Albuquerque Public Schools, Albuquerque, NM

The District's support services department (called the health/mental health services department) includes counseling, psychological services, nursing, social work services, coordinates school-linked services, and oversees the School-Based Medicaid Services budget and the Title IV Safe and Drug Free Schools budget. In developing a new vision, the Department is organizing its "Continuum of Learning Support" in terms of

- Building a School Wide Foundation of Learning Supports
- Systems for Intervening Early-after-problem-onset
- Systems for Treatment.

At the same time, it adopted the language of "overcoming barriers to learning through developing a comprehensive, integrated enabling component." The component is described as encompassing six areas:

1. Classroom Focused Enabling (enhancing classroom-based efforts to enable learning)
2. Home Involvement in Schooling
3. Student and Family Assistance
4. Support for Transitions
5. Community Outreach for Involvement and Support
6. Crisis Assistance and Prevention

At this time, the District is piloting a comprehensive database to increase accountability by evaluating the relationship between student support and academic achievement. This involves working with the data management division to include information relevant to barriers to learning and benchmarks and indicators of improvement available in computer data requests (e.g., language, attendance, suspension, expulsion, mobility) "Three data collection forms have been designed to retrieve behavioral health related information from schools for students contacts, program utilization, and training participation."

A New Vision of Health/ Mental Health Services

Lynn Pedraza, Director H/MH Services
Janalee Barnard, Coordinator of Counseling
Albuquerque Public Schools
Albuquerque, New Mexico

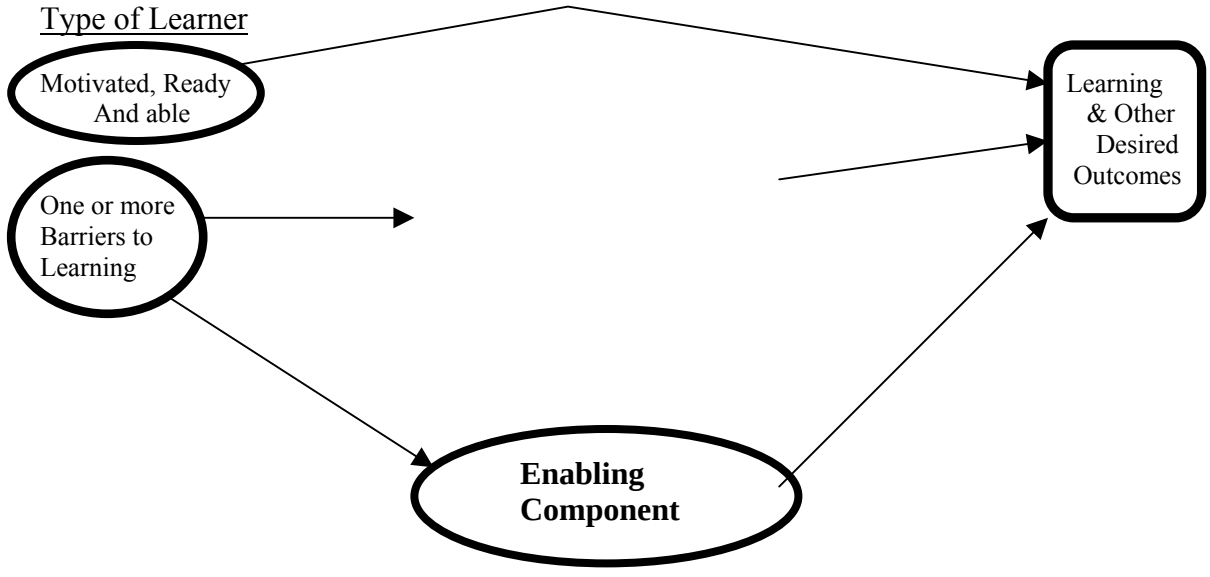
Needs

- Provide equal access to a meaningful education
- Increase student attendance rates
- Increase school completion rates
- Increase appropriate student behaviors
- Increase safe & informed student choices
- Forge collaborative links with community agencies
- Address barriers to learning

Examples of Barriers to Learning

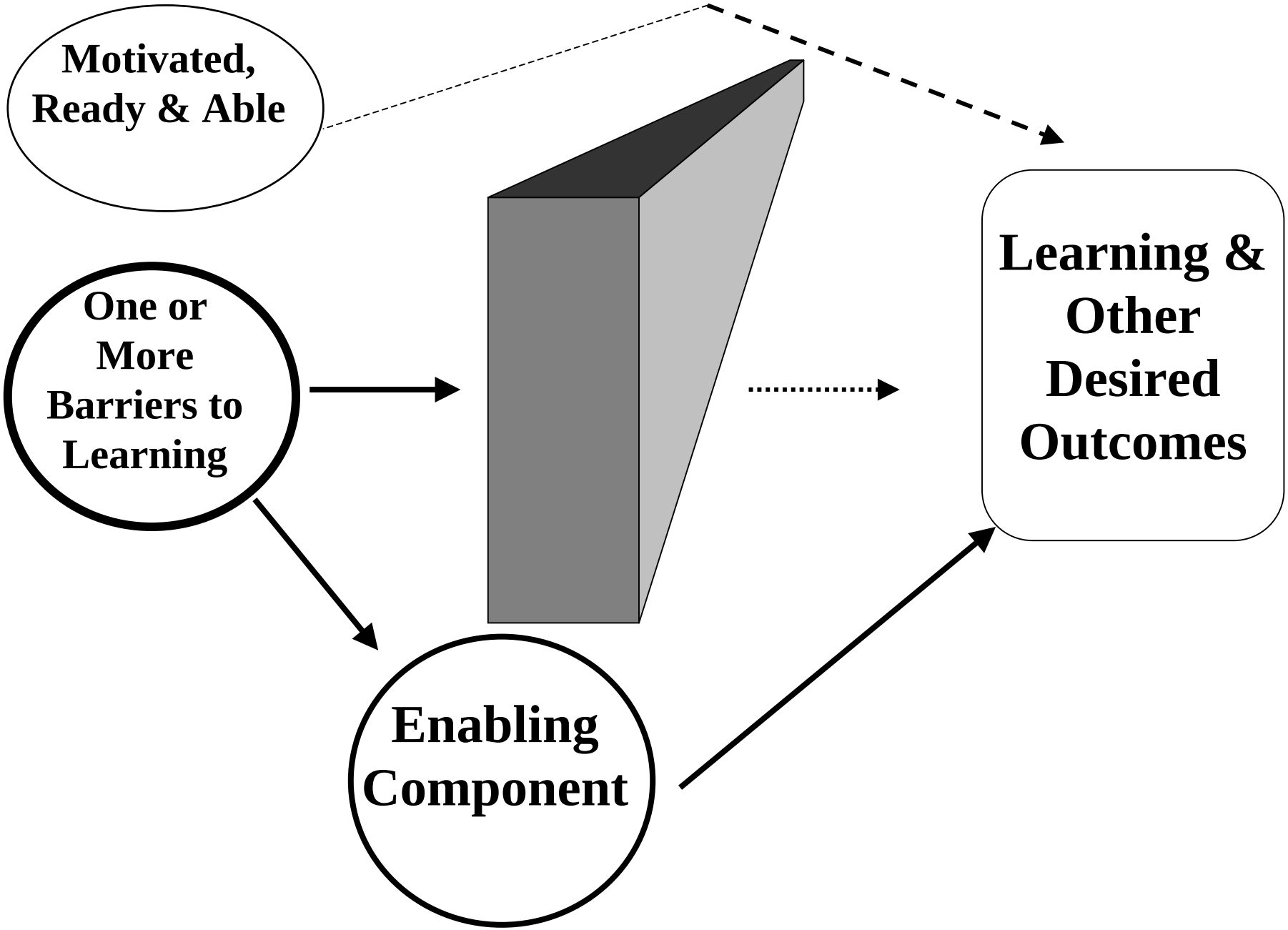
- School attendance, dropout concern, or school anxiety
- Special Ed issues, learning concerns
- Family complaint or concern, lack of cooperation, family-student conflict
- Family problems: i.e., divorce, mental illness, abuse, and domestic violence
- Administrative concerns, suspensions school violations, conflicts
- Violence or threats of violence, suicide or threats of suicide
- School-wide prevention and intervention
- Staff support

Overcoming barriers to learning



Overcoming Barriers to Learning

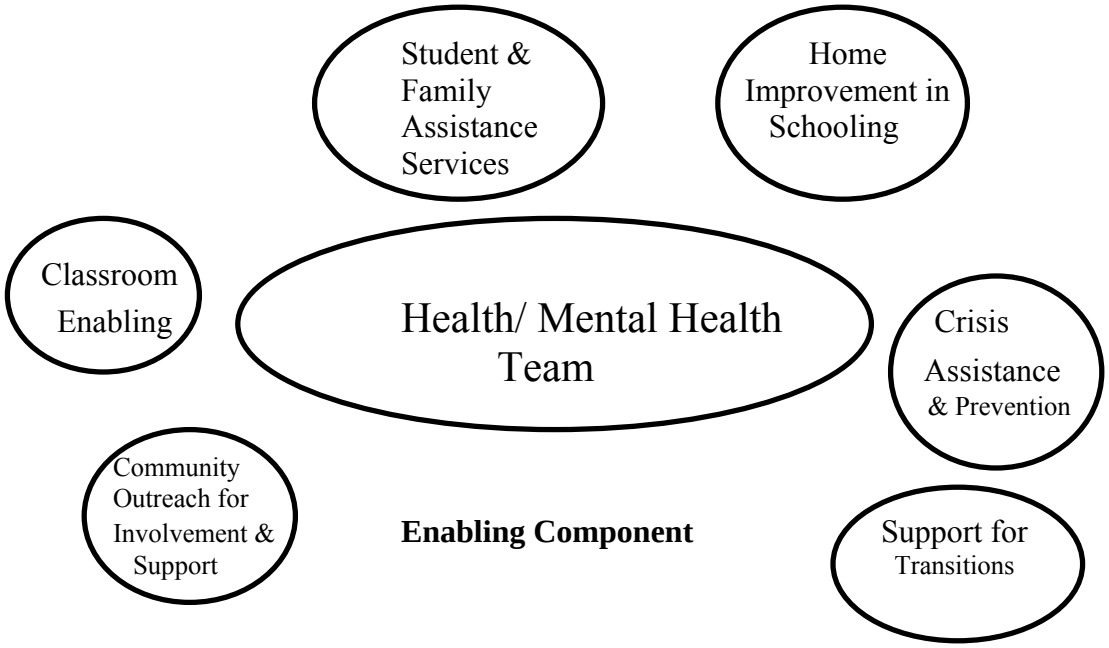
Type of Learner



How Will We Create a Better Process to Address Barriers to Student Learning?

- **Leaning from a proven successful model**
- **Create school health/mental health services collaboratives**
- **Train other school staff members**
- **Collaborate with other schools in the cluster**
- **Increase number of counseling staff & social workers in schools**
- **Use needs-assessment and evaluation to guide change**
- **Evaluate our work as we go forward**

A Comprehensive, Integrated Approach For Addressing Barriers to Learning (UCLA model)



Model Highlights

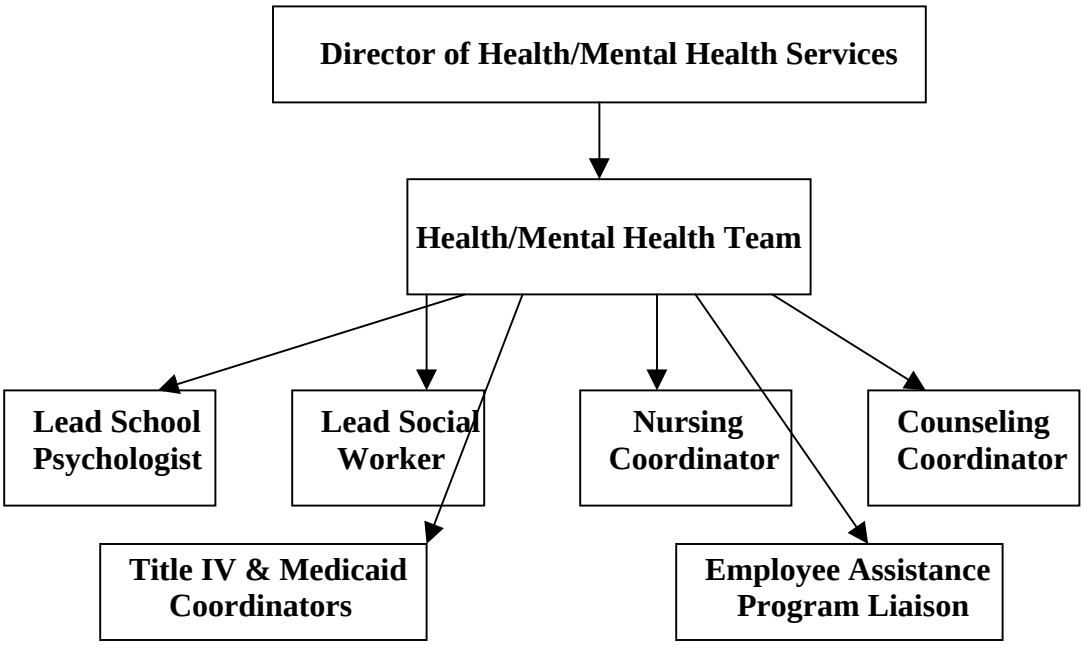
- Address the health/mental health needs of students who are having difficulty
- Multi-disciplinary teams of health/mental health professional teams
- Determine an appropriate plan of action

District Support

- Realignment of leadership to model collaboration
- Consolidated grants from Title IV and Medicaid for Health/Mental Health initiatives in the schools
- Development of collaboratives with outside agencies
- Providing technical expertise to clusters/schools to understand Health/Mental issues
  -Comprehensive Services Coordinator
  -Component Manager
- District training and inservices on barriers to learning and health/mental health issues
- Supports the District Educational Plan for Students Success
- Social workers-pilot to unify services

- **Assistance to schools in needs-assessment and planning**
- **Clinical support of counselors**
- **Technical assistance to principals and staff members in program development**
- **Community outreach & involvement evaluation:**
  - **System, roles, functions, programs, and impact**

Health/Mental Health District Leadership Team



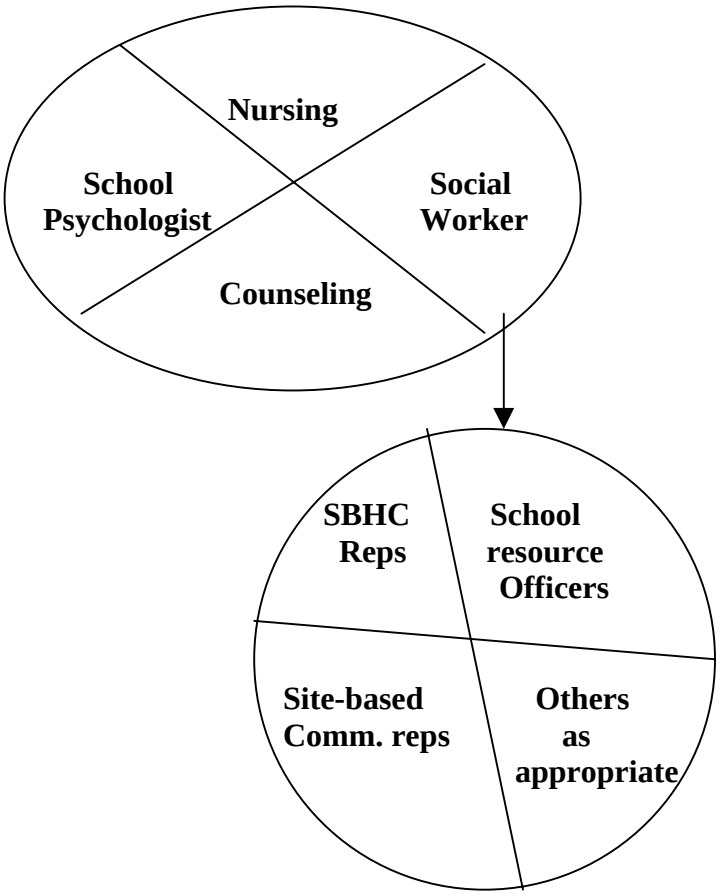
Implementation Process

- **Volunteer pilot cluster selected**
- **Provided training regarding the Health/Mental Health team model**
- **Both Cluster level and School level Health/Mental Health Teams formed**

Who is on the Team?

- **School Psychologist, the lead**
- **School Counselor**
- **Social worker**
- **Nurses**
- **Representative from school-based health center (if appropriate)**
- **Other staff and community members as needed**
- **Student and family member as needed**

Health/Mental Health Services Collaborative Model



Needs Assessment

Based on the six Programmatic Areas
What is currently in place?
What is needed?

The goal is to Provide comprehensive Health/Mental Health Services to Address barriers to Learning.

Enabling Components

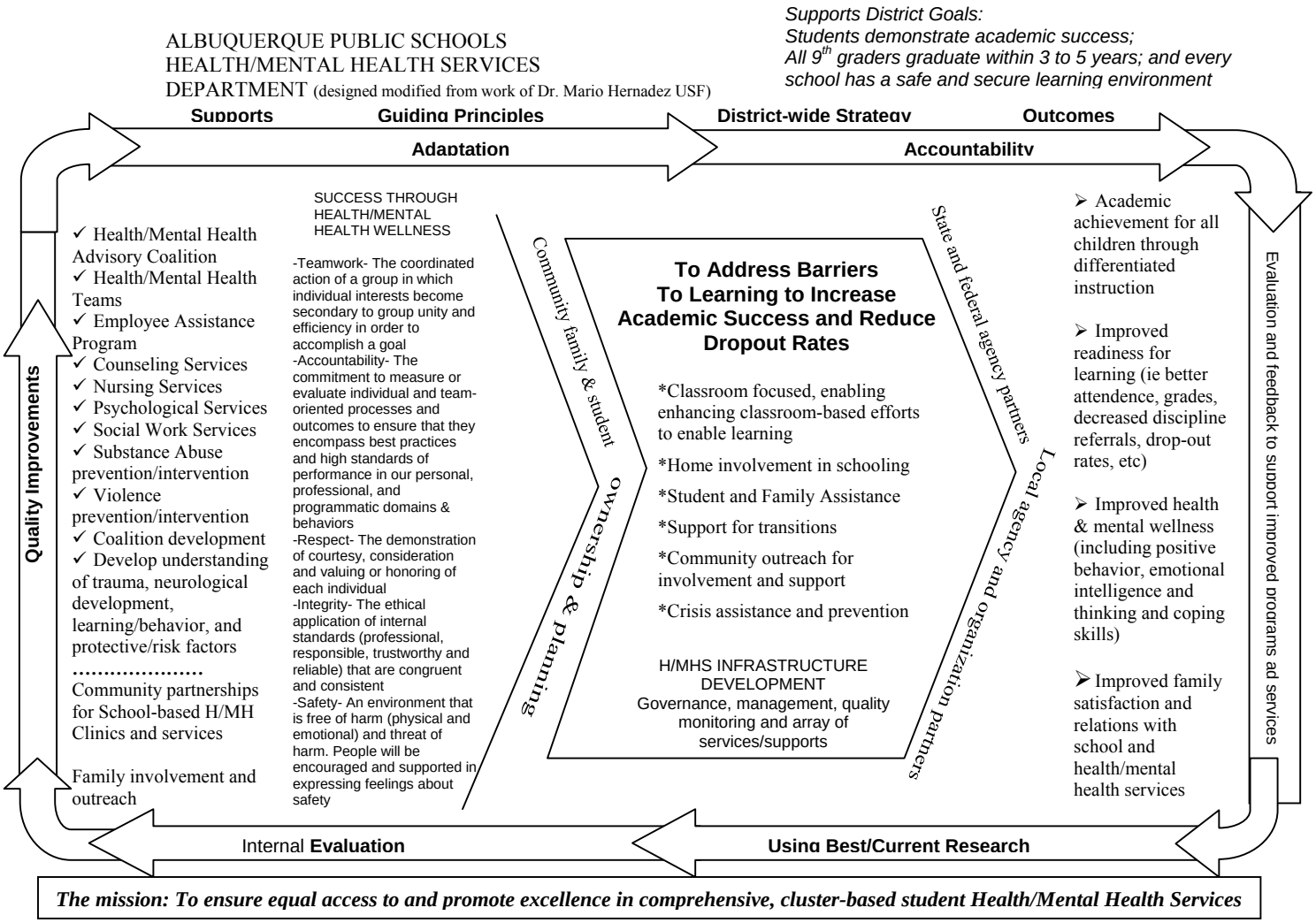
- Classroom focuses
- Assistance Programs/Services
- Home Involvement in Schooling
- Support for Transitions
- Community Outreach
- Crisis Assistance/ Prevention

The Ultimate Vision

- Address barriers to learning
- Implement a comprehensive Health/Mental Health Services model
- Provide services flexible and responsive to student needs
- Make available to all students
- Be proactive in seeking out opportunities to collaborate with students' families & community

Challenges

- Change!
  -Restructuring Systems
- Need to educate on barriers to learning and its importance to overall school reform
- Space for additional staff & activities
- Staff must be trained
- Flexible schedules for counselors and social workers
- Counselors given duties other than counseling
- Short term employees



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SCHOOL HEALTH /MENTAL HEALTH TEAMS
Albuquerque Public Schools
Albuquerque, New Mexico

What is the School Health/ Mental Health Team?

The School Health/Mental Health team is a multidisciplinary team of health/mental health professionals (school counselors, nurses, social workers, psychologist, etc). Other staff and community members are included, as needed. School concerns may differ somewhat for each school participating in the program. The health/mental health team defines the scope of issues to be addressed at each school. Some of the general issues may include *prevention, mediation, intervention, crisis response, post crisis follow-up or debriefing, and program development,* More specifically, it is appropriate for the team to work with concerns of students, administration, teachers and parents. Some of the shared concerns might be:

- School attendance, dropout concern, or school anxiety.
- Special education issues, leaming concerns.
- Parental complaint or concern, lack of cooperation, parent-student conflict,
- Family problems: i.e. divorce, mental illness, abuse, and domestic violence.
- Teacher concerns, teacher-student conflict, teacher-parent conflict.
- Administrative concerns; suspensions, school violations, conflicts.
- Violence or threats of violence, suicide or threats of suicide.
- School-wide prevention and intervention
- Staff support

A member of the school health/mental health team assumes the role of chairperson. The team receives referrals and reviews previous actions taken and the outcomes. The team develops a plan of action and the various participants are assigned interventions to implement consistent with their role.

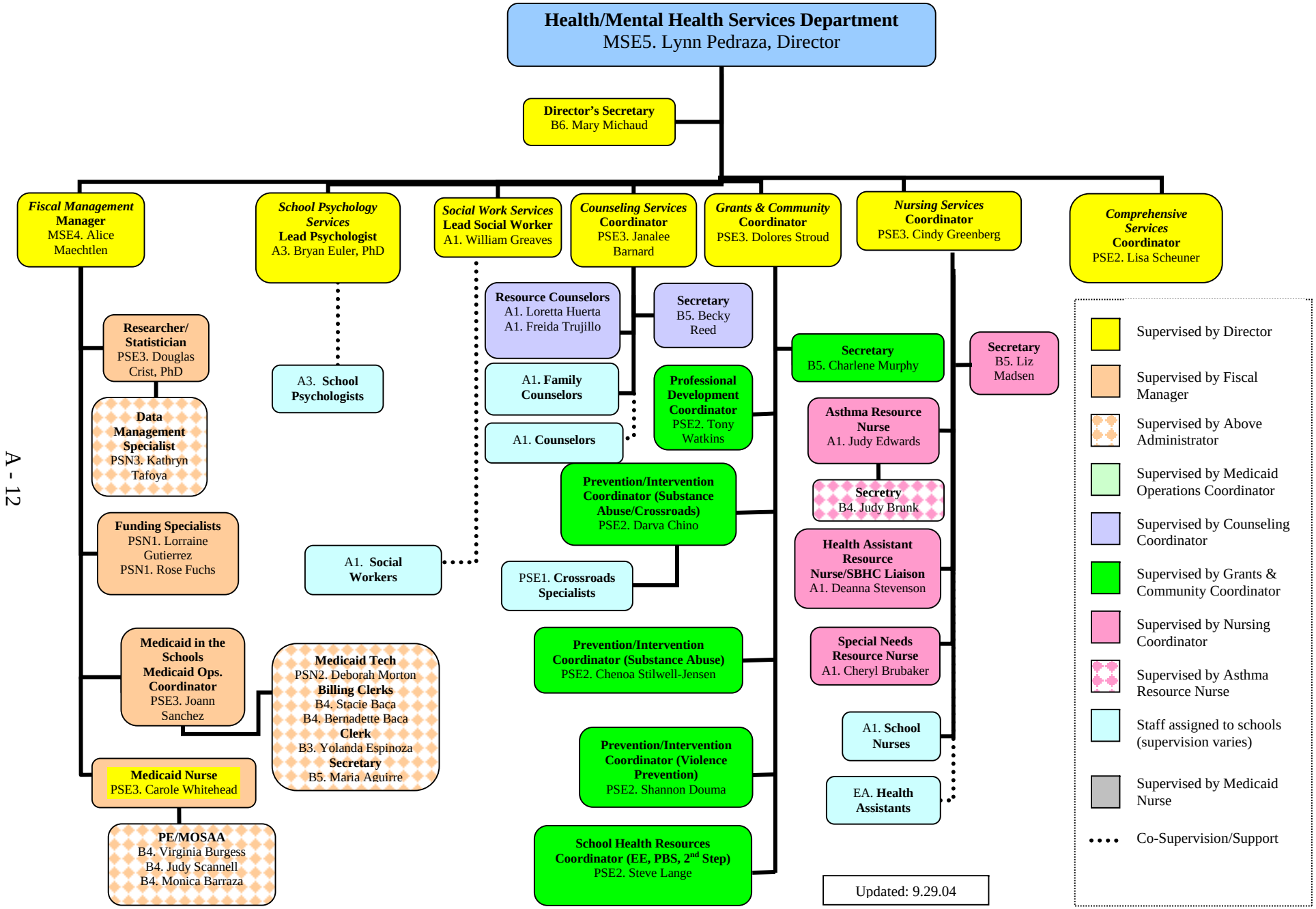
Why Have School Health/Mental Health Team?

The purpose of creating the teams was to address the health/mental health needs of students who are having difficulty and determine an appropriate plan of action. The primary goals of the health/mental health teams include:

Address barriers to learning Prevent certain school problems and to ameliorate existing problems. Respond to crisis situations. Develop additional programs to address wellness in the schools. Foster and increase communication among educators, family members, and the community. Help others understand child development. Provide a forum for health/mental health professionals to coordinate services and to dialog about student/school issues

APS Health [Mental Health Services has designed an evaluation process to assess the effectiveness of the School Health/Mental Health team model. School Health/Mental Health teams have been trained to use a standardized student referral form which gives data on the reason for referrals/issues addressed, number of students served, outcomes and frequency of review. Student ID numbers will also track attendance rates, retention, and grade completion. This evaluation process is presently being piloted. Plans are for it to be fully in place Fall 2002.

March 2002


Health/Mental Health Services Department
MSE5. Lynn Pedraza, Director
Director's Secretary
B6. Mary Michaud
Fiscal Management Manager
MSE4. Alice Maechtlen
School Psychology Services Lead Psychologist
A3. Bryan Euler, PhD
Social Work Services Lead Social Worker
A1. William Greaves
Counseling Services Coordinator
PSE3. Janalee Barnard
Grants & Community Coordinator
PSE3. Dolores Stroud
Nursing Services Coordinator
PSE3. Cindy Greenberg
Comprehensive Services Coordinator
PSE2. Lisa Scheuner
Researcher/ Statistician
PSE3. Douglas Crist, PhD
Data Management Specialist
PSN3. Kathryn Tafoya
Funding Specialists
PSN1. Lorraine Gutierrez
PSN1. Rose Fuchs
Medicaid in the Schools Medicaid Ops. Coordinator
PSE3. Joann Sanchez
Medicaid Nurse
PSE3. Carole Whitehead
PE/MOSAA
B4. Virginia Burgess
B4. Judy Scannell
B4. Monica Barraza
A3. School Psychologists
Medicaid Tech
PSN2. Deborah Morton
Billing Clerks
B4. Stacie Baca
B4. Bernadette Baca
Clerk
B3. Yolanda Espinoza
Secretary
B5. Maria Aguirre
Resource Counselors
A1. Loretta Huerta
A1. Freida Trujillo
A1. Family Counselors
A1. Counselors
A1. Social Workers
Secretary
B5. Becky Reed
Professional Development Coordinator
PSE2. Tony Watkins
Prevention/Intervention Coordinator (Substance Abuse/Crossroads)
PSE2. Darva Chino
PSE1. Crossroads Specialists
Prevention/Intervention Coordinator (Substance Abuse)
PSE2. Chenoa Stilwell-Jensen
Prevention/Intervention Coordinator (Violence Prevention)
PSE2. Shannon Douma
School Health Resources Coordinator (EE, PBS, 2nd Step)
PSE2. Steve Lange
Secretary
B5. Charlene Murphy
Asthma Resource Nurse
A1. Judy Edwards
Secretry
B4. Judy Brunk
Health Assistant Resource Nurse/SBHC Liaison
A1. Deanna Stevenson
Special Needs Resource Nurse
A1. Cheryl Brubaker
A1. School Nurses
EA. Health Assistants
Secretary
B5. Liz Madsen
Updated: 9.29.04
Supervised by Director
Supervised by Fiscal Manager
Supervised by Above Administrator
Supervised by Medicaid Operations Coordinator
Supervised by Counseling Coordinator
Supervised by Grants & Community Coordinator
Supervised by Nursing Coordinator
Supervised by Asthma Resource Nurse
Staff assigned to schools (supervision varies)
Supervised by Medicaid Nurse
Co-Supervision/Support

Albuquerque Public Schools
Health/Mental Health Services Department

Project for Outcomes Management (POM)

Preparedfor:

Director,
Health/Mental Health Services Department

Submitted by:

Data Management

Project for Outcomes Management

An information management system has been developed to support process improvement and outcomes management activities for the Department. This comprehensive system, referred to as the Project for Outcomes Management (POM), applies analytical approaches to develop and integrate a variety of information retrieval and data entry protocols that populate a large relational database, and interface with other external information management systems.

The relational database serves as the centralized data repository for compiling data obtained from Departmental activities conducted throughout the district,. The maid data repository accepts information entered from multiple sites, has the potential to b e exploited for server-based website information retrieval and/or scanner-based data entry, and is compatible with statistical analysis and graphing applications for in-depth analysis of outcomes. Moreover, the system can exchange information with the District's Information Technology Services Department (via diskettes or CDs) so that data can be matched on a student case-by-case basis as well as studies in aggregated formats. Data sets currently processed by POM include, but are not limited to, the following that can be grouped according to school and cluster locations: (1) enrollments, (2) withdrawals by type, (3) grade point averages, (4) attendance and attrition rates, (5) Terra Nova annual student achievement scores, (6) Language Assessment Scores for verbal and reading and writing skills of students who have a primary home language other than English, suspensions and expulsions, grade level, special education level, free and reduced lunches, mobility, etc.

Data mining procedures are conducted on approximately 86,000 records every 40 days to compile and analyze outcomes for specific projects. POM procedures and existing databases can be update, and/or paralleling relational databases can also be constructed, to meet the specific needs of new or expanding projects.

OVERVIEW

1. Basic program operations are outlined in the Project for Outcomes Management (POM) flow diagram (Page 3)
2. Two computer service data requests (Forms AD19) will be developed, and one current AD19-based data run will be modified, to provide student-specific and general outcomes data critical to the evaluation Departmental performance
   a. Anew "PERFORM I" (**Page 4**) report will provide the following for each student requiring H/MH Services
      i. Terra Nova annual student achievement scores
      ii. Language Assessment Scores for verbal skills (LAS-Oral) skills of students who have a Primary Home Language Other than English (PHLOE)
      iii. Language Assessment Scores for reading and writing (LAS-R,W) skills of students who have PHLOTE.
      iv. Grade Point Average (GPA) for most recent grading period v. Attendance rate vi. Suspension date
      vii. Expulsion date
      viii.Gradelevel
      ix. Special education level
   b. "PERFORM V will be run approximately three weeks after the close of each school semester
   c. A new "PERFORM2" (**Page 4**) report will aggregate data for all students NOT requiring H/MH Services using the same indicators identified in "PERFORM 1 "
   d. PERFORM2" will be run approximately three weeks after the close of each school semester
   e. A revised "DEM20DAY" report will provide the following (as aggregated data) on all students
      i. Number of enrollments (preexisting)
      ii. Number of withdrawals (preexisting)
      iii. Average MS GPA (preexisting)
      iv. Average HS GPA (preexisting)
      v. Attendance rate (preexisting)
      vi. Attrition rate (preexisting)
      vii. Counts by withdrawals codes (preexisting)
      viii.Terra Nova scores (added)
      ix. LAS-Oral scores (added)
      x. LAS-RW scores (added)
      xi. Grade 4-vel (added)
      xii. Special education level (added)
      xiii.Free and Reduced Lunches (added)
      xiv. Mobility (added) f. "DEM20DAY" (**Page 4**) will be run using the preexisting schedule (about every 20 days)
3. Three data collection forms have been designed to retrieve behavioral health-related information from schools for student contacts, program utilization, and training participation
   a. "Student Contacts Form" (**Page 5**)
      i. Source Information (Part A) -- Obtains APS Employee and school location information.
      ii. Student Contacts (Part B) - Tracks individual behavioral health interventions by staff name, role group, and school location using student IDs.
      iii. Group Contacts (Part Q - Tracks group attendance for behavioral health interventions by staff name, role group, and school location using group activity counts.
   b. "HIMH Services Core Information & Program Utilization Form" (**Page 6**)
      i. Source Information (Part A) - Obtains APS Employee and school location information
      ii. Core Information (Part B) - Tracks school operational data and personnel assignments by staff name, role group, and location

iii. Program Utilization (Part Q - Program Utilization (Part Q - Tracks program utilization data by staff name, role group, and location

c. "Master Sign-In Sheet" for participation in Professional Development activities
   i. Sign-in sheets for each role group (**Pages 7-13**)
   ii. Tracks attendance at Professional Development sessions by staff name, role group, and school location
d. "Training Course Evaluation" (**Page 14**)
   i. Provides instructor and course content evaluations for professional development courses

4. POM protocol should be managed in general by H/MH Services leadership staff for their respective role groups
   a. At initial implementation, data collection forms will be paper-based and must be returned via personal delivery, APS mail, or fax
   b. Manual computer data entry modules have been developed that are matched specifically to each collection form
      i. Data collection forms to be completed on site by appropriate professional staff
      ii. Completed forms to be returned either as each activity is conducted ("Master Sign-In Sheet" and "Training Course Evaluation") or within 10 working days of the end of every 9 week grading period ("Student Contacts & Program Utilization")
   c. After startup, potential phase-in implementation of forms that can be scanned
      i. Data collection forms to be completed on site by appropriate professional staff
      ii. Completed forms to be returned either as each activity is conducted ("Training Course Evaluation") or within 10 working days of the end of every 9 week grading period ("Student Contacts & Program Utilization")
      iii. Matthew Gurule (Business Operations) has offered to provide guidance for logistical issues surrounding
         1. Scanner form design
         2. Purchase of scanner
   d. After startup, potential phase-in implementation of web-based forms
      i. Forms can be completed on site by appropriate professional staff with computers
      ii. Data on WebPages can be submitted (*.html file) as each activity is completed ("Training Course Evaluation" and "Student Contacts & Program Utilization" or within 10 working days of the end of every 9 week grading period ("Student Contacts & Program Utilization")
      iii. Requires purchase of dual processor Pentium server
      iv. Matthew Gurule has offered to provide guidance for logistical issues surrounding
         1. Purchase of Computer Server
         2. Coordination with Information Technology Services Department
         3. Networking

5. A comprehensive relational database has been developed to provide an information management, analysis, and reporting system for POM (**Pages 15-16**)
   a. Frequent updating of the relational database will occur on an ongoing basis prior to implementation and with any future changes to program operations
   b. Linked databases have been developed to log:
      i. Student (individual and group) contact (direct services) and training attendance information by participating school-based behavioral health staff (**Pages 17**)
      ii. Core information and program utilization information by designated school-based behavioral health staff (**Pages 18**)
      iii. Attendance at professional development sessions via data entry option I (**Pages 16-17**)
      iv. Core operations and personnel assignments information at each participating school (**Page 16,18**)
      v. Attendance at professional development sessions via data entry option 2 (**Pages 16, 19-20**)
      vi. Evaluation of professional development activities (**Pages 16,19,21-23**)

Health/Mental Health Services

How Our Department Supports APS Schools

Lynn Pedraza, Ed.S.
Director,
APS Health/Mental Health Services

Often, schools are the de facto Mental Health System

"Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them. It is time that we as a Nation took seriously the task of preventing mental health problems and treating mental illnesses in youth."

- Surgeon General David Satcher, 2000

Why this work is so important!

"The major barrier to school readiness for children is often not the lack of appropriate cognitive skills but rather the absence of needed social and emotional skills."

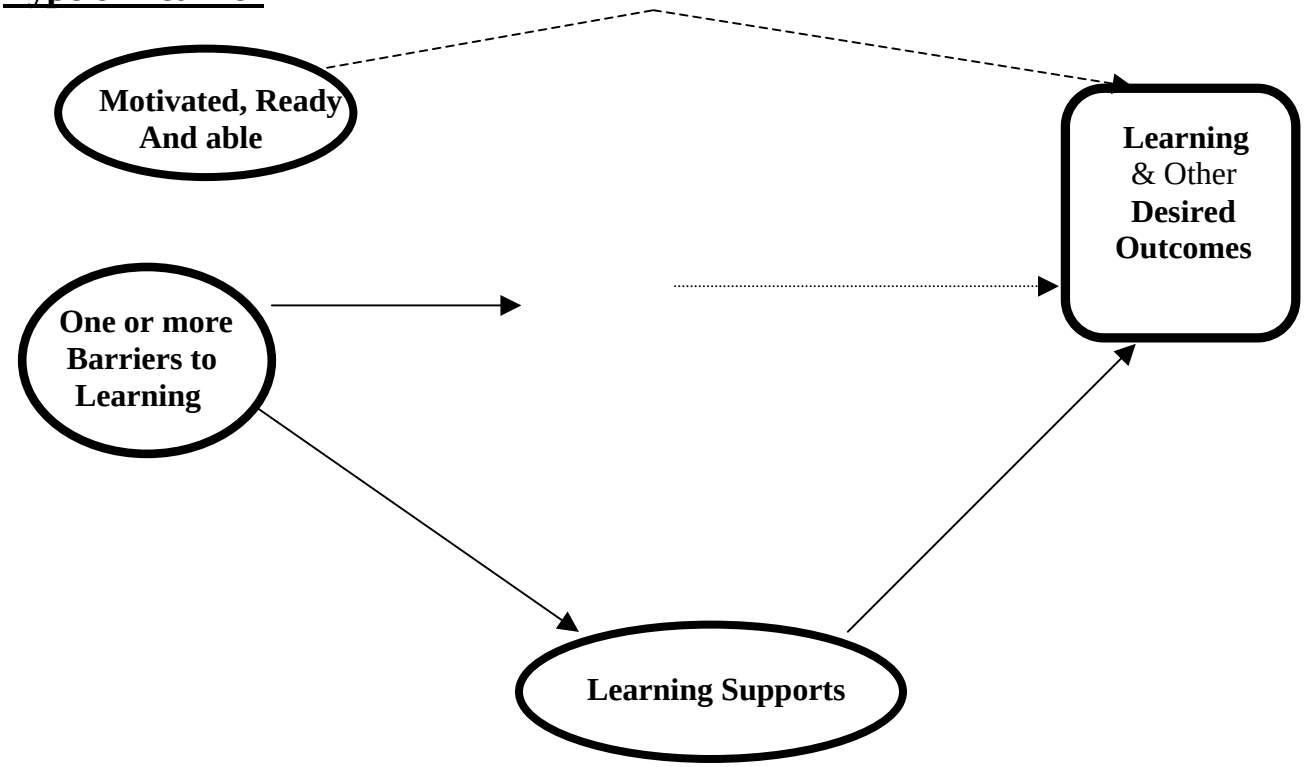
- Florida Commission on Mental Health and Substance Abuse, 2001, p.8.

Our Mission

To ensure <u>equal access to</u> and <u>promote excellence in</u> comprehensive, cluster-based student Health/Mental Health Services.

Overcoming barriers to learning

<u>Type of Learner</u>



Health/Mental Services:

A key effort of our department is giving greater focused attention to planning, accountability, and responsibility for the overall health and well-being of children. The ability to pool multiple resources allows for
more services, programs, and supports.

6 December 2002

Who we are?

The APS Health/Mental Health Department is made up of

- 10 Divisions overseen by a Director
- 166 staff that we directly supervise and evaluate, as well as, provide support and professional development
- In addition, we provide indirect supervision and professional development for another 440 staff within APS

For a total of 606 APS staff...

ALL committed to serving our students' health and mental health needs!!!

An overview of our services:

- **Employee Assistance** - Counseling and referral to APS employees and their families
- **Counseling Services** - Leadership and support to the district-wide, school-based counselors
- **Nursing Services** - Leadership, support, and professional development to district-wide, school-based nurses
- **Psychological Services** - Leadership, support, and professional development for consultation with general education and special education teachers, administrators, and parents
- **Social Work Services** - Clinical supervision and professional development of school social workers
- **Violence Prevention** - Align and monitor district-wide efforts for violence prevention and intervention
- **Substance Abuse Prevention** - Align and monitor district-wide efforts for substance abuse prevention and intervention
- **Provide research & oversee** Safe and Drug Free School Grants and Medicaid in the Schools Initiative
- **Provide outreach** to families to help them apply for Medicaid
- **Coordinate services, programs, and supports** with outside health/ mental health providers

The Conundrum!

What we are doing
NOW
is not enough!

Seriousness of the Problem: Mental Health as an example

National Prevalence of Serious Emotional Disturbance (SED)

Population Proportions
(9 to 17 year-olds)

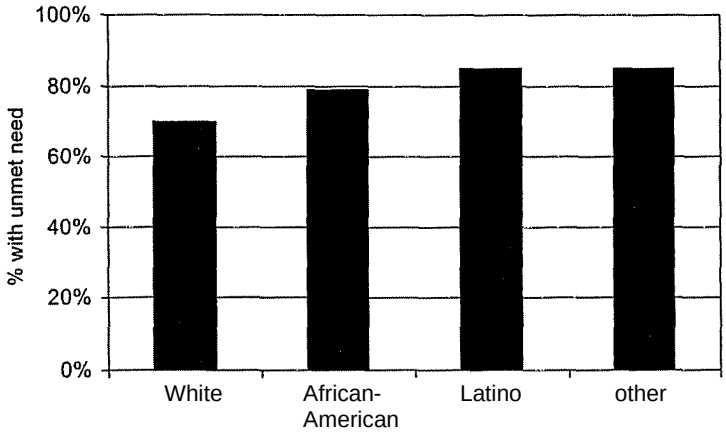
20% Youth with any diagnosable disorder

9-13% Youth with SED, with substantial functional impairment

5-9% Youth with SED & extreme functional impairment

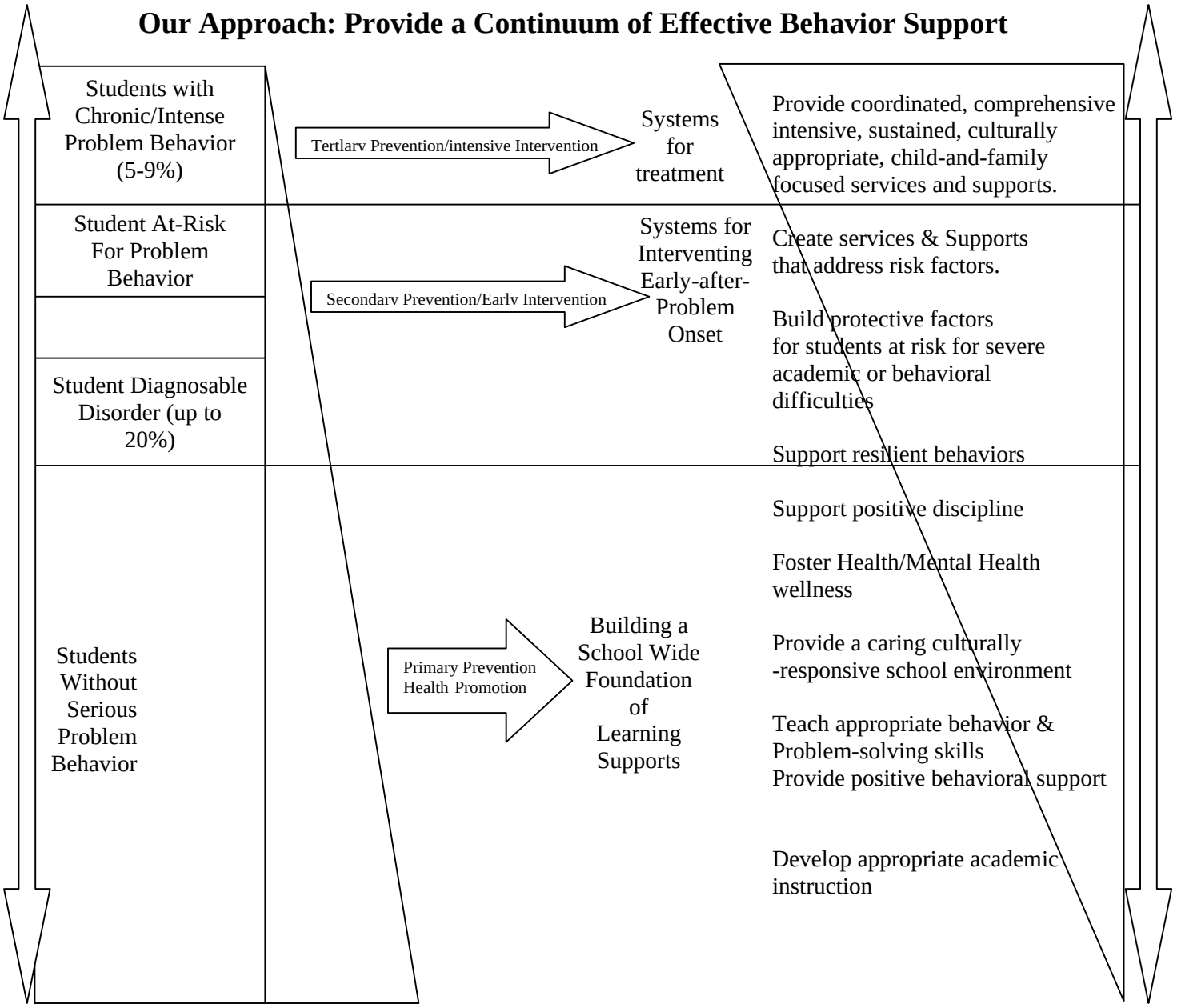
Many Children in Need are Not Receiving Services

Unmet Need for Mental Health Services
Based on National Data



Calculations based on data from the National Health Interview Study, Sturm et.al, 2000

Our Approach: Provide a Continuum of Effective Behavior Support



Albuquerque Public Schools
Health/Mental Health Services Department

Supports District Goals:
- Academic excellence
- High graduation rates
- Safe schools
- Resources for results
- Parents are partners
- Positive District climate

SUCCESS THROUGH HEALTH/MENTAL HEALTH WELLNESS

- Teamwork: the coordinated action of a group in which individual interests become secondary to group unity and efficiency in order to accomplish a goal
- Accountability: The measurement and evaluation of individual and team-oriented processes and outcomes to ensure that they encompass best practices and high standards of performance in out personal, professional, and programmatic domains & behaviors
- Respect: The demonstration of courtesy, consideration and valuing or honoring of each individual
- Integrity: The ethical application of internal standards (professional, responsible, trustworthy, and reliable) that are congruent and consistent
- Safety: an environment that is free from harm (physical and emotional) and threat of harm. People will be encouraged and supported in expressing feelings about safety.

- Health/Mental Health Advisory Coalition
- Health/Mental Health Teams
- Employee Assistance program
- Counseling Services
- Nursing Services
- Psychologist Services
- Social Work Services
- Substance Abuse prevention/intervention
- Violence prevention/intervention
- Coalition development
- Development of understanding of trauma, neurological development, learning/behavior, and protective/risk factors

Community partnerships for School-based H/MH Clinics and services

Family involvement and outreach

TO ADDRESS BARRIERS TO LEARNING TO INCREASE ACADEMIC SUCCESS AND REDUCE DROPOUT RATES

- Classroom focused, enabling-enhancing classroom-based efforts to enable learning
- Home involvement in schooling
- Student and Family Assistance
- Support for transitions
- Community outreach for involvement and support
- Crisis assistance and prevention

H/MHS INFRASTRUCTURE DEVELOPMENT
Governance, management, quality monitoring & array of services/supports

Surgeon General's Suicide National Data -1997

- For young people 15-24, suicide is third leading cause of death
- In 1996, more youth and young adults died from suicide than cancer, heart disease, AIDS, stroke, pneumonia, & birth defects COMBINED

2001 New Mexico YRRS

(Youth Risk Resiliency Survey)

- 13.7% of students had attempted suicide in the 12 months prior to the survey
  - 15.5% of females
  - 7.1 %of males
  - Up from 9.1 %in 1999

Albuquerque Public Schools is representative of NM student statistics.

Our Multi-tiered Framework

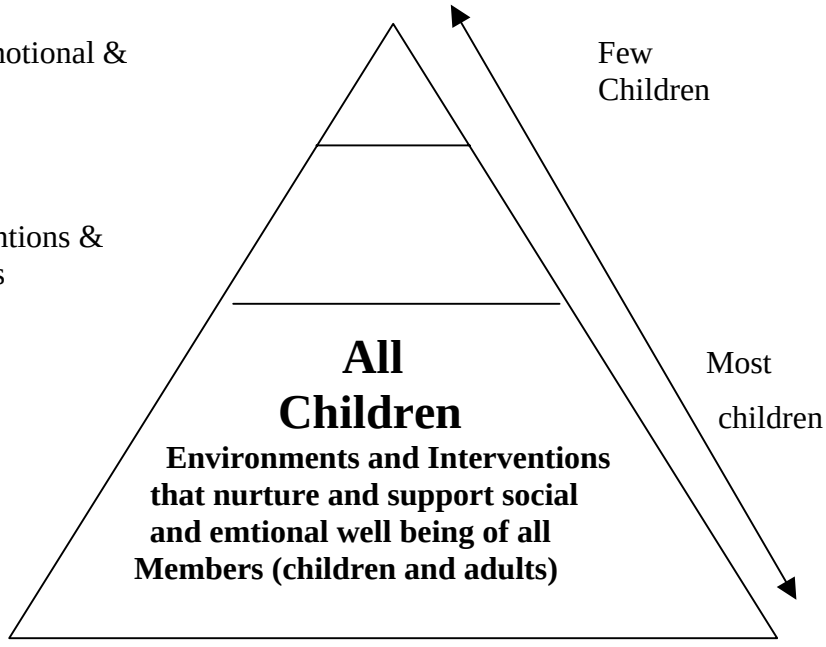
Intensive Interventions and Supports

For children with serious emotional & Behavioral challenges

Early Intervention

Timely and targeted interventions & Supports for moderate needs

Positive Child, Youth And Family Development And Problem Prevention



THE GOOD NEWS:
Effectiveness of Our Current Work

- **Leverage resources**

- **Able to integrate current expert know edge of substance abuse, violence prevention, health and mental health professionals**

- **Able to support more services by money within the department**

- **Able to respond to school crisis situations with our own Crisis Team**

(that share with the state on an as-needed basis)

Our Department is able to:

- *Be* ***efficient***
- *Keep* ***abreast of current state-of-the-art services and supports***
- *Respond* ***to school crisis situations utilizing our own Crisis Team (which we share with the state on an as-need basis)***
- *Support and monitor* ***an evolving range of research-based programs & services designed to enable student learning & well-being***
- *Develop* ***coordinated & fully integrated supports & services with other facets of schools' comprehensive plans.***

- *Utilize* ***multiple resources in schools, in clusters, district-wide, & in the home and community to maximize resources for capacity building, implementation, filling gaps, and enhancing essential program & services.***
- *Promote* ***the use of least restrictive & non-intrusive forms of intervention.***

Health Care in the Schools

For example, in the 2001-2002 School Year, APS School Nurses

- Made 25,362 referrals to health care professionals
- Developed 2,875 Individual Health Plans
- Oversaw the administration of over 26,171 doses of medication
- Completed 28,701 health histories
- And much, much more

Many of these children would not receive ANY health care if it were not for the school nurses!

What was the Strategy?

- 1998 - Piloted a cluster-based model that integrated services based on cluster community needs
    - Provided Consolidated Grants (Medicaid and Title IV money braided) for cluster-based decision making
- 2002 - Expanded model to all clusters
    - Brought emphasis to local level with needs assessment and focus groups at school level, then at cluster-level
- District level staff reviewed the individual school/cluster assessments to "get the big picture" and maximize resources
- Examples:
    - If more than one cluster wanted a particular training, the training could be brought into the district with multiple clusters getting the benefit at a cost savings
    - If a cluster wanted an outside provider to do therapy part-time and another cluster wanted part-time help, district level staff could combine resources for one FTE

How do we compare to other districts?

When doing an informal telephone survey with a district with 4,264 students and one with 22,600 students we discovered:

APS is similar to other districts in staff-to-student ratio for

- school psychologists
- nurses
- counselors and
- social workers

In addition, because APS can braid resources, APS has:

- Two resource counselors
- Two resource nurses
- Two nutritionists
- Seven family counselors
- Five substance abuse counselors
- Fourteen outside therapists in the schools

Another benefit that results from APS' ability to braid resources is that APS has:

- Multiple School-based Health centers in partnership with outside agencies (and we still need more!).
- Expanded the number of social workers to meet the needs of general education students as well as special education.
- When cuts are made to resources, like the Medicaid-in-the-Schools Program, we do not have to terminate staff mid-year.

What we need from you?

- Willingness to be our objective observers and advisors
- Openness to understanding what our children face as learning barriers
- Willingness to share creative ideas and solutions
- Openness to be our bridge to the broader community

Health/Mental Health Services Department Mission

Addressing Barriers to Learning

Goals	Objectives	Strategies	Milestones for 03/04
1. To promote academic excellence and high graduation rates	**1a. To provide comprehensive nursing services to address student health issues that may be leading to student absences and/or low attention span.**	• Nurses will care for students in health rooms. • Nurses will provide student health screenings and assessments. • Nurses will provide asthma education to children, parents and staff.	• **Nurses cared for students who made 697,927 health room visits.** • **Nurses provided 277,907 student health assessments.** • **Nurses supervised approximately 170,000 doses of medication to students in health rooms.** • **Three-hundred-forty-one (341) students were part of a CDC funded asthma program.**
	1b. To provide coordinated mental health services to all students so that issues interfering with academic success can be addressed.	• **Health/Mental Health teams will be maintained and facilitated at all schools.** • **School counselors will address the academic, career, and personal/ social needs of all APS students.** • **Braided social workers will support students' mental health needs.** • **School psychologists will support students through consultations with the Health/Mental Health teams at each school.**	• **Health/Mental Health teams met at least bi-monthly at every school in the district.** • **School counselors provided 160,778 individual sessions, 14,957 group sessions, 25,359 classroom presentations, and mediations with 9,100 students.** • **Social workers and psychologists provided 3,672 students with 11,145 contacts to address mental health issues.** • **Psychologists provided 540 consultations to Health/Mental Health Teams.**

Goals	Objectives	Strategies	Milestones for 03/04
2. To promote safe schools	**2a. To provide a safe school environment**	• Nurses do an on-going safety inspection at each school. • Nurses will provide annual Blood-borne pathogen training to all school staff. • H/MH staff will provide support to school-based Crisis Teams as they respond to school-wide crisis. • School psychologists will provide training/support to school-based Threat Management Teams at every school.	• **Inspections were completed at all 126 schools. Problems were reported to risk management as required.** • **Blood-borne Pathogen trainings were conducted at all schools. Training documentation was given to Risk Management.** • **Counselors assisted fifteen (15) schools with Crisis Team interventions.** • **School psychologists refined and redesigned the Threat Management Team protocol.**
	2b. To provide students with tobacco, alcohol and other drug prevention strategies and programs.	• **Support schools that choose to implement the following ATODA programs:** o **Protecting Me, Protecting You curriculum (K – 5th).** o **Project ALERT (6th – 9th)** o **TNT (Towards Not Tobacco Use) for grades 5th – 9th, NOT (Not on Tobacco) for grades 7th – 12th and other TUPAC initiatives.** • **Provide Crossroad programs at four (4) high schools (2 FT and 2 PT)**	• **Protecting You, Protecting Me curriculum was reviewed/ researched .** • **Two (2) schools were assisted with Project Alert.** • **TUPAC funds provided tobacco prevention services to sixteen (16) schools.** • **Five (5) high schools had full-time Crossroads counselors which served 414 students.**

Goals	Objectives	Strategies	Milestones for 03/04

2. To promote safe schools (continued)	2c. To help students develop skills for successful interpersonal relationships in order to prevent violence at school and in the community.	• **Support schools that choose to implement the following violence prevention programs:**
		  • **Second Step curriculum for grades K – 8th.**
		  • **Project Sentry (Gun Violence Prevention) program for grades 6th – 8th .**
		  • **Bullyproofing Your School curriculum for grades K – 8th.**
		  • **Peer Mediation program for grades K -12th.**
		  • **Positive Behavior Supports (PBS) for grades K – 12th .**
		  • **Experiential education programs to staff and students.**
		  • **Safe Zone (Support for Gay, Lesbian, Trans-gendered, Bisexual and other targeted students) for grades 6th – 12th**
			• **Eighteen (18) new schools received training and materials for Second Step. Three (3) other schools received assistance in their continued implementation of Second Step.**
			• **Between April and May, three (3) new schools received the Project Sentry program.**
			• **Twelve (12) schools received technical assistance for Bullyproofing Your School.**
			• **Twenty-three (23) schools received technical assistance with their Peer Mediation programs.**
			• **Five (5) new schools were supported in the implementation of PBS. One (1) school started the second year of implementation.**
			• **Twenty-two (22) schools were provided with experiential education services.**
			• **Forty-three (43) middle/high schools have implemented the Safe Zone program.**

Goals	Objectives	Strategies	Milestones 03-04
3. To promote resources for results	3a. To provide professional development to APS staff on mental health issues that interfere with student achievement.	• **Provide four district-wide workshops on health/mental health issues.** • **Provide mandatory child abuse and neglect training.** • **Provide training to school staff on evidenced-based curricula such as Second Step and Positive Behavior Supports** • **Provide training to school based staff who will be implementing other APS prevention programs such as Parent Involvement Programs (PIP) and Peer Mediation programs at their schools.** • **Provide training for each role group on best practices and current procedures.**	• **Professional development on various health/mental health topics was provided to 2,010 APS employees.** • **Nurses held monthly in-service trainings with CEUs for all nursing staff.** • **New nurses had eight (8) mandatory training sessions and a test that they must pass.** • **Counselors participated in quarterly district and level meetings.** • **New counselors attend a monthly meeting** • **Social workers attend monthly peer supervision by level (elementary, middle and high).** • **Level 1 school psychologists have weekly supervision by the Lead Psychologist.** • **All new school psychologists are mentored by more experienced school psychologists.**

Goals	Objectives	Strategies	Milestones 03-04
3. To promote resources for results (continued)	**3b. To apply for funding for various health/mental health school-based initiatives and braid fiscal resources to maximize school-based support.**	• Write and manage grants to provide additional funds for learning supports that remove barriers to learning at schools. • Manage Medicaid School Based Services reimbursement programs to provide district and cluster services. • Facilitate and manage cluster-based assessment and planning.	• **Four (4) new grants were awarded (Project Sentry, CYFD Police Training, CDC Asthma and ACF Mediation Rally).** • **Eight grants (including Title IV) totaling $1,587,765 were managed to provide learning supports to students.** • **$3 million Medicaid dollars were managed.** • **H/MH staff meet will all clusters to assess their H/MH needs.**
	3c. To foster relationships with community agencies who provide needed resources to the schools in our district	• **Facilitate the Community Advisory Board.** • **Build new and continue existing partnerships with various community agencies.**	• **Forty (40) community members provided input to the Health/Mental Health Services Department.** • **Health/Mental Health staff partnered with community agencies such as:** ❖ **American Lung Association,** ❖ **Bernalillo County Community Health Council** ❖ **DWI Planning Council** ❖ **NM PTA** ❖ **UNM School Based Health Centers** ❖ **Juvenile Justice Agencies** ❖ **Children, Youth and Family Department** ❖ **State/County Emergency Response Services**

Goals	Objectives	Strategies	Milestones 03-04
4. To promote parents as partners	4a. Whenever possible, to include parents in addressing student's health/mental health issues.	• **Health/Mental Health staff will refer students and families to outside service providers when appropriate.** • **Implement the PIP Program (Parent Involvement Program - alternative to suspension for substance abuse).** • **Assist families in signing up for Medicaid services.** • **Provide brief family counseling sessions** • **Include parents on the Community Advisory Board**	• **24,637 health referrals were made by nurses to outside providers.** • **Five (5) community mental health agencies were contracted to provide services at twenty-four (24) schools.** • **PIP was available at twenty-three (23) schools.** • **APS mental health staff provided 1,977 students with family counseling sessions.** • **1,394 students were signed up for Medicaid.** • **Six (6) parents participated in the CAB.**

APS HEALTH/MENTAL HEALTH STANDARDS

School-reform across the country is "standards-based" and accountability driven (with the dominant emphasis on improving academic performance as measured by achievement test scores.) Given these realities, efforts to reform student support in ways that move it from its current marginalized status must delineate a set of standards and integrate them with instructional standards. And, to whatever degree is feasible, efforts must be multifaceted approaches to addressing barriers and promoting healthy development.

As with many other efforts to push reforms forward, policy makers want a quick and easy recipe to use. Most of the discussion around accountability is about making certain that program administrators and staff are held accountable. Little discussion wrestles with how to maximize the benefits (and minimize the negative effects) of accountability efforts. As a result, in too many instances the tail is wagging the dog, the dog is getting dizzy, adndthe public is not getting what it needs and wants.

School accountability is a good example of the problem. Policy makers want schools, teachers, and administrators (and students and their families) held accountable for higher academic achievement.

As measured by what?

As everyone involved in school reform knows, the only measure that really counts is achievement test scores. These tests drive school accountability, and what such tests measure has become the be-all and end-all of what school reformers attend to. This produces a growing disconnect between the realities of what it takes to improve academic performance and where many policy makers and school reformers are leading the public.

This disconnect is especially evident in schools serving what are now being referred to as "low wealth" families. Such families and those who work in schools serving them have a clear appreciation of many barriers to learning that must be addressed so that the students can benefit from the teacher's efforts to teach. They stress that, in many schools, major academic improvements are unlikely until comprehensive and multifaceted programs/ services to address these barriers are development and pursued effectively.

At the same time, it is evident to anyone who looks that there is no direct accountability for whether these barriers are addressed. To the contrary, when achievement test scores do not reflect an immediate impact for the investment, efforts essential for addressing barriers to development and learning often are devalued and cut.

Thus, rather than building the type of comprehensive, multifaceted, and integrated approach that can produce improved academic performance, prevailing accountability measures are pressuring schools to maintain a narrow focus on strategies whose face validity suggests a direct route to improving instruction. The implicit underlying assumption of most of these teaching strategies is that students are motivationally ready and able each day to benefit from the teacher's instructional efforts. The reality, of course, is that in too many schools the *majority* of youngsters are not motivationally

ready and able and thus are not benefiting from the instructional improvements. For many students, the fact remains that there are a host of external interfering factors.

Logically, well designed, systematic efforts should be directed at addressing such factors. However, current accountability pressures override the logic and result in the marginalization of almost every initiative that is not seen as directly (and quickly) leading to academic gains.

Ironically, not only does the restricted emphasis on achievement measures work against the logic of what needs to be done, it works against gathering evidence on how essential and effective it is to address barriers to learning directly.

All this leads to an appreciation of the need for an expanded framework for school accountability -- a framework that includes direct measures of achievement and much more.

Standards for an Enabling or Learner Support Component

A Learner Support component is an essential facet of a comprehensive school design. This component is intended to enable *all* students to benefit from instruction and achieve high and challenging academic standards. This is accomplished by providing a comprehensive, multifaceted, and integrated continuum of support programs and services at every school. The district is committed to supporting and guiding capacity building to develop and sustain such a comprehensive approach in keeping with these standards.

All personnel in the district and other stakeholders should use the standards to guide development of such a component as an essential facet of school improvement efforts. In particular, the standards should guide decisions about direction and priorities for redesigning the infrastructure, resource allocation, redefining personnel roles and functions, stakeholder development, and specifying accountability indicators and criteria.

The following are 5 major standards for an effective Enabling or Learner Supporter component:

Standard I. *The Learner Support component encompasses an evolving range of research-based programs and services designed to enable student learning and well-being by addressing barriers to learning and promoting healthy development.*

Standard II. *The Learner Support component is developed, coordinated, and fully integrated with all other facets of each school's comprehensive school improvement plan.*

Standard III. *The Learner Support component draws on all relevant resources at a school, in a family of schools, district-wide, and in the home and community to ensure sufficient resources are mobilized for capacity building, implementation, filling gaps, and enhancing essential programs and services to enable student learning and well-being and strengthen families and neighborhoods.*

Standard IV. *Learning supports are applied in ways that promote use of the least restrictive and least intrusive forms of prevention/ intervention required to address problems and accommodate diversity.*

Standard V. *The Learner Support component is evaluated with respect to its impact on enabling factors, as well as increased student achievement.*

Meeting these standards is a shared responsibility. District and school leaders, staff, and all other concerned stakeholders work together to identify learning support needs and how best to meet them. The district and schools provide necessary resources, implement policies and practices to encourage and support appropriate interventions, and continuously evaluate the quality and impact of the Learner Support component.

Standard I

Standard I encompasses a guideline emphasizing the necessity of having a full continuum of programs and services in order to ensure all students have an equal opportunity for success at school. Included are programs designed to promote and maintain safety, programs to promote and maintain physical and mental health, school readiness and early school-adjustment services, expansion of social and academic supports, interventions prior to referral for special services, and provisions to meet specialty needs.

Quality Indicators for Standard I:

- All programs/services are based on state-of-the-art. Best practices for addressing barriers to learning and promoting positive development.
- The continuum of programs and services ranges from prevention and early-age intervention—through responding to problems soon after onset—to partnerships with the home and other agencies in meeting the special needs of those with severe, pervasive, or chronic problems.
- Routine procedures are in place to review the progress of the component's development and the fidelity of its implementation.

Standard II

Standard II encompasses a guideline that programs and services should be evolved within a framework of delineated areas of activity (e.g., 5 or 6 major areas) that reflect basic functions schools must carry out in addressing barriers to student earning and promoting healthy development. A second guideline stresses that a school-based lead staff member and team should be in place to steer development of these areas at each school and ensure that all activities are implemented in an interdisciplinary well-coordinated manner which ensures full integration into the instructional and management plan.

Quality Indicators for standard II:

- All programs/services are established with a delineated framework of areas of activity that reflect basic functions a school must have in place for addressing barriers to learning and promoting healthy development.
- At the school level, an H/MH team is functioning effectively as part of the school's infrastructure with responsibility for the individual support of students as well as ensuring resources are deployed appropriately and used in a coordinated way. The team is facilitating (a) capacity building, (b) development, implementation, and evaluation of activity, and (c) full integration with all facets of the instructional and governance/ management components.
- Ongoing professional development is (a) provided for all personnel implementing any aspect of the Learner Support component and (b) is developed and implemented in ways that are consistent with the district's Professional Development Standards.

Standard III

Standard III encompasses a guideline underscoring that necessary resources must be generated by redeploying current allocations and building collaborations that weave together, in common purpose, families of schools, centralized district assets, and various community entities.

Quality Indicators for Standard III:

- Each school has mapped and analyzed the resources it allocates for learner support activity and routinely updates its mapping and analysis.
- All school resources for learner supports are allocated and redeployed based on careful analysis of cost effectiveness.
- Collaborative arrangements for each family of schools are in place to (a) enhance effectiveness of learner supports and (b) achieve economies of scale.
- Centralized district assets are allocated in ways that directly aid capacity building and effective implementation of learner support programs and services at school sites and by families of schools.
- Collaborative arrangements are in place with a variety of community entities to (a) fill gaps in the Learner Support component, (b) enhance effectiveness, and (c) achieve economies of scale.

Standard IV

Standard IV encompasses guidelines highlighting that learner support activity should be applied in all instances where there is need and should be implemented in ways that ensure needs are addressed appropriately, with as little disruption as feasible of a student's normal involvement at school.

Quality Indicators for Standard IV:

- Procedures are in routine use for gathering and reviewing information on the need *for* specific types of learner support activities and *for* establishing priorities *for* developing/implementing such activity.
- Whenever a need is identified, learner support is implemented in ways that ensure needs are addressed appropriately and with as little disruption as feasible of a student's normal involvement at school.
- Procedures are in routine use for gathering and reviewing data on how well needs are met; such data are used to inform decisions about capacity building, including infrastructure changes and personnel development.

Standard V

Standard V encompasses a guideline for accountability that emphasizes a focus on the progress of students with respect to the direct enabling outcomes each program and service is designed to accomplish, as well as by enhanced academic achievement.

Quality Indicators for Standard V:

- Accountability for the learner support activity focuses on the progress of students at a school site with respect to both the direct enabling outcomes a program/ service is designed to accomplish (measures of effectiveness in addressing barriers, such as increased family involvement with child and schooling, fewer referrals for specialized assistance, fewer referrals for special education, fewer pregnancies, fewer suspensions and dropouts), as well as academic achievement.
- All data are disaggregated to clarify impact as related to critical subgroup differences (e.g., pervasiveness, severity, and chronicity of identified problems).
- All data gathered on learner support activity are reviewed as a basis for decisions about how to enhance and renew the Learner Support component.