

SYSTEMS-BASED PRACTICE EDUCATION SYSTEM Updated January 2020

SYSTEMS-BASED PRACTICE: EDUCATION SYSTEM OBJECTIVES*

Knowledge

The resident will demonstrate an adequate knowledge of:

- 1) The child and adolescent psychiatrist's role in working with schools and individual youth/families regarding their educational needs.
- 2) School culture and the roles and approaches of school personnel.
- 3) Legal aspects of education as they relate to youth with psychiatric diagnoses.
- 4) Process and components of a special education evaluation and individualized education program.
- 5) Goals and development of a behavioral intervention plan.
- 6) School-based mental health care models.
- 7) How school-based mental health clinics affect access to mental health services for students.
- 8) Current issues affecting education system (Response to Intervention, common core state standards, school safety, zero tolerance).
- 9) Ways the consulting child and adolescent psychiatrist promotes student safety and advocacy in the education setting.

Skills

The resident will demonstrate the ability to:

- 1) Understand the challenges/stressors youth may face when working with school personnel.
- 2) Understand the challenges/stressors family members may face when working with school personnel.
- 3) Understand the challenges/stressors school personnel may face when working with youth with behavioral problems.
- 4) Perform a school observation on one student.
- 5) Participate in a school-based committee meeting.
- 6) Identify relevant features of an individualized education program and critique the components related to the youth's behavioral/emotional functioning.
- 7) Demonstrate an empathetic understanding of the needs of youth, families and school personnel.
- 8) Complete a consultee-oriented consultation in the context of a system of care.
- 9) Understand the opportunities and challenges involved in providing interdisciplinary collaboration and advocacy for youth with behavioral/emotional disorders and their families.
- 10) Acquire a caring, proactive approach to all team members to promote system competence.
- 11) Include feedback from school personnel in their assessment of the child.

* Parentheses refer to systems-based practice competencies in the RRC Program Requirements.¹ See Appendix 1.

Attitude

The resident will demonstrate the commitment to:

- 1) Reflect on attitudes towards youth with behavioral problems in the classroom.
- 2) Reflect on attitudes towards school personnel working with youth with behavioral problems.
- 3) Exemplify a family-driven, youth-guided approach to service provision in the education setting.
- 4) Exemplify a family-driven, youth-guided approach to program evaluation, development and implementation when working on safety and advocacy initiatives.

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OVERVIEW

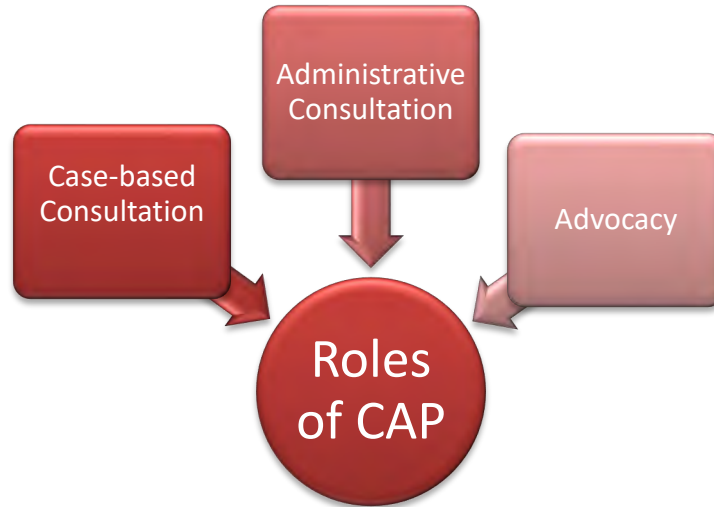
This module provides a review of important points regarding the education system for child and adolescent psychiatrists (CAPs) and trainees. Because most children in the U.S. attend school, it is vital to understand the basics regarding the school culture, school personnel, legal aspects (i.e. special education laws), and special education evaluation and planning for an individual child. Furthermore, the role of the child psychiatrist in working with the schools will be explored. We recommend using the AACAP “Practice Parameter for Psychiatric Consultation to Schools” when reviewing this module.²

I. INTRODUCTION

- 95% of U.S. children attend school.
- School is one of the primary community resources for supporting a youth’s emerging development.
- Students who may have high rates of undetected and/or untreated psychopathology include students with special education services for learning or emotional problems, students who have had significant exposure to maltreatment or other trauma, and students with poor academic performance due to excessive absenteeism, multiple disciplinary actions or slow learning.³⁻⁵
- Despite education policy and legislative supports in the past three decades, youth with emotional and behavioral disorders have not fared well in the public schools.⁶ In school, these youth have disproportionately higher dropout rates and academic failure than their peers without disabilities. They have a greater likelihood of being arrested, living in poverty, being unemployed, using illegal drugs, and becoming teen parents. They have also been educated in more restrictive environments.
- There are challenges and tensions in the education system including financial, safety, legal, and accountability issues.

II. ROLE OF THE CHILD AND ADOLESCENT PSYCHIATRIST

- 1) CAPs frequently collaborate with the youth, family and school personnel to promote the youth's intellectual, psychological, and socioemotional development.
- 2) Examples of CAP roles:
 - a) Case-Based Consultation
 - i) Family members seek CAP recommendations for their child's school-based service needs. Findings are shared with school personnel and supplement the mental health treatments.
 - ii) School employs CAP to assess students with problems and recommend services. CAP usually doesn't provide treatment but shares findings with school personnel and makes recommendations for mental health and school services.
 - iii) CAP provides assessment and treatment services to students in school-based or school-linked mental health clinics.
 - iv) In each of these roles, the CAP might have an opportunity to provide consultative input to the classroom teacher.
 - b) Administrative-Based Consultation
 - i) CAP advises schools about general mental health issues (i.e., managing crisis situations, developing and implementing prevention programs).
 - ii) CAP combines case and systems consultation along with collaboration with youth, family and multiple community agencies.
- 3) Three objectives should guide the CAP in consultative role⁷:
 - a) Strengthen the relationships of all professionals involved in the student's educational objectives.
 - b) Encourage recognition of dynamic forces which may impede the student's progress.
 - c) Help school personnel generate responses to problems by teaching new skills and finding common goals.
- 4) Advocacy Role of CAPs
 - a) For individual child
 - b) For individual schools
 - c) For school systems
 - d) At state and/or national level



III. SCHOOL ADMINISTRATIVE PROCEDURES

- Public and private schools are usually accountable to an elected board.
- Parochial schools are usually accountable to their religious entity.
- In public schools, the special education administration is responsible for implementing the state's interpretation of the federal education rights legislation and is accountable to the state's Department of Education.
- Parochial and private schools are not accountable to the state's Department of Education in regards to special education.

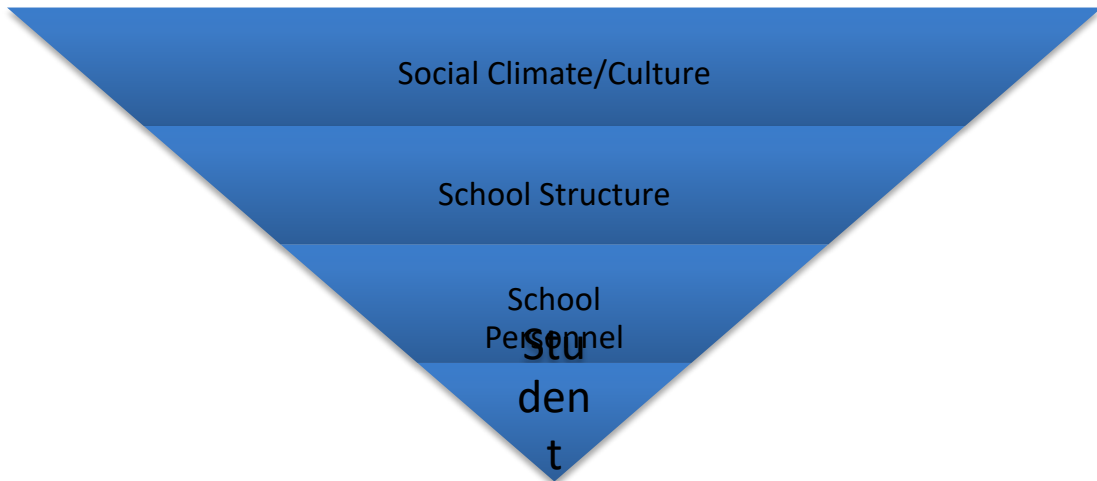
IV. SCHOOL PERSONNEL

- 1) Professional school staff
 - a) Administrators (system and school level)
 - b) Regular education teachers
 - c) Special education teachers
 - d) Support services staff
 - i) School counselor
 - ii) Psychologist
 - iii) Social worker
 - iv) Resource officer
 - v) Nurse
- 2) CAP should understand the school staffing and role of each professional to develop collaborative interdisciplinary relationships.^{8,9}

V. SOCIOCULTURAL MILIEU OF SCHOOL

- 1) Social milieu derives from:
 - a) Socio-demographic composition of student body and school personnel (social inputs)
 - b) Size, structure, processes of school (social structure)
 - c) Cultural characteristics (social climate)
 - i) Norms
 - ii) Expectations

- iii) Feelings
- d) Social climate of a school has a substantial impact on student's academic achievement and mental health. A positive social climate can result in a student surpassing expectations based on social inputs or structure.¹⁰ School climate can also influence whether a student with psychiatric or learning challenges remains in school or quits.
- 2) Cultural Issues
 - a) Essential for school personnel to learn new skills for understanding, motivating, teaching and empowering each individual student regardless of race, ethnicity, sex, religion, or creed.
- 3) Psychiatric Consultant
 - a) Need to understand the sociocultural milieu of the school (including staff issues and the nature/extent of parental involvement).
 - b) Ways to learn about the milieu²:
 - i) Walk hallways/playground
 - ii) Eat in lunchroom
 - iii) Observe classrooms
 - iv) Attend extracurricular activities
 - v) Attend Parent teacher associations/parent teacher organization activities
 - vi) Interview representatives of key constituent groups (e.g. students with mental disabilities)



VI. LEGAL ASPECTS OF EDUCATION (See Practice Parameter²)

- 1) 14th Amendment
 - a) Prohibits discrimination
 - b) Earlier, children with disabilities were excluded from public school
 - c) Brown v. Board of Education¹¹ rectified this asserting that education is a “right that must be available to all on equal terms.”
- 2) Section 504 of the Rehabilitation Act¹² mandates inclusion without discrimination for any person with a physical or mental impairment that substantially limits a major life activity.
- 3) Education for All Handicapped Children Act¹³

- a) Mandates provision of special education and related services to meet the unique needs of children with physical or mental disabilities.
- b) First time federal funds became available to support the efforts of states to develop individualized special education programs.
- c) Amendments:
 - i) Education of the Handicapped amendments¹⁴
 - ii) Individuals with Disabilities Education Act¹⁵
 - (1) Expanded protection to children younger than 6 years old.
 - (2) Expanded list of disabilities:
 - (a) Autism
 - (b) Deafness
 - (c) Deaf-blindness
 - (d) Emotional disturbance
 - (e) Hearing impairment
 - (f) Mental retardation
 - (g) Multiple disabilities
 - (h) Orthopedic impairment
 - (i) Other health impairment
 - (j) Specific learning disability
 - (k) Speech-language impairment
 - (l) Traumatic brain injury
 - (m) Visual impairment
 - (3) Defined special education and related services.
 - (4) Increased early intervention services.
 - (5) Child Find is a component of IDEA that requires states to identify, locate, and evaluate all children with disabilities, aged birth to 21, who are in need of early intervention or special education services.
- d) IDEA amendments¹⁶
 - i) Increased related services.
 - ii) Delineated specific guidelines for school-based discipline of children with disabilities.
 - iii) Expanded parental rights in special education process.
- e) Individuals with Disabilities Education Improvement Act of 2004¹⁷
 - i) School districts and early intervention providers are now required to use research-based, peer-reviewed instruction and therapeutic services for children between birth and age 21.
 - ii) “Least restrictive environment” now requires that the child’s school placement be “as close as possible to the child’s home (and) unless the individualized education program (IEP) of a child with a disability requires some other arrangement, the child is educated in the school that he or she would attend if nondisabled.”
 - iii) Transition plan now required when a child reaches age 16 (up from age 14), or younger, if appropriate. In addition, transition plan must include “appropriate measurable post-secondary goals based upon age appropriate transition assessments related to training, education, employment, and where appropriate, independent living skills.”

- f) IDEA: Provisions related to children with disabilities enrolled by their parents in private schools¹⁸
 - i) Parentally-placed children with disabilities in private school do not have an individual entitlement to services they would receive if they were enrolled in public school.
 - ii) The local education agency (LEA) is required to spend a proportionate amount of IDEA federal funds to provide equitable services to this group of children.
 - iii) It is possible that some of these children will receive services and others will not.
 - iv) LEAs are required to consult with private school representatives and representatives of parents of parentally placed children with disabilities during the design and development of special education and related services for these children.
- 4) Americans with Disabilities Act¹⁹
 - a) Requires all education institutions other than those operated by religious organizations, to meet the needs of children with psychiatric problems.
 - b) Prohibits the denial of educational services, programs or activities to students with disabilities and prohibits discrimination against all such students.
- 5) No Child Left Behind Act of 2001²⁰
 - a) Federal Plan for comprehensive education reform
 - b) Four principles
 - i) Stronger accountability for results – states working to close the achievement gap and make sure all students achieve academic proficiency.
 - ii) More freedom for states and communities – states and school districts have flexibility in how they use federal education funds.
 - iii) Proven education methods – emphasis on determining which educational programs/practices are evidence-based.
 - iv) More choices for parents – parents of children in low-performing schools have new options.

There is considerable local variation in the interpretation of the federal educational rights legislation. Psychiatrists need to be knowledgeable about the laws and regulations for the state and locality in which they practice.

VII. SPECIAL EDUCATION EVALUATION (See Practice Parameter²)

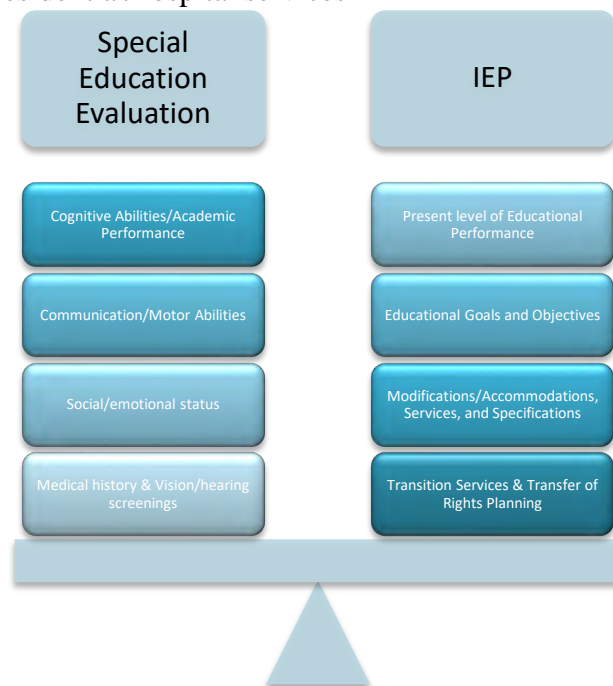
- 1) A comprehensive individual evaluation of all suspected areas of disability conducted by a multidisciplinary team of school-based professionals.
- 2) The comprehensive evaluation determines eligibility for special education services based on eligibility criteria and whether the difficulties affect the student's educational progress.
- 3) Typical components:
 - a) Usual components:
 - i) Cognitive abilities
 - ii) Communication abilities
 - iii) Academic performance

- iv) Social/emotional status
- v) Medical history and current health status
- vi) Vision/hearing screenings
- vii) Motor abilities
- b) Additional components (as indicated):
 - i) Intelligence testing
 - ii) Speech-language testing
 - iii) Achievement testing
 - iv) Neuropsychological testing
 - v) Physical examination
 - vi) Occupational/physical therapy evaluation
 - vii) Psychiatric assessment

VIII. INDIVIDUALIZED EDUCATION PROGRAM (See Practice Parameter²)

- 1) If findings from special education evaluation indicate child has a disability (meeting criteria under IDEA) and would benefit from special education and related services, the school-based team develops a written IEP for the child in collaboration with his/her parents.
- 2) Typical components of an IEP:
 - a) Usual components:
 - i) Present level of educational performance
 - ii) Educational goals and objectives with measurable benchmarks
 - iii) Educational modifications and accommodations
 - iv) Special education and related services
 - v) Placement and participation specifications
 - vi) Transition services planning
 - vii) Transfer of rights planning
 - b) Additional components/related services (as indicated)
 - i) Adapted physical education
 - ii) Audiology
 - iii) Assistive technology
 - iv) Behavioral Intervention Plan (BIP)
 - v) Counseling services
 - vi) Extended school year services
 - vii) Home-based support
 - viii) Medical services
 - ix) Occupational therapy
 - x) Orientation/mobility services
 - xi) Parent counseling/training
 - xii) Physical therapy
 - xiii) Psychological services
 - xiv) Recreation
 - xv) Rehabilitation counseling services
 - xvi) School health services
 - xvii) School social work services
 - xviii) Speech-language services

- xix) Transportation services
- 3) IEP is reviewed and revised annually.
- 4) Comprehensive reevaluation conducted every 3 years to determine if child continues to meet eligibility criteria and what services should be provided.
- 5) Behavioral Intervention Plan (BIP)
 - a) Children with a disability that engage in disruptive behavior at school should have a BIP written into their IEP.
 - b) Goal of BIP: preventing suspensions or expulsions.
 - c) BIP Development:
 - i) Findings of a functional behavioral assessment that identifies the disruptive behaviors with their precipitants, functions and settings.
 - ii) Specifies behavioral goals based on functional alternatives to disruptive behaviors and behavioral interventions designed to help student achieve behavioral goals.
- 6) Education Placement Options
 - a) The IEP will specify in what setting the special education and related services will be provided. The setting must be both appropriate to the child's needs and least restrictive of his/her interactions with peers without disabilities.
 - b) Examples:
 - i) Regular classroom
 - ii) Regular classroom with consultative services to teacher
 - iii) Regular classroom with accommodations/supports
 - iv) Regular classroom with pull-out resource services
 - v) Special education classroom with some pull-out regular education
 - vi) Special education classroom
 - vii) Special school
 - viii) Home services
 - ix) Residential/hospital services



IX. SECTION 504 PLAN (See Practice Parameter²)

- Applies to any person with a physical or mental impairment that substantially limits a major activity.
- Does not require a specific disability designation or a need for special education services as eligibility requirements.
- Students are evaluated and an accommodation plan is designed that specifies reasonable program modifications and classroom modifications.
- BIP can be developed and implemented as part of 504 plan.
- Federal funds are not available to support the efforts of states to develop Section 504 plans.

X. SCHOOL-BASED MENTAL HEALTH CARE

- 1) School-based mental health professionals bridge the discontinuity in mental health services between schools and community agencies.
 - a) School-Based Service Delivery Models²¹
 - i) Consultation - as described previously
 - ii) School-Based Health Clinic
 - (1) Provide acute and referral physical health services
 - (2) Some level of mental health services
 - (3) Purpose is to provide integrated health care
 - iii) School-Based Mental Health Centers - support development of mental health intervention and prevention programs
 - iv) Multiple Systems Model
 - (1) Comprehensive school-based mental health programs (clinical services, consultation school staff, prevention/enrichment programs)
 - (2) Interdisciplinary collaboration with other child-serving agencies
 - v) Positive Behavior Interventions and Support (PBIS)
 - (1) School-wide system to teach, model and reinforce social behaviors
 - (2) Helps establish a learning climate in which pro-social behavior is the norm
 - (3) The families are included in the intervention practices
 - (4) Youth is a part of the team and helps create strategies that will be effective in producing positive social and academic skills
 - (5) PBIS is further discussed later in this module.
 - b) Opportunities
 - i) Accessibility
 - ii) Earlier identification and intervention
 - iii) Integration of service delivery
 - iv) Broad participation in treatment teams
 - v) Knowledge of local school community
 - vi) Measurement of outcomes
 - c) Challenges
 - i) Bureaucracy
 - ii) Controversial health care issues
 - iii) Population mobility
 - iv) Funding

XI. WRAPAROUND PROCESS²²

- 1) “A planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes.”²³
- 2) A community-based approach to provide comprehensive, integrated services through inter-professional collaboration, and collaborations with families.
- 3) In the school setting, supports move toward behavioral intervention procedures that focus on:
 - a) Child’s challenging behaviors
 - b) Teaching replacement behaviors
 - c) Systematic reinforcement of desired behaviors
- 4) Influenced the increased use of positive behavioral support systems.

XII. CURRENT ISSUES IN EDUCATION

- 1) Response to Intervention (RTI)
 - a) According to the National Center on Response to Intervention, “The purpose of RTI is to provide all students with the best opportunities to succeed in school, identify students with learning or behavioral problems, and ensure that they receive appropriate instruction and related supports” <http://www.rti4success.org>)²⁴
 - b) RTI definition: “response to intervention integrates assessment and intervention within a multi-level prevention system to maximize student achievement and to reduce behavior problems. With RTI, schools identify students at risk for poor learning outcomes, monitor student progress, provide evidence-based interventions and adjust the intensity and nature of those interventions depending on a student’s responsiveness, and identify students with learning disabilities and other disabilities.”
 - c) Four essential components of RTI:
 - i) a school-wide, multi-level instructional and behavioral system for preventing school failure
 - ii) screening
 - iii) progress monitoring
 - iv) data-based decision making for instruction, movement within the multi-level system, and disability identification (in accordance with state law).
 - d) Resources: UCLA Center Mental Health in Schools for CEU <http://smhp.psych.ucla.edu>
- 2) Common Core State Standards
 - a) To ensure all students are ready for success after high school, the Common Core State Standards establish clear, consistent guidelines for what every student should know and be able to do in math and English language arts from kindergarten through 12th grade.
 - b) Standards were drafted by experts and teachers from across the county and focus on developing the critical-thinking, problem-solving, and analytical skills students will need to be successful.

- c) Forty-three states, the District of Columbia, four territories, and the Department of Defense Education Activity have voluntarily adopted the standards.
 - d) The standards are research and evidence based; aligned with college and career expectations; based on rigorous content and application of knowledge through higher-order thinking skills; built upon strengths and lessons of current state standards; and informed by other top performing countries to help students for success in our global economy and society.²⁵
- 3) National School Mental Health Curriculum
- a) The Mental Health Technology Transfer Center (MHTTC) Network Coordinating Office and National Center for School Mental Health (NCSMH) developed a national school mental health curriculum that focuses on core features of effective school mental health initiatives.²⁶
 - b) The curriculum is divided into eight modules and is intended for local individualization as the local trained educators help train their colleagues regarding comprehensive school mental health.

XIII. SCHOOL SAFETY

- 1) School violence
 - a) For most children, the school day unfolds with no threats to their safety or security.
 - b) There are incidents of individual aggression towards peers and school staff. This is a major issue in many communities.
 - c) There have also been incidents of aggression towards whole groups of students and staff (i.e., Columbine).
 - d) Drug and alcohol use is also a major concern for schools and can be linked to this problem.
- 2) Safe Schools/Healthy Students
 - a) A federal grant program designed to increase knowledge about what works best to reduce school violence.
- 3) Responding to a Crisis
 - a) Almost every school has had a major crisis; every school is likely to have one. Besides natural disasters, students experience violence and death related to suicide of friends, gang activity, snipers, hostage taking and rape. Please view these websites for resources:

[Center for Mental Health in Schools at UCLA](#)
[Federal Emergency Management Agency](#)
[National Association of School Psychologists](#)
[National Child Traumatic Stress Network](#)

XIV. SPECIAL CONSIDERATION: RETHINKING “ZERO TOLERANCE”

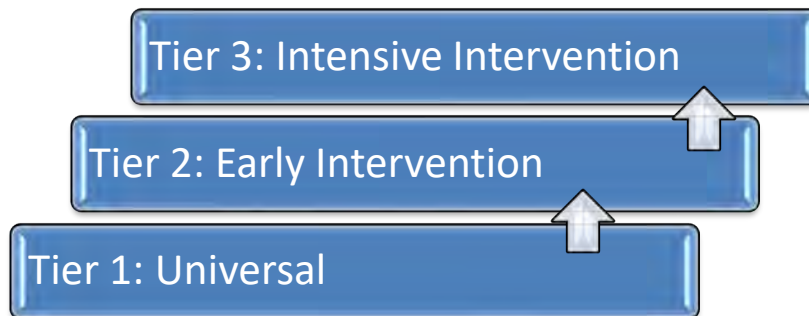
- 1) In response to concerns about student violence, many states and school districts have implemented “zero tolerance” school policies, whereby students who misbehave are suspended, expelled, or arrested by police.²⁷⁻²⁹
- 2) Zero tolerance in schools is an outgrowth of the zero tolerance approach in the 1990s to illicit drugs, and was initially embraced by school districts in response to dangerous behavior and acts of violence in school settings, following school

- shootings that also occurred in that decade. Over time, however, zero tolerance policies broadened to include nonviolent student misdemeanors and other minor infractions that historically were handled internally within the school,
- 3) As a result of the *exclusionary discipline* resulting from zero tolerance policies and practices, there have been many negative consequences, some unintentional but significant nevertheless.²⁹ These include the following²⁷⁻²⁹:
 - a. The ongoing engagement of police at schools, which increases the likelihood of students being arrested.
 - b. Suspension or expulsion of students from school, resulting in their being at home alone, on the street, falling behind academically, dropping out of school, and arrest in the community while out of school.
 - c. Arrest for minor infractions at school, which can lead to incarceration in juvenile justice facilities, a permanent criminal record, and lifelong stigma and loss of opportunity.
 - d. In effect, zero tolerance as implemented in high schools and also in secondary education settings over the past two decades has constituted the criminalization of normal childhood behaviors. The resultant referral of students to juvenile court and the subsequent placement of many in jails has been referred to as “the school-to-prison pipeline.”^{28,29}
 - e. In addition to the above generic concerns about zero tolerance, it has also been demonstrated that these practices are not being applied equally, with African American and Hispanic students being suspended and arrested at much higher rates than Caucasian students. This perpetuates social inequality and lack of opportunity for minorities, often on a multi-generational level.
 - f. In like manner, zero tolerance has also been applied unequally against special education students, who have also been subject to discrimination.
 - 4) There is no evidence that zero tolerance has decreased school violence, made schools safer, or improved the school climate for other students, all of which constituted the rationale for this approach. On the contrary, zero tolerance has led to abdication by teachers and school personnel of their responsibility to administer routine student discipline themselves in a fair manner, with the best interest of the student in mind.
 - 5) At present, at the federal, state, and local level, policy-makers, educators, juvenile justice directors, judges, police officers, and others are rethinking zero tolerance and revamping approaches to discipline at schools. Zero tolerance is now seen as a last resort, a possible response to the most dangerous situations.
 - 6) Other approaches being used in place of zero tolerance are broadly-based and positive in nature. They include the following:
 - a. Flexibility of responses, with responsibility residing in the school with the educators and a focus on keeping students in school.
 - b. Counseling for students.
 - c. Information for students.
 - d. Warning letters to students.
 - e. Community service within the school.
 - f. Peer mediation.
 - g. Parent-teacher conferences.
 - h. Other involvement of parents and legal guardians.

- i. Use of school-wide programs based on positive practices and a positive school culture.

XV. POSITIVE BEHAVIORAL INTERVENTIONS AND SUPPORTS (PBIS)

- 1) An alternative to zero tolerance, and more importantly, a comprehensive approach to the promotion of student mental health and wellbeing in schools, involves what is referred to as positive behavioral interventions and supports (PBIS) in schools.
- 2) PBIS involves an implementation framework designed to enhance academic and social behavior outcomes for all students, by implementing data-driven, evidence-based behavioral practices and organizing systems and resources to improve implementation fidelity. As such, PBIS involves “the application of Response to Intervention principles to the improvement of social behavior outcomes for all students.”³⁰
- 3) PBIS involves strong collaborations moving to partnerships among families, schools, mental health, and other community systems. It involves a three-tier, positive approach to students and to prevention.³¹
 - a. Tier 1 involves programs and services for all students, including those in general education and special education, with a primary goal being the maintenance of a positive, strengths-based school culture. By involving all students, Tier 1 is Universal.
 - b. Tier 2 involves systems that additionally support students regarded as being at risk, typically 10-15% of all students. By involving at-risk students, Tier 2 involves Early Intervention.
 - c. Tier 3 involves systems that provide additional interventions, including mental health treatment, to a small number of youth, typically 1-5% of the students, with the goal of reducing the intensity and duration of symptoms. By involving individual students with the greatest need, Tier 3 involves Intensive Intervention.



- 4) The three-tier approach is often represented visually as involving an inverted triangle. Students receiving just Tier 1 interventions constitute 80% or more of the students, from the base of the triangle to most of the way up. Students receiving Tier 2 interventions encompass 10-15% of the students, at a higher part of the triangle. Students receiving Tier 3 services encompass 1-5% of the total students, and constitute the tip of the triangle at the top.
- 5) School-Wide Positive Behavior Support (SW-PBS) is another term that encompasses the same commitment to positive practices, prevention, family engagement, and a systems of care perspective within schools. It also uses a multi-tiered approach. An

emerging term to integrate such approaches is known as an Interconnected Systems Framework for School Mental Health.³¹

- 6) Significantly, such approaches promote the following: positive school culture; positive student-teacher relationships; different levels of prevention based on proactive interventions; positive student mental health and coping; and partnerships with families, communities, and child-serving systems.
- 7) Child and adolescent psychiatrists should be familiar with PBIS and positive practices in general, in order to support such systems and practices and help schools move away from punitive practices.

CONCLUSION

Nearly all children attend school, and most children attend public schools, whether in regular or special education. It is essential that children succeed in school, so that they obtain literacy and the many skills needed to successfully join the workforce and become self-sufficient members of the community. Through use of this module in conjunction with the Practice Parameter on Psychiatric Consultation to Schools, CAPs can become familiar with all aspects of the education system – administrative procedures; school personnel; the sociocultural milieu; legal mandates and legislation; specific educational procedures and processes; school based mental health and linkages to the wraparound process; school safety; avoidance of punitive practices; and opportunities for positive practices in education. Whether working directly with the school, indirectly as a member of a mental health team, or clinically with children and their families, the CAP has many opportunities to collaborate with the educational system and to fulfill a variety of meaningful roles.

APPENDIX 1*

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

IV.B.1.f) Systems-based Practice. Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

* Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Child and Adolescent Psychiatry.

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405_ChildAdolescentPsychiatry_2019_TCC.pdf?ver=2019-03-28-161025-277. July 1, 2019.

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RECOMMENDED READINGS

- AACAP. Services in school for children with special needs: what parents need to know. http://www.aacap.org/cs/root/facts_for_families/services_in_school_for_children_with_special_needs_what_parents_need_to_know. Accessed August 27, 2009.
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WEB RESOURCES

- Center for Mental Health in Schools at UCLA
<http://www.smhp.psych.ucla.edu>
- Center for School Mental Health Analysis and Action at University of Maryland
<http://csmh.umaryland.edu/>
- FEMA
<http://www.fema.gov>
- U.S. Department of Education
<http://www.ed.gov/index.jsp>
- U. S. Department of Education – IDEA
<http://idea.ed.gov>
- U.S. Department of Education – Parent Guide for IEP
<http://www.ed.gov/parents/needs/speced/iepguide>
- U.S. Department of Education – PBIS
<http://www.pbis.org>
- Safe and Drug-Free Schools Programs Office
<http://www.ed.gov/offices/OESE/SDFS/>
- Child Find
<http://www.childfindidea.org>
- National Association of School Psychologists
<http://www.nasponline.org>
- National Child Traumatic Stress Network
<http://nctsnet.org>
- National Dissemination Center for Children with Disabilities
<http://www.nichcy.org>
- No Child Left Behind
<http://www.ed.gov/nclb>
- SAMHSA National Mental Health Information Center
<http://mentalhealth.samhsa.gov>

Education System - Discussion Vignette I – Trainee Version

Takira is a 3 year 6 month old girl who has recently moved from another state with her family. She was born prematurely and has multiple medical problems and developmental delays. She saw her new pediatrician last week who is treating her for medical problems and referred her for a psychiatric consultation due to the developmental delays and behavioral concerns.

The mother reports that Takira has 0hearing loss in her left ear, speech and motor delays. In their previous hometown she received speech, occupational and physical therapies. They enjoyed working with their care coordinator in Early Intervention. When Takira turned 3 years old she began attending a developmental preschool class in the local school. The family wants to know how to access similar preschool services now.

In addition, since their move the mother reports that Takira is very different. She is fussy and irritable most of the time. Plus, she is not sleeping well and refusing to eat at times. The mother is worried that Takira may have a “behavioral problem.”

Her father is a manager at the local pharmaceutical company and works long hours. Her mother is at home with Takira. The mother hopes to return to college soon to finish her elementary education degree. Takira’s 10 year old brother is a typically developing 4th grader. The parents are interested in accessing educational services for Takira.

1. The parents are interested in accessing educational services. What education laws apply in this case?
2. The parents are new to the community, so how would you advise the parents to proceed to access school services?
3. The parents worked with the school district and a special education evaluation process was begun. With your knowledge of Takira’s history what typical evaluation components (both usual and additional) would be helpful to assess her educational needs?
4. Findings indicate that Takira qualifies for special education and related services. What is the next step?
5. Name some additional components/related services that may be indicated for Takira:
6. You evaluate the child and determine that the child’s symptoms are consistent with an adjustment disorder diagnosis. You provide recommendations regarding parenting activities to help address the child’s symptoms that are accepted by the parents. What is your best next step?

Education System - Discussion Vignette II – Trainee Version

Juan is a 13 year old Hispanic male in 7th grade with a long term history of attention-deficit/hyperactivity disorder (ADHD), combined type, mixed receptive-expressive language disorder and oppositional defiant disorder. He has been treated with multiple medications and continues with moderate ADHD symptoms. He is having more severe conduct problems and marijuana has just been found in his school locker. He currently is being seen by a therapist, a CAP, and case manager at the community mental health center.

In 4th grade he had a special education evaluation and received exceptional children's designation (emotional disturbance and speech language impairment). Accommodations in the school setting have helped some but his teachers have noted that he is failing most of his classes this year. In addition, his conduct problems are getting worse. Despite these problems, he continues to excel in soccer.

Juan's parents are working hard to provide for their family of six. The parents struggle with English but their children are fluent in English and Spanish. They are concerned that Juan may be involved with the "wrong crowd" at school. The parents are very willing to work with the school and other providers to help Juan.

1. You are Juan's CAP at the community mental health center. Juan's therapist sees you and reports Juan is getting worse. There are appropriate consents from his parents to communicate with the school. The case manager wants to help obtain more information. Name all school personnel that you would identify as resources for information regarding Juan's academic, social and emotional functioning.
2. Juan reportedly has been evaluated and given the designation of emotional disturbance and speech language impairment. What information from his current school would help the treatment process?
3. The parents, mental health providers, and school personnel have agreed that a team should be assembled and meet. Juan's school participates in a wraparound program with the community mental health center and is interested in using this process. Who might be involved in a child and family team?
4. What possible contributions could Juan make in the child and family team?
5. What types of cultural concerns might be explored?
6. What are some ideas the child and family team might identify to help Juan?