
- Build collaborative university-mental health-school district relationships to address mental health barriers to learning.

RECOMMENDATIONS

Dr. Carl Paternite
Miami University

Enhance healthy development of all school-age children.

Build collaborative university, mental health, school district relationships to address mental health barriers to learning.

Deliver mental health services in the natural setting, where children and families spend their time.

Utilize local needs assessments including the perspective of multiple stakeholders to guide programming decisions.

Take seriously what school districts identify as the most pressing mental health needs in their buildings.

Empower educators as important members of the school-based mental health team.

Deliver key mental health services in the school, including – assessment, counseling, pro-active case management, prevention programs, and mental health education.

Expand in-service and pre-service education for educators and mental health professionals, focusing on mental health problems as barriers to learning and addressing the value of the delivery of mental health services in schools and other natural settings.

BUTLER COUNTY TEAM

"I want to reinforce the notion that all of the collaborators from the mental health side and other community agencies are critical partners as we look at school reform. I would challenge us to think about educational reform instead of school reform, because it's not just a school issue. It is important for us to bring everyone to the table around educational and community building reform, rather than just a focus on what happens within the school day.

As you think about communities and educational reform, look at the role of mental health in after-school programming, and that window of opportunity where we're spending a lot of energy making sure that we have high quality after-school settings. Part of this needs to be taking advantage of that critical time to introduce these same types of services and support."

Dr. David Andrews
Center for Learning Excellence

We approach our work through a variety of initiatives. We're involved in primary prevention and mental health education, early direct intervention for identified children, and treatment for children and adolescents with more severe or chronic mental health problems.

I want to highlight three key concepts that guide our work, concepts that are either evidence-based or evidence-linked.

- The first key concept is that **the school is the most promising point of engagement for our work.**

  Clearly, there is a problem with the model that we as mental health providers have used for decades for delivery of service to children and adolescents, that being the clinic-based model. The clinic-based model for service delivery to children and adolescents is deeply flawed, if not failed. I realize that such a statement is very pointed, but it is evidence-based. If we look to epidemiological data, as was referred to earlier in this hearing, the majority of children who need mental health service do not receive it in the current clinic-based delivery system, and large numbers of children need service. Further, for those children who are served in the clinic-based model, the evidence for effectiveness is mixed at best. We believe that there is evidence to suggest that the school, in comparison to the clinic, is a much more promising point of engagement for our work with youth.

- The second key concept is **local needs assessment from the perspective of multiple stakeholders should guide our programming decisions** in school-based mental health efforts.

- The third key concept is **empowerment of educators as important members of the school-based "mental health" team is essential.**

  I fully endorse what Mark Weist has suggested about the importance of educators. Mark, who is the director of the National Center for School Mental Health Assistance in Baltimore, has suggested that **educators are the "linchpin" for school-based mental health programming**. I think he is right on target with that assertion. Educators are the people who are right there with our children, day in and day out. By educators, I certainly mean teachers, but also administrators, custodians, school bus drivers, playground aides, and cafeteria workers. We could go on and on. They are in an ideal position to promote developmental assets in children, and to promote protective factors and resiliency in all school-age children. For every child I work with in my therapy room, a typical educator works with hundreds of children.

- Finally, as I suggest on the last page of the handout, I want to remind you that the spectrum of what's involved in school-based mental health programming is broad. Certainly, intervention services are important, including assessment, various forms of counseling or therapy, proactive case management, and staff consultation. In addition, important preventive services include mental health education, supportive services for well functioning youth, early identification of problems, consultative and in-service activities, curriculum-based approaches, and school-wide initiatives.

In particular, there's a tremendous amount of work that needs to be done in mental health education with the adults. That becomes clearer to us every year that we work in the schools — there's considerable work that needs to be done in the pre-service education of mental health workers and the pre-service education of educators, and there's work that needs to be done in the in-service training of both.

"I think our approach to this is to understand that it's one building at a time, it's one classroom at a time, and that you cannot necessarily adopt a set of programs and then try to fit them into the environment. I think you have to actually do the assessment and really tailor your programs and services that fit not only the environment, but the people who are there to build those kind of team relationships, really from the ground level up.

I think we can apply different principles and concepts that guide us in that process, but to be open to the fact that when you've seen one school-based mental health program, you've seen one school-based mental health program. So the need to be flexible and adapt your resources to fit the situation is something I think we would strongly advocate for."

John Staup
Butler County Team

PANEL MEMBER

Dr. David Andrews, *Director*
Center for Learning Excellence
Panel Member

I'm impressed by the amount of harmony between the two systems. What do you attribute that to, what appears to be a very collaborative system?

Mr. Staup:
I think because of the demands that are placed on public schools today, they're motivated. They're motivated to consider what options are out there. I think that's probably true for mental health as well.

I mean, to be really honest with you, part of what's motivating us is probably driven in part by resources, that if we continue to practice the traditional models or the traditional ways of doing business, we're not convincing people that there's value and benefit to it.

So, I think we're both motivated to reach out to one another, to find some common ground and some shared ways of addressing the needs of both systems.

I think the other is just simply having the attitude that we come at this from the point of view that we're here to help the schools. Our role is a supportive role to the school's mission. We frame it from the standpoint that you'll see in all of our literature addressing barriers to learning.

I think we tried to encourage the mental health providers to understand that they're not just going into a school building to do case finding and to do the things that they do, but they're there to assist the teachers and the administrators to carry out their mission.

So to kind of come at it from a supportive role, I think, is also very helpful, because then the schools, I think, can find that as a much more acceptable way of working.

The flexibility within both groups has been critical.

We do really believe and value that time on task and we wanted to find ways within our system that we could continue to address the educational needs of kids while continuing to address those emotional needs, and so forth.

QUESTIONS & ANSWERS

Dr. Stephens:
I'm interested from the social worker aspect, I'm sure that not everybody came over on the teaching staff right away to really be fully convinced that this was the way to go. Were there some things that you did to win people over once you started?

Mr. Rausch:
One of the biggest things for me was to step out of the mental health role, and probably the most obvious example that I have of that was during conference nights, one night — well, I'm not a teacher, I don't have conferences, but I wanted to be there, I wanted to be available. And I just sent a memo around to the teachers saying, listen, I'm going to be here for the next three hours, I don't have much to do, I don't have parents to meet with, if there's any way I can assist you this evening, let me know. If it's making copies, if it's running messages, whatever.

I had some teachers after that — that had never spoken to me before — really kind of open up like, wow, you're here, you understand that we have a lot to do, and that we have some difficult work.

So that was much of it, is just getting that one-on-one interaction. I've tried to make a commitment to myself that I'm going to have at least five minutes of time one-on-one with every teacher every month.

Mr. Leslie Abel, *Executive Director*
Stark County Community Mental Health Board
What did you do to engage the parents and caregivers in this process?

Mr. Rausch:
That has been a little more difficult than I would have hoped, but we're having some significant success.

I originally started doing a parent education series based on what I thought parents would want, and I didn't get anybody. So then I developed a survey, a parent survey, and I sent that home and said, okay — and I gave a list of maybe 15 or 16 different topics — of these topics, what ones, if you had the time and the availability, would you consider attending, and then compiled the results from that, and then changed my parent education series from what I thought they wanted to what they wanted.

The school does some fantastic things like family nights. Like one night they had a game night that was just board games, Connect Four and Monopoly. They provided dinner for the folks and encouraged the parents to come and just play games with their children.

I make sure that I attend all of those events and that I talk to parents one-on-one and just let them know who I am and what I do in the school, then I sat down and I played games with families. There are reading nights and math nights, so I really work to try to engage the parents through the school system as much as possible so that they can begin to see that, you know, that I'm an okay being there.

Mr. Staup:
Working with parents is not based on need, it's based on trust. And the process of communicating and building trust then allows you to establish a relationship where you can now address the need.

But many parents, for a variety of reasons, have not had positive experiences in their own years of growing up in education, or as a parent of a child, especially if the child has problems.

Now, that's somewhat over generalized to say that, but I think it's true in many cases. So I think by recognizing that it starts with building trust and being persistent and not misinterpreting the failure to show up as resistance, but perhaps for some other reason is helpful to — kind of like for Greg — to kind of go back to the drawing board and figure out, okay, my first attempt didn't work, maybe my second or third or fourth, and you continue until you find the connection.

Dr. Al Neff, *Associate Director*
Center for Learning Excellence
Panel Moderator

Our next witness is Joyce Lemke, the program designer for the Stark County Educational Service Center.

Stark County is listed on the program as a team nominated by the Center for Learning Excellence. We worked with some folks at the Ohio Department of Education and the consultants that are out and around the state each week, and we've been trying to identify some of the programs that we think are out ahead of the curve with some of these issues.

Ms. Joyce Lemke
Stark County Educational Service Center
Center for Learning Excellence Team

One of the things that we've begun to do in Stark County is we hope to weave together a program designed that is a continuum of services available across the county that, taken together, would provide programming assistance for most young people. And the struggle is that we aren't very good at telling one another what we're up to. And so a lot of times it has become a gold mining adventure in that as we travel around.

So, what happens is that people in isolation get an idea and develop it and it perhaps serves the students for whom they designed it very well, perhaps it would serve other students very well, also, but we don't know about it.

What we're trying to do is to provide to all alternative programming in the county a coordinated set of staff development opportunities.

People who work in alternative education in Stark County need to know four things well.

- First of all, some kind of foundational piece about how we're going to deal with those students who present challenging behaviors. The strategy we have chosen is William Glasser's Choice Theory Reality Therapy, and what we have found is that there are two things that seem to resonate with our staff. The first one is the idea that students are responsible for their behaviors, as is everyone; and the second thing that resonates with them is the quality school idea.
- The second piece of staff development that we are asking everyone to do in common is the project Adventure Leadership Challenge, Outward Bound kind of programming, that the gentleman from New Miami also referenced, and we have found that those kinds of experiences seem to be very helpful to students who are at risk or have problems with mental health.
- The third thing is Dr. Peter Benson's asset building approach to education, and we have incorporated into all of our intake procedures a strengths-based interview where we really begin to try to discover and uncover what the strengths students have that they bring to us as they come to whatever alternative program it is that we're providing to them.
- And then the last piece is an education piece, finally, and that is Dr. Phil Schlecht's work. One of the things we're beginning to focus on now that we're up and running is the quality of that programming not only meeting students' mental health needs but also meeting their educational needs.

  And it is our impression that that has not been a very high priority for a lot of developing alternative programs, including some of our own, so what we're working on now is, in fact, designing the high-quality, engaging work that would allow students to become competent academically, as well as socially and interpersonally.

STARK COUNTY CENTER FOR LEARNING EXCELLENCE TEAM

STARK COUNTY CENTER FOR LEARNING EXCELLENCE TEAM

Ms. Carol Lichtenwalter
Stark County Family Council
Center for Learning Excellence Team

My job as Director of our Family Council is to get you to think even a little broader than just collaboration between mental health and education.

And I think what our county has done very well is really look holistically at the needs of children, and our schools have taken a look and said if we're going to meet these needs, we needed lots of partners, we need partners from our juvenile court system, we need partners from our mental health systems, our health systems, our alcohol and drug systems.

And Stark County has taken really strong efforts to develop what we call a seamless system of care, in that we've developed common practices across all of our systems to work together and meet the needs of kids, something called wraparound. I'm sure many of you are familiar with that.

We pooled dollars, we team, we meet constantly about children who have multiple needs in our county, and education is a strong partner in that endeavor. I couldn't have said that about six years ago, though.

We've designed a human service system that has very different cultures in each individual department. And in order to work together, we need to get to know one another. We need to build relationships, we need to understand the work of our sister partners and providers in the community. So I believe our council has served as an infrastructure for that learning, and has really helped to facilitate the coming together of these various cultures and developing common products for kids and families.

And the tool that you have there is a very simple, not a glitzy tool, but it helps communicate to our community the strong commitment our schools are making to do things differently. It's solid evidence that education is just not about education anymore. It's about true partnership with lots of agencies, and lots of people not working in offices anymore, traditional settings, it's about doing business differently.

I think the whole notion of support and training each other about what we're learning, this is all new work. What we've found is there's no real road maps for any of this stuff, and what working together teaches us is that we can learn from one another and we can grow and develop, and you see progress so much quicker when we can share ideas and resources, which happens all the time in our community.

One of the things that I also wanted to address is that I think one of the things the whole Ohio Family and Children First initiative brought to light in a public — in a public way was the whole notion of family involvement. And I'm so proud of the parents that were here today, because I got involved in this work because **I'm the parent of a child with special needs, and that family involvement piece is so critical to the success of whatever we do. And that partnership — not only just as professionals and collaborators, but as parents — is extremely important.** One of the strategies we've used in Stark County to promote family involvement is the addition to our school staff of family involvement coordinators, and these are parents who are representatives of the neighbors of the school, who know the community, know the families, and they're hired part-time to work with the school staff to bridge communication and understanding between the family and the school staff.

RECOMMENDATIONS

Stark County Alternative School Team

Recommendations for staff development:

All must work from a common foundation relating to how we deal with students who present challenging behaviors beginning with – students are responsible for their behaviors and schools need to provide quality service to all students.

Utilize an asset building approach to education including a strengths-based assessment at the outset and teaching strategies that build on strengths identified.

Integration of "Outward Bound" types of programming into programs in alternative schools.

Design and deliver high-quality, engaging educational services that allow students to become competent academically, as well as socially and interpersonally.

It's kind of spreading like wildfire. In our county we started with just three schools, then it went to 11 schools, and I think we're up to 20 schools now that have family involvement coordinators. And their job is varied, it is different in every building, but it all has to do with connecting families to school and making them feel comfortable in working with the school and helping their children be successful.

I heard someone mention that 10 percent of our children in school are probably in need of some sort of mental health service or intervention. I have three children, and my youngest son is going to be 16 next week, and five years ago my husband was diagnosed with leukemia. My then ten-year-old son went through a tremendous change at school, because of the stress in our family's life. He's a very good student — his grades and his behavior started declining, and without even me lifting my finger to call the school, they linked him to professional counseling and help, because the resource was available. Now, I didn't even know about that for a couple months until my son told me about this nice lady he talked to, you know, at school, who helped.

But I think that the other 90 percent of kids in our school districts are all at risk of educational stressors, and I think the importance of this resource being available to our kids is something we need to consider.

So, I just wanted to bring that issue up. This isn't just for the minority of children. This is for a much broader reason, because life today is pretty challenging for us as adults, and kids have it just as bad.

Mr. Richard Hull
Fairless High School
Center for Learning Excellence Team

I appreciate the opportunity to speak with you, and I have to say I agree with everything I heard this morning. I haven't heard anything I disagree with.

And I agree with the last statement by Joyce that it's not just for 10 percent of the students. I have a thousand students in grades 7 through 12, and in that six-year period, as they grow and mature, I know that they all have individual needs, and sooner or later, there's some crisis or need I'm going to have to have a service to help walk them through so that they can get back on track and go about becoming the best citizens and the best learners that they can be.

So sometimes their stay in a care system is brief, and sometimes it's a long time, and you're always asking the question, is it nature or is it nurture? Some kids come in with needs that are part of their chromosomal background, they have chemical deficiencies that create problems that they need both mental health and educational services to support. Some kids come from environmental backgrounds where the environment they've been living in has created problems in their situation.

A few years ago, I went to Fairless High School. When I got to Fairless High School, I found a district that was a low-wealth district that hadn't passed levies and were struggling with that. They had maintenance issues, they had faculty and staff issues, they had discipline issues, they had all sorts of issues.

And I said, well, we're here about children and we're about getting them to be productive adults, not only educationally but as citizens and as social human beings.

"I'm the parent of a child with special needs, and that family involvement piece is so critical to the success of whatever we do. And that partnership — not only just as professionals and collaborators, but as parents — is extremely important."

Carol Lichtenwalter
Stark County Family Council

STARK COUNTY CENTER FOR LEARNING EXCELLENCE TEAM

So I'd like to tell you I'm not from Fairless High School, what I'd like to tell you is I'm from Fairless Family & Community Center, because that's what we are. We teach children to socialize with other children, we teach them how to go about their first dates and relating to the opposite sex. We teach them how to be citizens, how to respect law officers, how to respect the senior citizens in their neighborhood, how to learn to be patient and growing up and going through the process of somebody who's becoming a leader. We teach them how to access resources to solve problems and we educate them. So, we really are a community center.

That's what I think we as governments need to start realizing, if we want world class schools, we really need world class communities, and that means bringing all of our resources together.

So, I began doing that. I began seeking out partners, and through Les and Carol and Joyce, and many other people in Stark County, I began building resources for my school.

And through local mental health agencies, I acquired a mental health counselor for my building who's there every day, reports there the same time the teachers do, leaves the same time — no, leaves later than some teachers, but some teachers stay late too.

I recruited a mentor coordinator for mentoring children through the local alcohol and drug services board. Through the COPS program, I was able to get a sheriff deputy full time in my building.

I went to Family Services, which is another local agency, and brought in a parent mentor, apparently as Joyce told you about, to begin working as an advocate to let the parents know that the school is here to help them. And besides helping them, we can be a good resource for them.

Parents have questions, as you heard, parents need education, they need to know what's going on. This person can help mentor them.

We've added, through a grant through the Department of Human Services, PRC grant tutors in an after-school homework program so kids who are struggling get their home work done and can be prepared the next morning when they go into class.

We've added a summer program when we identified kids coming out of 6th grade who have already experienced failure, who have already experienced suspension, who may have already had contact in juvenile court, who may already have mental health issues, whatever the risk factors are, we try to identify them, we take them through a summer program.

Exactly half the summer program's unadulterated fun because we're going to have a good time. We're going to go to Sluggers & Putters, or we're going to Cedar Point, and they're just not going to miss that. That always happens on Thursday. The other half of the program is learning the skills I need to manage my life, how to get along with my classmates and appropriately establish social groups, as opposed to gangs, or the kinds of cliques that have negative connotations that lead to negative behaviors.

We talk about at-risk behaviors, how to say no in the right situation, how to handle that. Because in 5th, 6th and 7th grade often is the first time they're going to ask you to smoke, it's the first time they're going to hand you a joint, ask you to drink a bottle of beer, and it's the first time you're going to find yourself home alone with a member of the opposite sex you've now taken an interest in. So we get into all those at-risk behaviors and how to handle those.

RECOMMENDATIONS

Recommendations for agencies partnering with schools:

Assist schools with resource development, grant writing, negotiating, and identifying partners to assist in doing the work of integrating mental health service into the school.

We also handle positive asset behaviors, goal setting, what will studying do for me, what will being able to solve problems do for me in the long run, what will a respectful relationship with teachers do for me, what will being respectfully related to the businesses in my community. When I walk into the local Dairy Mart or I walk into the local grocery store and I'm not doing things I shouldn't do, but I appear to be very polite young person, that four years later when I want a job, they're going to say, I've seen that kid in here many times, I'm going to hire that young person. But it's about results. What outcomes did we get? I've laid in front of you a set of outcomes. There's data from eight years ago and data from the beginning of this year.

Les Abel and Dr. Hank Rubin

Eight years ago when I went to the school, we had 111 kids who were severe academic discipline problems, who were getting suspended, getting expelled, going to juvenile court. Of those 111, probably half a dozen to maybe a dozen and a half have been in and out of jail. Seven have been in jail for murder in that original group, okay. And that first year alone, 60 of them were adjudicated delinquent, meaning they violated a law that would put them in jail as an adult. Their graduation rate was 65.5 percent at that time, which was the lowest in Stark County. Below Canton, Alliance, Massillon, the lowest of the 17 districts. Their interest in going to college was 27 percent, as measured by survey. That also was the lowest in the county. And their ACT average score was 18.6, which was also the lowest in the county at that time.

Their original proficiency scores were 66 percent in writing, 74 percent in reading, 37 percent in math, 59 percent in citizenship, and science was not offered that first year. That's a '94 score because science came on later, 49 percent.

Our high mark in writing as of last year is 96 percent, in reading is 95 percent, the stars of the next three are because these are now current mid-year scores as of this year. We won't have final scores until after the March round, and we're hoping that math was up at least one more point because it will be the first time we've met the math standard, which is 75 percent, but we're hoping to get to 80. We think we're going to get that 75. We're hoping citizenship will go over to 90. And as you can see, we're anywhere from 35-40 percent gains to over a 100 percent gains in those scores.

These are things that are built by a community raising children, a community that involves parents, that involves the other institutions that you at the state level and at the local level have put in place to help build communities. And when taxpayers get angry or they question things, they want to know why our institutions aren't making things work. You make things work by getting down to the local level, by setting accountability standards, and then helping each other meet them.

And my goal is to take an overwhelmed system and to get that system back off to where it's a reasonable system. What I mean by that is if out here you had one local hospital and you had an airport where you had a plane crash and you had a highway where you had an icy day and a lot of cars crash, and also a local manufacturing plant burned down, all at the same hour, your hospital would be overwhelmed and people would needlessly die because they didn't have enough resources.

Well, that's sort of what's happened in our country over the last 30 years with drugs and alcohol and inner city neighborhoods. Doesn't mean there weren't good people there, doesn't mean there weren't people working hard, but the system got overwhelmed.

And if by getting down to a community level, I can take that 60 and reduce it to two, when I take that two to the court, they've got a lot more room to deal with that two than they do to deal with the 60.

LORAIN COUNTY TEAM

So, my job at the community level is to make my community the most efficient community at solving problems and making families and children our number one resource and asset, but also our number one commitment to raising healthy individuals. And we use the Maslow's Hierarchy of Needs Pyramid. And in that pyramid, if you've ever seen at the bottom of the pyramid, right off the bat is survival. I have to have housing, I have to have clothing, I have to have food. There are places in America which just don't have housing, clothing and food. The next thing above that is I have to have love and a sense of belonging in a family unit, whether it's a traditional unit or not. That's a very psychological basic need.

The next thing above that is then I have to then have a sense of belonging among my peers, and I'm beginning to build self-esteem. If you don't get up into the next half of the pyramid where the educational issues come in, the cognitive issues, the aesthetics, the self-actualization, and finally the transcendentalism, where I begin to pay society back. If the bottom of the pyramid is crumbled, you're wasting all day long shuffling the chairs of the Titanic when you're not fixing the hole. You've got to go back to the bottom of the pyramid and rebuild it and then you can have success at the top of the pyramid. And that's what's taken us seven years to do with Community Partners. Having worked, as I said, in rural and urban, diverse and more than one type of a school district in terms of a population. I believe you can tweak the model to the needs of every district and make it work if those institutions are all in the community working together at the same time. That's what we've done, those are our results so far. It's a work in progress.

RECOMMENDATIONS

Lorain County Team

Develop expertise in the mental health system that can provide a unified approach and resources to schools dealing with prevention, earlier identification and intervention and other specialized mental health services and supports delivered in the school building.

Develop cross-system infrastructure to reduce gaps and increase coordination of services across the child-serving systems including joint planning, funding and contracting.

Use local resources to deliver services differently i.e. in natural settings.

Ms. Amy Levin, *Executive Director*
Lorain County Community Mental Health Board
Lorain County Team

Lorain County has about 45,000 school-aged children in 14 school districts. The county is characterized as urban and rural and also suburban, and it brings all the accompanying strengths and problems.

This last year, 2,500 young people received services in the network of agencies contracted by the Board of Mental Health.

When we look at the Surgeon General's report that's been referred to, we can estimate that about 4,500 young people in Lorain County will need services every year. And according to his numbers, about 2,250 youngsters will have extreme problems, and we've heard about some of those today.

A few years back, before this heightened concern about children's mental health was on our screen, the Lorain County Board of Mental Health, with very broad help from the community, went to work and revised its plan for children's mental health services. The plan has really wanted to put together a full continuum of prevention assessment and treatment services, and they also had an abiding concern for the children who were already having difficulty and that we were very clearly not reaching.

Consequently, one of the steps that went into the plan was to increase access and to provide earlier intervention for kids and families — and we've been hearing about that — and to take services to them, and that meant taking services to the schools.

We looked at several models. The Comer model looked a lot like Children's and Family's Council, and that's kind of rolling out there in place, so we're going to go to a model which is more of a catalyst model which is basically adding a resource to the team and working for the team and the school and bringing focus to the mental health issues.

We did several things then to kind of put that in place.

- First of all, we contracted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to provide a somewhat unified approach, as the various districts would allowted with one agency to develop that expertise and to

Parent/Advocate

Ms. Marcy Dvorak
Parent/Advocate
Lucas County

I'm wearing several hats today, and maybe I should explain what those hats are. One is that my job is the executive director of NAMI of greater Toledo. However, I am also here as an LISW, a psychiatric social worker of 25 years, administrator, private practitioner, therapist, and mother of a 22 year old son who was diagnosed with bipolar disorder at the age of 14.

I also want to tell you that my experience as a parent is probably a little unique. I want to tell you my mother was diagnosed with severe mental illness, with paranoid schizophrenia, and I felt I would be quite confident in dealing with my son's illness. I can tell you that I wasn't confident nor was I capable.

I'd like to point out the things that we've all agreed on today. One is that children with mental health difficulties ranging from severe mental illness all the way to emotional disturbances are in our school systems, and there are severe and serious consequences to not addressing those needs. Those consequences are not just for the schools; those consequences are for society as a whole. But I think we've also heard that there are some real measurable kinds of things that we can look at in terms of addressing the needs.

The other thing we talked about here today is that schools have a captive audience. I know that in my discussions with many educators, they sometimes bemoan that fact, but it's true. There are two places that children are, in their homes, and in schools. Unfortunately, I think that we as a community have put a tremendous burden on schools that they have not been able to handle the way they wished.

We have been talking a lot in NAMI about the statistics of our kids who graduate from high school, which is anywhere from 40 and 60 percent. I've heard the abysmal percentage of kids that are labeled SED graduating from high school. There are children in the school systems, and my son would have been one of them, who would have been locked away in an institution 20 or 30 years ago. And when schools and communities are simply saying, we don't know how to deal with this, we need to acknowledge and understand that.

As we learn more about the diagnosing and treatment of children with mental health issues, we also understand how complex it is and how much we don't know. There's a famous quote, "As our light shines, the circumference of the darkness gets larger." We know more of what we don't know and that is what we're struggling with today.

I'm hearing a couple things that we can all agree with. There must be consistency in philosophy and attitude among all the partners involved. I would also say that the partnership and the teamwork have to form upon agreed outcomes and agreed definitions of what success is.

John is a 13-year-old Caucasian male who attends middle school. He has lived with his father the last five years, after his parents bitterly divorced. The father won custody of John after an investigation and some substantiation of the mother's alleged drug and alcohol abuse. John expressed severe problems in school. He threw chairs at students and the teacher, he knocked holes in the classroom wall, he skipped school, and he was failing in his classes. At home, he was equally aggressive towards his father and had been reported to the police for domestic violence.

At the time of the mental health intervention, John was on house arrest, except for school hours, was fairly depressed, quickly defiant towards authority, and had continuous academic failure. John is placed in a learning disability class and has a mental health diagnosis of conduct disorder and attention deficit disorder.

An interdisciplinary team of teachers, guidance counselors, and school-based mental health counselors established a service plan with John and his father that consisted of individual counseling with John at school, family counseling with John and father at school, a family case manager in the home, weekly meetings between the teacher and the counselors, and weekly monitoring of his academic work between the guidance counselor and the mental health counselor.

Currently, John does not express any aggression at school, he no longer skips school, his grades are average, and his parent — though with more work to do — does report that John is less problematic at home and has decreased his defiance.

Fannie Johnson-Baxter
Applewood Centers, Inc.

John

There are success stories among the children who have had the benefit of on-site counseling. As an example, there's a little boy I first encountered in grade 2, and I'll call him Jason, who was referred to the intervention assistance team because he always looked angry, noncommunicative, often fought with other children. He was referred for special help with the guidance center therapist.

Jason was unhappy. His parents were divorced. He lived with his mother and sisters. He had minimal contact with his father, who had started a new family in another town. And, finally, he was diagnosed as clinically depressed.

Jason worked through his issues with our therapist, and in third grade, he's still fighting, but not as much. More often he talked back. Didn't strike out, but talked back. By fourth grade, he had stopped fighting, now throwing tantrums only at home, not at school.

Also diagnosed with ADD, he would become frustrated when he could not finish his work. Today, as a fifth grader, he's described as on-task, getting good grades, usually happy, maintaining friends, and making good choices most of the time.

Now his major objectives are improving and concentrating on his work, and as is typical of fifth grade boys, trying to be more organized.

Throughout the process of working with Jason, the therapist was able to help the family and school reframe their picture of Jason. He had been labeled as a tough, mean-spirited youngster. Supportive mental health services and help from school staff have saved a little boy from certain failure and unhappiness throughout his school experience.

Francine Toss
Oberlin City Schools

Jason

One of the things you must understand is that we are not just dealing in this room with children who have mental health problems; we are dealing with children with severe mental illness. And though all of us draw in our breath at the idea of children being on extremely heavy doses of medication, there are some children for whom that is what is saving their lives, and that's what needs to happen. And the issues and the problems with those children are extremely severe and totally overwhelming.

I think when we're talking about accessible services for people who need them; the key word is accessible. And I think that's why so many folks have stood up here and talked about the fact that schools are the primary place where we should be delivering mental health services.

I want you to understand what it's like for a parent to have to try and keep a job, maintain a relationship, and deal with other children, do what the school needs, feels is important, as well as provide what sort of services they can possibly provide.

We were in a situation where we had some financial luck for a while, in terms of handling my son. My son was adopted at the age of 3, and he was a child who had been severely abused, but we did not realize there was also a tremendous history of mental illness. Once he was diagnosed as an adolescent, I had a wonderful therapist and psychiatrist who were able to see him in the evenings after work. However, three months into the year, we went through every bit of insurance that was available for him. I then needed to utilize the Medicaid that my son was eligible for because he was a special needs adoption.

The therapist explained to me that I no longer could have appointments at 6:00 at night or 7:00 at night because those appointments were saved for people who were paying privately or people who were paying with good insurance, that Medicaid families came at 1:00 or 2:00 in the afternoon. I just want you to try to understand what it's like to try to force a five-foot-eleven-inch, ten-year-old into a car from school at 1:00 in the afternoon, twice a week. Then try to explain to my supervisor, at work, where I was going for four hours every afternoon, to try to get him into treatment.

I cannot emphasize enough how many families are desperately seeking treatment needs and how many turn to jails and to criminal justice as a way to provide that kind of support.

And I want you to know that from the NAMI folks sitting in this room, we have all said that this is an unbelievably historic event. I don't know if people

realize that, to have you sitting in this room talking about our children, and talking about collaborating and keeping them in school, keeping them learning and keeping them safe, is a wonderful thing and we truly appreciate it.

Dr. Michael Hogan, *Director*
Ohio Department of Mental Health

We have to work within a system traditionally focused on serving kids with the most severe mental illness, primarily as a result of limited funding, but also due to historically insufficient research regarding effective strategies for prevention or early intervention. We must respond to the growing awareness among many people about the role mental health plays in the healthy social and emotional development of young children.

We must balance addressing the needs of the children and youth while also moving toward a prevention, early intervention model which reduces this model in the future, which Marcy said very eloquently. We must try to do both with little or no funding.

We need to redesign the service system from a clinic model to one that provides services where children and adolescents spend most of their time in schools, childcare centers, and homes.

We need to collaborate with other agencies and organizations, a long list, but collaboration has come through so strongly.

And to prove that we've been listening to Dr. Andrews and others, we need to move to a results-based accountability system with documented success based on hard evidence. So we thank the team from Stark County in that regard as well.

So in the future perhaps this event will prompt us to see it as being historic, but perhaps what it really represented here was the coming together of people, interests, ideas and needs to create a springboard from which we can do much better in the future.

"I want to underline, again, the scope of the challenges we face and the consequences of our not attending to the task of transition.

It brought to mind a report that I had seen recently which studied trajectories of kids with serious emotional problems, and found out that three to five years after leaving school, 48 percent of young women with emotional disturbance were mothers, as compared with 28 percent of young women with other disabilities, not a cohort of all young women in general.

Fifty-eight percent had been arrested, versus 19 percent with other disabilities. And 10 percent of youth with emotional disturbance were living in a correctional facility, halfway house, drug treatment center, or on the street. Twice as many as among the students with other disabilities. Failure to attend to transition services has significant consequences."

Dr. Michael Hogan
Director, ODMH

RECOMMENDATIONS

Marcy Dvorak
A Parent's Perspective:

There are severe and serious consequences to not addressing the needs of children in schools who are experiencing mental health difficulties ranging from severe mental illness to emotional disturbance.

There are interventions that have positive measurable outcomes for children with mental illness and emotional disturbance.

We as a community have put a tremendous burden on schools that they have not been able to handle in the way they wished or as effectively as they wish.

At this point we are all singing the same song with regards to children and mental health. We may be singing in different keys, but it is the same song.

There are children in the schools who would have been in an adolescent psychiatric hospital 20 – 30 years ago, and what schools and communities are saying is that they don't know what to do with those students.

There must be consistency in philosophy and attitude among all partners involved in serving these students.

We must have agreed upon outcomes and definitions of success.

We must have accessible services for children and families who need them.

We must have a template for how to provide services in the schools effectively.

We must have incentives for collaboration between the mental health system and schools.

We must resolve the issues involving billing for mental health services and providing funding for mental health services delivered in the schools.

Mental health services in the schools cannot be some strange thing on the side and need to be delivered in a manner that reduces barriers to learning and enhances the learning/teaching environment.

We need to find the balance between mental health services as prevention and intervention.

We need to create a system where the financial incentives and the concepts of success come together so that educators, clinicians and families do not have to hack a new way out of the jungle each time a need is identified for kids.

A Family's Experience

Letter to Dr. Michael Hogan

Director Hogan and members of the panel on Mental Health and School Success,

My name is Susan Mikolic. I reside in Willoughby, OH. I serve as President of NAMI of Lake County, board member of the NAMI Ohio Board of Directors, and co-chair of the NAMI Ohio Children's Committee. I have two children who have mental illness. My oldest is 13 and he has Bipolar Disorder, Attention Deficit Disorder, and a history of Post-Traumatic Stress Disorder. My younger son is 11 and has Bipolar Disorder, Attention Deficit Hyperactivity Disorder, Anxiety Disorder, and 5 learning disabilities. I was once asked during a public speaking engagement if my children weren't "severe" examples of children with mental illness. No, my children are "typical" children with mental illness. Rarely does a child with mental illness have only one diagnosis. Because these children's neurological systems are off-balance, these children tend to have multiple co morbidities. My children are no exception. My youngest son has been accommodated with inclusion and pull-out services for several years. My older son's illness has been severe and debilitating. He has been serviced in a Partial Hospitalization/Day Treatment program, inclusion setting, home instruction, and is now transferring into a SD self-contained setting.

Securing services for our children has been a struggle all the way. I think the biggest common denominator in this struggle has been the lack of knowledge about mental illness among the school staff interacting with our children as well as ingrained judgments about children with mental illness. We, as most all parents of mentally ill children, have been told that our child was just being lazy, refusing to do work. Yes, on the most surface level this would be the observation. However, our children are much more complex than that superficial assessment. My children are coping with extreme emotion swings, concentration problems, attention problems, medication side effects, poor sleep, and the list goes on. We need to ask, "What are the child's behaviors telling us? What do they need?" Then work to meet those needs so that our children can involve themselves in learning. One cannot learn when they are falling asleep from powerful medication, when their thoughts are racing in a mania, when they have entirely lost initiative from a depression. When children are in exacerbations of their mental illness, they cannot access the general education curriculum. Instead of providing accommodations to help our children, we are repeatedly told by school staff that we are enabling our children as they push our children beyond their limits and sacrifice their health. I have repeatedly heard this scenario over and over again in my advocacy work with families. I have experienced it first-hand throughout my children's school careers.

We have been told we will have to forfeit LD designation to add SED designation. We have had to pay Psychiatrists to come to IEP meetings to explain, in her words, "that we are making a choice between "should I kill myself today" and algebra. We as parents are not believed when we inform the school of our children's challenges. We have been offered a "choice" of home instruction Monday/Wednesday and Tuesday/Thursday at 2:45 or 3:00 p.m. We have been offered home instruction 1 hour 2x/week because my son can only handle 1 hour of academics a day and the district can't find a tutor to do it.

But as a more complete example of what our children are up against, I will briefly describe the challenges our family fought this school year with my oldest son. In the spring, we met to plan his 7th grade IEP with services in a SED inclusion setting. Yes, plan for what 7th grade would bring. However, none of the 15+ school personnel at that meeting informed us how very different the structure of 7th grade would be, requiring him to change classes for every class, 11 different personalities to adjust to, 11 different sets of expectations, chaos in the halls, gym and hall lockers. These things may seem insignificant to a healthy adult, or even a healthy child, but for my child these are huge barriers. Again, I imagine out of lack of knowledge, those at the IEP meeting felt these things weren't worthy of mention. They were, however, to prove to be the antecedent of my son's decompensation onto suicidality and catatonia. Fall classes began and within two weeks my son was identifying how stressed and pressured he was feeling. I began to communicate with school about the need to reduce his stress and the need to access the accommodations planned for in his IEP. At one month into school, his Child Psychiatrist was alarmed at the decompensation that had occurred in just one month. She cautioned we must reduce his stress immediately. I sent letters, notes, made calls, and had meetings with school personnel as we tried to implement his IEP which allowed for him to return to his SED class if he was feeling stressed or having a bad day. I asked that the school use my son as his own barometer of what he

could handle for the day. He knows best how he is feeling. This suggestion was met with disdain. I was "called to the principal's office" and told I was enabling my son. I was actually supporting my son's survival strategy. During exacerbations of his illness, he cannot handle large groups of people, sometimes any people at all. He was feeling very volatile and was asking to accommodate his need for less chaos and stress. As I said in a recent letter to our Special Education Director, "if my child had leukemia and was asking to go to the nurses office because he was feeling nauseated, he would be escorted there . . . no questions asked . . . and, with much empathy." At a minimum, my child should be able to state his needs and have them honored. Instead, they labeled and pushed him relentlessly to go to inclusion classes. Eventually he became so unstable, depressed, and suicidal that we had to remove him from school. He was hospitalized twice this fall and was so severely depressed he was unable to dress, talk, or leave the house. He has slowly emerged from the depression with the stress of school eliminated. He began home instruction just before Christmas and will transfer to a self-contained SED class this month. He has lost 3 months of education because the staff refused to believe that his disability was getting in the way of his education and reduce his stress.

The fix? We need to somehow have school personnel experience the challenges our children face and change their mindset. I believe the fix will need to involve more than education. I provided my son's entire school team with a 45-minute education about his illness and how to work with him at the beginning of the year yet this education did not change their approach with my son. We need to change mindsets, prejudice, and stigma.

Another major challenge once there is agreement to provide services, is that the type of services our children need are, for the most part, unavailable. Our children need a therapeutic approach. Some also need a behavioral approach, but that's just a portion of the affected children. Most programs available to our children are behavior-oriented programs. They are missing the mark. Our children need therapy in their day. My son will transfer into a behavior-oriented SED class. We will place him there because he needs a small group setting. He does not need to be with SED kids all day, but that is the only way to get him into a small group setting with the present menu of program options. We do not design services for kids . . . we place kids into existing programs. We as parents must pick the least of the evils among the programs offered. My son might just make it in a self-contained SED class, but what he will achieve will not be "school success" . . . he will survive school.

How might my child benefit from school-based mental health services? He might be able to achieve some stability in his illness, allowing him to access the education being offered. When children are unstable, they cannot learn. The bottom line is most of our children need therapeutic services to achieve any measure of school success. I have seen what having therapy in the day can do. My son made tremendous progress in understanding himself and learning anger management skills while he was served in a partial hospitalization/day treatment program. But there was a price to pay. He was schooled in a mental health center, away from any contact with typical children. He also was exposed to daily restraint and seclusion of fellow classmates. Our family was burdened with therapeutic expenses. This was not a Free and Appropriate Public Education. This could all have been accomplished in a school setting, importing the therapeutic services into the school.

I have a glimmer of hope. I have served on a task force with our local Special Education Regional Resource Center (SERRC), whose goal is to design a true continuum of services, including school-based mental health services, for SED children. The group knows what needs to be done. Getting what needs to be done past the politics will be the real challenge.

I urge all parents with children with mental illness to get involved with their local school district. Write letters to the Special Education Director, school board, and SERRC Director. I also urge them to get involved with their local NAMI chapter who can provide support and assist with organized advocacy efforts. If the local NAMI chapter doesn't service children, get on their board and start a children's division. We must speak up for our children. They are counting on us.

Sincerely,

Susan Mikolic, *President*
NAMI of Lake County

CASE STUDY

"One District's Needs"

Oberlin City School District is a small rural/city, we're never sure what we are, district of 1,067 students. The buildings are configured as follows: Eastwood, K-5, Langston Middle, 6-8, and Oberlin High School, 9-12.

Up to 45 percent of the student population qualified for the free and reduced lunch program. Oberlin is the highest poverty district in Lorain County. Last year Intervention Assistance Team (IAT) meetings were held for 135 students or 13 percent of our population. Individual buildings report that a range of 50 to 95 percent of the students referred for IAT have emotional issues involved in their presenting behaviors.

Using Eastwood School, our K-5 building, as an example, current issues and a picture of what the future holds, we find a disconcerting set of facts. Eastwood, with an enrollment of 282 students and a class size ratio of 1 to 17, held 57 IAT meetings last year. 27 or 47 percent of those students had mental health components involved.

We found that these children were already seeing a counselor, other than the school counselor, and/or were taking medications other than Ritalin. A number of the children were on multiple medications. The list of medications in use among these children, all less than eight years old included Risperdal, Prozac, Paxil, Wellbutrin, Clonidine and Depakote. There are many children in the building who are taking Ritalin and Adderall as well. The Oberlin district is fortunate to have on-site services of a guidance center therapist. And guidance centers is the Lorain vernacular for Applewood Centers. We're one of the two in Lorain County.

The collaboration between guidance centers of Lorain County, supported in part by the Lorain County Board of Mental Health, provides essential on-site services to parents and the students.

Our therapist has been with us for four years, offering continuity and building relationships in our community. Currently we receive services one and one half days a week. The therapist works in all four schools, providing psycho-educational group therapy as needed. Last year, there were four groups of eight students each, and each group ran for about six weeks.

Individual therapy for 13 students is conducted after school at the public library. It goes well beyond the school day in its scheduling and really meets the needs of the children and the families who are participating.

Of the 13 individual students receiving therapy, three carry insurance that covers the help, five are eligible for Medicaid, and five are paying on a sliding scale. We feel that insurance coverage could be improved. Some insurance programs, for example, do not cover guidance centers as one of their identified providers. If there were more universal coverage, we do believe that more parents would take advantage of the services that we could offer.

Without question, we could use increased time with the therapist or counselor on-site. Many issues impacting the lives of children manifest themselves at school. School is the place where social interaction tests the social and emotional health of our youth, as we all know on Monday morning.

For those working with youth who exhibit oppositional defiant tendencies, for example, the school

Case Study, continued

Lorain County Team

experience can be a real challenge. School staff would benefit from assistance from a trained mental health professional understanding the behaviors being displayed by students. Students receiving counseling on-site would benefit from more timely attention to their needs.

And the earlier we identify students' needs, obviously, the more effective the intervention will be on future learning and school success.

We estimate that we could probably use twice as much time as we currently have. Schools do their part. They start with the IAT, which have been a wonderful addition, that all-around thinking about youth today, and they try to help parents know their importance in the process. They introduce the parent to the guidance centers' assistance as yet another team member ready to assist them and their families. They find, however, that even though partners or parents say they want help, they often don't follow through.

Due, in part, to the lack of follow-through, the psycho-educational groups were started in the schools. Always with parent permission, our groups usually center on anger management, the cycle of anger, recognition of feelings, and communicating effectively. Held on-site on a regular basis, the group work does impact student behavior and school success.

We estimate that 80 percent of those youngsters who are participating in group work would benefit from additional outside counseling. In-school therapy is important. The therapist knows the youngsters, she often acts as part of the transition team between schools. As I described, we have a K-2, 3-5, 6-8, 9-12 setup, and it's hard to make a transition to a new school every couple of years.

Although the therapist's schedule doesn't allow her time to be part of the regular IAT, she does provide a written summary for those on the team. If we had more time from our therapist, we would definitely involve her in the IAT process, and she would, therefore, I think, increase other effects on the teachers who are working on the team so they could become more self-sufficient in their teamwork.

In-service training for teachers who work with youth would certainly enhance their skills in working with the difficult issues that present themselves each day. Mental health services at schools today are minimal at best, the wonderful examples we've heard today aside. The collaboration between mental health professionals and educational professionals is critical for those working in the field of education. Teachers need and want to know what to do better.

The opportunity to work together as caring professionals is powerful. The students' needs seem to be far greater than the resources at hand to deal with those needs. Teacher training doesn't prepare teachers for the complex situations they encounter in the classrooms every day.

Many parents are real parent partners in the educational process. A significant number of parents, however — often parents of youngsters exhibiting nonproductive behaviors — don't work with the schools in exploring interventions that we feel would be helpful.

Ms. Francine Toss
Oberlin City Scholls

Resource Guide

ODMH and Ohio's Public Mental System 38
ODMH Early Childhood Mental Health Initiative 39
Symptoms of Childhood Depression 40
Red Flags – A Depression Awareness Program 41
Internet Sites relevant to MH in Schools 42
Additional Resources 43
Special Education Regional Resource Centers (SERRC) 44
The Ohio State University Center for Learning Excellence 45
Panelist Biographies 46
Ohio Mental Health/Alternative Education Network 48

Ohio Department of Mental Health and Ohio's Public Mental Health System

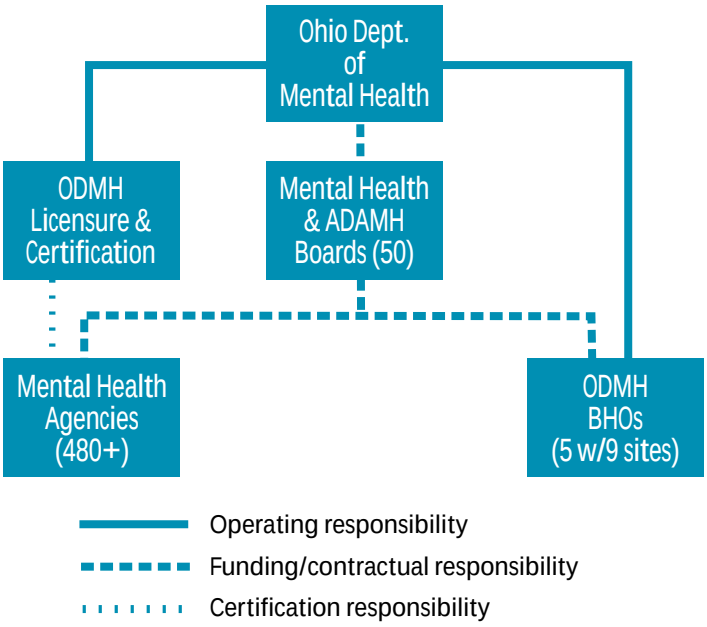
The mission of the Ohio Department of Mental Health is to establish mental health and recovery from mental illness as a cornerstone of health in Ohio, and assure access to quality mental health services for Ohioans at all levels of need and life stages.

Last year, Ohio's public mental health system provided care to more than 250,000 individuals, including nearly 90,000 adults who are disabled by severe mental illness and 75,000 children with emotional disorders. This public system includes ODMH, 50 county-based mental health boards, and nearly 500 community mental health agencies. The Boards, which in most cases oversee both mental health and addiction services, do not directly provide services. They act as local mental health authorities, funding, planning, monitoring and purchasing services provided by private agencies and the Behavioral Healthcare Organizations (BHOs) operated by the Department. This approach, which emphasizes local management and control, generates strong citizen involvement and local financial support for mental health services.

The Department's five BHOs provide adult inpatient care at nine sites around the state to 1,100 people on a daily basis, and admit and discharge 5,800 people each year. The BHOs also provide outpatient services to 3,500 adults and children annually through their Community Support Network programs via contracts with the local Boards.

ODMH licenses private psychiatric hospitals and residential facilities, and certifies community mental health agencies. The department approves local boards' service plans, provides technical assistance to the boards, and conducts research concerning the causes and treatment of mental illness.

Ohio's public mental health system is funded via about $436 million in state general revenue funds, $160 million in local levies, $138 million in federal Medicaid receipts, and $311 million in federal, private and other funds.



Ohio Department of Mental Health Early Childhood Mental Health Initiative

The ODMH Early Childhood Mental Health Initiative was launched in SFY 2000 to increase the quality of Ohio's existing early childhood programs—Welcome Home, Early Start, Early Intervention, Early Head Start and Head Start, subsidized child care (both family child care homes and center-based services,) and public pre-schools—by adding mental health consultation services. The Initiative is focused on ensuring the healthy social and emotional development of young children—those from birth to age six. It intends to promote healthy social and emotional development and addresses the behavioral health care needs of young children to increase children's readiness for school and later school success.

The Ohio General Assembly included new funding in the ODMH's 2000-2001 budget to specifically focus attention on the healthy emotional development of Ohio's youngest citizens. The ODMH Early Childhood Mental Health Initiative builds on hard evidence from research on brain development in infants and toddlers.

An advisory board established to guide the Initiative includes representatives from Ohio Department of Job and Family Services, Ohio Department of Eucation, Ohio Department of Health, Children's Hospital Association, Head Start, Infant Mental Health subcommittee of the Early Intervention Coordinating Council, local ADAMHS boards, local mental health providers, families and local mental health providers and families.

One of the goals of the ODMH Initiative is to build capacity to enable each Board area to have an early childhood mental health professional to provide consultation for early childhood programs and parents with an emphasis on serving children in early childhood settings in non-clinical intervention to increase the quality of Ohio's early childhood programs.

A major focus of the ODMH Initiative is on training mental health professionals to serve as consultants to an array of early childhood programs, including Early Start, Early Intervention, Early Head Start, Head Start, and child care. Activities include public awareness, and regional training sessions for mental health and early childhood professionals to develop consultation skills.

A total of $1.4 million was allocated per fiscal year for the Initiative. For SFY 2001, grants totaling $1,235,000 were awarded to twenty-five community mental health boards, representing 36 counties. A variety of activities have been planned by the local boards to utilize the funding that was received. Some of the activities are new and others are continuations and expansions of existing programs. The majority of the activities proposed include:

- Provision of mental health consultation services to early childhood programs, including Head Start, Early Start, Early Intervention, public and private child care centers and a few home-based programs
- Cross-systems training in early childhood mental health for professionals
- Education for parents and early childhood staff on healthy social and emotional development of young children
- Establishment of collaborative teams to support early childhood mental health initiatives
- Public awareness and community education activities

An evaluation to develop a profile of young children needing behavioral health care services and a framework for evidence-based prevention and early intervention strategies is also a part of the ODMH Initiative. This is currently being developed. We anticipate the effectiveness of the Initiative will be measured by tracking decreases in incidences of anti-social behavior among young children in center-based care, improvements in the skills among early childhood staff to effectively deal with young children with emotional problems, and improvements in the skills of parents and other caretakers to create nurturing environments for their young children. The final strategy for analysis of the initiative is development of a "best practices" guide highlighting the effectiveness of various interventions with early childhood providers and parents and the impact on young children.

Ohio Department of Mental Health

Bob Taft, Governor
Michael F. Hogan, Ph.D., Director

Childhood Depression

Center for Mental Health Services, (1993). Federal Register 58(95): 29422-29425.

Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

(American Academy of Child Adolescent Psychiatry)

Symptoms May Include:

- Changes in sleeping patterns
- Refusal to sleep alone; hysterical crying when left alone
- Refusal to eat or inability to stop eating
- Bed wetting
- Refusing to attend school
- Outbursts of anger – name calling or breaking things
- Stealing meaningless or inexpensive items
- Hoarding food
- Refusal to play with other children, sulking, crying, bullying, fighting, picking on younger children
- Sadness, unhappiness—verbal expression of self-contempt and misery
- Talk of death or dying, especially talk of suicide

Red Flags

Ohio Department of Mental Health

Helen Cain Jackson, MSW, LISW
Project Manager, Red Flags Program
Ohio Department of Mental Health
614-466-1195/1984

Victoria Snyder
Coordinator, Red Flags Program
MH Association of Summit County
1-800-991-1311

A Comprehensive Childhood & Adolescent Depression Awareness Program for Schools

What is Red Flags?

Red Flags is a universal prevention program that is school-based. The program was developed by Penny Frese, Ph.D., and a 14-member task force under the leadership of the Ohio Department of Mental Health, to help students, parents and school staff recognize and respond to signs of depression and related mental illnesses. Red Flags is a three-pronged program that includes: in-service training for school personnel, a video-based curriculum for students called Claire's Story: A Child's Perspective of Childhood Depression, and a seminar for parents, students and the community.

Why Red Flags?

FACT: Professionals estimate that 3-5 percent of children and 8-12 percent of adolescents experience clinical depression each year.

FACT: A recent survey reported that approximately half of all 10-16 year-old boys and girls with high levels of aggression are also depressed.

FACT: Children with untreated depression are at high risk for substance abuse and suicide.

FACT: Two-thirds of depressed children go undiagnosed and untreated. Treatment for depression has an 80 percent success rate, higher than treatment for heart disease or diabetes.

From Pilot Success to Statewide Dissemination

Red Flags was piloted in 10 Ohio middle schools during the 1998-1999 school year, reaching 3,150 students, parents and school personnel.

Students significantly increased their knowledge of clinical depression based on pre/post tests. All participating schools indicated the program was "very needed."

The Ohio Department of Mental Health and the Ohio Department of Education have since made Red Flags Program Kits available to every public middle school in Ohio. A private donor has made the Kit available to all non-public schools.

To date, more than 420 public schools and 100 non-public schools have requested and received program Kits in all 88 counties. Red Flags in Children's Behavior information brochures have been distributed to more than 115,000 children and adults. Red Flags led to 500 children being referred to mental health professionals during the 1999-2000 school year.

For more information: **www.redflags.org**

Catalogue of Internet Sites Relevant to Mental Health in Schools

Advocates for Youth—Support Center for School-Based and School-Linked Health Care
http://www.advocatesforyouth.org/support.htm

Alpha Center
http://www.ac.org

American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/web/aacap

Building Coalitions
http://www.ag.ohio-state/edu/~ohioline/lines/kids.html

Center for Child Health and Mental Health Policy
http://www.dml.georgetown.edu/depts/pediatrics/gucdc/index.html/

Center for Effective Collaboration and Practice
http://www.air-dc.org/cecp/cecp.html

Center for Mental Health in Schools
http://smhp.psych.ucla.edu

Center for Mental Health Services (CMHS)
http://www.samhsa.gov/cmhs.cmhs.htm/

Center on Families, Communities, Schools and Children's Learning
http://ericps.ed.uiuc.edu/readyweb/s4c/ctrfam/html

Center for Research on At-Risk Students
http://www.wmich.edu/at-risk/

Children Now
http://www.danai.com/~children/

Collaboration Framework
http://www.cyfernet.org/nnco/framework.html

Community in Schools
http://www.cisnet.org/

Connecting the Home, School, and Community
http://www.sedl.org:80/hscp/welcome.html

Council for Children with Behavioral Disorder (CCBD)
http://www.air.org/cecp/teams/stratpart/ccbd.htm

Electronic Schoolhouse
http://electronic-schoolhouse.org

Facts For Families
http://www.aacap.org/web/aacap/factsFam/

Family USA
http://epn.org/families.html

Family and Youth Services Bureau (FYSB)
http://www.acf.dhhs.gov/programs/fysb

Family Village
http://www.familyvilage.wisc.edu/

Federation of Families for Children's Mental Health
http://www.ffcmh.org

Florida Mental Health Institute (FMHI)
http://www.fmhi.usf.edu/

A Guide to Promising Practices in Educational Partnerships
http://www.ed.gov/pubs/PromPract/index.html/

Healthy Schools, Healthy Communities
http://www.bphc.hrsa.dhhs.gov/hshc/hshc1.htm

Maternal and Child Health Bureau
http://www.os.dhhs.gov/hrsa/mchb/

Mental Health InfoSource
http://www.mhsource.com/

Mental Health Net (MHN)
http://www.cmhc.com/

Mindmatters
http://www.ei.com.au/mindmatters

National Center for Services Integration (NCSI)
http://eric-web.tc.columbia.edu/families/TWC/ncsi.html/

National Center to Improve Practice, (NCIP)
http://www.edc.org/FSC/NCIP/

National Information Center for Children and Youth with Disabilities (NICHCY)
http://nichcy.org

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

National Institute on the Education of At-Risk Students
http://www.ed.gov/offices/OERI/At-Risk/

National Transition Alliance for Youth with Disabilities (NTA)
http://www.dssc.org/nta/html/index_2.htm

Parents of Children with Challenging Behaviors
http://www.neosoft.com/~parent/chain.html

Research and Training Center on Family Support and Children's Mental Health
http://www.rtc.pdx.edu/

School Based Program Funding Information
http://www.cdc.gov/nccdphp/dash/funding.htm

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov/

Technical Assistance Center for the Evaluation of Children's Mental Health Systems
http://www.tac.pie.org/eval

SOURCE: These sites are a contribution: "From the Center's Clearinghouse" http://smhp.psych.ucla.edu

Additional Resources

Strengthening Community School Partnership

The Collaborative Wellness Kit, Together We Can, Institute for Education Leadership, 202-822-8405

A Compact for Learning: An Action handbook for Family-School-Community Partnerships, Partnership for Family Involvement in Education & US Department of Education, 800-USA-LEARN.

Creating A Community Agenda: How Governance Partnerships Can Improve Results for Children, Youth, and Families. Center for the Study of Social Policy, Washington, D.C., 1998, 217-371-1565.

Getting to the Grassroots: Neighborhood Organizing and Mobilization. A Matter of Commitment—Community Collaboration Guidebook Series #6, Charles Bruner & Maria Chavez, NCSI Clearinghouse, 1997, 515-280-9027.

Learning Together*: The Developing Field of School-Community Initiatives,* Atelia Melaville and Martin J. Blank, The Charles Stewart Mott Foundation, 1998, 800-645-1766.

Partnership Self-Assessment Tool and Guide to Successful Public-Private Partnerships for Child Care, Child Care Partnership Project, nccic.org/ccpartnerships or 202-628-4200.

Schools and Community Partnerships: Revitalizing Urban Schools and Neighborhoods, Michelle Cahill. Cross-Cities Campaign for Urban School Reform, 312-322-4880.

Strong Families, Strong Schools: Building Community Partnerships for Learning, U.S. Department of Education, 1994, 800-USA-LEARN.

A Training Guide for Organizing Collaborative Enterprise, United Way of America & The Institute for Educational Leadership, 1999, 202-822-8405.

Resources from the Coalition for Community Schools (www.communityschools.org or 202-822-8405 ext. 45)

Community Schools: Partnerships for Excellence. May 2000.
A Policy Approach to Create and Sustain Community Schools. April 2000.

Community Schools OnLine:
- *Questions and Answers about Community School, Vol. 1, No. 7*
- *Community Schools for Excellence Public Education Campaign, Vol. 1, No. 8*

Improving Community School Programs and Services

Characteristics and Features of Community-Based Family Support Programs, Carl Dunst, Family Resource Coalition, Best Practices Project, Commissioned Paper II, 1995, 312-341-0900, ext. 108.

Core Competencies for Youth Workers, A Guided Tour of Youth Development, and The Handbook of Positive Youth Outcomes, Youth Development Institute. Networks for Youth Development, Fund for the City of New York, 212-925-6675.

Health is Academic: A Guide to Coordinated School Health Programs, Editors Eva Marx and Susan Frelick Wooley, Teachers College Press, 1234 Amsterdam Avenue, New York, NY 10027.

Homework Assistance & Out-of-School Time: Filling the Need, Finding a Balance, Susan O'Conner & Kate McGuire, National Institute on Out-of-School Time, 1998 www.niost.org or 781-283-2510.

Improving Results for Children, Youth and Families: A Comprehensive Guide to Ideas and Help: *"Where the Tube Hits the Road: Providing Services, Supports and Opportunities that Improve the Lives of Children, Youth, and Families,"* Karen Pittman & Michele Cahill, Center for Youth Development and Policy Research. Vol. 1., 202-884-8404

Making the MOST of Out-of-School Time: The Human Side of Quality, 11 min. video. National Institute on Out-of-School Time. 1998, www.niost.org or 781-283-2510.

The NSACA Standards for Quality School-Age Care, edited by Janette Roman, National School-Age Care Alliance. www.nsaca.org or 617-298-5012.

Where the Kids Are: *How to Work with Schools to Create Elementary School-Based Health Centers,* National Health and Education Consortium, c/o the Institute for Educational Leadership, 202-822-8405.

Youth Development: A Primer, Wanda E. Fleming & Elaine Johnson, Center for Youth Development and Policy Research, 1996, 202-884-8267

Finding Funding for Community School Initiatives

Getting to The Bottom Line: State and Community Strategies for Financing Comprehensive Community Service System, Frank Farrow and Charles Bruner, NCSI Clearinghouse, 1993, 515-280-9027.

Investing in the Future: Child Care Financing Options for the Public and Private Sectors, Child Care Action Campaign, 1992, 212-239-0138.

Resources from The Finance Project (www.financeproject.org or 202-628-4200):

Finding Funding: A Guide to Federal Sources for Out-of-School Time & Community School Initiative, Nancy Reder, March 2000.

Financing After-School Programs, Robert Halpurn, Carol Cohen, and Sharon Deich, July 2000.

Financing Family Resource Centers: A Guide to Funding Sources and Strategies, Sara Watson and Miriam Westheimer, May 2000

State Program and Financing Policies for School-Age Children and Youth, Barbara Langford and Amy Dawson, December 2000.

Strategy Briefs on Innovating Financing Strategies:

- *Creating Dedicated Local Revenue Sources for Out-of-School Time Initiatives,* September 1999;
- *Using TANF to Finance Out-of-School Time and Community School Initiatives,* October 1999;
- *Maximizing Federal Food and Nutrition Funds for Out-of-School Time and Community School Initiatives,* February 2000;
- *Financing Facilities for Community School Programs,* August 2000;
- *Using Medicaid Funds for Out-of-School Time and Community School Initiatives,* October 2000;
- *Accessing Tobacco Settlement Funds to Support Services for School-Age Children and Youth,* October 2000.

Special Education Regional Resource Centers (SERRC)

The Ohio Department of Education, through the Division of Special Education, recognized in 1968 that a state agency could not successfully relate to each individual teacher, supervisor, and school district. Federal funds were used to create a new linkage between the state and the school districts.

Under Ohio's State Plan submitted in accordance with P.L. 94-142, part of the discretionary portion of Title VI-B is used to fund the Special Education Regional Resource Center (SERRC) network system. This statewide mechanism was designed to develop and implement services and priorities in keeping with the Individuals with Disabilities Education Act (IDEA), formerly called the Education of the Handicapped Act (EHA). The SERRCs fulfill a critical role in providing timely and specialized assistance to parents and school personnel by:

1. Assisting school district personnel in providing appropriate services to children with disabilities, through technical assistance and cooperative planning;
2. Providing regular and special education teachers, support personnel, administrators, and parents with resources designed to improve the quality of instruction for children with disabilities, through the delivery of instructional materials and methodologies designed to meet the individual needs of children with special needs; and
3. Providing staff development to local school district personnel and parents, on an individual and team basis, to improve the quality of instruction for children with disabilities.

Currently, there are sixteen Special Education Regional Resources Centers that provide services to all school districts, county boards of mental retardation and developmental disabilities, and institutions in the state of Ohio. Each SERRC has the following four components: Identification and Program Development Project (IPD); Educational Assessment Project (EAP); Instructional Resource Center Project (IRC); Early Childhood Services Project (ECS)

Each center functions through a participatory management system based on a governing board composed of superintendents of schools; special and general education personnel; at least two parents of children with disabilities; and representatives from nonpublic schools, county boards of mental retardation and developmental disabilities, regional institutions, and universities in the region. Governing boards may include representatives from other community agencies.

As regional entities, the SERRCs serve the important function of identifying local needs and designing and delivering services in ways that benefit regional constituents. At the same time, the SERRC system assists the Division of Special Education, playing an essential role in statewide networking activities, advocacy on behalf of students with disabilities, and state and national outreach and information dissemination.

Ohio's SERRC Directory

Central Ohio
470 Glenmont Ave.
Columbus, OH 43214
614-262-4545
614-262-1070 Fax

Cuyahoga
5983 West 54th Street
Parma, OH 44129
440-885-2685
440-885-1859 Fax

East Central Ohio
141 McDonald Drive, SW
New Philadelphia, OH 44663
330-343-3355
1-800-363-6687
330-843-3357 Fax

East Shore
7900 Euclid-Chardon Road
Kirtland, OH 44094
440-256-8483
440-256-0404 Fax

Hopewell
5350 West New Market Road
Hillsboro, OH 45133
937-393-1904
937-393-0496 Fax

Lincoln Way
1450 W. Main Street
P.O. Box 3969
Louisville, OH 44641
330-875-2527
330-875-7621 Fax

Miami Valley
1831 Harshman Road
Dayton, OH 45424
937-236-9965
937-239-0161 Fax

Mid-Eastern Ohio
420 Washington Ave., Ste. 1000
Cuyahoga Falls, OH 44221
930-929-6634
1-800-228-5715
330-920-3645 Fax

North Central Ohio
1495 West Longview, Ste. 200
Mansfield, OH 44906
419-747-4808
1-800-424-7372
419-747-3806 Fax

North East Ohio
1400 Tod Ave. NW/Box 1900-IP
Warren, OH 44483
1-800-776-8298
330-394-0667 Fax

Northern Ohio
1230 Beechview Drive, Ste. 100
Vermilion, OH 44089
419-833-6771
419-833-6761 Fax

Northwest Ohio
10142 Dowling Road
Bowling Green, OH 43402
419-833-6771
419-833-6761 Fax

Pilasco-Ross
411 Court Street
Portsmouth, OH 45662
440-354-4526
740-353-2980 Fax

Southern Ohio
507 Richland Avenue
Athens, OH 45701
740-594-4235
1-800-882-6186
740-592-5690 Fax

Southwestern Ohio
1301 Bonnell, 3rd Floor
Cincinnati, OH 45215
513-563-0045
513-563-0588 Fax

West Central Ohio
1045 Dearbaugh Avenue, Ste. 1
Wapakoneta, OH 45895
419-738-9224
1-800-688-2845
419-788-9199 Fax

The Ohio State University Center for Learning Excellence

An Initiative of the John Glenn Institute for Public Service and Public Policy
In Partnership with the College of Human Ecology and the College of Education

http://cle.osu.edu

In August 2000, Governor Bob Taft announced the formation of the Center for Learning Excellence (CLE) at Ohio State, with Human Ecology Dean David W. Andrews as director. The Center has been awarded nearly $1 million in State and Federal funds to support the work of 127 alternative education programs serving 490 Ohio school districts. Since July of 1999, these programs have received nearly $40 million in State funding. All State funds awarded to the programs must be matched at the local level.

Most of the programs supported by the Center provide an alternative to out-of-school suspension or expulsion. Some provide a mix of prevention and intervention activities and services. All programs are required to work collaboratively with community mental health, substance abuse, human services, juvenile justice, and family support and intervention agencies. Many of the students participating in the alternative education programs have been truant, disruptive, have threatened other students or school staff members, or are at risk of dropping out of school.

The three most important responsibilities of the Center for Learning Excellence are:

- conducting and collecting research to identify *evidence-based* strategies for removing the barriers to school success facing these at-risk learners;
- providing professional development and training for staff working in alternative programs and for their community partners; and,
- conducting a summative evaluation of all programs and formative (process) evaluations of selected programs.

The Center is sponsored by the Ohio Alternative Education Advisory Council. The Council is chaired by Attorney General Betty Montgomery and includes, as members, Governor Taft's education advisor, the directors of the Ohio Departments of Mental Health, Alcohol and Drug Addiction Services, and Youth Services, and the State Superintendent of Public Instruction. Funding is provided by the Ohio Department of Education, the Ohio Department of Mental Health, and the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

Although the Center has been in existence for only nine months, it is already having a significant impact in several ways:

- The Center played a key role in planning the Alternative Education Summit conferences held in August 2000 and April 2001. Each conference was attended by more than 600 staff members from the alternative education programs and by many community partners.
- Enrollment and outcome data have been collected on more than 15,000 students who participated in alternative education programs during the first seven months of the 2000-2001 school year. Protocols to be used in conducting formative (process) evaluations are being developed and field-tested before using them with selected programs.
- A website has been established to provide alternative education programs with information about evidence-based and promising practices and about other services available from the Center. The Center is linked electronically to all program sites, Ohio Department of Education staff, and Advisory Council staff.
- The Center has recruited six community-based mental health service providers with proven track records to become part of a "Mental Health/Alternative Education Network." The Network members receive funding from the Center to provide technical assistance to alternative education programs on a regional basis.
- The Center was recently awarded a $330,000 Substance Abuse and Mental Health Services Administration (SAMHSA) grant to enhance the core functions of the Center.

Panelist Biographies

A. Leslie Abel

Les Abel is the Executive Director of the Stark County Community Mental Health Board, a position he has held since 1979. Previously, he had been the Assistant Director at the Stark Board and the Wayne-Holmes Board. Les had also directed the Child Assistance Program, a joint venture between the Erie/Ottawa Mental Health Board and the Vermilion Schools. He received his Bachelor's degree from the College of St. Charles Borromeo, did graduate work in Rome, Italy (where he played first base on an Italian baseball team). He received his Master's Degree in School Psychology from Kent State University. Les currently serves as the Chair of the Institutional Review Board at Mercy Medical Center and is on the Board of Directors of the Stark County Out of Poverty Partnership. He and his wife, Mary Ann, have three children.

David W. Andrews, Ph.D.

David W. Andrews, Ph.D., is dean of the College of Human Ecology and professor of Human Development and Family Science at The Ohio State University. He has invested the last 18 years in developing, implementing, evaluating, and administering programs designed to enhance family and individual development. Prior to his appointment as dean of Human Ecologyin July 1998, he was Assistant Director of OSU Extension for 4-H Youth Development at Ohio State. Before joining Ohio State, he headed the Department of Human Development and Family Studies at Oregon State University.

Over the years, Dr. Andrews has focused his expertise in child development on programs that serve high-risk youth. He administered longitudinal research studies on the prevention of adolescent problem behavior, funded by the National Institute of Mental Health and the National Institute of Drug Abuse. Most recently, he was instrumental in creating the Center for Learning Excellence at Ohio State's John Glenn Institute for Public Service and Public Policy. He currently serves as director of this center, which is charged with supporting Ohio's alternative education prevention and intervention initiative as well as other programs for high-risk youth.

Jody Demo-Hodgins

Jody Demo-Hodgins is Director of the Crawford-Marion Board of Alcohol, Drug Addiction and Mental Health Services (ADAMH). She has served in this capacity since 1997, after holding the position of associate director at the board since 1989. Prior to working for the ADAMH Board, Jody worked for the Marion Adolescent Pregnancy Program (MAPP), a contract agency of the ADAMH Board. She held a variety of jobs at MAPP during her nine years there, including child development specialist, family life educator and was the agency director for two years. In addition, Jody has worked as a child protective services worker, school social worker and group home supervisor.

Jody and her husband Jim are the parents of Jamie, a sophomore at the Ohio State University and Carly Joy, a high-school sophomore.

Michael F. Hogan, Ph.D.

Dr. Michael Hogan has served as Director of the Ohio Department of Mental Health (ODMH) since March 1991. In the past two decades, he has held leadership positions and led reform in the mental health systems of three states. Serving in the Massachusetts Department of Mental Health from 1976 to 1984, he developed innovative community mental retardation and mental health services, and served as Regional Administrator and Superintendent of Northampton State Hospital. Dr. Hogan served from 1984 to 1987 as Deputy Commissioner, and from 1987 to 1991 as Commissioner of Mental Health in Connecticut.

Since 1991, he has guided Ohio's public mental health system through broad, challenging reforms.

Dr. Hogan holds a bachelor's degree from Cornell University and a doctorate from Syracuse University. He served from 1994 to 1998 on the National Advisory Mental Health Council and was President of the Board of the National Association of State Mental Health Program Directors Research Institute. He has authored a book and numerous chapters and articles. He and his wife Barbara have three sons.

Hank Rubin, Ph.D.

Dr. Hank Rubin is currently the Associate Superintendent of the Center for Student, Families and Communities. Prior to his associates superintendent position he was the past president of the Ohio Department of Education.

Dr. Rubin is a nationally recognized scholar and trainer in the fields of collaborative leadership and public administration. His book *Collaboration Skills for Educators and Nonprofit Leaders* (Lyceum Books, 1998) has been adopted by training programs and universities throughout North America. Dr. Rubin has held executive positions in federal, state and local education agencies; higher education; philanthropy; and business. He has served as president and chief executive officer of the Institute for Collaborative Leadership since its founding in 1997.

On January 18, 2000, Dr. Rubin was appointed Associate Superintendent for Students, Families and Communities by the Ohio Board of Education.

Dr. Rubin earned his BA and MA from the University of Chicago and his Ph.D. from Northwestern University.

Anne E. Stephens, Ph.D.

Dr. Stephens is currently the Executive Director of the Ohio Department of Education. She received her bachelor's from West Liberty State College, master's degree in Reading from West Virginia University, and she received her doctorate of Educational Administration from LaSalle University.

In the past, Anne served her community in several capacities such as a teacher, Assistant Superintendent for the Steubenville City Schools, Superintendent for the Buckeye Local Schools and a Graduate School Professor at the University of Steubenville.

Anne has been the featured speaker for such activities as Skill Development for Pre-Schoolers in Cheyenne, Wyoming, Early Prevention of School Failure in Chicago, IL.

First Lady Hope Taft

Ohio's First Lady Hope Taft grew up in Camden, Arkansas. She attended Mary Baldwin College, and graduated from Southern Methodist University in 1966 with a bachelor's degree in Business Administration

In 1967, she married Bob Taft and they lived in Southeastern Asia and Springfield, IL. Bob attended the University of Cincinnati Law School before continuing his career of public service.

Over the past twenty-five years, Hope Taft has volunteered and served on more than two dozen boards. However, her greatest commitment has been to drug and alcohol prevention, especially among our youth.

Mrs. Taft began her career of voluntary public services with Cincinnati Restoration, Inc., a mental health agency. She later became a co-founder of Citizens Against Substance Abuse, Ohio Parents for Drug Free Youth, and the Ohio Alcohol and Drug Policy Alliance. She is an Ohio Certified Prevention Consultant. She serves on the President's Commission for Drug Free Communities.

Mrs. Taft has received recognition from many groups for her volunteer efforts, including the Cincinnati Enquirer's "Woman of the Year" award, the JC Penney Golden Rule Award for Outstanding Volunteer Service, the FBI Director's Community Leadership Award, the National Leadership Award from Community Anti-Drug Coalitions of America, and the Parent Award from Parents Resource Institute for Drug Education. In 1993, Hope was granted an honorary Doctor of Humane Letters from the College of Mt. St. Joseph in Cincinnati, Ohio. She was inducted into the Ohio Women's Hall of Fame in 1996.

The Governor and Mrs. Taft have jointly received the Oak Tree Award from the Ohio PTA and the Peace of the City Award from the Jewish Community Relations Council of Cincinnati.

The Governor and Mrs. Taft have one daughter, Anna.

Jane Wiechel, Ph.D.

Jane Wiechel is the Chief of Staff and Policy Director for Governor Taft's Ohio Family and Children First Initiative.

Prior to her position in the Governor's office, she served as an Executive Director with the Ohio Department of Education. In that capacity, she provided leadership for the Office of Early Childhood Education and the Ohio Literacy Campaign. It was also during this time that she served a four-year term on the National Association Education Young Children (NAEYC) Governing Board.

In addition to her career with the state, Jane has been a classroom teacher at the preschool, elementary and junior high school levels. She has taught regular education, special education and adult basic literacy education.

Jane received her undergraduate degree from Kent State University. She received her master degree in reading from Bowling Green State University and her doctorate in education policy and leadership from the Ohio State University.

Al Neff, Ph.D., Panel Moderator
Associate Director
The Center for Learning Excellence
The Ohio State University

Ohio Mental Health/Alternative Education Network

If you have questions or need assistance in developing school-based mental health services, please contact the agency that serves your area of the state:

City of Cleveland/Northeast Ohio Region

Counties: Ashtabula, Columbiana, Cuyahoga, Geauga, Lake, Lorain, Mahoning, Trumbull

Positive Education Program (PEP)
Theresa C. Johnston, Ph.D.,
Director of PEP Assist
3100 Euclid Ave.
(216) 361-7232, ext. 200
(216) 361-7295 fax
Cleveland, Ohio 44115
E-mail: tjohnston@pepcleve.org

Southeast Ohio Region

Counties: Adams, Athens, Belmont, Coshocton, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Scioto, Vinton, Washington

Woodland Centers, Inc./Southern Local School District Project
Teresa Julian-Goebel, Clinical Therapist
3086 State Route 160
Gallipolis, Ohio 45631
(740) 446-5500 office
(740) 446-4402 fax

Tom Weaver, District Technology Coordinator
P.O. Box 98
Racine, Ohio 45771
(740) 949-2611, ext. 318, office
(740) 949-3309 fax
E-mail: SHS5@frognet.net

Central Ohio Region

Counties: Champaign, Clark, Crawford, Delaware, Fairfield, Fayette, Franklin, Greene, Highland, Knox, Licking, Logan, Madison, Marion, Morrow, Pickaway, Pike, Ross, Union

Children's Hospital
Behavioral Health Services
Bradley Casemore,
Administrative Director
899 E. Broad St.
Columbus, Ohio 43205
(614) 221-0209 office
(614) 221-0225 fax
E-mail: casemore@chi.osu.edu

Gregory Foster,
Community Support Worker
899 E. Broad St.
Columbus, Ohio 43205
(614) 365-6976 office
(614) 221-0225 fax
E-mail: fosterg@chi.osu.edu

Linda Maxwell,
School-Based Team Leader
899 E. Broad St.
Columbus, Ohio 43205
(614) 221-9922 office
(614) 221-9523 fax
E-mail: maxwell1@chi.osu.edu

North Central Ohio Region

Counties: Ashland, Carroll, Holmes, Medina, Portage, Richland, Stark, Summit, Tuscarawas, Wayne

Heartland Behavioral Healthcare
Charles Johnston, Director
Child and Family Services
3076 Remsen Road
Medina, Ohio 44256
(330) 722-0750 office
(330) 723-0068 fax
E-mail:
johnstonc@mhmail.mh.state.oh.us

Northwest Ohio Region

Counties: Allen, Auglaize, Erie, Fulton, Defiance, Hancock, Hardin, Henry, Huron, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert, Wood, Williams, Wyandot

Children's Resource Center
Dr. Ellen Anderson, Program Manager
School-based Services
1045 Klotz Road
P.O. Box 738
Bowling Green, Ohio 43402
(419) 352-7588 office
(419) 354-4977 fax
(888) 466-5437 toll-free
E-mail: ellena@crc.wcnet.org

Southwest Ohio Region

Counties: Brown, Butler, Clermont, Clinton, Darke, Hamilton, Miami, Montgomery, Preble, Shelby, Warren

Miami University Psychology Clinic
Center for School-based Mental Health Programs
Carl Paternite, Ph.D., Director
Benton-Hall
Miami University
Oxford, Ohio 45056
(513) 529-2416 office
(513) 529-2420 fax
E-mail: paternce@muohio.edu

Betty Haley, Secretary
Benton-Hall
Oxford, Ohio 45056
(513) 529-2423 office
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You may also contact the
Center for Learning Excellence at
The John Glenn Institute for
Public Service and Public Policy
The Ohio State University
807 Kinnear Rd.
Columbus, Ohio 43210
(614) 247-6350 office
(614) 247-6447 fax
Website: http://cle.osu.edu

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The Substance Abuse and Mental Health Services Administration
of the United States Department of Health and Human Services

Ohio Mental Health/Alternative Education Network

An Initiative of the Center for Learning Excellence
And
The Ohio Department of Mental Health

THE **CENTER FOR LEARNING EXCELLENCE** AND THE **OHIO DEPARTMENT OF MENTAL HEALTH** HAVE JOINED TOGETHER TO DEVELOP A NETWORK OF SUPPORT FOR THE EXPANSION AND IMPROVEMENT OF MENTAL HEALTH SERVICES IN SCHOOLS THROUGHOUT OHIO. **S**IX AGENCIES AND ORGANIZATIONS HAVE AGREED TO EXTEND THE WORK OF THE CENTER BY BECOMING REGIONAL AFFILIATES. **E**ACH AGENCY HAS BEEN SELECTED BECAUSE IT HAS A HISTORY OF OUTSTANDING SERVICE TO CHILDREN, FAMILIES, AND SCHOOLS.

THE GOAL OF THE NETWORK IS TO ASSIST SCHOOLS IN ADDRESSING EMOTIONAL AND BEHAVIORAL BARRIERS TO LEARNING BEGINNING WITH A SPECIAL FOCUS ON STUDENTS PARTICIPATING IN THE OHIO ALTERNATIVE EDUCATION CHALLENGE GRANT PROGRAM. **T**O THE EXTENT POSSIBLE, THIS ASSISTANCE WILL PROMOTE IMPLEMENTATION OF EVIDENCE-BASED AND PROMISING PRACTICES BY PARTICIPATING SCHOOL DISTRICTS AND LOCAL MENTAL HEALTH SERVICE PROVIDERS.

Ohio Department of Mental Health

Bob Taft, Governor
Michael F. Hogan, Ph.D., Director

THE OHIO STATE UNIVERSITY

THE JOHN GLENN INSTITUTE FOR PUBLIC SERVICE & PUBLIC POLICY
CENTER FOR LEARNING EXCELLENCE

For more information
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this publication call
Office of Children Services
and Prevention
at 614/466-1984.

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