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Mission Statements

Memphis City Schools Mental Health Center

To provide psychological and social support services to foster emotional well-being, encourage academic achievement, eliminate barriers to student success, and promote safe and drug free schools.

The Memphis City Schools Mental Health Center is licensed through the Tennessee Department of Mental Health and Developmental Disabilities to provide outpatient mental health services, adolescent non-residential alcohol and drug treatment and prevention services, and treatment services for co-occurring substance use and mental health disorders. The Memphis City Schools Mental Health Center is a 501(c)3 charitable organization, chartered by the state of Tennessee.

Division of Exceptional Children and Health Services

The mission of the Division of Exceptional Children and Health Services is to enhance education opportunity through comprehensive services that address academic, social, health, emotional, psychological, and behavioral needs of students, families, schools, and the community.
Ms. Betty Mallott-Chair
Ms. Stephanie Gatewood
Ms. Sara Lewis
Ms. Patrice Robinson
Mr. Martavius Jones
Dr. Jeff Warren
Dr. Kenneth T. Whalum
Ms. Tomeka Hart
Dr. Freda Williams
Dr. Kriner Cash
Dr. Snowden Carruthers
Mr. Michael Wissman
Mr. Billy Orgel
Mr. David Reaves
Mr. Joseph Clayton
Mr. David Pickler
Ms. Diane L. George
Mr. Christopher Caldwell
Ms. Teresa Jones
Mr. Raphael McInnis
Ms. Venecia Kimbrow
Mr. Kevin Woods
Mr. Reginald Porter, Jr.
Mr. Valerie E. Speakman
STATE OF TENNESSEE

CHARTER OF INCORPORATION

BE IT KNOWN THAT Edgar H. Bailey, Hugh H. Bosworth, John T. Shea, Mrs. Lawrence Coe, and Mrs. Arthur N. Seessel, Jr., are hereby constituted a body politic and corporate, by the name and style of THE MEMPHIS SCHOOL MENTAL HEALTH CENTER, INC., Memphis, Tennessee, for the purpose of sponsoring and maintaining a center for the study, diagnosis, treatment and prevention of mental and emotional disorders of children and adults, to further community education, and to engage in all activities which promote an interest in mental health.

The general welfare of society, not individual profit, is the object for which this charter is granted, and the members are not stockholders in any legal sense of the term and no dividends or profits shall be divided among the members.

The general powers of said corporation shall be:

1. To sue and be sued by the corporate name.

2. To have and use a common seal, which it may alter at pleasure; if no common seal, then the signature of the name of the corporation, by any duly authorized officer, shall be legal and binding.

3. To receive property, real, personal or mixed, by purchase, gift, devise, or bequest, to sell the same and apply the proceeds toward the promotion of the objects for which it is created, or hold any such property and apply the income and profits towards such objects. Unless otherwise specifically directed in the trust instrument by which any real or personal property, money or other funds, are given, granted, conveyed, bequeathed, devised to, or otherwise vested in this corporation, the directors or authorized finance committee of this corporation shall have power to invest funds thus received, or the proceeds of any property thus received, in such investments as in the honest exercise of their judgment they may, after investigation, determine to be safe and proper investments, and to retain any investments heretofore made.
4. To establish by-laws, and make all rules and regulations not inconsistent with the laws and Constitution, deemed expedient for the management of corporate affairs.

5. To appoint such subordinate officers and agents, in addition to a president, vice president and secretary-treasurer, as the business of the corporation may require.

6. To designate the name of the office, and fix the compensation of the officer.

7. To borrow money to be used in payment of property bought by it, and for erecting buildings, making improvements, and for other purposes germane to the objects of its creation, and secure the repayment of the money thus borrowed by mortgage, pledge, or deed of trust, upon such property, real, personal or mixed, as may be owned by it: and it may in like manner secure by mortgage, pledge, or deed of trust, any existing indebtedness which it may have lawfully contracted.

The within named incorporators shall, within a convenient time after the registration of this charter, elect from their number a president, vice president and secretary-treasurer, and such other officers as they deem necessary, said officers and the other incorporators to constitute the first Board of Directors. Thereafter, said officers and members of the Board of Directors shall be elected as the by-laws may provide. The term of officers may be fixed by the by-laws, the said term, however, not to exceed three years. All officers shall hold office until their successors are duly elected and qualified. In all elections, each active and privileged member present as provided by the by-laws, shall be entitled to one vote, and the result of said election shall be determined by a majority of the votes cast. Due notice of any election must be given by advertisement in a newspaper, personal notice to the members, or a day stated in the minutes of the Board one month preceding the election.

The Board of Directors shall keep all records of their proceedings, which shall be at all times subject to the inspection of any member. The members may at any time dissolve the corporation by
BY-LAWS

AMENDED 6-23-09

MEMPHIS SCHOOL MENTAL HEALTH CENTER

MEMPHIS, TENNESSEE

ARTICLE I

General

Section 1

These By-Laws supplement the charter of incorporation of the Memphis School Mental Health Center of Memphis, Tennessee. They shall become effective when ratified by a majority of the incorporators.

Section 2

The name of the organization shall be the Memphis School Mental Health Center of Memphis, Tennessee, and its principal place of business shall be determined by the Board of Directors of the corporation.

Section 3

The purpose of this organization shall be to establish and operate facilities and services for the study and treatment of problems of mental health and to engage in all activities which promote an interest in mental health, particularly in that of children.

ARTICLE II

Organization

Section 1

The corporate powers, business, property, and the affairs of the
corporation shall be under the control of the Board of Directors. This Board of Directors shall consist of a number of members equal to the number of members of the Memphis Board of Education. The identity of the individual members of this Board of Directors shall coincide with that of persons elected to the Memphis Board of Education. The term of office of each member of this Board shall coincide with his tenure with the Memphis Board of Education.

Section 2

All policies pertaining to the functioning of this Board of Directors or to any facilities or services for which it is responsible shall coincide with policies established for the Memphis Board of Education and in accordance with standard established by the Tennessee Department of Mental Health.

ARTICLE III

Meetings

Section 1

The Board of Directors shall meet annually or in special meetings on the request of five members or when called by the President.

Section 2

A quorum for the conductance of business shall consist of five members present at a regular or called meeting of the Board.

ARTICLE IV

Officers

Section 1

The officers shall consist of a president, a vice president and a
secretary. The president and vice president shall be the president and vice president of the Board of Education of the Memphis City Schools, respectively. The secretary shall be the secretary of the Board of Education and need not be a director of the corporation. A change in Officers of the Board of Education of the Memphis City Schools shall automatically result in a change in the officers of the corporation. Officers of the corporation may succeed themselves for an unlimited number of terms.

ARTICLE V

Fiscal Matters

Section 1

All funds allocated to the operation of the affairs of this corporation shall be handled by procedures standard to those of the Memphis Board of Education.

Section 2

The books and records of the facility shall reflect all of the financial transactions of the corporation and shall be made available for audit by the Comptroller of the Treasury, State of Tennessee, upon request.

ARTICLE VI

Operation of Facilities

Section 1

The Board of Directors of this corporation shall designate the operation of such services and facilities as it may deem to provide to the Division of Psychological Services of the Memphis Board of
Education.

Section 2

Such services as are indicated in Section 1 above in this Article shall meet the approval of the Commissioner of the Tennessee Department of Mental Health or his designated representative.

ARTICLE VII

Staff

Section 1

The staff of facilities and services operated by this Board of Directors shall meet the employment requirements of the Memphis Board of Education and the State Department of Mental Health.

Section 2

Salary schedules for staff shall be in accordance with schedules established for positions within the Memphis City Schools.

Section 3

All staff of the Memphis School Mental Health Center shall be considered as regular employees of the Memphis Board of Education. All personnel policies pertaining to employees of the Memphis Board of Education shall be considered as pertaining to and binding upon the Memphis Board of Education and staff of the Mental Health Center.

ARTICLE VIII

Parliamentary Procedures

Section 1

The rules contained in Roberts Rules of Orders Revised shall
govern the Board in all cases to which they are applicable, and in which they are not inconsistent with the By-Laws or special Rules of Order of the Board.

**ARTICLE IX**

**Amendments of the By-Laws**

**Section 1**

These By-Laws may be amended by a majority of affirmative votes of the Board of Directors present at any regular or special meeting: provided notice of the proposed changes shall be sent to the Directors one week prior to the meeting.
Section I: Introduction
Introduction

The Memphis City Schools Mental Health Center (MCSMHC) is an administrative component of the Memphis City Schools Division of Exceptional Children & Health Services and a state-licensed mental health center; holding licenses from the Tennessee Department of Mental Health and Developmental Disabilities to provide outpatient mental health services and alcohol and drug prevention and treatment services.

Founded in 1969, the MCSMHC received the inaugural Award for Excellence for School Psychological Services Programs awarded jointly by the American Psychological Association's Division of School Psychology (APA-Division 16) and the National Association of School Psychology (NASP) in 1982. In 2007, MCSMHC was cited in the book School Psychology, Past Present and Future (Fagan, T. and Wise, P.S.) as a model urban school mental health program.

The MCSMHC employs over 120 supervising psychologists, school psychologists, school social workers, case managers and alcohol and drug counselors and offers an array of school-based services (Figure 1) including:

- Psycho-educational assessment
- Individual counseling to promote social-emotional development
- Crisis intervention and postvention
- Threat assessment
- Alcohol and drug counseling
- Parent training
- Group counseling to promote development of social skills and interpersonal communication
- Specialized services to Alternative and Innovative school students
- Academic and behavioral consultation to parents and teachers
- Functional Behavior Assessments and Behavior Intervention Planning
- Case management services to pregnant and parenting students
- Summer Programs
- Social work services to students in the Day Treatment program

Contact:
Dr. Randy Schnell, Director
Office: (901) 416-1386
e-mail: schnellr@mcsk12.net
Core Team Services

MCSMHC serves the majority of its clients (Memphis City Schools students) through referrals made by Student Support Teams located in each school. These “problem solving teams”, designed to address academic, behavioral, and other school adjustment problems, are composed of a student’s parents, teachers, school counselor, and other members, which may include the school psychologist and school social worker. As part of the teams’ process, a student may be referred to the school psychologist and/or school social worker for counseling services (group, individual, or family), or testing for special-education and Section 504 eligibility. When students are referred due to social-emotional challenges, the mental health professionals also lead the team in functional behavioral assessments/ behavior intervention planning.

When Student Support Teams (S-Teams) or Individualized Education Program (IEP) teams decide that assessments are needed to determine special education eligibility or to, otherwise, assess the educational and social-emotional needs of students, referrals are made to the school psychologist to conduct such evaluations. School Psychologists are involved in assessments for Autism, Developmental Delay, Emotional Disturbance, Functional Delay, Intellectually Gifted, Mental Retardation, Multiple Disabilities, Other Health Impairment, and Traumatic Brain Injury, as well as other disabilities.
Introduction

Additionally, Center clinicians serve as members of S-Teams and IEP Teams to address the emotional and behavioral needs of students. To begin this process, Mental Health Center clinicians, in partnership with school staff and parents, conduct functional behavioral assessments to better understand the functions of a student’s behaviors. The team then develops behavioral intervention plans to assist in providing for the student’s behavioral needs.

School Social Workers and School Psychologists also conduct evaluations of children who are suspected of having a diagnosis of Attention-Deficit/Hyperactivity Disorder. They perform these assessments in order to determine eligibility under Section 504 of the Rehabilitation Act of 1973 so that necessary services and aids may be provided to meet the educational needs of handicapped students. Supervision of core team services is provided by licensed doctoral level psychologists.

Contacts:
Dr. Mary Berk, Supervising Psychologist Northeast Region
Office: (901) 416-0410
e-mail: berkm@mcsk12.net

DR. Anitra Shelton Quinn, Supervising Psychologist Northwest Region
Office: (901) 416-1331
e-mail: quinna@mcsk12.net

Dr. Natalie Wilkins, Interim Supervising Psychologist Southeast Region
Office: (901) 416-1397
e-mail: wilkinsn@mcsk12.net

Dr. Princess Coleman, Supervising Psychologist Southwest Region
Office: (901) 416-0411
e-mail: colemanp@mcsk12.net

Innovative School Team Services

The Memphis City Schools Mental Health Center Innovative Schools Team supports students, teachers, parents, and other education-related stakeholders in removing barriers to teaching and learning by providing specialized mental health services in these schools. The team’s primary goals are to help improve school climate, and assist students, teachers, and family members in solving problems in a manner that supports academic, emotional, and adaptive social learning.

The Innovative Schools Team serves a variety of students; these include students who are suspended, expelled, college preparatory, and attending the Transition Center, “Choice” and “Success” schools. Program structures are set to accommodate students who are in need of special learning environments (enrichment and remedial) in which student-teacher ratios are low and opportunities for success are maximized. Strategies include individualized academic and social skills training. General and special education students are also served.

The Innovative School Team consists of school psychologists, school social workers, and a Supervising Psychologist. Mental Health professionals services equivalent to those providing Core Team services except that services to Innovative Schools students are more frequent and inclusive. These highly-trained specialists work closely with other service providers (guidance,
behavior specialists, nurses, physical and speech therapists, homecare agents, outside agencies, regional mental health teams) to maximize best practice service delivery to students, family members, faculty, staff, and administrators.

**Contact:**
Supervising Psychologist: Dr. James R. Bailey  
Office: 901-416-0445 or 901- 416-5600  
e-mail: baileyj@mcsk12.net

**Alcohol and Drug Clinical Program**

The Adolescent Outpatient Alcohol and Drug Treatment Program of the Memphis City Schools Mental Health Center is a low intensity adolescent outpatient program designed to serve the needs of students of the MCS who are experiencing problems with the use of alcohol and other drugs such that they are eligible for a DSM-IV diagnosis of substance abuse or dependence and who can benefit from an outpatient program.

Services offered include:
- Comprehensive substance use assessment,
- Individual counseling,
- Family counseling,
- Group counseling,
- Relapse prevention counseling,
- Family consultation, and
- Referral (if a higher level of care is necessary).

Individual counseling is usually provided at the school in which the student is enrolled and family counseling is conducted at the MCSMHC, the Pupil Services Center, the student's school, or another MCS facility. Individual counseling is also available at the MCSMHC. Treatment Groups are typically held at the Pupil Services Center (PSC) for students who have been board suspended for an alcohol- or other drug-related offense. If a student is unable to benefit from outpatient therapy, every effort is made to secure a placement in line with the student's needs. In the case of a student returning from a period of residential or inpatient treatment, relapse prevention and supportive counseling is available at the school through the A&D Clinical Team as an adjunct to the student's Aftercare program developed by the residential or inpatient facility.

All services are provided at no cost to students of the Memphis City Schools. The MCSMHC Alcohol and Drug Adolescent Outpatient Treatment Program is funded in part by a grant from the TN Department of Mental Health and Developmental Disabilities, Division of Alcohol and Drug Abuse Services.

The Intensive Focus Group Program is a prevention/intervention program concerned with the identification of substance use and prevention of deterioration of functioning and condition due to substance use. This is done by providing Intensive Focus Group services to students at the first instance of their coming to the attention of the discipline system of the MCS for an alcohol-
or other drug-related offense. Students are screened and assessed in order to determine whether they are in need of more intensive services.

The Intensive Focus Group Program is a structured, time-limited, educational/counseling program for students at high risk to become harmfully involved with alcohol and/or other drugs. The program is presented in a group format grouped by age, developmental level, and degree/extent of substance use. A trained alcohol and drug counselor facilitates each Intensive Focus Group. Activities in the program include lectures, experiential activities, and self-awareness activities designed to provide participants with accurate information regarding alcohol and other drugs as well as skills in decision-making, impulse control, communication, and stress management. Specialists in HIV/AIDS and other STD's and members of the Memphis Police Department's Crime Prevention Unit also conduct group sessions on *HIV/AIDS and Drug Use* and *Legal Issues Of Drug Use and Abuse*, respectively.

**Contact:**
Dr. Lisa Clark, Supervising psychologist  
*Office*: 901-416-5600  
*e-mail*: clarkl@mcsk12.net

**Threat Assessment Team**

The Threat Assessment Team (TAT) promotes the safety of Memphis City Schools by conducting extended threat and mental health assessments with students whose behavior is indicative of substantive threats of violence to others. The purpose of the assessment is to: 1) evaluate the student’s intent, their motivation for making threats and their existing mental/emotional adjustment; 2) identify risk factors for violence in general; and 3) make recommendations intended to reduce the risk of violence and enhance school adjustment. These services are dedicated to addressing the safety of all students/faculties as well as the mental/behavioral health needs of students.

The TAT is comprised of one Supervising Psychologist, three School Psychologists and three School Social Workers having advanced degrees in their respective professions. In addition to previous experience in education, special education, child/adolescent psychology and clinical social work, team members have received specialized training in conducting both threat and risk assessments.

**Contact:**
Supervising Psychologist: Dr. Ken C. Strong  
*Office*: (901) 416-6290  
*e-mail*: strongk@mcsk12.net

**Crisis Response Services**

MCSMHC responds to school based mental health emergencies and crisis incidents by providing expert mental health services to students and consultation to staff. In the event of a crisis, the
center deploys a team of professionals that includes school social workers, school psychologists and supervising psychologists to provide assessment, supportive counseling, and assistance to administrators in coordinating a crisis response plan and postvention services.

MCSMHC clinicians have received specialized crisis response training to address events that may severely impact the psychological functioning of students. Responders are called to schools for a variety of incidents impacting individual students (e.g. suicide threat), groups of students (e.g. death of student), and school wide populations (school shooting). Clinicians are also involved in recovery activities including defusing and debriefing, and follow-up with students, teachers, and parents.

Once a crisis occurs, a school administrator calls a dedicated crisis hotline at the center. Basic information is taken and conveyed to a supervising psychologist who deploys a team to the school. Responders maintain contact with the supervising psychologist for direction and support. Details of the event and response are recorded and entered into a confidential data base.

**Contact:** Dr. Randy Schnell, Director  
*Office:* (901) 416-1386  
*e-mail:* Schnellr@mcsk12.net

**Day Treatment Program Services**

The Memphis City Schools Mental Health Center provides eight licensed mental health clinicians (six School Social Workers, one School Psychologist) and one supervisor (LCSW) to deliver a full range of mental health services to the students served in the seven CDC-ED Day Treatment classes district-wide. One MCSMHC professional is assigned full-time to each classroom to provide ongoing individual and group therapy as indicated by the students' Individualized Education Plans. They also work alongside the special education teacher and two para-professionals in the classroom to observe student functioning, provide positive behavioral supports, and behavioral “de-escalation” or crisis interventions. They maintain regular contact with the students' caretakers and serve as liaisons between the school, the family and the community in procuring additional services as needed. They also participate in weekly psychiatric consultation provided through a contract with the University of Tennessee Center for the Health Sciences.

**Contact:** Ms. Annice Overall  
*Office:* (901) 416-0424  
*e-mail:* Overallar@mcsk12.net

**Prevention Services and Training**

MCSMHC clinicians provide ongoing prevention services to students throughout the school year. For example, the MHC offers annual suicide prevention instruction to all ninth graders. This service is delivered in conjunction with the Family Life Curriculum unit on depression and suicide.
Introduction

Each year, school psychologists team with school counselors to train all elementary school faculties and some secondary school faculties on the Student Support Team process. Student support teams, comprised of classroom teachers, counselors, parents and mental health personnel, engage in a problem solving to assist students experiencing academic and/or behavioral difficulties. Faculties and principal groups also receive professional development to enhance instructional strategies with students showing traits of ADHD and on evaluating the risk potential of students who threaten or commit violent acts.

Summer Programs

MCSMHC summer staff participate in specialized programs to address the social-emotional development of students. These programs, sometimes taking the form of brief summer camps, are offered at a limited number of school locations. Students may be referred by their schools for a summer camp or students may be seen as an adjunct to summer school programs. The camps support improved adaptive functioning in a variety of domains including social skills, emotional sensitivity, trauma recovery, and resilience. These skills are taught in an enjoyable environment often utilizing play therapy techniques.
Section II: Program History
Program History

The concept of the Memphis City Schools Mental Health Center (MCSMHC) had its beginnings in the winter of 1964 when a small group of professionals began to meet and discuss the possibility of creating a mental health center within the context of large urban school system. Those individuals were lead by Dr. Leon Lebovitz, who at that time was the only psychological services employee (on a half-time basis) in the Memphis City Schools. Dr. Lebovitz was well aware of the literature in school psychology and of the growing movement toward school mental health consultation. Thus, Dr. Lebovitz made use of several of the major tenets of the mental health consultation model as he began to develop the concept of the MCSMHC:

a. Mental health services to children need to be preventive in nature.
b. A great deal of primary and secondary prevention can be accomplished within the context of a school system, “where the students are”.
c. Optimal use of resources can be achieved by “piggy-backing” mental health services on existing systems.

In November of 1969, the Memphis Board of Education and the Tennessee State Department of Mental Health finalized and put into operation the Memphis School Mental Health Center. This project was the culmination of approximately two years of discussion among representatives of the two organizations. The birth of MCSMHC represented a breakthrough in the development of community mental health services in an urban school district.

Under the leadership of Dr. Lebovitz, MCSMHC made dramatic structural and programming gains from 1970-75. During this period Cherokee Mental Health Center (later Oakville Mental Health Center) and Berclair Mental Health Center opened as satellite centers where clinical staff were housed. The administrative office remained at the BOE. In 1971 the Center received grant from the TN. Department of Mental Health [under Title 4(a)] to provide mental health services to needy children. This contract ended in 1973.

In 1975, Dr. James Paavola was named as the second director of MCSMHC. Having graduated from one of the few doctoral school psychology programs in the country, Dr. Paavola had been employed as a school psychologist with MCSMHC from its inception. Dr. Paavola’s tenure coincided with the enactment of PL94-142, the federal law mandating a free and appropriate education for all children. This new law triggered a dramatic expansion of services to disabled children. Specialized evaluation procedures for special education eligibility were federally mandated leading to a significant increase in the number school psychologists to conduct these evaluations.

The next decade witnessed a massive proliferation in referrals for special-ed testing. Archival records reveal a 3000 case backlog of special education testing cases during the 1980-81 school year.

During this period, MCSMHC was instrumental in the mandated implementation of School Support Teams, which were established as a managerial structure and problem solving
process for students referred for special-education consideration. School psychologists became integral to the functions of these teams.

Under Dr. Paavola’s tenure, the Center received a social services block grant (under Title XX) to provide mental health services to victims of child physical or sexual abuse. The Center partnered with the TN Department of Children’s Services to identify and serve these children.

With structural program improvements and an expansion of services to schools, including provision of alcohol and drug prevention and treatment services, MCSMHC received an Award for Excellence from the American Psychological Association (APA) and National Association of School Psychologists (NASP) in 1982. During the 1980’s MCSMHC gained further recognition as a model provider of school mental health services. In 1986 the Center was featured in a full page article in APA Monitor, the organization’s monthly newspaper. Professional articles featuring MCSMHC programs and services were also published in the Journal of Professional School Psychology and in an edited book (see attachments) during this period. In 1993, MCSMHC received a second award by the APA as a Model program for Service Delivery.

With Dr. Paavola’s promotion to Associate Superintendent, Dr. Geri Nichol was named as Center Director in 1995. Also trained as a school psychologist, Dr. Nichol had been working as Assistant Director for the Center when promoted. Upon Dr.Nichol’s retirement in 1995, the Center entered into a period of dubious direction after approximately twenty-five years of stable leadership. After one year with interim director, Ms. Arlie Dancy, MCSMHC was lead by Dr. Katheryn Lelauren for less than one year. From 1997 to 1999, Center supervisors reported directly to an assistant superintendent. In 1999, Ms. Jeanne Chapman became Director of the Division of Health and Social Support, encompassing MCSMHC, guidance, and school health.

Perceiving the need for evaluation of the Center’s program services and processes, Assistant Superintendent, Dr. Johnny Watson initiated a program review in 2000 by consultant Dr. James Paavola. As part of his report, Dr. Paavola presented a highly critical appraisal of the Center’s administrative leadership. During that year, Dr. Angie Sanders was promoted to the new position of Clinical Services Coordinator in an attempt to stabilize the program. Dr. Sanders had been serving as Supervising Psychologist with the center at the time of her appointment.

**Current Structure**

The Center’s administrative model was maintained until 2003. In 2003, 33 school psychologists and three supervising psychologists were transferred from MCSMHC to the Division of Exceptional Children (DEC) in large part to resolve compliance problems with special education testing timelines. As the 2003 school year drew to a close, the Division of Health and Social Support was eliminated. Consequently, the DEC, MCSMHC and School Health Services were reorganized under the new Division of Exceptional Children and Health Services (DECHS). There is no record that the MCSMHC Board of Directors met to discuss the Center reorganizations during this period. After the departure of Dr. Angie Sanders, Dr.
Program History and Current Structure

Randy Schnell, a twenty year employee of the Center, was promoted to Mental Health Center Clinical Services Coordinator under the new DECHS Executive Director, Dr. Patricia Toarmina. Under the district’s administrative realignment in 2011, Dr. Schnell was promoted to MCSMHC director. (The Director position had not been filled since 2003-10.)

Memphis City Schools Mental Health Center has been an administrative component within the DECHS since the onset of the 2003-04 school year. This structure (See Figures 1 and 2) was established to promote increased communication and coordination of services to students and schools. Since this reorganization, “on time” completion of testing for special education eligibility has increased dramatically and coordination of procedures/regulations has led to increased program efficiency. In 2007, MCSMHC was cited in the book School Psychology, Past Present and Future (Fagan, T. and Wise, P.S.) as a model program for school mental health organization. Center clinicians are now better able to consistently conform to the array of regulations that direct their work. Because of the co-location of personnel who now comprise the division, mental health staff have direct access to professionals with whom timely, ongoing, face-to-face contact is often necessary.

The Memphis City Schools Mental Health Center continues to function as an independent private nonprofit corporation devoted to providing services to Memphis area children with learning and/or adjustment difficulties. MCSMHC has provided leadership in development of several services including the Student Support Team model, Threat Assessment program, and Crisis Response program in the early 1990’s and, more recently, the district’s three tier RtI academic model and the Behavior Plus intervention and data system. The MCSMHC is unique in that it blends the talents, orientation, and philosophies of the professions of psychology, social work, education, prevention, and public welfare. Services are provided at no charge to MCS students and their families. Some services are also provided to private schooled students.

References
Policy Statement: School-Based Mental Health Services Pediatrics Vol. 113, No. 6, June 2004, pp. 1839-1845


New York State Office of Mental Health School Based Mental Health (SBMH) Internet Search

Center for School Based Mental Health Programs: Miami (Ohio) University Shared Agenda Overview Internet Search
### Executive Director
Provide leadership, management and supervision for Special Education, Mental Health and School Health Services.

### Mental Health Director
Coordinates’ administrative and clinical functions of the Mental Health Center to meet licensing/compliance requirements through data management, monitoring and reporting, while assuring professional and ethical guidelines upon timely delivering of services to schools, teachers and parents.

### Supervising Psychologists
Supervise School Psychologists and School Social Workers on assessment, eligibility, treatment and behavioral issues. Consult with Special Education Coordinators on IDEA and ethical concerns and coordinate Crisis response.

### School Psychologists
Provide consultations, assessments, interventions and preventive services to students, teachers and families.

### School Social Workers
Provide consultation, evaluation, and referral and treatment services to children, families and schools, using social work, mental health, and education.
Section III:
Service Delivery Model
Memphis City Schools Mental Health Center has adopted a holistic, three tiered service model for provision of academic and behavioral supports to all students. As illustrated, this model is designed to address both the academic and behavior needs of all students (Figure 1).

This model, referred to as Response to Intervention (RtI), serves as a unifying methodology for applying a continuum of universal prevention services for all students, moderate intensity intervention for students at risk, and high intensity intervention for students who have begun to demonstrate significant deficits or problem behaviors. Figure 2 highlights some of the activities and interventions used to address student needs in each tier. Figure 3 illustrates services provided in all three tiers by specific MCS departments. The majority of services are provided by programs in the Department of Student Support and MCS Mental Health Center.
Service Delivery Model

Memphis City Schools Mental Health Center Annual Report – 2011/2012
Service Delivery Model

The Three Tier Model

The three tiered mental health service delivery model represents a systematic method for evaluating the academic and social-emotional needs of all students and for fostering positive student outcomes through carefully selected screening, instruction, prevention activities, and interventions. In accordance with this model, services and programs are provided for students at increasing levels of intensity when formal monitoring of performance and progress indicate a need.

A three tiered instruction and intervention model may be effectively applied to students experiencing academic or behavior challenges. For many students it is impossible to separate the relative influences and interactions of academic and behavioral deficits on their overall performance. Therefore, the interrelated influences of behavioral and academic proficiencies on global student performance call for an intervention model that can simultaneously address deficiencies in both domains. As a student is determined to not be responding to instruction and/or school wide behavioral expectations, both academic and behavioral strategies are considered when planning interventions.

Instruction and interventions encompassed within this model may fall within three broad classes or tiers.

**Tier I** consists of core academic and behavioral instruction and supports, prevention activities, and universal screening to identify students’ specific individual needs.

**Tier II** involves more intensive, targeted, relatively short term interventions for students considered at-risk (i.e. students have begun to show risk factors or signs of weak or diminished performance).

**Tier III** interventions are individualized, longer term interventions often requiring a student specific plan and additional resources. Students requiring Tier III services would have typically been unsuccessful in Tier I and Tier II interventions and begun to demonstrate significantly maladaptive behaviors and/or prolonged academic deficits.

These core components are necessary for implementation of a three tier model:

- **Universal Screening**
  All students are assessed with valid, time-efficient measures of academic and behavioral skills to identify those who are “at-risk”

- **Timely Research Based Intervention Implemented with Fidelity**
  Intervention is provided according to design when problems first appear

- **Frequent Monitoring of Student Progress**
  Student progress is assessed frequently so progress can be examined and changes made if necessary

- **Interventions Increase in Intensity**
  Interventions are increased in intensity of desired progress is not made

- **Decisions Based on Data**
  A student’s academic and behavioral performance using progress monitoring data and decisions are made based on those data
Benefits

The three tier model, incorporating PBIS and RtI, represents a proactive approach for addressing the academic and behavioral needs of all students. Emphasizing measures of fidelity to ensure validity of implementation, the model promotes research based prevention activities, instruction, and intervention to ensure student success. By ensuring fidelity of implementation, insufficient academic or behavioral instruction may be ruled out when students do make adequate progress.

The three tier model will help professionals:

- Immediately identify students having academic or behavioral difficulty
- Initiate research-based intervention early in the student’s program when that help is most beneficial
- Incrementally track student progress over time using data based progress monitoring
- Monitor the effectiveness of instruction for individual students and whole classes
- Frequently monitor student progress and provides data for decision making
- Incorporate multiple systems of intervention represented in the three tiers
- Compare students’ performance and progress with others is the class, school, and district
- Encourage an environment of clearly communicated and actively reinforced rules, reward structures and sanctions for violations
- Employ systems and strategies that prevent behavior problems rather than relying on punitive consequences to deter problem behavior
- Reduce over-identification of minority students as academically or behaviorally disabled
- Use of most effective behavioral interventions (i.e. social skills instruction, instructional and curricular adaptations, and behavioral approaches)
- Promote positive school climate, positive expectations, and healthy relationships as primary factors in school performance

Policy and Legislation:

The three tier model is supported for improving student academic performance by district policies. MCS policy (4.603) states that at-risk students should be identified “as early in the school year as possible” and that schools “continuously monitor student’s progress and place students in the appropriate academic settings and programs that will foster student learning and master of subject matter”. Further, policy states that “interventions will occur on an ongoing basis”. The Student behavior policy (6.313) strongly supports “effective prevention and intervention strategies that prevent” maladaptive behavior. Behavior programs that “teach, model, encourage, reward, and support positive behaviors in students” are advocated as well. The Student Support Process is discussed as a means for integrating “school and district-wide behavior intervention strategies with all aspects of a school’s support services”. Utilization of specific classroom strategies, school-wide strategies and district-wide strategies is presented in detail.

State and federal legislation specify the use of the three tier model. Tennessee statute 3.104 states, “To ensure the prevention and correction of reading difficulties as well as improving reading instruction for all students, districts and schools must adopt a three tier reading model for reading instruction”. The Individuals with Disabilities Education Act (2004) encourages the use
of RtI for identification of Learning Disabilities (LD) and federal regulations mandate use of RtI components in its LD standards.

**Positive Behavior Intervention Support**

The Positive Behavior Intervention Support (PBIS) process has been adopted by a growing number of school systems around the nation, including many Tennessee districts. PBIS teams develop school wide systems that support staff to teach and promote positive behavior in all students. Using PBIS, schools build their capacity to establish positive social cultures and implement effective school wide and classroom behavioral support.

PBIS activities are essential for an effective three tiered system of prevention and intervention. Rather than focusing solely on academic supports, PBIS emphasizes school-wide support systems to address student social-emotional and behavioral adjustment. Using PBIS, schools establish proactive strategies to define, teach, and support appropriate student behaviors. Incorporating this holistic “systems” approach, the capacity of schools to impact the behavioral functioning of all students is enhanced by making problem behavior less effective and less relevant, and desired behavior more functional. PBIS practices apply research-validated strategies in classroom and non-classroom environments.

Utilizing PBIS, all students (and teachers) participate in activities and programs designed to create a supportive school climate and to increase skills for positive relationships and social/emotional development. Students who, after receiving these universal supports, continue to exhibit behavioral adjustment problems progress through a hierarchy of increasingly more intensive interventions. These may include group and/or individual counseling, therapeutic in-school suspension, functional behavioral assessment /behavioral interventions, teacher-parent consultation, referral for community services, or home visits. Depending on the nature of presenting problems, a student may also be referred for special education evaluation.

The school level structure and processes for PBIS are established by the PBIS team: the team is comprised of administrators, faculty, curriculum leaders, school counselors, itinerant staff, the student body, and support staff (e.g., building maintenance, cafeteria workers, and bus drivers). The school PBIS team functions to:

a) Conduct a self assessment resulting development of a school and classroom discipline plan,

b) Maintain the plan by monitor compliance and effectiveness,

c) Identify and implement a program for celebrating and rewarding the successes of individual students and teachers, and groups (e.g., classrooms) of students and teachers.

d) Identify and implement prevention programs and activities designed to foster positive behavioral adjustment,

e) Establish referral mechanisms for referring students to Tier II and Tier III interventions,

f) Implement a program for positive parental involvement.

MCS Mental Center clinicians participate actively in the PBIS process by:

- Participating in the evaluation of schools’ PBIS implementation
- Participating in schools’ PBIS teams to develop school wide activities
- Providing universal and targeted classroom prevention training
• Participating in the district wide Healthy Choices initiative
• Administering Youth Risk Behavior Surveys to eligible students district wide
• Consulting with parents whose children fail the Well Child Mental Health Screen administered district wide

Response to Intervention

Response to Intervention (RtI) is the practice of: a) providing high quality (academic and behavioral) instruction and intervention matched to student need, b) monitoring progress frequently to make decisions about modifications to instruction and, c) applying student performance data to inform general educational decisions. RtI may be applied to decisions in regular education, remedial programming, and special education, creating a well integrated system of instruction/intervention guided by child outcome data. (National Association of State Directors of Special Education, 2005). Student outcome data are essential for:

• making accurate decisions about the effectiveness of general and remedial education and interventions;
• early identification/intervention with academic and behavioral problems,
• preventing unnecessary and excessive identification of students with disabilities;
• deciding eligibility for special education programs; and
• determining individual education programs as well as delivering and evaluating special education services.

Utilizing RtI, students are administered effective, evidence based academic and behavioral instruction. If satisfactory progress does not occur, students then progress through a hierarchy of increasingly more intensive individualized interventions. This process may ultimately culminate in an assessment for special education, but not before careful analysis of the RtI data and a determination that options in the general education program have been exhausted.

MCS Mental Health Center clinicians may serve a number of functions in the RtI process. These include:

• Assisting with administration and interpretation of curriculum based assessment and progress monitoring
• Providing consultation and mentoring to teachers and parents regarding students’ academic and behavioral functioning
• Serving as active members of Student Support Teams
• Providing student assessment for special-ed eligibility, conducting Functional Behavioral Assessments and assist in the development of Behavior Intervention Plans
• Providing individual, group, and family counseling
• Conducting Threat Assessments for students threatening or committing acts of violence
• Providing diagnostic and therapeutic intervention for students with problems resulting from alcohol and/or drug use
• Providing case management services to pregnant and parenting students
• Providing consultation and behavioral assessment of preschool and Head Start students
Using RtI to Enhance Parent Involvement

RtI is designed to foster parental participation in their children’s education. Parental involvement is crucial to all phases of a successful RtI program. Schools must make a concerted effort to involve parents as early as possible beginning with instruction in the core curriculum. At the start of the school year notices should be sent home to all parents explaining processes and resources in place to address the needs of all students. This letter should be welcoming and convey the school’s intention to establish partnering relationships with parents.

Beginning early in the school year, parents receive data from the school including standardized test results, benchmark assessment reports, report cards, and other documentation of student progress. As universal screening or benchmark data reveal a significant delay in student’s progress, parents should be (a) notified that a standard intervention is being initiated or (b) invited to a problem solving meeting to discuss student specific interventions. Parents of students receiving intervention should receive progress monitoring reports at least monthly.

The Student Support Team

The Student Support Team (S-team) is a multi-disciplinary team typically consisting of a student’s teacher(s), parent(s), school counselor, and a district mental health clinician (Figure 4) that functions as a forum for discussing, planning, and evaluating a student’s progress in Tier 2 and Tier 3 academic and behavioral interventions. In this function, the S-Team can enhance team members’ skills in utilizing data to evaluate student performance, implement academic and behavioral interventions, and establish other supports, when needed.
Service Delivery Model

The S-team is a problem solving forum for parents, teachers, counselors, administrators, support staff, and community agencies to discuss concerns around the academic and behavioral adjustment of individual students. This process promotes efficiency through a multi-systemic, “wraparound” approach to service delivery (Figure 5). This approach emphasizes the student’s development within environmental systems including school, family, and community. The value of the S-Team is expressed through the communication among the adults with most influence on the student, as well as other professionals who work cooperatively to provide support.

**Figure 5**

**Multi-systems/“Wraparound” Approach**

The student support process is designed to assure that all general education students are given the opportunity to be successful by providing a structured support system for teachers and parents when students are not succeeding academically and/or behaviorally. To operationalize this process, the S-Team serves as a forum for its members to engage in a structured, student-focused problem-solving process. The team serves to improve the quality of teaching and learning by utilizing data to evaluate individual student performance and determining interventions.

The S-Team is central to delivery of Tier 2 and Tier 3 services under the RtI model. Once the team evaluation of the student is completed, implementation of standard protocol (Tier II) or individualized (Tier III) interventions is begun. The student’s progress is graphed by plotting
weekly data points. Intervention fidelity is assessed by methods such as objective observation or performance outcome analysis.

Summary

Memphis City Schools Mental Health Center has adopted a holistic, three tiered service model for provision of academic and behavioral supports to all students. This model incorporates two complementary approaches, Positive Behavior Intervention Support (PBIS) and Response to Intervention (RtI). This model offers many benefits to the district including the adoption of research based instructional strategies implemented with fidelity and frequent systematic tracking of student progress to measure progress and help determine instructional needs. The Student Support Team is integral in the implementation of the three tier model as a forum for parents, teachers and other professionals to problem solve and develop plans for students’ growth. The model is supported by district policy and state/federal legislation.
Section IV:
Contracts and Grants
Contract and Grant Funded Services

The following contracts and grants (totaling $586,260) were in place for the 2011-12 school year. Memphis City Schools Mental Health Center was the grantee in all cases. (Documents follow this page.)

1. Tennessee Department of Mental Health and Developmental Disabilities:
   A. Adolescent Outpatient Treatment ($198,260.00)
   B. Intensive Focus Group for early intervention services ($135,000)

   MCS students experiencing problems with substance abuse receive individual and group counseling via a research based intervention program. Parent support and consultation to school personnel are also provided.

2. Tennessee Department of Education: Suspension/Expulsion Reduction for High School Students with Disabilities ($174,000.00)

   Mental Health Center clinicians partner with special education teachers to provide the Why Try motivational curriculum to students with disabilities in six selected schools. The Why Try program serves as part of school wide plan to reduce suspension and expulsion rates among students with disabilities.

3. Shelby County Government Head Start: Psychological services consisting of student observations, functional behavior assessments/behavior intervention plans, and teacher-parent professional development and consultation. ($25,000.00).

   Under terms of this contract, a variety of services are provided at a maximum annual compensation for the district of $25,000. These services consist of: a) classroom observations, b) student observations, c) consultation to parents and teachers, d) teacher professional development, and e) Functional Behavior Assessments and Behavior Intervention Plans.

   MHC clinicians observe all MCS Head Start classes and provide written reports for the teachers. These reports include general recommendations and recommendations for specific students who appear to have special needs. Observations of specific students are also conducted when teachers have concerns and require consultation to help meet these students’ needs. Center clinicians also provide training and consultations to teacher/parent teams and groups, as well as individual parents and teachers. **55 classroom observations and 24 consultation sessions were conducted during the 2010-11 school year.**


   ($578,000 over two years)

   Memphis City Schools Mental Health Center, in partnership with Well Child, Inc., will work with pregnant and parenting high school students to assure necessary prenatal and
postnatal medical care. Students will receive instruction on child development and nurturing, non-violent parenting practices. In home services are offered and “baby stores” with free items are located at two sites in the city.

*To begin in the 2012-13 school year

5. TDOE Discretionary Grant to Reduce Suspensions/Expulsions Among High School Students with Disabilities

The need for this project is state performance goals and indicators for children with disabilities are established which are consistent with high expectations and with education goals and standards for children without disabilities. The aim is to show a reduction in suspension/expulsion rates for SWD for the 2011-2012 school year. MCS is out of compliance for having a suspension/expulsion rate over one (1) percent for SWD. During the 2008-2009 school year, the suspension/expulsion rate was as high as 8.02%, a two percent increase. Research has repeatedly shown that suspension, expulsion, and other punitive consequences are not the solution to dangerous and disruptive student behavior. The number of suspensions for selected schools has decreased compared to the same time last school year. Parent meetings and faculty presentations will assist with achieving a reduction in suspensions/expulsions along with increased appropriate use of ISS and principal and staff will be more knowledgeable of suspension/expulsion requirements for students with disabilities.
Section V: Referral Process
Referral Process

During the 2011-12 school year, referrals to MCSMHC were processed using an electronic data system developed with the Professional Consulting Group (PCG) during the previous school year. This system fosters a seamless and efficient referral process and significant time saving for teachers: 1) student demographic information was imported from the district’s SMS data base, 2) documentation academic and behavioral benchmarks, interventions, and progress monitoring were imported from the Ed Plan data System, and 3) completed referral forms were submitted electronically to the S-Team chairperson for processing.

During the 2011-12 school year, the majority of referrals were made by school personnel and parents through Student Support Teams (S-Teams) that exist in all Memphis City Schools. School counselors, who function as S-Team facilitators, receive the documents from teachers electronically and then schedule the meeting. At the S-Team meeting, the counselor documents additional history and the new interventions. Typically, MCSMHC staff conduct parent teacher interviews, offer consultation, conduct Functional Behavior Assessments and develop Behavior Intervention Plans. When appropriate, the team may make a recommendation for special-education assessment or Section 504 disability assessment.

The Student Support Teams function as a problem solving forum for parents, teachers, counselors, administrators, support staff, and community agencies to discuss concerns around the academic and behavioral adjustment of individual students. Teams review student referral data, examine interventions previously conducted, conduct informal assessment, and develop and monitor intervention plans.

Referral (and S-Team) procedures continue to promote a holistic philosophy of student adjustment through an ecological, multi-systemic approach to service delivery. This approach emphasizes the student’s development within environmental systems including school, family, and community (see Student Support Team subheading in the Service Model section).

Students were also referred via procedures external to the S-Team process. These students are referred to one of three MCSMHC “specialty teams” which to address the needs of students a) with alcohol and/or drug problems, and b) who have committed serious acts or threats of violence (particularly against school personnel). Students were referred to the Alcohol and Drug Clinical Program (see Section VII C) primarily through the Pupil Services Center where student expulsions are processed, however referrals may have also come from school personnel, parents or student self referral. Traditionally, the Pupil Services Center has also been the primary source of referrals to the Threat Assessment Team (see Section VII B), though an increasing number of referrals were made by school principals seeking consultation or assessment of violent students.
Section VI: Program Innovation and Growth
Section VII:

School Year in Review
Program Development and Innovations

All MCSMHC personnel strive toward personal professional growth and continual program development through innovation, creativity, and initiative. These seven initiatives represent work toward this end.

The Behavior Plus data system, in full implementation, was made available to all school personnel in grades K-8. Among the various modules, the Universal Behavior Screening offered teachers an efficient and detailed technology with which to measure student social-emotional growth and track it over time.

The Behavior Plus data system represents “best practices” for assessment and behavior planning related to students’ social-emotional adjustment. The Behavior Plus System is compatible with the three tier model (see Section III) utilized by MCS problem solving teams to address the academic and behavioral needs of students experiencing difficulties.

The Threat Assessment Team (TAT) and the Office of Student Management Systems, in a collaborative effort, developed procedures that now allow the TAT to enter data on all new threat assessment referrals into the Power School Student Management System. Principals, assistant principals and district administrators may now see when a student has been referred to the TAT and whether the threat was transient (and returned to the district hearing officer for adjudication) or substantive/serious. In substantive cases, the student’s assessment date will be indicated as well as the date the threat assessment report was completed. When checking the disciplinary history of a student who has transferred from one school to another, it will be possible for a principal/assistant principal to see if a threat assessment was recently conducted, and how to get assessment findings.

The TAT and the Office of Policy Development worked together in recent months to formalize threat assessment procedures as part of the policy on Student Behavior (6.313). These changes explain the actions taken by the disciplinary hearing authority in responding to dangerous weapons violations and substantive threats. The policy also serves to clarify how “threat” is defined and offers some guidance to school administrators in responding to threats.

The TAT has been meeting recently with staff from PCG to explore the feasibility of creating an Ed Plan component that would allow electronic reporting and tracking of threat assessment cases.
MCS Mental Health Center has been integrated into programs and services for MCS preschool students by contributing to the MCS PreK-3 Continuum and to a MCS contract with Shelby County Head Start.

In our previous report, we were encouraged by district approval for hiring four Behavior Analysts to provide specialized support to K-3 students experiencing severe social-behavioral adjustment challenges. These professionals, under the auspices of MCSMHC, would offer their specialized training and skills for evaluation and provision of direct services with these students. Further, the Behavior Analysts would provide direct support and coaching to individual teachers experiencing difficulties with student behavior. After months of processing through the MCS Human Resources-Compensation Department, these positions were recently posted. Services to K-3 student will begin 2nd semester.

A cooperative agreement has been arranged among MCS, Well Child, Inc. and Life Enhancement Services USA (LLS) to provide psychiatric services to MCS students in need of medical assessment (and intervention, if necessary) for suspected psychiatric problems. Psychiatric services will initially be offered to a small number of schools at the MCS Northside Health Clinics and expand to additional schools until all schools are eligible to receive the service by each of the four clinics. Psychiatric Services will be provided by a board certified child and adolescent psychiatrist and nurse practitioner.

Psychiatric services provided through the MCS clinics, compared with services from other providers, will offer parents at least three advantages:
- Transportation by Well Child, Inc.
- Flexible options for third part reimbursement
- Short waiting time for services.

Referral procedures have been established providing that MCSMHC clinicians, in cooperation with parents and school personnel, evaluate students with significant social/emotional/behavioral challenges to determine the need for a psychiatric examination. When a student is identified, the clinician or parent contacts LLS by phone or through the LLS website to make the referral.
Medical and counseling services to pregnant and parenting teens are funded through a contract with Shelby County Government. In a cooperative agreement among MCSMHC, Well Child, Inc. and a variety of other social service agencies, services from MCSMHC to pregnant and parenting teens include:

- Identification, recruitment, linkage/referral, and tracking of student clients,
- Transportation to medical appointments at the MCS Health Clinics provided by Well Child, Inc.
- Group counseling services utilizing the *Adults and Children Against Violence (ACT)* *Parents Raising Safe Kids Curriculum*. This is a research based curriculum sponsored by the American Psychological Association,
- Consultation to school personnel fostering positive educational outcomes, including graduation.
- Home visitation to promote clients’ social-emotional development.

Approximately 320 students will receive services from MCSMHC under this contract. Social workers will establish cooperative relationships with schools and community partners to improve clients’ access to medical and social

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**Mental Health 101** is a multi-modality professional development program designed to inform teachers about, 1) mental health issues affecting students and 2) the purpose and procedures of the Student Support Process. There are three component modules to the program.

**Video Presentation**: District personnel may view this 13 minute video on the MCS media site to learn how to recognize symptoms of mental health problems in young people and learn methods for supporting our students.

**Faculty Presentations**: This power point training presented to faculties by MCSMHC clinicians help teachers focus on their role in the S-Team process including, referrals, FBA/BIP, regulations, etc..

**TLA Presentation**: This four module sequential series presented at the TLA is titled: *Eliminating Barriers to Learning: Enhancing Students’ Social-Emotional Development*

- Module I: Eliminating Barriers for Learning: The Foundation
- Modules II: Social-Emotional Development, Mental Health, and Learning
- Module III: Making Help Accessible to Students and Families
- Module IV: Strategies To Promote a Positive Classroom Climate

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*Memphis City Schools Mental Health Center Annual Report – 2011/2012*
Co-occurring Disorders

A transformation has occurred in the philosophy and process of treating students with co-occurring mental health and substance abuse disorders. Research tells us that the majority of youth referred for substance abuse treatment have at least one co-occurring mental health disorder (COD); a DSM-IV-TR mental health disorder and a substance use disorder (SUD). Adolescents with substance use disorders are at a six times risk of having a co-occurring psychiatric disorder (Dennis, 2004). New procedures have been established as follows:

- Assessment of students for substance abuse disorders will include screening and, when necessary, full assessment of co-occurring mental health disorders.
- Maintenance of psychotherapy to treat the co-occurring disorder once substance abuse treatment is completed.
School Year in Review 2012-13

The following tables and narratives represent discussion and partial compilation of data for clinical services provided by the MCSMHC four regional teams, Innovative School team, Threat Assessment Team, Alcohol and Drug Clinical Program, Student Advocacy Services, and Crisis Response Team. Also represented are additional clinical services provided by Mental Health Center clinicians.

Part A  School Team and Innovative School Services
- Special Education Testing
- Counseling Services
- Functional behavior Assessments and Behavior Intervention Plans

Part B  Threat Assessment Services

Part C  Alcohol and Drug Counseling Services

Part D  Crisis Response Services

Part E  Well Child Mental Health Screening

Part F  Suicide Prevention

Part G  Preschool and Head Start Services

Part H  Summer programs

Part I:  Suspension Reduction for High school Students with Disabilities
Part A

Regional and Innovative School Team Services
Testing of Students with Disabilities

Number of Students Tested

During the 2011-12 school year, school psychologists conducted 3253 psychoeducational evaluations or reevaluations of students with suspected disabilities (Table 1) including initial evaluations, reevaluations of previously identified special education students, and CLUE evaluations. Examination of the most recent seven year trend reveals a steady rate of testing except for the 2008-09 school year when there was a significant decline. (Figure 1). Coincidentally, MCS initiated the RtI intervention plan that year. On a positive note, the number of students tested for the district’s gifted program continues to increase reflecting the success of Child Find processes. This trend notwithstanding, there was a significant decline in the number of Section 504 referrals for ADHD. This decline resulted from an improvement in the ADHD screening process, which resulted in fewer 504 evaluations for ADHD and a greater number of ADHD evaluations for special education eligibility.

Table 1
Number of Special Education and 504 Evaluations Completed

<table>
<thead>
<tr>
<th>Region</th>
<th>Initial Evaluations</th>
<th>Reevaluations</th>
<th>CLUE Evaluations</th>
<th>TOTAL Spec.-Ed.</th>
<th>ADHD (504)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>373</td>
<td>228</td>
<td>454</td>
<td>1056</td>
<td>122</td>
</tr>
<tr>
<td>Northwest</td>
<td>245</td>
<td>158</td>
<td>160</td>
<td>563</td>
<td>68</td>
</tr>
<tr>
<td>Southeast</td>
<td>422</td>
<td>242</td>
<td>222</td>
<td>886</td>
<td>70</td>
</tr>
<tr>
<td>Southwest</td>
<td>319</td>
<td>193</td>
<td>108</td>
<td>620</td>
<td>17</td>
</tr>
<tr>
<td>Innovative</td>
<td>9</td>
<td>5</td>
<td>0</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Total 2011-12</td>
<td>1368</td>
<td>826</td>
<td>946</td>
<td>3138</td>
<td>380</td>
</tr>
<tr>
<td>Total 2010-11</td>
<td>1432</td>
<td>882</td>
<td>939</td>
<td>3253</td>
<td>504</td>
</tr>
<tr>
<td>Total 2009-10</td>
<td>1224</td>
<td>760</td>
<td>948</td>
<td>2932</td>
<td>495</td>
</tr>
<tr>
<td>Total 2008-09</td>
<td>1008</td>
<td>819</td>
<td>899</td>
<td>2724</td>
<td>509</td>
</tr>
<tr>
<td>Total 2007-08</td>
<td>1274</td>
<td>847</td>
<td>858</td>
<td>2979</td>
<td>588</td>
</tr>
<tr>
<td>Total 2006-07</td>
<td>1468</td>
<td>656</td>
<td>809</td>
<td>2933</td>
<td>382</td>
</tr>
<tr>
<td>Total 2005-06</td>
<td>1544</td>
<td>645</td>
<td>718</td>
<td>2907</td>
<td>---</td>
</tr>
</tbody>
</table>
**Percent of Initial & Reevaluations On Time**

A primary work goal for school psychologists is the on-time completion of psychoeducational testing to determine referred students’ eligibility for special education services. Since the reorganization of the Division of Special Education and Health Services at the outset of the 2003-04 school year, school psychologists have dramatically improved on time testing (i.e., “turnaround time”). Testing turnaround time is measured in two categories, *initial evaluations* (regular education students being tested for the first time) and *reevaluations* (current special education students referred by their IEP team usually to determine continued eligibility).

Turnaround time for initial evaluations is measured as the number of school days from the date of parental written consent for testing to the date the school psychologist delivers the completed assessment report to the principal. School psychologists are required to complete this process within thirty school days, ten days fewer than the forty school days required for determination special education eligibility by TN Department of Education. Turnaround time for reevaluations is a more complicated calculation and varies according to students’ individual circumstances. But in all cases, testing must be completed within forty-five school days.

In *Table 2*, turnaround time data are reported for each of the district’s five regional teams, including the team serving Innovative Schools. As shown, many fewer students are tested for special education in the Innovative Schools than in any of the four regions. Among other reasons, this is largely due to the relatively small number of Innovative schools. Overall, ninety-nine percent (99%) of *initial evaluations* and *reevaluations* were delivered to schools on time. Data not shown indicate that nearly all cases not completed on time were no more than five days late.
Table 2
Testing Turnaround Time: Percent of Initial & Reevaluations on Time

<table>
<thead>
<tr>
<th>Region</th>
<th>Initial</th>
<th>Reeval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Northwest</td>
<td>98%</td>
<td>99%</td>
</tr>
<tr>
<td>Southeast</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Southwest</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Innovative</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>99%</strong></td>
<td><strong>99%</strong></td>
</tr>
</tbody>
</table>

Another way to measure turnaround time efficiency is by calculating the percentage of school psychologists who complete their testing cases within the thirty day requirement. This statistic is also useful accountability measure for individual school psychologists. Table 3 shows that ninety percent (96%) of school psychologists completed at lease ninety percent (90%) of their testing cases on time. Nearly all (93%) of school psychologists completed 100% of their cases on time.

Table 3
Testing Turnaround Time: Percent of School Psychologists’ on Time

<table>
<thead>
<tr>
<th>School Psychologists on Time</th>
<th>Initial</th>
<th>Reeval</th>
</tr>
</thead>
<tbody>
<tr>
<td>95-100%</td>
<td>92%</td>
<td>97%</td>
</tr>
<tr>
<td>90-95%</td>
<td>7%</td>
<td>3%</td>
</tr>
<tr>
<td>80-89%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>
Counseling Services

Among the varied Tier II and Tier III interventions offered through MCS Mental Health Center, student counseling, by far, represents the most utilized direct service to students. Individual, group, and (less frequent) family counseling are offered in all Memphis City Schools. Regular education students are referred for counseling primarily through Student Support Teams (S-Teams). Special education referrals are processed through IEP Teams. Using the Universal Screening module of the Behavior Plus data system, school personnel obtain data to identify students’ social-emotional challenges, as well as their strengths. This information is used to target students’ needs and plan relevant interventions.

Group Counseling

Group counseling is often the intervention of choice for teaching social skills, practicing conflict resolution, and communicating the value of mutual supportiveness among peers. In many cases, group counseling is delivered via research based intervention programs, however, the group format, structure, and content are tailored to the students comprising the group. Factors such as the student’s age, cognitive development, social development, and ability to behaviorally self manage determine the extent to which group interaction may be primarily concrete, didactic and behaviorally focused or process oriented and experientially focused. Group members share common goals, which are almost always related to their social, academic, and/or behavioral functioning at school. Achievement of counseling goals is fostered through play, role playing, art, fantasy, and direct instruction, among other modalities. Each student’s goal attainment is documented after each session and when the group sequence has ended. Teachers and parents are involved in the evaluation of students’ short term and long term outcomes.

Individual Counseling

Counseling students one-on-one is effective for addressing highly personal or emotional issues when self disclosure in a counseling group is inappropriate. Individual counseling is also encouraged for students who are behaviorally unmanageable in counseling groups. In individual counseling, students learn to recognize their maladaptive choices and behavior patterns and adopt more adaptive functional skills. Typically, students are referred by others and are not motivated to enter counseling. Our mental health clinicians utilize play, among other techniques, to engage students in the therapeutic process.

Students enter individual counseling upon receipt of written informed parental consent. In compliance with State regulations, clinicians conduct intake evaluations of referred students, keep detailed records, and develop treatment plans. Treatment plans include input and from parents and teachers with the expectancy that these adults will participate in the intervention process. Center clinicians receive individual clinical supervision a minimum of once a month per case from a supervising psychologist.
Review of data

Table 1 summarizes group and individual counseling data for the 2010-11 school year. For the two combined modalities, individual and group counseling, over 27 thousand student contacts were made (taking into account that each counseling group there were about four student contacts). “Student contacts” is defined as the number of students multiplied by the number of times each student was seen. There were equivalent numbers of individual counseling sessions and group counseling sessions. Many more students are seen in group counseling because several students are seen simultaneously.

Table 1

Number of Individual and Group Counseling

<table>
<thead>
<tr>
<th></th>
<th># of Students Seen in Individual Counseling</th>
<th># of Individual Counseling Sessions Conducted</th>
<th># of Counseling Group Sequences</th>
<th># of Counseling Group Sessions</th>
<th># of Students Enrolled in Counseling Groups</th>
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</thead>
<tbody>
<tr>
<td>Totals</td>
<td>461</td>
<td>6,082</td>
<td>450</td>
<td>6396</td>
<td>2166</td>
</tr>
<tr>
<td>2009-10</td>
<td>488</td>
<td>6162</td>
<td>431</td>
<td>6097</td>
<td>2276</td>
</tr>
<tr>
<td>2011-12</td>
<td>518</td>
<td>7457</td>
<td>373</td>
<td>8386</td>
<td>2322</td>
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</tbody>
</table>

Treatment Plan Turnaround Time:
Percent of Initial Reports and Case Summaries Completed On Time

In its policies and procedures manual, the TN Department of Mental Health and Developmental Disabilities (DMHDD) has established requirements for developing individualized (student) client treatment plans. The treatment plan guides the clinician’s work by helping identify problems and associated intervention goals. In treatment planning, the clinician establishes a conceptualization of the case dynamics and outcome expectancies. Treatment plans must be written within 30 calendar days from date the student was admitted for intervention (“turnaround time”) and updated at six month intervals. Treatment plans document:

- an interview evaluation of the student’s social, developmental, behavioral, health, and relevant family history
- results of standardized student behavioral ratings
- relevant student records (e.g., discipline, attendance, standardized test scores)
- a DSMIV diagnosis and substantiation of the diagnosis
- treatment goals and modalities/methods for achieving the goals
In Table 2, treatment plan turnaround time is addressed in two ways, percentage of treatment plans completed on time and percentage of clinicians who completed at least 90% of their treatment plans on time. By both measurements, excellent performance is indicated. Ninety-eight percent of treatment pans were completed on time and 97% of social workers completed at 90% of their plans on time.

Table 2

On Time Treatment Plan Completion Percentages

<table>
<thead>
<tr>
<th>Percentage of plans completed on time</th>
<th>99%</th>
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</thead>
<tbody>
<tr>
<td>Percentage of clinicians completing all cases on time</td>
<td>99%</td>
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</table>
Functional Behavior Assessments and Behavioral Intervention Plans

In contrast to other types of student evaluation that measure internal mental and emotional traits, the Functional Behavior Assessment (FBA) measures the impact of situational events that predict and maintain students’ problematic behavior. Utilizing a standard protocol from the Behavior Plus data system, Student Support Team (S-Team) or IEP team members determine the function of the student’s behavior. In this function based approach, effective solutions to problem behaviors focus on environmental events that trigger and maintain those behaviors. Maladaptive behaviors are considered to serve a function or purpose for the student and the FBA process is designed to determine those functions and guide the development of a plan for reducing problem behavior and increasing appropriate behavior. Information is gleaned from a variety of student data including:

- interviews with parents, teachers and the student,
- observations of the student,
- interview with the student
- student records,
- academic and behavioral benchmark assessments,
- standardized behavioral ratings.

These data are used to: (a) obtain a measurable description of the problem behavior, (b) identify the setting events that predict when the behavior will and will not occur, and (c) identify the consequences that maintain the problematic behavior. From this information, the Team identifies key features of the student’s environment that influence the student’s behavior.

Underlying the FBA process is the belief that behavior serves a function or purpose for the student, is predictable, and is changeable. Improving a behavior often requires comprehensive changes in the student’s routine, skill set, or interactions with others. Once the S-Team or IEP Team completes the FBA, they have the necessary information to understand the functions of specific behaviors and develop strategies for, a) modifying events that trigger problematic behaviors, b) teaching appropriate alternative behaviors, and, c) modifying ineffective consequences for those behaviors.

The final steps of the FBA/BIP process are teacher consultation and mentoring, progress monitoring, and follow up. To maximize the likelihood of a successful outcome, it is usually necessary to assist teachers in implementing the Behavior Intervention Plan. Regularly scheduled student observations, coaching and encouragement for the teacher, collection and graphing of behavioral ratings, and follow up meetings to evaluate or revise the plan, are essential.

During the 2010-11 school year, MHC clinicians facilitated 508 Functional Behavior Assessments and Behavior Intervention Plans (Figure 1).
Figure 1

Number of FBA/BIP's: A Four Year Comparison

![Bar Chart]

- 2008-09: 788
- 2009-10: 953
- 2010-11: 804
- 2011-12: 508
Part B

Threat Assessment Team
Threat Assessment Team

Introductory Remarks

Last year marked our 10th year as a team. We have consistently provided year-end summary reports of data, and have occasionally made comments about our interpretations/impressions of those data. Heretofore, however, we have not had much to say about our subjective experience. As of this writing, we have handled just over 2,800 referrals, and in doing so have learned quite a lot about the daunting challenges faced by most of the students we see. We all know intuitively that students’ attitudes, beliefs, and behaviors are related to their daily life experiences – by their families, the communities they live in, and the schools they attend. Because the nature of our work is violence prevention, we are particularly concerned about the effects of those experiences on students’ violence risk. Not surprisingly, most of the students who we see reside in communities besieged by violence: places where violent behavior has become the norm for everyday life – putting children in harms way while at the same time making it essential to their survival. We know that these communities are characterized by high unemployment; poverty; widespread abuse of drugs and alcohol; domestic violence; and crime, including gang activity. Many tell us about their experiences with the violent loss of one or more close family members and friends or, more typically “associates.” Asked about their experiences one student had this to say: “What you mean friends? I don’t have friends. I only have associates and I don’t trust them either.” Students describe the violence they have witnessed on the streets and in their homes. Too often they tell us about the physical and/or sexual abuse they have endured. Asked for an explanation about why he stabbed a fellow student, a young man was perplexed and stated to us “I didn’t have no choice. What you mean man, I told you I didn’t have no choice. They disrespected me.”

We know that students who are repeatedly exposed to violence begin to experience an array of emotional and behavioral problems. This is especially true when their parents and other family members are unable to insulate, otherwise protect them or, worse still, encourage violence. As a seventh grade girl recently put it to us “My mama gave me the knife and told me ‘You need to take care of your own business, and that’s what I was doing.’

Exposure to violence and other traumatic experiences have a dramatic impact on a child’s ability to learn, establish healthy relationships, and behave appropriately. What we find, among many of the students we see, is that academic performance, school rules, and expectations have become low priorities, rendering their teachers’ best efforts to teach ineffectual.
“Left unchecked over time, violence consistently escalates from non-physical (seemingly minor) to physical (deadly).” Arnold Goldstein, Low Level Aggression: First Steps on the Ladder to Violence, 1999

**Overview**
The Threat Assessment Team (TAT), administered by MCS Mental Health Center (MHC), under the direction of the Division of Exceptional Children and Health Services (DEC) conducts assessments with students believed to represent a substantive threat of harm to other students or school personnel. Students seen for threat assessment are, for the most part, among the one percent of students at the very tip of the prevention pyramid’s third tier illustrated above. Typically, they have issued substantive threats (with evidence of ongoing intent) and/or have been in possession of dangerous weapons at school.

**Threat Assessment**
- Safety plan w/ intensive monitoring and supervision
  - Frequent check-ins with selected staff
  - Weapon checks if indicated
- MCS Mental Health & community-based treatment as indicated
- Alternative school placement as needed
- Interventions for overage students
- Referral for special education eval/services when indicated
Threat Assessment Team

As illustrated in the figure at the bottom of page 2, students undergoing threat assessment require safety plans upon reentry to school, whether they are first served in an alternative setting, adjusted to a new school or returned to their previous school. At minimum, provisions include increased monitoring and consistent problem solving opportunities, through a check-in procedure, with an identified counselor or other staff member selected by the principal. If a student has been in possession of a weapon, the safety plan includes weapons checks carried out per board policy. Other recommendations to address academic, behavioral, and psychosocial challenges may include functional behavioral assessments, behavior intervention plans, special education evaluations, gang-related interventions, counseling and/or mental health care, and family/community services.

Threat assessment and management require a multi-disciplined approach. In addition to screening threats and conducting assessments, the TAT works closely with Principals, Regional Superintendents, the Office of Safety, Security and Emergency Management, and the Office of Risk Management. We continued to collaborate with Pupil Services, MCS Mental Health Center, the Division of Exceptional Children and Health Services, the Juvenile Court of Memphis and Shelby County, and community mental health providers.

For the third consecutive year, parents and students undergoing threat assessments completed Satisfaction/Feedback Questionnaires (See Appendix A for full results). We were pleased to see that students and parents continue to express very positive feelings about their threat assessment experiences. These include: 1) the TA process (appointment scheduled quickly, being seen on time, having enough privacy, etc.); 2) the rapport/relationship (staff were easy to relate to, feeling respected, feeling heard, questions adequately explained); 3) the outcome (perceived value of the recommendations, increased understanding of the need for threat assessment); and 4) willingness to follow recommendations.

The team also: 1) provided training in threat screening and safety plan implementation to all principals in April, 2012 (Appendix B); 2) distributed threat assessment reports to principals, the office of innovative schools, counselors, mental health staff, regional superintendents and the office of safety and security; and 3) provided threat assessment training to University of Memphis doctoral level school psychology graduate students.

Guidelines for administering safety plans have been developed and were distributed and discussed with principals at the spring training (Appendix B). These documents provide procedures for conducting check-ins (monitoring and problem solving) with those students having been seen for threat assessments, and weapons checks for those students who were seen as the result of a weapon violation.

**Refferrals/Infractions**

In 2011-2012 323 students were referred to the TAT from 118 different schools (103 regular, 10 charter, and 5 alternative). This amounted to a 4% increase in referrals over 2010-11. The behaviors of 251 (78%) of these students were determined to constitute substantive (serious) threats, warranting a comprehensive assessment (Figure1). Two hundred thirty-one (231/92%) of these students have now been seen for assessment. Of the remaining twenty students, some have withdrawn from the district, and some have had difficulty keeping scheduled appointments. In four cases, parents declined to participate, and the student was referred back to Pupil Services for adjudication.
Figure 1: Percent of Referrals Determined to be Substantive/Serious Threats Annually

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<td>46</td>
<td>49</td>
<td>67</td>
<td>79</td>
<td>80</td>
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</table>

Weapons Cases
As in previous years, students were referred for possession of sharps (knives and other such weapons - box cutters, razors, shanks, screwdrivers, scissors, etc.) more frequently than any other infraction. The number of students referred for having sharps (147) is up significantly (18%) this year over last (125). This year, referrals for sharps among elementary and middle school students returned to numbers more typical of previous years (Figure 2). We have no idea how to account for the unusual increase among elementary students and the decrease among middle schoolers that we saw last year.

Figure 2: Possession of Sharps for Elementary, Middle and High School Students Past 7 Years
Threat Assessment Team

The TAT received six (6) referrals this year in which students threatened others with or used “tasers” on others. As noted last year, these weapons have become more readily available as costs have declined, and they also can more easily be passed through metal detection devices. Undoubtedly gun possession is the most dangerous infraction for any district, and MCS is striving to eliminate these incidents altogether. This year the TAT received referrals on 16 students who had been in possession of a firearm at school (Figure 3). It is always important to differentiate between the number of students referred and the actual number of guns involved. In three incidents, one gun was handled by more than one student, and the actual gun count was 12. Two years ago the TAT began to also conduct assessments with any student expelled for having engaged in a felony offense in the community (off campus) during which they were in possession of or used a firearm. This year we saw two students having such charges, down from seven in 2010-11.

Figure 3: Number of Firearm Referrals

Threats and Other Violent Offenses
The number of referrals for serious threats to other students (66) was down, though not significantly from 2010-11 (71). Although referrals for serious threats to staff had been on the rise in recent years, we experienced a significant decrease in these referrals from 60 to 48 or by 20% in 2010-11, and those referrals remained relatively unchanged this year at 52. Other infractions that were generally consistent with recent year referrals included: 9 school-wide threats; 6 other weapon possession (bat, bottle, brick, hand-weight, pepper spray); 4 possession of brass knuckles; and 2 sexual battery/rape.

Referrals by Grade
With regard to students’ grade placement at the time of their referral (Figure 4), the proportion of elementary students referred was, up by 4% from last year. Changes at the middle school level, as a percentage of referrals, had been trending downward over the previous five years (a 52% decline) until this year when, for unexplained reasons, their referral rate jumped to 33%. The drop in referrals among 7th graders had been remarkable (to only 5% of referrals in 2010/11), but this year that increased to 13%. This year, high school grades accounted for 33% of referrals, down from 53% in the previous year. In general, referral rates tend to be consistent with what one would expect intuitively. Referral rates typically increase from lower to higher grades up to a point. Year after year, however, referrals of 11th and 12th grade students are markedly lower than 9th and 10th grades. This is consistent with disciplinary referrals in general, and is probably related to two factors: 1) Students at these grade levels are more focused and loathe do things that will interfere with their graduating; and 2) Many of the students who have had serious disciplinary problems over time are no longer enrolled.
Figure 4: Percent of Referrals by Grade - Past Six Years

Figure 5 illustrates the number of referrals received this year at each grade level for the four most frequently occurring offenses. Consistent with last year’s figures, over two thirds (47) of these elementary referrals involved the possession of sharps. Among middle school referrals, the percentage of sharps was close to half at 46%. Also this year, there were five students involved in either bringing or handling a gun (3) at school. In 2010-11 only one middle school referral involved gun possession. As in previous years, referrals for threats to both students and staff increase markedly for those in middle school grades and decline among high schoolers.

Figure 5: Number of Referrals 2011-12 at Each Grade Level – Four Most Frequent Referrals

Referrals by Gender
Not unexpectedly, given expulsion statistics, the ratio of referrals for boys to girls year after year is about 3:1 (Figure 6). However, while girls make up only one fourth of all students referred, they are responsible for one third of those involving sharps, and seven of the nine referrals for pepper spray and tasers. Boys, on the other hand, account for all of the referrals associated with guns, whether bb/pellet/toy (8) or higher caliber/real (18).
Those with disabilities have consistently been overrepresented as a percentage of total referrals; however as Figure 6 illustrates, that percentage has declined significantly from earlier years. As noted last year, this change seems to be consistent with broader reductions in expulsions of students receiving special education services. We believe that continued training and communication with principals, provided by the Division of Exceptional Children and Health Services have, in part, resulted in reductions.

As in all previous years, students having learning disabilities are the most frequently referred (49%). They are usually followed by those having other health impairments (typically ADHD), and that was true this year at (15%). Those having intellectual disabilities and those with emotional disturbance are usually third or fourth most frequently referred, as was true this year at 11% and 8% respectively. It is well-established that special education students are at greater risk of violence (Borum, 2000). Although research is limited, it is also believed that general education students tend to have better outcomes from interventions aimed at reducing violence risk than do students with disabilities (Cornell & Sheras, 2006).
Therefore, the implementation of effective behavior plans, including safety provisions and supervision, are necessary to reduce risk among special education students. Children with ADHD are known to be at particularly high risk and thus, effective intervention is essential. We are optimistic that the district’s prevention and intervention efforts will improve academic and behavioral outcomes for many of our highest risk students; Camp Why Try being just one recent example.

About half of the students referred for threat assessments each year have been overage for grade. This year, the percentage of overage students was just over half of all students referred (54%). As previously noted, overage students are more at risk for a number of destructive outcomes, including violence than are their age-mates who are on grade level. Regardless of district/school interventions designed to reduce the frequency of retentions, those referred for threat assessments will continue to be overrepresented because academic failure is a well known violence risk factor.

Case examples
Each year, the TAT assesses a number of students who, at the time they are seen, represent a clear and imminent danger to other students and/or school personnel. An example of a recent cases is described below. All names and other identifying information have been changed.

Case 1:
Marcus, a middle school student, was referred following his 90 day expulsion for threats to school personnel. He had been experiencing increased behavior problems and aggression as well as declining grades. On this occasion he assaulted a fellow student and was referred to the office. While being questioned about the incident, he became increasingly agitated/angry and he threatened to “fire on” the assistant principal and the school officer if they touched him or said anything more to him. He also threatened to shoot up the assistant principal’s house, adding that he would “get his boys to do a drive by” for him. Marcus further threatened to get one of his teachers for “lying on” him about the assault and added “We’ve already been planning it.” Given an opportunity to calm down, Marcus persisted in making threats and asserted that he wasn’t making threats, but rather “promises.” School mental health staff were contacted, and following their onsite crisis response, Marcus was transported to a psychiatric hospital for inpatient evaluation. The threat assessment was conducted two weeks later, when Marcus’s parents sought to re-enroll him in school. During the course of the assessment the TAT learned that Marcus had been referred to the office thirty-one times in the past four years. Among those referrals were several incidents of fighting, assault, threats, and bullying. This was Marcus’s fifth expulsion, four of which had been for making threats and one for sexual harassment. A review of Marcus’s medical records revealed that he had an extensive history of outpatient and inpatient psychiatric care for aggressive and threatening behavior at school, self injurious behavior, and suicidal ideation. He was known to have experienced physical abuse as a young child, and had been both a victim and witness to other very severe incidents of domestic violence. He had a number of psychiatric diagnoses including Post Traumatic Stress Disorder, Depressive Disorder, and Anxiety Disorder. None of this history had previously been disclosed to the school due to several custody and placement changes. Following his threat assessment, Marcus was placed in an innovative school where he remained through the end of the school year. An evaluation of Marcus’s academic, behavioral, and emotional adjustment was completed. Mental health intervention included further psychiatric evaluation. Marcus and his parents participated in intensive outpatient treatment, and Marcus was able to return to his regular middle school.
Appendix A
Parent & Student Feedback
2009/10 through 2011/12
Parent Comments

- I liked the professional conduct of the team.
- I appreciate the threat assessment team for their help and opening my eyes to certain areas that need to be addressed with my child.
- The process can be improved by providing some snacks.
- I am thankful for the help.
- I was very impressed with the way you reviewed the situation and gave my son and me a chance to see and help resolve this serious matter.
- We need more of this. Great! Wished the people at the school would be more like the Threat Assessment Team. Thanks!
- The process can be improved by allowing someone from the school such as a teacher, guidance counselor or mentor to be present.
- Nothing is perfect, but this was needed.
- I didn’t expect fair treatment, but this has shown me more than I was aware of concerning my grandson. Thank you all very much.
- The threat assessment team helped my daughter with her problem
- Keep up the good work.
- To improve things; make sure the child threatens someone.
- Everything was explained thoroughly and I felt like thy really cared about my son’s feelings and his behavior.
- I think everything was fine. It was well explained and it let me know a lot about my child that I didn’t know. I need to help bring his confidence level up.
- I think they have taught me something that I can use to help my sone with some of his problems at school.
- The team was great all the way around.
- The threat assessment process needs to begin when the problem begins at the child’s school. Needs to be started earlier, but the procedure is great. Thanks.
- While some of the questions made me uncomfortable, the format was explained to me and helped to alleviate my concerns.
- The members of this assessment team were very helpful in this situation.
- I loved meeting with this team. Although further counseling will occur, the assessment was very therapeutic.
- Interview needs to be done together with both people.
- I am happy it’s over with.
- The wait was too long. The process was too long.
- Everything was helpful and brought me to an understanding of my child so that we can heal and move forward.
- I believe that it’s an excellent idea to have threat assessment team. They are willing to research what is really going on with our children.
- I think threat assessment is a good thing to have. I can understand the purpose for it now.
Student Comments

- They listened to me.
- She was good and encouraging.
- She was a respectable lady.
- I wouldn’t change a thing. My voice was heard.
- Maybe it will help me stop hanging with the wrong crowd.
- I will do my best to do my part.
- Now that I talked to them I’m doing better.
- My words were twisted and their own conclusions were drawn.
- Thanks a lot!
- You all are doing a great job of helping us kids out.
- Please put me back in school!
- The threat assessment team was very helpful. They listed to me and showed respect.
- I liked him, he broke down words for me.
- It was very easy to talk to him about everything.
- Let me choose what school I want to go to.
- Thank you, thank you, thank you.
- She was very respectful and understanding.
- She’s a good woman. Ya’ll did everything good.
- I’m just ready to go back to school.
- I liked being here.
- Don’t scare people so much. But, besides that I enjoyed myself.
- She made me feel like I was talking to my Mom or one of my sisters.
- She is a good person. She made me happy.
- This process should be used on serial killers and aggressive animals. Completely useless. I should be able to do my own report an lie on the individuals who lied so strongly on me.
- Give me anger manager classes.
- Get more waiting rooms and snacks and games.
- You all did your jobs, so I have no complaints.
- I’m ready to go back to school and have a great year.
- She helped me release some of my stress.
- There is nothing they could do better. They were on point.
- OMG! This was the most devastating thing ever, but it went great.
- I understood what she was telling me and I would like to follow the procedure and I wouldn’t like to come back (not that it was bad though).
- Well the experience was great but I was a little uncomfortable at first. I’m not saying that they made me uncomfortable. It was just me constantly thinking the worst. After I got used to the environment I felt better and I’m glad I came.
- Please don’t tell my mother anything again. Please!!
Appendix B
Safety Plan Implementation
Safety Plan Implementation Procedures

I. Overview

The Student Support Team or IEP Team will meet in order to review the threat assessment summary and recommendations and to develop and implement the Safety Plan.

The Safety Plan includes Check-Ins with the returning student. When the student’s expulsion involved possession of a weapon, the Safety Plan will also include Weapons Checks conducted by the Principal/Assistant Principal or their trained designee(s).

II. Check-In Process

1. The designee for check-ins will be determined by the Principal or Assistant Principal.
2. The number of check-ins per week should be decided in the S-Team meeting. The emphasis is on frequent but brief (usually 15 minute) contacts.
3. Check-Ins are crucial to an effective safety plan, and the designee must ensure that the check-ins occur. For example, they will seek out the student if they fail to show for a scheduled check-in, and in the event of a student’s absence from school, will meet with them upon their return.
4. The time and location for check-ins should be consistent and the location offer privacy. Early morning check-ins are advised in order to “nip problems in the bud.”
5. The student should be encouraged to initiate a check-in any time they feel the need.
6. The termination point for check-ins should be decided upon and clearly documented during a follow-up S-Team meeting.

III. Check-In Content

1. The focus is on identifying practical responses to immediate school-related concerns (conflict with a student/teacher, bullying, traveling to/from school, etc.)

   ✓ Other concerns (problems with mood – depression/anxiety, health, family issues, etc.) that may require more intensive intervention should be addressed separately (counseling by the school counselor or mental health center staff)

IV. Documentation - All check-ins must be documented in the student’s disciplinary file.

V. Weapons Checks

1. Weapons checks will be conducted within the guidelines of MCS policy (section 6.303). Privacy and respect for the student’s dignity will be maintained.
2. The pattern of checks should vary by day and time of day.
3. The frequency of checks will be determined by the Principal or Assistant Principal.
Safety Contract

Name _____________________________  School ________________________  Date _______

1. Check-Ins
   • The Principal’s designee to conduct Check-Ins _____________________________
   • Check-Ins will be held _____________________________ (where), at __________ (time),
     on __________________________________________ (days).

2. Weapons Checks    _____  N.A.
   • Weapons checks will be conducted by the principal/assistant principal or designee in
     accordance with Policy # 6.303.
   • Parent/guardian will remind student about weapons and check their belongings each day
     before they leave home for school.

   **Student:** I agree to attend my Check-Ins and use the time to discuss and solve problems I
   am having at school. I will cooperate with weapons checks (if required). I will request an
   extra Check-In if I’m having a conflict with another student or a teacher. I will not bring a
   weapon onto school property under any circumstances.

   **Parent(s):** I agree to help my son/daughter get to school on time and attend Check-Ins. I
   will check to be sure that my son/daughter does not leave home with any unauthorized items.
   I will notify the school about any problems at home or in the neighborhood that might spill
   over into the school.

   **Staff:** We agree to provide regular Check-Ins as scheduled. We will ensure privacy in
   conducting weapons checks (if required).

   _______________________________  _______________________________
   Student                                     Parent(s)

   __________________________          ____________________________
   Student                                     Parent(s)

   __________________________          ____________________________
   Student                                     Parent(s)

   __________________________
   School Personnel
Parent Feedback Summary 2009-10 through 2011-12

Threat Assessment Parent Feedback Summary 2009-10 through 2011-12

The appointment was scheduled quickly, 09-10 10-11 11-12
Strongly Agree 63% 76% 65%
Agree 34% 19% 32%
Neutral 32% 2% 1%
Disagree 1% 2% 2%
Strongly Disagree 1% 0% 0%

I was seen on time. 09-10 10-11 11-12
Strongly Agree 71% 79% 75%
Agree 32% 20% 25%
Neutral 1% 1% 0%
Disagree 0% 0% 0%
Strongly Disagree 0% 0% 0%
Parent Feedback Summary 2009-10 through 2011-12

The purpose of the threat assessment was clearly explained.

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<tr>
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We had enough privacy during the threat assessment.

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<tr>
<td>Strongly Agree</td>
<td>78%</td>
<td>83%</td>
<td>83%</td>
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<tr>
<td>Agree</td>
<td>21%</td>
<td>17%</td>
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<td>Neutral</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
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<tr>
<td>Disagree</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Disagree Strongly</td>
<td>1%</td>
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</table>
Parent Feedback Summary 2009-10 through 2011-12

It was easy to talk to this person

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<td>Strongly Agree</td>
<td>71%</td>
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<td>76%</td>
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<td>Agree</td>
<td>27%</td>
<td>22%</td>
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<td>4%</td>
<td>2%</td>
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<tr>
<td>Disagree</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Disagree Strongly</td>
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This person respected me

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<td>Agree</td>
<td>22%</td>
<td>16%</td>
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<tr>
<td>Disagree</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
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### Parent Feedback Summary 2009-10 through 2011-12

**My Concerns Were Heard**

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<tr>
<td>Agree</td>
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<td>16%</td>
<td>20%</td>
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<td>1%</td>
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<tr>
<td>Disagree</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Disagree Strongly</td>
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**Questions Easy to Understand**

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<td>31%</td>
<td>15%</td>
<td>24%</td>
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<td>Neutral</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
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<tr>
<td>Disagree</td>
<td>0%</td>
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<tr>
<td>Disagree Strongly</td>
<td>0%</td>
<td>1%</td>
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</table>

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![This Person Listened to My Concerns](chart1.png)

![The Questions Were Easy to Understand](chart2.png)
Parent Feedback Summary 2009-10 through 2011-12

When we Talked About the Results I Understood:

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<tr>
<td>All of it</td>
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<td>81%</td>
<td>95%</td>
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<tr>
<td>Most of it</td>
<td>6%</td>
<td>17%</td>
<td>5%</td>
</tr>
<tr>
<td>Some of it</td>
<td>3%</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>None of it</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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When We Talked About the Results I Understood:

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<th>11-12</th>
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<td>10%</td>
<td>0%</td>
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<tr>
<td>Most of it</td>
<td>80%</td>
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<tr>
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I Think the Recommendations Are:

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<th>11-12</th>
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</thead>
<tbody>
<tr>
<td>Excellent</td>
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<td>65%</td>
<td>66%</td>
</tr>
<tr>
<td>Good</td>
<td>24%</td>
<td>26%</td>
<td>27%</td>
</tr>
<tr>
<td>Fair</td>
<td>3%</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>Poor</td>
<td>2%</td>
<td>1%</td>
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</tbody>
</table>

I Think the Recommendations Are:
Parent Feedback Summary 2009-10 through 2011-12

<table>
<thead>
<tr>
<th>The Best Recommendation</th>
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<th>11-12</th>
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<tbody>
<tr>
<td>Safety Plan</td>
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<td>38%</td>
<td>44%</td>
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<tr>
<td>Behavior Intervention Plan</td>
<td>27%</td>
<td>23%</td>
<td>20%</td>
</tr>
<tr>
<td>S-Team</td>
<td>14%</td>
<td>10%</td>
<td>16%</td>
</tr>
<tr>
<td>Mental Health Intervention</td>
<td>15%</td>
<td>17%</td>
<td>16%</td>
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<tr>
<td>Community Activities</td>
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**The Best Recommendation Was:**

<table>
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<th>11-12</th>
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<tr>
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<td>97%</td>
<td>96%</td>
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<tr>
<td>Some of the Recs</td>
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<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>None of the Recs</td>
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<td>0%</td>
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</table>

**I Will Follow:**

<table>
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<tr>
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<th>11-12</th>
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</thead>
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<tr>
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<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>Some of the Recs</td>
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<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>None of the Recs</td>
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</table>
Parent Feedback Summary 2009-10 through 2011-12

I Understand the Need for the Threat Assessment:

<table>
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<th></th>
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<th>11-12</th>
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</thead>
<tbody>
<tr>
<td>Much Better Now</td>
<td>78%</td>
<td>81%</td>
<td>82%</td>
</tr>
<tr>
<td>Better Now</td>
<td>22%</td>
<td>18%</td>
<td>17%</td>
</tr>
<tr>
<td>Still Don't Understand Need</td>
<td>0%</td>
<td>2%</td>
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</table>

Was the Threat Assessment Helpful to You?

<table>
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<th>11-12</th>
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</thead>
<tbody>
<tr>
<td>Very Helpful</td>
<td>94%</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>Somewhat Helpful</td>
<td>6%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Not Helpful</td>
<td>0%</td>
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</table>
Parent Feedback Summary 2009-10 through 2011-12

What Was the Most Helpful Parts of the TA?

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<tr>
<td>My Interview</td>
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<tr>
<td>My Child's Interview</td>
<td>11%</td>
<td>13%</td>
<td>21%</td>
</tr>
<tr>
<td>The Informing Meeting</td>
<td>33%</td>
<td>32%</td>
<td>32%</td>
</tr>
<tr>
<td>The Recommendations</td>
<td>14%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>The Resource List</td>
<td>9%</td>
<td>5%</td>
<td>14%</td>
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<tr>
<td>None of IT</td>
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Overall Satisfaction

<table>
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<th>09-10</th>
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<tr>
<td>Excellent</td>
<td>90%</td>
<td>83%</td>
<td>86%</td>
</tr>
<tr>
<td>Good</td>
<td>7%</td>
<td>14%</td>
<td>12%</td>
</tr>
<tr>
<td>Fair</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Poor</td>
<td>0%</td>
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</table>
### Student Feedback Summary for 2009-10 through 2011-12

<table>
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<th>Question #1</th>
<th>Year</th>
<th>Year</th>
<th>Year</th>
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<tbody>
<tr>
<td>It was easy to talk with this person.</td>
<td>09-10</td>
<td>10-11</td>
<td>11-12</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>46%</td>
<td>52%</td>
<td>54%</td>
</tr>
<tr>
<td>Agree</td>
<td>43%</td>
<td>37%</td>
<td>35%</td>
</tr>
<tr>
<td>Neutral</td>
<td>9%</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td>Disagree</td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0%</td>
<td>0%</td>
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</table>

![It Was Easy to Talk with This Person](chart1)

<table>
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<tr>
<th>Question #2</th>
<th>Year</th>
<th>Year</th>
<th>Year</th>
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<tbody>
<tr>
<td>The person I talked to respected me.</td>
<td>09-10</td>
<td>10-11</td>
<td>11-12</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>67%</td>
<td>70%</td>
<td>75%</td>
</tr>
<tr>
<td>Agree</td>
<td>32%</td>
<td>23%</td>
<td>21%</td>
</tr>
<tr>
<td>Neutral</td>
<td>1%</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Disagree</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0%</td>
<td>0%</td>
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![The Person I Talked to Respected Me](chart2)
Student Feedback Summary for 2009-10 through 2011-12

<table>
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<th>Question #3</th>
<th>Year</th>
<th>Year</th>
<th>Year</th>
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<tbody>
<tr>
<td>The person I talked to listened to me.</td>
<td>09-10</td>
<td>10-11</td>
<td>11-12</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>69%</td>
<td>74%</td>
<td>81%</td>
</tr>
<tr>
<td>Agree</td>
<td>28%</td>
<td>21%</td>
<td>17%</td>
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<tr>
<td>Neutral</td>
<td>3%</td>
<td>4%</td>
<td>2%</td>
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<tr>
<td>Disagree</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0%</td>
<td>0%</td>
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<table>
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<th>Year</th>
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<tbody>
<tr>
<td>The person I talked to understood me.</td>
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<td>10-11</td>
<td>11-12</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>57%</td>
<td>56%</td>
<td>73%</td>
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<tr>
<td>Agree</td>
<td>32%</td>
<td>35%</td>
<td>22%</td>
</tr>
<tr>
<td>Neutral</td>
<td>9%</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>Disagree</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1%</td>
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Question #5

The questions were easy to understand.

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<th>11-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>46%</td>
<td>52%</td>
<td>53%</td>
</tr>
<tr>
<td>Agree</td>
<td>39%</td>
<td>35%</td>
<td>31%</td>
</tr>
<tr>
<td>Neutral</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>Disagree</td>
<td>2%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Strongly disagree</td>
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<td>0%</td>
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Question #6

When we talked about the recommendations I understood:

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<tr>
<th>Year</th>
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<th>10-11</th>
<th>11-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>70%</td>
<td>70%</td>
<td>74%</td>
</tr>
<tr>
<td>Most</td>
<td>24%</td>
<td>21%</td>
<td>22%</td>
</tr>
<tr>
<td>Some</td>
<td>5%</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>None</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
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</tbody>
</table>
# Student Feedback Summary for 2009-10 through 2011-12

## Question #7
I will do my part to follow the recommendations.

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<tr>
<th>Year</th>
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<th>None</th>
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<tr>
<td>09-10</td>
<td>92%</td>
<td>7%</td>
<td>1%</td>
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<tr>
<td>10-11</td>
<td>90%</td>
<td>9%</td>
<td>1%</td>
</tr>
<tr>
<td>11-12</td>
<td>96%</td>
<td>3%</td>
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## Question #8
What grade would you give the recommendations?

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<th>B</th>
<th>C</th>
<th>D</th>
<th>F</th>
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</thead>
<tbody>
<tr>
<td>09-10</td>
<td>68%</td>
<td>25%</td>
<td>5%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>10-11</td>
<td>70%</td>
<td>20%</td>
<td>6%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>11-12</td>
<td>70%</td>
<td>25%</td>
<td>1%</td>
<td>1%</td>
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Question #9
I understand why I was referred for threat assessment.

<table>
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<th>Year</th>
<th>Year</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>No</td>
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<td>3%</td>
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Question #10
Was the threat assessment helpful to you?

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<th>Year</th>
<th>Year</th>
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<tbody>
<tr>
<td>A lot</td>
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<td>75%</td>
<td>86%</td>
</tr>
<tr>
<td>A little</td>
<td>14%</td>
<td>23%</td>
<td>12%</td>
</tr>
<tr>
<td>None</td>
<td>0%</td>
<td>2%</td>
<td>2%</td>
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</table>
Student Feedback Summary for 2009-10 through 2011-12

<table>
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<th>09-10</th>
<th>10-11</th>
<th>11-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
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<td>78%</td>
<td>78%</td>
</tr>
<tr>
<td>B</td>
<td>16%</td>
<td>14%</td>
<td>19%</td>
</tr>
<tr>
<td>C</td>
<td>2%</td>
<td>7%</td>
<td>1%</td>
</tr>
<tr>
<td>D</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>F</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Grade You Would Give Us for the Work We Did with You and Your Family.
Part C

Alcohol and Drug Counseling Services
Overview

Alcohol, tobacco, and other drug (ATOD) use and abuse by children and adolescents is a multi-faceted, multi-dimensional, multi-causal phenomenon complicated by the wide variation in development in childhood and adolescence along physical, emotional, cognitive, and moral dimensions and the interaction of that development with the nature, degree, and level of familial and communal support available to the adolescent. The probability that a student will become an abuser of, or dependent on, alcohol or other drugs is a function of the existence of protective and vulnerability factors in the student’s environment(s). In the circumstance where vulnerability factors “outweigh” protective factors, the student can be considered at risk to experience a constellation of problems, including substance use and abuse.

The MCSMHC Early Intervention Group Program is a prevention/intervention program directed at a specifically identified student population at high risk to develop substance-related problems. The identified population consists of those students who have just come to the attention of the MCS discipline system by receiving their first alcohol or other drug-related suspension or expulsion and who are not eligible for a DSM-IV diagnosis of substance abuse or dependence. The goal of the program is to prevent further deterioration of functioning and condition.

In order to comply with the suspension or expulsion, the student and parent/guardian must make an appointment with an Alcohol and Drug Counselor for a comprehensive alcohol and drug use assessment. Each student is given an integrated screening for mental health and substance use problems and then, depending on the findings, is further assessed to determine the appropriate level and types of services that would best address his or her needs. The student is then assigned to one of two levels of the Early Intervention Group Program or to a Treatment Group. Participation in the group program is mandatory as a condition of clearing the A&D-related board suspension.

The twice-weekly, 10-session program is presented in a group format. Early Intervention students must attend at least 7 out of the 10 group sessions as a condition of clearing the A&D-related suspension. Students are grouped by age, developmental level, and degree/extent of substance use. Each Early Intervention Group is facilitated by a licensed alcohol and drug counselor. Activities in the program include lectures, experiential activities, and self-awareness activities designed to provide participants with accurate information regarding alcohol and other drugs as well as skills in decision-making, impulse control, communication, and stress management. In addition, specialists in HIV/AIDS and other STD's and members of the Memphis City Schools Division of Security conduct group sessions on HIV/AIDS and Drug Use and Legal Issues of Drug Use and Abuse, respectively. The Early Intervention Group Program Plan is developed every year and submitted to the TN Department of Mental Health and Developmental Disabilities, Division of Alcohol and Drug Abuse Services (DADAS).

Early Intervention Group Levels  The Early Intervention Group Program consists of two levels of group that make up the early intervention component of the MCSMHC’s A&D Clinical Program. Level I Group is appropriate for students receiving their first A&D-related board
suspension whose involvement with alcohol and other drugs is in the very early stages and who do not meet DSM-IV criteria for substance abuse or dependence. Level II Group is appropriate for students who do not meet DSM-IV criteria for substance abuse or dependence but who may have a longer history of use, have received a previous A&D-related board suspension, may be involved in dealing drugs, or may be gang involved.

**Parent Groups** A Parent Group for parents of students attending Early Intervention Groups is offered at a centrally-located facility, the Pupil Services Center (in the facilities of Northwest Prep Academy). Parent Groups are not conducted at the Innovative Schools due to a lack of sufficient staff and the fact that Early Intervention Groups at the Innovative School sites are conducted during the school day. However, parents are invited to attend the first and last sessions of the Early Intervention Groups at schools, if they can do so, and are invited to attend the Parent Group sessions conducted after school in the facilities of the Northwest Preparatory Academy.

The Memphis City Schools Mental Health Center A&D Clinical Program’s Parent Group is for parents of Early Intervention Group participants. The group meets twice weekly for 1.0 hour group sessions over a period of 5 weeks at the same time the Early Intervention Groups are held at Northwest Preparatory Academy.

The goals of the Parent Group are:

- to educate parents in dealing more effectively with their teen’s substance abuse problems
- to motivate parents to clarify their role as effective parents
- to empower parents to take an active role in supporting their teens to be drug free in a positive and respectful way

Parents and teens are given an opportunity to begin meaningful conversation as they come together at the initial session a “multi-family group” to develop the students’ and parents’ change plans. They are encouraged to develop goals and solutions and work toward them throughout the group process. Parents are encouraged to develop an accountability relationship with their children and are challenged to hold their teens accountable for their behavior. They are taught how to establish and convey clear limits and expectations to their teens and how to set and follow through on appropriate consequences without being too passive or aggressive. Parents are also taught effective methods for engaging their teens in ongoing positive conversations that result in positive communication and improved relationships. A final multifamily group session is held so that the parent and teen can assess their progress toward their goals and present them to the larger group.

Parents are given detailed factual information on the effects of drug use for teens. They are also provided with a home Urine Drug Test and are taught how to use it within the framework of positive and negative consequences. They are taught how to utilize random home Urine Drug Screens as an effective way of encouraging positive communication between themselves and their teens, of increasing their awareness and involvement in the solution, and of monitoring overall progress. Parents are encouraged to develop a No Drug Use Rule for their families and are given the information to accomplish this. Parents are supported in becoming better parents.
through fine-tuning their skills as parents so that they may better assist their teens in living drug free and fulfilled lives.

**Services Provided**

During 2011/2012, Early Intervention Groups were conducted after school with students suspended or expelled for alcohol or drug related offenses at seven different locations. Early Intervention Groups were conducted at a central location, the Pupil Services Center, in the facilities of the Northwest Preparatory Academy, for students: 1) returned to their home schools 2) assigned to Innovative Schools with normal times, or 3) assigned to the Northwest Preparatory Academy. Groups were conducted during the school day at the remaining Preparatory Academies for the students assigned to those schools.

**Assessments Conducted and Students Eligible for Early Intervention Groups:**

During the 2011/2012 school year, the A&D Clinical Team staff conducted a total of 527 A&D assessments with 368 students (70%) qualifying for the Early Intervention Group Program. One-hundred-nineteen of the remaining students met DSM-IV diagnostic criteria for a substance-related disorder and were referred to the MCSMHC Adolescent Outpatient A&D Treatment Program. All other students were not assigned to a group for one of the following reasons: 1) graduating seniors suspended at the end of the school year, 2) too young for assignment to an Early Intervention Group (those students were typically elementary school students and were followed-up at their home schools), 3) had their suspension/expulsion voided by the Pupil Services Center Hearing Officer due to lack of evidence, 4) withdrew from the MCS, or 5) were released from the compulsory attendance law. Graph 1 provides a breakdown of the assessment results for the 2011/2012 school year.

**Graph 1**

**Group Assignments Based on Assessment Results**

2011/2012
**Descriptive Characteristics of Students Receiving A&D Assessments:**
Five hundred twenty-seven (527) alcohol and drug assessments were conducted during the 2011/2012 school year. Twenty-two (22) students assessed were under the age of 12 (4%); 91 were students 13.0 or 14 (17%); 354 were students between the ages of 15 and 17 (67%); and 60 were students 18 years old or older (12%). Graph 2 below illustrates the ages of students assessed.

![Graph 2](image)

Four hundred sixty-two students assessed were male (88%) and 65 were female (12%). Four hundred ninety-one (491) students were African-American (87%); 17 students were Caucasian (3%); and 19 were Hispanic (4%). Eighty-three (83) students assessed were identified as Special Education students (16%).

**Descriptive Characteristics of Students Assigned to the Early Intervention Group Program:**
Three hundred sixty-eight (368) students were initially assigned to Early Intervention Groups during the 2011/2012 school year. Ninety (90) of those assessments were students between the ages of 12 and 14 (24%); 234 were students between the ages of 15 and 17 (64%); and 44 were of students 18 years old or older (12%). Three hundred ten students (310) assigned to Early Intervention Group were male (84%) and 58 were female (16%). Three hundred forty-three (343) students were African-American (93%); 10 students were Caucasian (3%); 15 were Hispanic (4%).

**Early Intervention Groups Provided:**

- **A&D Staff:** 7
- **Groups:** 32
- **Total sessions:** 3200
During the 2011/2012 school year, a total of 32 Early Intervention Groups were conducted. Seventy-four (74) of the 368 students initially assigned to Early Intervention groups were unavailable to attend the group to which they were assigned due to withdrawal from the MCS, failure to enroll in the Innovative School to which they were assigned, incarceration, graduation at mid-year, or re-scheduling to a subsequent group. One hundred eight-eight of the 294 remaining students available to participate in the Early Intervention Groups completed the group program (64%) by attending at least 7 out of 10 sessions. The chart below presents a summary of Early Intervention Groups conducted during the 2011/2012 school year.

### Early Intervention Groups

<table>
<thead>
<tr>
<th>Initially assigned to Early Intervention</th>
<th>Available to attend group</th>
<th>Completed group program</th>
</tr>
</thead>
<tbody>
<tr>
<td>368</td>
<td>294</td>
<td>188</td>
</tr>
</tbody>
</table>

**Intensive Focus Parent Groups:**

During the 2011/2012 school year, a total of 8 Parent Groups were provided for parents of Early Intervention Group participants. Ninety-six parents (41%) of students assigned to an Early Intervention Group attended at least one Parent Group session and a total of 80 Parent Group sessions were provided.

**Early Intervention Group Sessions Provided:**

Over the course of the 2011/2012 school year, a total of 3280 Early Intervention Group sessions were provided to Early Intervention Group participants and their parents.

**Client Outcomes**

For the 2011/2012 school year, an Early Intervention Group Program Plan was created and submitted to the Tennessee Department of Mental Health, Division of Substance Abuse Services, which partially funds the program through a grant. The 2011/2012 Early Intervention Group Program Plan included a main goal and a number of objectives to meet that goal. The extent to
which that goal and objectives were met constitutes the evaluation of the Early Intervention Group Program. Evaluation of the program was conducted by gathering critical use and risk data at the time of the initial alcohol and drug assessment using the locally developed Early Intervention Group Baseline Data Collection Instrument and the Alcohol and Drug Group Evaluation/Final Session Questionnaire, which gathered the same information.

Program Goal:

The primary goal of the Early Intervention Group program was that students who completed the program would

1. cease or reduce alcohol and/or drug use
2. increase their perception of harm from substance use
3. decrease their intention to use alcohol or drugs over the next six months
4. increase their self efficacy regarding substance use in specific situations

Students completed a baseline drug use questionnaire at the initial assessment and a final session questionnaire which inquired about their drug use over the past 30 days as well as their perception of harm from drug use, their intent to use any or all of 5 substances (alcohol, cigarettes, marijuana, inhalants, cocaine) during the next six months, their self efficacy regarding drug use (specifically marijuana) in specific situations (during the school day, before school, with my girlfriend or boyfriend, when I feel stressed, when I feel angry). Matched pre- and post-data was collected for 166 participants.

Progress toward Goal:

1. Cease or reduce alcohol and/or drug use

Marijuana: 100 of the 166 Early Intervention Group participants reported using marijuana during the 30 days prior to the initial assessment. On the final session questionnaire, 88 of those 100 students reported no use or reduced use. Sixty-six of the Early Intervention Group participants reported no use of marijuana in the 30 days prior the initial assessment. Sixty-five (65) of those 66 also reported no marijuana use at the final group session. Overall, 153 (92%) out of 166 Early Intervention participants reduced or ceased marijuana use by the end of the program.

Alcohol: Sixteen of the Early Intervention Group participants reported using alcohol during the 30 days prior to their initial assessment. Fourteen of those participants reported no use or reduced use on the final session questionnaire. The other 150 participants who reported no alcohol use initially also reported no use at the end of the Early Intervention Group program. Overall, the percentage of alcohol use decreased from 10% to 1%.

Other Drugs: Three Early Intervention Group participants reported use of other drugs in the 30 days prior to the initial assessment. All 3 participants reported no use at the final session. However, 2 other Early Intervention Group participants did report other drug use in the 30 days prior to the final session.
The chart below illustrates the change in self-reports of drug use for those students who completed the program and the pre- and post- measures.

**Number of Students Out of 166 in Early Intervention Groups Using Within Prior 30 Days at Baseline and Post-test**

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>100</td>
<td>13</td>
</tr>
<tr>
<td>Alcohol</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td>Inhalants/Other Drugs</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

2. **Increase perception of harm from substance use**
One-hundred eight (65%) of the 166 Early Intervention Group participants who completed the program and the pre- and post- measures manifested an increase in their perception of harm from the use of alcohol and drugs. In addition, 142 (86%) of participants manifested a score of at least 10 (range 0 – 15) on the *Perception of Harm* scale.

3. **Decrease intention to use alcohol or drugs (specifically marijuana) over the next 6 months**
One-hundred twenty-nine (78%) of the 166 participants who completed the program and the pre- and post- measures responded “DEFINITELY NO” or “PROBABLY NO” to the question “Do you think you will use marijuana in the next 6 months?” One hundred sixty-one of the participants (97%) scored at least 10 (range 0 – 15: Minimum score = 0, DEFINITELY YES on intention to use all 5 substances, Maximum score = 15, DEFINITELY NO on intention to use all 5 substances) on the post-test measure of intention to use.

4. **Increase levels of self-efficacy regarding marijuana use in specific situations**
One hundred eight (65%) of the 166 participants manifested an increase in reported self-efficacy between pre- and post-test. Students responded to the questions “Over the next six months, how confident do you feel that you will NOT use marijuana in the following situations:”
• During the school day
• Before school
• With my girlfriend or boyfriend
• When I feel stressed
• When I feel angry

The scale ranged from 0 (Not Confident at All) to 15 (Very Confident). One hundred forty (84%) scored at least 10 on the scale at post-test.

**Parent Outcomes**

Parents who attended the final parent group session were given a satisfaction scale which consisted of 10 items rated on a five-point scale (higher scores represented higher satisfaction). All parents were highly satisfied with their Parent Group experience as reflected by the average satisfaction score of 4.90.
Alcohol and Drug Services: Adolescent Treatment Report

The Adolescent Outpatient Alcohol & Drug Treatment Program of the Memphis City Schools Mental Health Center is a low-intensity outpatient treatment program designed for students who meet DSM-IV diagnostic criteria for a Substance-Related Disorder and whose needs can be met in an outpatient setting. The program is funded through an outpatient A&D treatment contract with the TN Department of Mental Health and Substance Abuse Services. Services provided through the program include: integrated screening for co-occurring mental health and substance use disorders; comprehensive substance use and mental health assessment; individual counseling; family counseling; group counseling; relapse prevention counseling; and referral services.

While referrals are accepted from parents, school administrators and counselors, and other agencies, the primary source of referrals for the MCSMHC Adolescent Outpatient A&D Treatment Program is through the discipline system of the Memphis City Schools (MCS), located at the Pupil Services Center (PSC). All services are provided at no cost to the clients.

The Seven Challenges® Program

In August, 2010, the A&D Clinical Program staff members were trained in the Seven Challenges® Program, an evidenced-based, developmentally appropriate, holistic (co-occurring capable) treatment program. The Seven Challenges® Program is designed for adolescent substance abusing and dependent individuals to motivate decisions and commitments to change. Once such decisions and commitments are made, the program guides young people toward success in implementing desired changes. The Seven Challenges® Program is a relationship-based program. Counselors start with an understanding that young people generally come into treatment against their will, or at best, with little enthusiasm about the experience. By utilizing the Seven Challenges® that form the core of the program, counselors help young people look at their lives and consider where their drug use fits with what has happened in the past, what is happening now, and what they would like to see happen in the future. Incorporating a cognitive/emotional, decision-making process, the Seven Challenges® Program does not attempt to dictate behavior or coerce young people. Rather it helps them learn to think for themselves, consider all relevant information, and then make their own wise decisions. The Seven Challenges® Program does not consider drug use a stand-alone, peripheral behavior in an adolescent’s life. People use drugs for a reason – to try to satisfy personal desires and needs. Therefore Seven Challenges® Program does not narrowly focus on drug-seeking and drug-taking behavior. It goes further and provides young people with an opportunity to identify and solve co-occurring, underlying psychological problems that motivate their drug use. This includes supporting them in their efforts at resolving trauma issues. Finally, the Seven Challenges® Program also places a strong emphasis on teaching social, psychological, and emotional life skills. Solving co-occurring problems and learning life skills empowers young people to meet their needs in healthy ways, without drugs. It puts them in a position from which they could choose, of their own accord, to give up drugs, but still have other ways to attain satisfaction, pleasure, and happiness in life.

1 Referrals are also received from sources other than the discipline system but the majority of referrals are from the discipline system.
**Services Provided**

**Assessments Conducted and Students Eligible for A&D Treatment:**

During the 2011/2012 school year, the A&D Clinical Program staff conducted a total of 498 A&D assessments, compared to 532 A&D assessments conducted during 2010/2011, a decrease of 6%. Of those 498 A&D assessments, 127 (26%) met DSM-IV diagnostic criteria and were referred for treatment. Three hundred forty-seven (70%) were assigned to one of two levels of the Early Intervention Group Program and the remaining 24 students (5%) were either: 1) graduating seniors; 2) too young for assignment to an Early Intervention Group (those students were typically elementary school students and were followed up at their home schools); 3) had their suspensions/expulsions voided by the Pupil Services Center Hearing Committee due to lack of evidence; or 4) were not assigned to either an Early Intervention Group or to the Outpatient A&D Treatment Program because they immediately withdrew from the MCS or were; 5) released from the compulsory attendance law. Students meeting DSM-IV diagnostic criteria for a substance abuse or dependence diagnosis were also offered additional individual counseling at their school (provided by an itinerant A&D counselor assigned to serve the school) and family counseling, if the family was agreeable. Table 1 represents the number and percentage of students receiving A&D-related board suspensions/expulsions whose assessments yielded a DSM-IV substance abuse or dependency diagnosis by Quarter for the 2011/2012 school year.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Total Assessed</th>
<th>Met DSM-IV Diagnostic Criteria</th>
<th>Percentage Meeting DSM-IV Diagnostic Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>80</td>
<td>26</td>
<td>33%</td>
</tr>
<tr>
<td>Q2</td>
<td>109</td>
<td>33</td>
<td>30%</td>
</tr>
<tr>
<td>Q3</td>
<td>196</td>
<td>52</td>
<td>27%</td>
</tr>
<tr>
<td>Q4</td>
<td>113</td>
<td>16</td>
<td>14%</td>
</tr>
<tr>
<td>Total</td>
<td>498</td>
<td>127</td>
<td>26%</td>
</tr>
</tbody>
</table>

**A&D Treatment Sessions Provided:**

During the 2011/2012 school year a total of 1689 A&D treatment sessions were provided, an increase of 5% over the 2010/2011 school year. Of that total, 985 were individual counseling sessions (58%), 526 were group sessions (31%), and 148 were sessions with parents (9%). The remaining 30 sessions (2%) were “Other” encounters in support of clients’ treatment such as assessment sessions, collateral contacts, or the like. Table 2 provides a breakdown of the number of A&D treatment sessions provided by modality by Quarter for the 2011/2012 school year.
### Table 2
Memphis City Schools Mental Health Center
Number of A&D Treatment Sessions Provided By Modality by Quarter
2011/2012 School Year

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Individual Sessions</th>
<th>Percent</th>
<th>Group Sessions</th>
<th>Percent</th>
<th>Family Sessions</th>
<th>Percent</th>
<th>“Other” Sessions</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>163</td>
<td>66%</td>
<td>36</td>
<td>15%</td>
<td>40</td>
<td>16%</td>
<td>9</td>
<td>3%</td>
<td>248</td>
</tr>
<tr>
<td>Q2</td>
<td>291</td>
<td>61%</td>
<td>125</td>
<td>26%</td>
<td>47</td>
<td>10%</td>
<td>11</td>
<td>2%</td>
<td>474</td>
</tr>
<tr>
<td>Q3</td>
<td>382</td>
<td>61%</td>
<td>187</td>
<td>30%</td>
<td>45</td>
<td>7%</td>
<td>10</td>
<td>2%</td>
<td>624</td>
</tr>
<tr>
<td>Q4</td>
<td>149</td>
<td>43%</td>
<td>178</td>
<td>52%</td>
<td>16</td>
<td>5%</td>
<td>0</td>
<td>0%</td>
<td>343</td>
</tr>
<tr>
<td>Total</td>
<td>985</td>
<td>58%</td>
<td>526</td>
<td>31%</td>
<td>148</td>
<td>9%</td>
<td>30</td>
<td>2%</td>
<td>1689</td>
</tr>
</tbody>
</table>

**Number of A&D Treatment Sessions Provided By Modality**

![Diagram showing the distribution of treatment sessions by modality.]

**Treatment Groups:**

Attendance at a 10-session Treatment Group is a requirement of those students who receive an alcohol- or other drug-related suspension or expulsion and who, as a result of the initial assessment, exceed the inclusion criteria for the Early Intervention Group Program by meeting the DSM-IV diagnostic criteria for a Substance Related Disorder. While Group attendance is mandated due to the nature of the suspension or expulsion, additional individual and/or family counseling services are voluntary and at the discretion of the parents and student. The majority of parents and/or students accepted the individual counseling services offered.

During the 2011/2012 school year, 14 Treatment Groups, originally consisting of a total of 85 assigned clients were completed. Treatment Groups were conducted at the Pupil Services Center (in the facilities of the NW Preparatory Academy), at Northeast, Southwest, and Southeast Preparatory Academies, as well as at Martin Luther King, Jr. Transition Academy. While 79 students were available to attend Group, 45 students completed the A&D Treatment Group to which they were assigned (57%). Six students (7%) were not available to complete the A&D Treatment Group to which they were assigned due to their withdrawal from MCS, failing to...

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2 Including Parent Groups
enroll in the Innovative School to which they were assigned, incarceration, referral to a higher level of care, or for some other reason no longer in MCS. See Table 3 below.

**Table 3**

A&D Treatment Groups Provided and Participants Meeting Minimum Number of Sessions for Completion of Group for 2011/2012 School Year

<table>
<thead>
<tr>
<th>N of Groups</th>
<th>N of Students Assigned</th>
<th>N of Students Available to Attend</th>
<th>N of Students Completing</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>14</td>
<td>85</td>
<td>79</td>
<td>45</td>
</tr>
</tbody>
</table>

**Client Outcomes**

**Treatment Progress Check-Ups**

A Treatment Progress Check-Up is conducted every three months that a client is in treatment (as well as at discharge). Data collected during the Treatment Progress Check-Up consists of a Drug Use History (covering the previous three months); the Treatment Progress Index (a brief 8 item questionnaire focusing on critical behaviors related to progress in treatment); a review of any additional legal charges or suspensions/expulsions; a review of school-related indicators; re-administration of any psychological well-being measures administered at intake or as part of the treatment planning process (such as the Beck Depression Inventory); a review of Treatment Plan Goals; and an assessment of progress by the clinician. Clients are divided into four groups: those who have shown uniform progress across all domains assessed during the Treatment Progress Check-Up; those who have shown mixed progress (progress in some but not all domains); those who did not make progress in any domains; and those whose outcome is unknown because staff were unable to contact them.

During the 2011/2012 school year, 160 Treatment Progress Check-Ups were attempted. Sixty-six (41%) of the Treatment Progress Check-Ups indicated positive progress, 62 (39%) showed mixed progress, and 13 (8%) Check-Ups indicated No Progress. Staff were unable to contact 19 clients (12%). Table 4 provides a breakdown of client progress for the 2011/2012 school year.

**Table 4**

Progress Results of Treatment Progress Check-Ups
2011/2012 School Year

<table>
<thead>
<tr>
<th></th>
<th>Client Contacts Attempted</th>
<th>Uniformly Positive Progress</th>
<th>Mixed Progress</th>
<th>No Progress</th>
<th>Unknown or Unavailable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>160</td>
<td>66</td>
<td>41%</td>
<td>62</td>
<td>39%</td>
</tr>
</tbody>
</table>

**Three Month Post-Treatment Follow-Up Results**

Telephone follow-ups with discharged treatment clients and a parent are attempted three months after discharge. A minimum of three telephone calls is attempted on different days and at different times in an effort to contact the former client and a parent. If possible, efforts are also made to see the former client at school.

During the 2011/2012 school year, Three Month Post-Treatment Follow-Ups were attempted with 79 former clients and their parents. Forty-one (52%) client questionnaires were successfully completed, 49 parents (62%) of former clients were successfully contacted, and both parents and
clients were successfully contacted in 39 (49%) instances. Table 5 provides a summary of Three-Month Post Treatment Follow-Ups conducted with clients and parents for the 2011/2012 school year.

### Table 5
**Number and Percentages of Three Month Post-Treatment Follow-Ups Completed**

<table>
<thead>
<tr>
<th></th>
<th>Client Follow-Ups Completed</th>
<th>Parent Follow-Ups Completed</th>
<th>Follow-Ups Completed on Either</th>
<th>Follow-Ups Completed on Both</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>41 of 79 (52%)</td>
<td>49 of 79 (62%)</td>
<td>53 of 79 (67%)</td>
<td>39 of 79 (49%)</td>
</tr>
</tbody>
</table>

**Follow-Up Results by Client Report:**

**Types and Amount of Treatment Services Provided.** Forty-seven (89%) of the 53 former clients who were successfully contacted for Three-Month Post-Treatment Follow-Ups during the 2011/2012 school year had been assigned to both individual and group treatment. Two (4%) had received individual counseling only, and the remaining 4 (8%) had declined individual treatment and received group treatment only.

**Helpfulness and Satisfaction.** Former clients contacted for the Three-Month Post Treatment Follow-Up were asked to rate both how helpful they felt their treatment experience had been and how satisfied they were with the treatment they had received, using a scale from 1 to 5. Forty-one clients responded with a mean rating of 4.16 for Helpfulness and a mean rating of 4.32 for Satisfaction. See the graph below.

**Client Perceptions of their A&D Treatment Experience**

**Helpfulness and Satisfaction Rating Scales**

![Bar graph showing mean ratings for Helpfulness and Satisfaction](image)

**Client Report: Discipline and Legal Problems.** Only one (2%) of the 41 former clients who were successfully contacted during the 2011/2012 fiscal year for a Three-Month Post-Treatment Follow-Up had received a suspension or expulsion since discharge from the A&D Treatment Program. Further, only 3 (7%) of the 41 had been arrested or received a juvenile summons since discharge.

**Client Report: Drug Use.** The drug of choice at intake for 39 of 41 former clients contacted for a Three-Month Follow-Up during 2011/2012 was marijuana (95%), with only 4 (10%) reporting any alcohol use at intake. At intake, reported levels of use of marijuana ranged from a low of 3...
days of the 30 days immediately prior to entering treatment to a high of 30 out of 30 days, with an average of 20.59 days out of the 30 days immediately prior to intake. In fact, 21 of the students reported daily marijuana use in the 30 days immediately prior to intake. At follow-up, 21 former clients reported abstinence from marijuana (51%). For the 20 reporting use at follow-up, 14 reported a decrease in use by more than 50%. Further, for the students who reported continued use during the 30 days prior to the Post-Treatment Follow-up, their reported marijuana use had decreased from a mean of 22.8 out of the 30 days prior to intake to a mean of 10 out of 30 days. Overall, 35 of 41 former clients contacted (85%) reported reduced or no marijuana use. The average number of days use at follow-up for all former clients contacted was 4.88 days.

Especially important to note is the fact that the data presented above includes all former clients who were successfully contacted, regardless of the amount of treatment they completed.

**Client Report of Change in Drug and Alcohol Use Between Intake and 3-Month Post-Treatment Follow-Up**

![Graph showing days of use in past 30 days at intake and follow-up.]

**Client Report: Marijuana use at intake and 3-Month Post-Treatment Follow-Up by Abstainers and Users. (Represented by number of days used in prior 30 days.)**

![Graph showing days of use in intake and follow-up for marijuana users.]

Memphis City Schools Mental Health Center Annual Report – 2011/2012
Follow-Up Results by Parent Report:

Helpfulness and Satisfaction. Parents contacted for the three-month post treatment follow-up were asked to rate both how helpful they felt the treatment their children received had been and how satisfied they were with the treatment their children had received, using a scale from 1 to 5. The graph below presents those results for the year.

Parent Perceptions of Helpfulness and Satisfaction with their Child’s A&D Treatment

School Enrollment. At the time of the Three-Month Post-Treatment Follow-Up, information was obtained from the parents of 49 former students who received treatment. The information indicated that 13 former clients had graduated (27%); 17 were enrolled in a “regular” MCS school (35%); 9 were enrolled in an Innovative School (18%); 6 were enrolled in a non-MCS school (12%); and 15 were not enrolled in any school (31%). Table 9 below presents those data.

Table 8
Enrollment Status of Former Clients at Three Month Follow-Up
By Parent Report
2011/2012 Fiscal Year

<table>
<thead>
<tr>
<th></th>
<th>Graduated</th>
<th>MCS Regular School</th>
<th>MCS Alternative School</th>
<th>Adult Ed.</th>
<th>Non-MCS School</th>
<th>Not Enrolled in MCS School</th>
<th>Released from Compulsory Attendance Law</th>
<th>Incarcerated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>13</td>
<td>17</td>
<td>9</td>
<td>0</td>
<td>6</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Discipline and Legal Problems. Only one of the 49 parents of former clients successfully contacted at follow-up reported an additional suspension/expulsion since the termination of treatment, although it was not a drug-related offense. According to parents, 3 former clients had received legal charges subsequent to termination of treatment.

Drug Use. Parents contacted at the Three-Month Post-Treatment Follow-Up were asked their perceptions regarding their child’s drug use during the prior 30 days. Twenty-one (21) of the 49 parents successfully contacted believed their children were no longer using drugs (43%); 9
reported they felt their children were continuing to use (18%); and 19 parents said they did not know if their children were still using (39%).

Program Goals

As was the case in the previous year, 2011/2012 Program Goals were established for the MCSMHC Adolescent Outpatient A&D Treatment Program.

Goal 1: The program would provide outpatient adolescent A&D treatment services to students enrolled in MCS by fulfilling the outpatient A&D treatment contract with the TN Department of Mental Health and Substance Abuse Services between July 1, 2011 and June 30, 2012.

Progress toward Goal: Assessments were initiated the second week of August, 2011 and were conducted at the Pupil Services Center (PSC) Monday through Friday throughout the school year. Treatment Groups, utilizing the Seven Challenges® program, were provided twice weekly for a total of 5 weeks at the PSC/Northwest Prep Academy and as could be arranged at the Innovative Schools and Prep Academies (Northeast, Southwest, and Southeast Preparatory cademies, as well as at Martin Luther King, Jr. Transition Academy). Ongoing Seven Challenges® Treatment Groups were conducted throughout the school year. A Parent Group for parents of clients assigned to the Treatment Group was provided at the same time and location of the Treatment Group at the PSC/Northwest Prep Academy. Individual and family outpatient treatment sessions were provided. See the appropriate section of the report above for details.

Goal 2: The program would assist adolescent clients in identifying and addressing problems related to substance abuse and establishing and maintaining a drug-free life style.

Progress toward Goal: Clinical staff developed individualized treatment plans for all clients admitted to treatment within the time frames specified for licensure and provided individual, group, and family treatment sessions, as appropriate. Please refer to the appropriate tables in the body of this report for specific numbers.

During the 2011/2012 school year, 80% of clients who took part in a Three Month Treatment Progress Check-Up showed either uniformly positive progress (66 individuals, 41%) or mixed progress (62 individuals, 39%). Forty-five clients assigned to Treatment Groups (and available to take part) successfully completed the Group (57%) and completed the final questionnaire.

On the Three-Month Post-Treatment Follow-Up, former clients who were contacted reported mean Helpfulness and Satisfaction scores of 4.16 and 4.32, respectively, on 5-point rating scales. This goal was met.

Goal 3: The program would use a holistic, highly effective, evidence-based treatment approach for adolescents that addresses drug problems, co-occurring problems, behavior problems, and remediation of skill deficits.

Progress toward Goal: All A&D counselors and the MCSMHC Director would be certified to provide the Seven Challenges® program in the Memphis City Schools. Alcohol and drug counselors would use the Seven Challenges® program with all of their individual clients and in all the treatment groups.
Alcohol and Drug:  
Adolescent Treatment

The MCSMHC Director conducted weekly staff meetings with A&D counselors to review individual treatment cases, discuss treatment strategies, and review Seven Challenges® journals. The MCSMHC Director met at least monthly, and often bimonthly, with each A&D counselor to discuss cases, review treatment charts, and provide oversight to ensure the fidelity of the Seven Challenges® program. In addition, the MCSMHC Director participated in quarterly support calls with clinical staff from Seven Challenges®.
Part D

Crisis response services
Crisis Response Services

MCSMHC responds to school based mental health emergencies and crisis incidents by providing expert mental health services to students and consultation to school and district staff. In the event of a crisis, the center deploys a team of professionals that may include school social workers, school psychologists and supervising psychologists to provide assessment, supportive counseling, and assistance to administrators in coordinating a crisis response plan and postvention services.

Definitions

*Emergency*: An incident that impacts only one student or a small number of students. An imminent threat of harm to self or others would typically be present (or perceived to be present by a school administrator).

*Crisis*: An incident that impacts all or most of the school and has a seriously adverse impact on school climate and individual students. Response to a school crisis requires deployment of several mental health clinicians to the school.

MCSMHC clinicians have received specialized crisis response training to address events that may severely impact the psychological functioning of students. Responders are called to schools for a variety of incidents impacting individual students (e.g. suicide threat), groups of students (e.g. death of student), and school wide populations (school shooting). Clinicians are also involved in recovery activities including defusing and debriefing, and follow-up with students, teachers, and parents.

Once an emergency or crisis occurs, a school administrator calls a dedicated hotline at the center. Basic information is recorded and conveyed to a supervising psychologist who deploys a clinician or team to the school. A team leader, often the supervising psychologist, is designated if a crisis requires a group of responders. The role of the team leader is to organize the team at the school and meet with appropriate school/district personnel to coordinate the response strategy. Typically, the supervising psychologist sends at least one clinician regularly assigned to the school to help acclimate the team to the school and staff.

In responding to the emergency or crisis, MHC clinicians record names, phone numbers and parent names of all students who receive individual crisis counseling. Students may be seen only one time without parental consent if the student appears to be in crisis. Parents of all students seen individually or in small groups for crisis counseling are be notified before the end of the workday. Written parental consent is obtained prior to any face-to-face follow up with a student.

Responders maintain contact with the supervising psychologist for direction and support. Details of the event and response are recorded and promptly entered into a confidential data base.

*Table 1* compares total emergency and crisis reports for the past four years. Though some fluctuation within categories is present, reports related to suicide continue to be, by far, the most frequent. The *Other* category refers to emergencies that didn’t fit into a discreet classification. These included miscellaneous severely disruptive or dangerous behaviors (e.g., erratic behavior due to loss of reality contact).
Table 1
Number of Crisis and Emergency Responses by Type:
Four Year Comparison

<table>
<thead>
<tr>
<th>Type</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Threat or Ideation</td>
<td>181</td>
<td>169</td>
<td>205</td>
<td>142</td>
</tr>
<tr>
<td>Suicide Attempt or Gesture</td>
<td>25</td>
<td>21</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Death of Student</td>
<td>22</td>
<td>21</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Homicidal Threat</td>
<td>21</td>
<td>15</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Death of Teacher</td>
<td>13</td>
<td>11</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>54</td>
<td>36</td>
<td>39</td>
<td>36</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>317</td>
<td>263</td>
<td>286</td>
<td>232</td>
</tr>
</tbody>
</table>

Table 2 graphically compares total emergency/crisis reports over the past three years. Though some fluctuation in school reporting is evident over time, no pattern of reporting incidence was apparent.

Table 2
Total Emergency/Crisis Reports:
Four Year Comparison

Table 3 accentuates the vast difference in reports related to thoughts or gestures of suicide compared to other reports. Consistent with research associating suicidal ideation with bullying victimization, the most common reason reported by students for suicidal ideation was being

Memphis City Schools Mental Health Center Annual Report – 2011/2012
bullied at school. Clinicians report all cases of bullying to school administrators and document follow up in their written reports.

Table 3
Comparison of Major Categories:
Four Year Comparison

Utilizing a pie chart, Table 4 compares incidence of categorical emergency/crisis reports by percent of total reports. Sixty percent of reports were associated with suicidal ideation or behavior. Conversely, there were relatively few school wide crisis reports.

Table 4
Emergency/Crisis Incident Pie Chart Comparison
Part E

Well Child Mental Health Screening
Well Child Mental Health Screening

Well Child, Inc. collaborates with Memphis City schools to provide preventive health care evaluations to children in school-based settings. The services include immunizations, comprehensive physical exams, and vision, hearing, dental, and behavioral-health screening. Believing that healthy bodies promote healthier students, Memphis City Schools supports Well Child’s health care model ensuring that school-age children have access to the best preventive health care services in a convenient, caring and comfortable environment.

Upon annually enrolling their children in school, parents are offered the opportunity to complete Well Child’s Pediatric Symptom Checklist (attached), a 17 question standardized measure of behavioral and social-emotional adjustment. For parents who choose to complete the questionnaire, response forms are processed through the local Well Child offices. Parents of students whose scores are considered “at-risk” receive a letter from Well Child referring the student for further mental health evaluation. The parent is provided contact information for three community mental health centers. Beginning in 2008, MCS Mental Health Center has been one of the three centers identified in the parent letter.

During the 1010-11 school year, MCS Mental Health Center received 35 calls from parents requesting mental health assessment and/or intervention. The number represents a decrease of seven from the previous school year (Figure 1). For the majority of referrals, parents described behavioral symptoms characteristic of ADHD.

Parent calls were responded to by the Center Director, who conducted parent interviews and discussed options for further evaluation and intervention. Of the 35 calls from parents, 33 were referred to the school’s Student Support Team (S-Team) for follow up. In 31 cases, the meetings were conducted as planned. In the S-Team meetings, the parent(s), teacher(s), school counselor, and mental health clinicians evaluated the presenting concerns and developed a plan designed to address the students’ needs. Referred students received a variety of services including functional behavior assessments, behavior intervention plans, counseling, psychoeducational testing, referrals to other agencies and programs, and parent/teacher consultation.
Figure 1

Well Child Referrals: A Three Year Comparison

![Bar graph showing the number of well child referrals from 2008-09 to 2011-12.](image-url)
Part F

Suicide Awareness and Prevention Training
Suicide Awareness and Prevention Training

The **Suicide Awareness and Prevention Training** project is a skills-based group intervention empirically designed to: a) increase the level of student information associated with teen suicidal activity, b) improve student help-seeking actions in response to the suicide indicators of self and peers, and c) decrease the number of students considering suicide as a solution to real and perceive difficulties.

The Suicide Awareness and Prevention Training Project (SAPTP) was established for MCS students in 2005 as a response to Youth Risk Behavior Survey data indicating a significant percentage (18.5%) of MCS students “seriously considered killing themselves during the past 12 months” as a solution to their problems. A larger percentage (27.1) of students from this group reported feeling so “sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.” Data from the Youth Risk Behavior Survey (administered through the US Center for Disease Control) over the past eight years indicate a positive trend among MCS high school students regarding reports of depression and suicidal behavior. Specifically, statistically significant improvement was measured in the domains:

- **Felt so sad or hopeless during almost every day for two weeks or more in a row that they stopped doing some usual activity during the past 12 months**
- **Made a plan for how they would attempt suicide during the past 12 months**
- **Attempted suicide during the past 12 months**

**YRBS Comparison: 2003 and 2011**

![Graph showing YRBS comparison](image)

SAPTP primary aim was to provide suicide prevention and awareness training to 100% of ninth grade Health and Wellness classes in MCS for the school year 2011-2012. Our ultimate expectation was to increase awareness and reduce the need for interventions associated with suicide related incidents.
**Implementation Course**

**Trainers level I:** A team of ten school social workers, psychologists, and supervising psychologists were trained to present the preventive Intervention (PI) information module to their professional Regional peers. Each team of two trainers represented four District Regions and Innovative School teams.

**Trainers Level II:** Level I team members trained other school social workers and psychologists (Level II) within their respective Regions. Level II trainers delivered the PI to students enrolled in Health and Wellness classes within the trainers’ Region.

**Outcome**

<table>
<thead>
<tr>
<th>Details</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of MCS ninth grade students receiving Prevention Training</td>
<td>4,564</td>
</tr>
<tr>
<td>Other students receiving suicide awareness/prevention training</td>
<td>1,241</td>
</tr>
<tr>
<td>Grand Total MCS students receiving suicide awareness/prevention training</td>
<td>5,805</td>
</tr>
</tbody>
</table>
Part G

Preschool and Head start Services
Part H

Summer Programs
Services to Preschool and Head Start Students

MCS Mental Health Center has become increasingly integrated into programs and services for MCS preschool students by contributing to the MCS PreK-3 Continuum and to a MCS contract with Shelby County Head Start.

**PreK-3 Continuum:** The MCS PreK-3 continuum is an inter-departmental, interagency initiative designed to support the needs of students through the end of third grade. This is a benchmark recognized as pivotal in positioning students for success in grades four and beyond. The process involves collaborating with community partners and parents to provide support prior to students entering MCS. The Continuum integrates several best practices and enhanced activities into a cohesive framework to support students and families in gaining the requisite skills to achieve or exceed proficiency by the end of grade three. MCS Mental Health Center has been active in establishing and implementing these practices.

In our previous report, we were encouraged by district approval for hiring four Behavior Analysts to provide specialized support to K-3 students experiencing severe social-behavioral adjustment challenges. These professionals, under the auspices of MCSMHC, would offer their specialized training and skills for evaluation and provision of direct services with these students. Further, the Behavior Analysts would provide direct support and coaching to individual teachers experiencing difficulties with student behavior. After months of processing through the MCS Human Resources-Compensation Department, these positions were recently posted. Services to K-3 student will begin 2nd semester.

**MCS and Shelby County Head Start Contract:**
Under terms of this contract, a variety of services are provided at a maximum annual compensation for the district of $25,000. These services consist of: a) classroom observations, b) student observations, c) consultation to parents and teachers, d) teacher professional development, and e) Functional Behavior Assessments and Behavior Intervention Plans.

Our clinicians observe all MCS Head Start classes and provide written reports for the teachers. These reports include general recommendations and recommendations for specific students who appear to have special needs. Observations of specific students are also conducted when teachers have concerns and require consultation to help meet these students’ needs. Center clinicians also provide training and consultations to teacher/parent teams and groups, as well as individual parents and teachers. **55 classroom observations and 21 consultation sessions were conducted during the 2010-11 school year.**
Summer Programs 2012

MCSMHC clinicians participate in specialized programs to address the social-emotional development of students. These programs, sometimes taking the form of brief summer camps, are offered at a limited number of school locations. Students may be referred by their schools for a summer camp or students may be seen as an adjunct to summer school programs. The camps support improved adaptive functioning in a variety of domains including social skills, emotional sensitivity, trauma recovery, and resilience. These skills are taught in an enjoyable environment.

Camp Treetops

Camp Treetops is a two week therapeutic summer camp serving middle school students at risk for becoming aggressive and/or involved in violent behavior as a result of having been exposed to violence in the home or community.

Rationale

Increased incidents of depression, Post Traumatic Stress Disorder, aggression and behavioral acting out have been found among students who witnessed violence. Camp Treetops’ therapeutic curriculum focuses on decreasing the probability that our students will participate in destructive behaviors that frequently thwart their ability to achieve a positive and successful school experience. Camp Treetops teaches and models pragmatic prosocial skills to help students cope with an array of difficult emotions, adversity, and trauma associated with perilous and violent communities, homes and lifestyles. Recognizing our limited ability to remove students from detrimental environmental circumstances, we are left with the option of promoting resilience to increase the likelihood of their educational success.

Summer Schedule

June 4 – 15, 2012
- Camp Site 1: Wooddale Middle School (Southeast Region)
- Camp Site 2: Westside Middle School (Northwest Region)

July 2 – 13, 2011
- Camp Site 3: Hamilton Middle School (Southwest Region)
- Camp Site 4: Kingsbury Middle School (Northeast Region)

Attendance Results

<table>
<thead>
<tr>
<th></th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Site 4</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Students</td>
<td>30</td>
<td>16</td>
<td>20</td>
<td>5</td>
<td>71</td>
</tr>
<tr>
<td># of Males</td>
<td>10</td>
<td>9</td>
<td>12</td>
<td>4</td>
<td>35</td>
</tr>
<tr>
<td># of Females</td>
<td>20</td>
<td>7</td>
<td>8</td>
<td>1</td>
<td>36</td>
</tr>
<tr>
<td>Average Daily Attendance</td>
<td>74.5%</td>
<td>69%</td>
<td>85%</td>
<td>88%</td>
<td>NA</td>
</tr>
</tbody>
</table>
Evaluation Results

<table>
<thead>
<tr>
<th></th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Site 4</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Students</td>
<td>25</td>
<td>13</td>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td>Parts I and II</td>
<td>72%</td>
<td>46%</td>
<td>83%</td>
<td>60%</td>
</tr>
<tr>
<td>Part III Objectives 1 &amp; 3</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Part III Objective 2</td>
<td>89%</td>
<td>69%</td>
<td>83%</td>
<td>60%</td>
</tr>
<tr>
<td>Survey Rating (average)</td>
<td>4.45</td>
<td>4.86</td>
<td>4.7</td>
<td>4.5</td>
</tr>
<tr>
<td>Assessment Results (avg)</td>
<td>3.29</td>
<td>3.42</td>
<td>2.99</td>
<td>3.45</td>
</tr>
</tbody>
</table>

The evaluation results were based on students who completed both the pretest and posttest. The pre/post-test consisted of three parts. Part I contained five true or false items related to information that was presented during camp. Part II was a five-item Likert scale that measured the likelihood that students will make healthy choices and engage in positive conflict resolution strategies. The results of Parts I and II of the test (page 1) were combined and were based on a 100 point scale. Part III (page 2) contained three questions/objectives in which students identified at least 1) one human resource/support, 2) one non-violent strategy for resolving conflict, and 3) one personal/individual strength.

The following expected outcomes were established during the initial development of the Camp Treetops summer program:

- Eighty percent of students in the camp will identify at least one resource upon completion of the program (Objective 1).
- Fifty percent of students in the camp will identify at least one preferred non-violent way of resolving conflict upon completion of the program (Objective 2).
- Eighty percent of students in the camp will identify at least one individual strength upon completion of the program (Objective 3).

The expected outcomes for 2012 Camp Treetops program were met at all four sites.

Camp Site 1 – Wooddale Middle School
Nine students achieved perfect attendance as they were present for eight days. Two other students maintained consistent attendance after their initial start date. Four of the students had attended Camp Treetops during a previous summer session. On Parts I and II, 13 of the 18 students (72%) that completed the pretest and posttest indicated gains, ranging from 2 to 24 points. On Part III, 15 students (83%) provided at least one acceptable response for all three objectives. The remaining students met expectations for 2 of 3 objectives.

Camp Site 2 – Westside Middle School
Two students (brothers) had attended a previous summer session of Camp Treetops. However, one of these students only attended the first day of camp due to enrollment in promotional summer school. Six students had perfect attendance. Another student only attended the first week due to family vacation plans.
On Parts I and II, 6 of 13 students (46%) that completed both tests indicated no change (3) or gains (3), ranging from 0 to 14 points. On Part III, nine students (69%) provided at least one acceptable response for all three objectives. The four remaining students identified at least one acceptable response for Objectives 1 and 3.

**Camp Site 3 – Hamilton Middle School**

Nine students attended every session and attained perfect attendance. Five students were repeating the program as they had attended during a previous summer session.

On Parts I and II, 15 of 18 students (83%) that completed both tests indicated no change (2) or gains (13), ranging from 0 to 42 points. One student made a gain of 4 points achieving a perfect score of 100. On Part III, 15 students (83%) provided at least one acceptable response for each objective. The remaining three students identified at least one acceptable response in 2 of 3 objectives.

**Camp Site 4 – Kingsbury Middle School**

Three of the students had attended Camp Treetops during a previous summer session. The same three students achieved perfect attendance during this camp. The other two students attended consistently after they began the program.

On Parts I and II of the posttest, 3 of 5 students (60%) indicated no change (1) or gains (2), ranging from 0 to 20 points. On Part III, three students (60%) provided at least one acceptable response for each objective. The two students who did not attain 100% identified at least one acceptable response for Objectives 1 and 3.

To further evaluate student progress in camp, a rubric was developed as a tool to provide a more comprehensive assessment. Using a five-point scale ranging from 1 (marginal or poor) to 4 (exemplary or excellent), the students were assessed in the following categories: attendance, participation, compliance, knowledge gained, and social interaction. The average scores for the total number of students that attended each site were reported in the evaluation results table.

The students completed a survey about their Camp Treetops experience with the understanding that providing their names was optional. The survey consisted of five questions and an overall rating from 1 (not helpful) to 5 (very helpful). The average scores for the overall rating were reported in the evaluation results table. The students were asked: 1) what they learned, 2) what they liked most, 3) what they liked least, 4) what was most helpful, and 5) what would they tell others about the program. Following are examples of student responses.

**Learned** – “that you don’t always have to be bitter and angry.”

**Liked most** – “how you can also learn while playing games”

**Liked least** – “the work sheets”

**Most Helpful** – “the life lessons and one on one talk.”

**Tell Others** – “Camp tree tops is a very fun place to spend time . . . to be yourself and learn about things that will help you in the long run.”
Camp Steady

Camp Steady is a Summer camp-type activity in which students experiencing homelessness are provided fun and relevant social-emotional leaning activities in a safe, interesting, and caring environment. In addition to participating in academic and recreational activities (provided by MCS Parent and Community Engagement staff and teachers), the children receive skilled-based group training from MCS Mental Health Center clinicians. A number of the children experience difficulties with school attendance, health concerns, and social/behavioral problems.

Rationale

The number of children identified as homeless within the Memphis area is increasing; MCS currently serves more than 1,800 homeless children. These children display special needs, including difficulties with school attendance, academic deficits, health concerns, and social and behavioral problems.

Camp Steady, administrated by the MCS Division of Parent/Community Engagement, has been in operation for the past seventeen years. The camp has provided academic and social support to children and adolescents.

For the past eight years the Camp Steady children have received additional academic and social-emotional skill-based group training from MCS Mental Health Center clinicians.

Project Goal

To provide skill-based group training to all children and adolescents attending Camp Steady for the entire six weeks. Our objective was to enhance participants’ social-emotional and academic adjustment.

Implementation

Six teams of MCS Mental Health Center school social workers and school psychologists conducted 8 groups for a total of 57 sessions (e.g., Stress Management, Dealing with Anger and Aggression, Study Skills 101) twice per week for 6 weeks. 207 students were enrolled for the summer session.

Summer Schedule

June 4 – July 12, 2012 at Airways Middle
Camp Why Try

The *WhyTry* Program is a strength-based approach to help students with disabilities overcome their school adjustment challenges and improve outcomes in the areas of truancy, behavior, and academics. *WhyTry* is based on sound, empirical principles, including Solution Focused Brief Therapy, Social and Emotional Intelligence, and multi-sensory learning.

The idea is straight-forward: Teach social and emotional principles to youth in a way they can understand and remember. This is accomplished using a series of ten pictorial metaphors. Each metaphor teaches a discrete principle, such as resisting peer-pressure, obeying laws and rules, and that decisions have consequences. The visual components are then reinforced by music and physical activities. The major learning styles—visual, auditory, and body-kinesthetic—are all addressed.

**Rationale**

Students with disabilities in MCS are disproportionately disciplined via suspension and expulsion compared to regular education students.

**Implementation**

Thirty-Five school social workers, school psychologists, and special education teachers were trained in teaching the Why Try curriculum. They implemented the curriculum in their schools in an effort to reduce the number of suspensions/expulsions. As part of the intervention, nearly forty students participated in a field trip to Bridges, where children are taught how to build positive relationships and become responsible individuals. (Bridges is a non-profit organization that helps youth and adults find their voice, experience their power and build positive relationships in order to create strong lives and extraordinary communities. It serves 15,000 adults and youth in the Memphis area annually, to build a community of leaders to advance racial, economic, educational and environmental justice.) Implementation took place as follows.

- Meetings were held at all identified schools with school administrators/staff regarding expectations. An average of eight key personnel was in attendance at each school (Sept-Nov 2011).
- Meetings were held with parents, introducing them to the program. The total number of parents in attendance (Oct-Feb 2011) was twenty-five. (According to the curriculum, groups work better with no more than ten students per session.) Two schools were successful in conducting consecutive groups during the school year.
- Consultation was provided to teachers regarding implementation. Nine teachers participated in the instruction and feedback sessions (Oct-April 2012).
- Seventy-two students participated in group sessions during the 2011-2012 school year. The target schools were Hillcrest High, Kirby High, Melrose High, Ridgeway High, Trezevant High, and White Station High.
Summer Camps

**Student Outcomes**

Pre and post surveys were administered to the students in the program and some of their initial responses are as follows.

Pre test surveys:
- Fifty-three percent (53%) said they did not try to come up with ways to solve problems.
- Forty-one percent (41%) stated they were likely to give in to friends and do things they did not want to do.
- Roughly half stated they did not believe what you do or think will change your future.

Post test surveys:
- Over eighty percent (80%) said they tried to come up with ways to solve problems.
- Fifty-five percent (55%) said they were less likely to give in to friends and do things they did not want to do.
- Forty-nine (49%) percent reported “almost always” as to whether they believed what you do or think will change your future.
Part I

Suspension Reduction Services for High School Students with Disabilities
Suspension Reduction Services for High School Students with Disabilities

The Why Try Program is a strength-based approach to helping youth overcome their challenges and improve outcomes in the areas of truancy, behavior, and academics. It is based on sound, empirical principles, including Solution Focused Brief Therapy, Social and Emotional Intelligence, and multi-sensory learning.

The idea is straight-forward: Teach social and emotional principles to youth in a way they can understand and remember. This was accomplished using a series of ten pictures (visual analogies). Each visual teaches a discrete principle, such as resisting peer-pressure, obeying laws and rules, and that decisions have consequences. The visual components are then reinforced by music and physical activities. The major learning styles ---- visual, auditory, and body-kinesthetic ---- are addressed.

Goals:
- To provide a research based group counseling intervention for students with disabilities.
- To remediate negative behaviors associated with school suspensions and expulsions
- To train thirty-five facilitators certified in teaching the Why Try curriculum for sustainability of the program and student follow up.

Participation

Thirty-Five school social workers, school psychologists, and special education teachers were trained in teaching the Why Try curriculum. They implemented the curriculum in their schools in an effort to reduce the number of suspensions/expulsions. Nearly forty students participated in a field trip this past school year (2011-2012) at Bridges which focused on building positive relationships and being a responsible individual. Bridges is a non-profit organization that helps youth and adults find their voice, experience their power and build positive relationships in order to create strong lives and extraordinary communities. It serves 15,000 adults and youth in the Memphis area annually, to build a community of leaders to advance racial, economic, educational and environmental justice.

- Meetings were held at all identified schools with school administrators/staff regarding expectations. An average of eight key personnel was in attendance at each school (Sept-Nov 2011).
- Meetings with parents introducing the program. Total number of parents in attendance (Oct-Feb 2011) was twenty-five. Nine was the average number of students in the groups at identified schools. (According to the curriculum, groups work better with no more than ten students per session.) Two schools were successful in conducting consecutive groups during the school year.
- Consultation with teachers regarding implementation/feedback. Nine teachers participated in feedback (Oct-April 2012). Some of the statements were as...
follows: All material will be useful, like that all learning styles are addressed, and the strategies used will help me internalize the information.

Student Outcomes

The overall numbers for students with disabilities from Kirby, Melrose, Ridgeway, Trezevant, Hillcrest, and White Station high schools with 10 or more suspensions decreased for the 2011-2012 school year.

Pre and post surveys were given to the students in the program and some of their initial responses are as follows:

Pre test surveys
- Fifty-three percent did not try to come up with ways to solve problems.
- Forty-one percent stated they were likely to give in to friends and do things they did not want to do.
- Roughly half stated they did not believe what you do or think will change your future.

Post test surveys:
- Over eighty percent said they tried to come up with ways to solve problems.
- Fifty-five percent said they were less likely to give in to friends and do things they did not want to do.
- Forty-nine percent reported “almost always” as to whether they believed what you do or think will change your future.

Student Participation and Progress

- Students attending camp/group sessions actively participated in all activities.
- A student verbally stated she had difficulty with controlling her anger but since attending the Why Try group sessions, she learned alternative methods to dealing with her anger.
- Seventy-two students participated in group sessions during the 2011-2012 school yr.
- Five out of six identified schools participated in the summer camp program. One school had students to sign up for the summer camp program but none reported to camp. Parents listed reasons as students attending summer school or visiting out of town as reason why students did not attend camp.

Barriers

- One identified school did not participate due to staff being non-committal/space
- Difficulty getting room at schools to conduct group sessions
- Problems with some school administrators allowing group sessions to begin early in school year. Some reasons given were: interfered with class time, no free class periods, and trained staff for the program were busy with other duties.
Suspension Reduction Services for High School SWD

- Struggle with getting staff who facilitated the group sessions (i.e.: special education teachers, mental health staff) to turn in monthly paperwork to gage effectiveness of program.

Table: Comparison of Regular-ed and Special-ed Student Expulsion/Suspension Percentages by School (2010-2011)

<table>
<thead>
<tr>
<th>SCHOOL</th>
<th>Expelled</th>
<th>Suspended</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Hillcrest High</td>
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<td>Suspended</td>
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<td></td>
<td>Total</td>
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<td>Suspended</td>
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<td>Total</td>
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<tr>
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<tr>
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<td>Total</td>
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<tr>
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<td>Total</td>
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<td>228</td>
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<tr>
<td>White Station High</td>
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<td>Suspended</td>
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# Table: Comparison of Regular-ed and Special-ed Student Expulsion/Suspension Percentages by School (2011-2012)

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<tr>
<th>SCHOOL</th>
<th>EXPULSION</th>
<th>SPED Enrollment</th>
<th>% SPED by Action</th>
<th>Non-SPED Enrollment</th>
<th>% Non-SPED by Action</th>
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