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Creating A Comprehensive Supportive Policy That Provides Equal Educational Access For The Mentally Ill Student: A Policy Advocacy Document

Lesley S. Roberts
National-Louis University

CREATING A COMPREHENSIVE SUPPORTIVE POLICY THAT PROVIDES EQUAL EDUCATIONAL ACCESS FOR THE MENTALLY ILL STUDENT: A POLICY ADVOCACY DOCUMENT

Lesley S. Roberts

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NLU Digital Commons Document Origination Statement

This document was created as *one* part of the three-part dissertation requirement of the National Louis University (NLU) Educational Leadership (EDL) Doctoral Program. The National Louis Educational Leadership Ed.D. is a professional practice degree program (Shulman et al., 2006).

For the dissertation requirement, doctoral candidates are required to plan, research, and implement three major projects, one each year, within their school or district with a focus on professional practice. The three projects are:

- Program Evaluation
- Change Leadership Plan
- Policy Advocacy Document

For the **Program Evaluation** candidates are required to identify and evaluate a program or practice within their school or district. The "program" can be a current initiative; a grant project; a common practice; or a movement. Focused on utilization, the evaluation can be formative, summative, or developmental (Patton, 2008). The candidate must demonstrate how the evaluation directly relates to student learning.

In the **Change Leadership Plan** candidates develop a plan that considers organizational possibilities for renewal. The plan for organizational change may be at the building or district level. It must be related to an area in need of improvement with a clear target in mind. The candidate must be able to identify noticeable and feasible differences that should exist as a result of the change plan (Wagner, et al., 2006).

In the **Policy Advocacy Document** candidates develop and advocate for a policy at the local, state or national level using reflective practice and research as a means for supporting and promoting reforms in education. Policy advocacy dissertations use critical theory to address moral and ethical issues of policy formation and administrative decision making (i.e., what ought to be). The purpose is to develop reflective, humane and social critics, moral leaders, and competent professionals, guided by a critical practical rational model (Browder, 1995).

Works Cited

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Abstract

The purpose of this policy advocacy document was to create a comprehensive policy supporting the education of students with mental illness disorders. Critical issues of school attendance, credit recovery, reintegration, and staff professional development formed the four parts of the policy statement. An examination of critical issues impacting students with mental illness, as well as an analysis of the educational, economic, social, political, moral, and ethical issues, were used to inform the creation of this policy. Stafford High School in Stafford School District (pseudonym) is highlighted as an implementer of the proposed policy, and as a model for other districts exploring implementation of the proposed policy.

Preface

Throughout the three years of the educational leadership doctoral program, there was a particular emphasis on social justice and equity. However, it was not until the third year that I began to look critically at the idea of equity versus equality. As I was working within the doctoral cohort, I was experience these inequities in my practical applications at work.

The foundation on which my career has been built is advocating for the rights of students with disabilities so that they may have an education that is fair and equitable. Fair and equitable does not necessarily mean equal; rather, equity for mentally ill students is leveling the educational playing field so everyone has an opportunity to achieve. Carefully considering these inequities prompted me to apply these concepts to my ongoing work, wherein I realized there was still work to be done to advocate for students with mental illness. While all students with disabilities exist under laws designed to protect them, Stafford School District's policies did not seem comprehensive enough to provide adequately for students with mental illness, since mental illness falls under the overarching umbrella of mental disability.

My research inspired me to advocacy, and more specifically to create a comprehensive policy that would support students with mental illness. Behind this call to advocacy were two-and-a-half years of understanding my role as a socially just leader within the doctoral cohort. It is time for application.

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SECTION ONE: VISION STATEMENT

Introduction to the Problem

Stafford High School (pseudonym) is part of a unit school district located in a wealthier section of the northwest suburbs of Chicago. Between August and October 2011 at Stafford High School, eight high school students were hospitalized for conditions related to mental illness (see Appendix A). Between August and October 2012, that number more than tripled to 25 (see Appendix B). All of these students during both time periods were diagnosed with mental disorders: depression, anxiety, mood disorders, chemical dependency, and eating disorders. Many of these students exhibited suicidal thoughts and were hospitalized anywhere from one week to more than two months at a time. My current position as Department Head of Special Services at Stafford High School affords me a balcony viewpoint, as well as knowledge of individual cases of struggling students. The special services department is comprised of special education teachers and therapists (e.g., school psychologists, school social workers, speech pathologists, etc.) whose primary role is to support students with identified disabilities.

Stafford High school students who suffer from mental illness often first come to the attention of school personnel through attendance concerns: they typically have difficulty maintaining their school attendance—and ultimately their grades—due to missed content. This issue may either go unaddressed for long periods, or it may be addressed ineffectively through the dean's office or the county truancy officer. Both of these options are technical "fixes" that do not solve the real problem of mental illness among high school students, which is inadequate academic and social emotional support resulting from their mental health disorders.

Help from home at Stafford is oftentimes spotty or missing altogether. Since mental illness can be hereditary, in many cases students who are mentally ill also have one or more immediate family members who are also mentally ill. This can complicate the problem; if one or more parents are unable to make difficult decisions on behalf of the student, the student continues to suffer medical and academic consequences. The problem then becomes pervasive and self-sustaining. At Stafford High School therapists and professionals are required to address a four-layered problem (attendance, mental health, academic, and family) without the support and guidance of a comprehensive mental health assistance policy. Therefore, the purpose of this policy advocacy document is to effectively support the academic and social emotional needs of students with mental illness at Stafford High School.

Critical Issues

At Stafford High School, there are no current school or district policies directly addressing mental health concerns. Rather, there are a variety of policies that individually attempt to address the issues surrounding student mental health. For example, students with attendance concerns whose parents do not appear to be supportive in bringing them to school may be referred to the county truancy office through the dean's office. This may result in a fine imposed on the family by the county truancy court and continued monitoring by the truancy officer. Parents of students struggling with attendance difficulties but working cooperatively with school staff may have their child referred to a therapeutic day school that offers supportive attendance (i.e., a staff member will physically get the student out of bed and take him or her to school). Some therapeutic day schools additionally have a mastery curriculum so the student can gradually master

challenging academic curriculum at his or her own pace. Integrated therapy throughout the school day to address the symptoms of his or her disability is also provided. Students who attend therapeutic day school based on the recommendation of Stafford High School—at the district's expense—continue to be considered part of their home school, and thus may attend home school activities when appropriate and participate in the graduation ceremony and activities with their peers.

However, while therapeutic day school is certainly a better option than being referred to the truancy office, neither of these solutions addresses the underlying psychiatric issues the student is facing. Sometimes a mental health diagnosis has already been made, and the student is under private care of a treating psychiatrist. However, sometimes a diagnosis is only suspected, and the parents either do not know the source of the problem or are in denial. Whether or not the student is under the care of a psychiatrist is largely dependent on affordability for the family: not all psychiatrists accept medical insurance and medications used to treat mental illnesses are costly, raising the issue of financial equity related to treatment.

There is a growing demand in recent years for Stafford High School to address more than the academic needs of students; social-emotional aspects of student life are being recognized as equally important. Increasing economic struggles and changing family structures that include increasing single-parent family homes have fueled the difficulties of educating students with mental illness. An increasing number of students at Stafford High School have been literally coaxed across the stage in an effort to simply give them their high school diploma. Instead of graduating academically and emotionally equipped, students are leaving school with limited academic knowledge, despite their

potential to learn. Even worse, they are leaving school with maladaptive coping skills, unprepared to cope with society and the social-emotional demands of the 21st century.

An examination of student suicides in the United States reveals that there are approximately 100-200 suicide attempts for every completed suicide among young adults ages 15 to 24 (Centers for Disease Control and Prevention, 2008). These statistics appear to be reflective of the ratio of suicide attempts to suicide completions within the Stafford High School population. Along with rising mental health referrals at Stafford High School, there was one suicide during the 2012-13 school year. This was the first suicide in three years, after a five-year stretch of approximately one per school year.

Without a specific policy that supports students and families struggling with mental health disorders, students in many high schools are left with minimal school psychological and school social work services, which are not intended to address psychiatric issues. Even in a best-case scenario, students' academic needs become secondary, families with minimal resources are largely left unsupported, and wealthier families receive splintered services at best. At the high school level, educators are largely concerned with preparing students to be productive in the world—whether through continuing education or gainful employment—and the absence of an adequate supportive educational policy addressing mental health issues for at-risk students is a gap that needs to be filled.

While the United States Congress has historically included mental disabilities in the definition of "disabilities" covered under federal law, there remains an unspoken distinction between mental disabilities and mental illness. The term 'mental disability' has traditionally been used to identify students with behavioral and cognitive disabilities,

while mental illness has not been directly addressed within the educational system. School psychologists are required to support students with cognitive, behavioral, and social-emotional disabilities, while psychiatrists are medical doctors who diagnose and treat mental illness outside of the school system: there is minimal interaction between psychiatrists and school psychologists on behalf of students. The goal of this recommended policy is to ensure adequate educational services for students with mental illness.

Recommended Policy

A comprehensive policy addressing the psychiatric, academic, and family support needed for students with mental illness should be created, using a comprehensive multi-dimensional approach: First, a student would need to be evaluated and diagnosed by a psychiatrist. A one-time evaluation should be provided by the school district. Though continued follow up could not be mandated, the district would provide suggested resources to parents. Second, within-district academic supports would be established so that students' academic needs could be addressed while they are receiving outside psychiatric services. Third, students would not be penalized for their school absences while they are receiving mental health services, since fear of missing assignments and work while hospitalized has always been a source of anxiety for students. Finally, family supports and family education would be incorporated into an intervention plan. A created Individualized Education Plan (including a reintegration plan) incorporating all four areas of a comprehensive mental health policy (academic, medical, school attendance, and family support), would individualize the needs of students. With a parent's permission, a

consulting psychiatrist would work with a school team to ensure that both medical and educational interventions jointly served the student.

Such a policy would provide financial assistance to families, as well as grant staff a process and a means of providing adequate educational services for students with mental illness. As we move into the 21st century, it is imperative that all students are provided equal access to a quality education, including students diagnosed with mental illness. Section 504 of the Americans with Disabilities Act, a mandate passed by Congress, requires schools to provide support for students with medical, intellectual, physical, emotional, and mental disabilities. However, it does so without bestowing school districts the funds to appropriately do so. Mental illness disabilities—diagnosed by medical doctors—have remained invisible. The price paid for not addressing mental illness has until now fallen primarily upon the mentally ill student and his or her family. Now is the time to alleviate this burden.

SECTION TWO: ANALYSIS OF NEED

The purpose of this section is to form a deeper understanding of the need to provide equitable education for mentally ill students. Five disciplinary areas are analyzed in order to create a full understanding of the problem: educational analysis, economic analysis, social analysis, political analysis, and moral and ethical analysis.

Educational Analysis

In the absence of a comprehensive policy that addresses the needs of the mentally disabled, there are obvious educational ramifications for mentally ill students and their families. When a student does not attend school, there are immediate consequences for their grades, but there are longer-reaching implications for their learning.

Students with poor attendance due to mental health issues initially miss a large number of days of school typically due to anxiety, school refusal, or depression. School officials are not always immediately alerted to the absences until students have missed so much work that they are failing or in danger of failing a class or multiple classes. By that time, school therapists and parents have identified the need for mental health supports, and school therapists typically suggest possible mental health referrals to parents. However, they are unable to make true referrals, since this would make the school district financially accountable and thus legally liable. The result is that months often pass while students are waiting for an appointment with an outside professional. In the interim, they either do not attend school or attendance is sporadic.

Adelman and Taylor (1998) have studied the fragmented services offered to students with mental health issues. They found that most special education programs designed to help students and their community counterparts work in relative isolation,

with no systematic or cohesive method of serving the academic and social needs of students. As stated by Adelman and Taylor, this leads to waste of time, resources, and limited efficacy. They propose growing 'full-service schools' that offer school-based and school-linked health clinics and family resource centers. This type of resource would increase efficacy, diminish lost academic instruction, and enhance case management on behalf of students. Adelman and Taylor suggest that education support services for students with mental illness should be systematically clustered into six areas: classroom-based efforts, prescribed student and family assistance, responding to and preventing crises, supporting transitions, facilitating home involvement in schooling, and community outreach. A policy that supports the integration of these six areas may limit the gaps in the academic education for students with mental disabilities.

An unwritten rule among school service providers is that students with depression, school anxiety, and other mental illnesses who have difficulty maintaining a positive attendance record should not be allowed homebound tutoring as part of their treatment. This is a philosophy that has been embraced by school therapists and other school personnel, as well as by medical doctors. In order for a student to receive homebound tutoring, the student usually must obtain a prescription from a medical doctor and present it to school personnel for consideration. However, though most medical doctors will write a prescription for homebound tutoring due to physical ailments, they almost never do so for mental ailments. Even if a student is indeed able to obtain a prescription for a mental ailment, it is highly unlikely school personnel would approve it. Students who have difficulty getting out of bed due to depression, or who have significant school anxiety concerns, are the most likely to exhibit poor school attendance.

Medical and school professionals alike have taken the position that allowing homebound tutoring services enables the disability, which in turn does not facilitate recovery. In the meantime, students may wait a minimum of sixty school days, and in more severe cases, up to an entire school year before receiving academic services.

The Center for School Mental Health Analysis and Action suggests that 20% of children have a mental health disorder, and 1 in 10 youth have a serious mental health problem severe enough to impair their home, school, and community functioning (CSMHA, 2007). These statistics may be used to estimate the number of students who have school attendance difficulties and therefore automatic loss of academic instruction. Due to their difficulties participating in the traditional school day, it is not only challenging to teach these students in a typical academic setting, but also to assess their knowledge through current traditional methods.

Economic Analysis

There are two economic perspectives that provide a view for analysis: One is the way in which school districts budget for educational treatment of students with mental disabilities. Through the Individuals with Disabilities Education Act (IDEA), a federal law that protects students with mental and physical disabilities, schools have traditionally provided school psychological services and school social work services to students who qualify to receive them. In accordance with this law, Stafford School District, like most districts, pays for students to receive educational therapeutic services within the school day. However, in addition to these mandated services, Stafford School District, one of the wealthier districts in Illinois, also pays for more severely evidencing students to receive a one-time risk assessment. This is a psychiatric assessment that provides an analysis of the

presenting problem, psychiatric diagnosis, and treatment recommendations. In addition, the evaluating psychiatrist will determine whether or not the student is safe to return to school. If a student requires educational outplacement at a therapeutic day school or a residential facility, Stafford School District covers financial costs. In cases where students are placed in out-of-state facilities, the district covers the cost of round-trip travel for parents. In situations where parents legally file for due process because they do not agree with the school district's recommendations, the district covers the cost of its own legal fees. Neither the district nor the state covers the psychiatric costs for ongoing treatment; parents are left to cover this cost.

There is also an issue of financial equity. In cases of mental health disabilities, private medical insurance does not always cover the cost of treatment. Families who can afford to independently cover expenses are able to provide this care for their child. However, families who are not in a financial position to cover this medical expense are not eligible to receive any care other than what the school district can provide. Even students who are covered by private insurance still experience barriers to quality care, including high out-of-pocket costs, a limited number of available specialists (psychiatrists, clinical psychologists, and clinical social workers are not currently available through the system), and transportation to and from care (Cunningham et al., 2012). There is a vast difference in service for students between those who are affluent and those with less means, leading to a case of equal access to services for students and their families.

On the national front, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA) into law in 2010. One of the most important provisions of

the ACA is increased access to health care services. While some provisions were effective immediately, all provisions are not expected to be in place until 2014. Under the act, students will no longer be able to be denied coverage due to preexisting conditions, there will be greater access to preventative care, and Medicaid coverage will be expanded (Cunningham et al., 2012). Starting in 2014, health insurance companies are required to cover mental health treatment to the same extent that they cover physical illness.

There are also adverse economic consequences for society at large when failing to provide a mental health safety net to children and youth: Students who do not receive optimal or even adequate mental health care graduate high school unable to function productively in society. The economic costs of providing inadequate care to mental health patients are great for taxpayers in the United States. In *The American Journal of Psychiatry*, Insel (2008) describes the direct and indirect economic costs of mental disorders on the nation. Direct costs include medication, clinic visits, and hospitalizations, which can be easily measured. Indirect costs, however, include reduced labor supply, public income support payments, reduced educational attainment, and costs associated with consequences such as incarceration or homelessness. These indirect costs are difficult to quantify, but critical for informing policy (Insel, 2008). Insel references The National Comorbidity Survey Replication (NCS-R), a population-based epidemiological study of mental disorders. The NCS-R extrapolated survey results from nearly 5,000 individuals with mental disorders and provided a conservative estimate of $193.2 billion in annual loss of earnings.

Social Analysis

Students with mental illness often have significant difficulties building and establishing positive peer and adult relationships. Their social anxiety or depression may prohibit membership in clubs, organizations, and other beneficial activities even when these activities are preferred. Mentally ill students also have significant difficulty maintaining friendships. They are also frequently unable to approach teachers with everyday clarifying questions regarding assignments, do not participate in classroom discussions, and have difficulty performing group work. Additionally, they have often missed sizeable amounts of school attendance days, which can compound their existing anxiety.

In an extensive report outlining the need for expanding home- and community-based mental health services and supports, the National Alliance on Mental Illness (NAMI) notes the following social problems experienced by students with mental illness: school attendance and performance, family and peer interaction and relationships, controlling behavior, involvement with law enforcement and the juvenile justice system, chemical dependency, self-harm and suicide related behaviors, increased hospital admissions, institutional care and other out-of-home placements (NAMI, 2009). Many of these social problems are reflected in the Stafford School District, particularly at the high school level.

In Stafford School District, between August 21st, 2012 and October 31st, 2013, there were 25 hospitalizations. This number was more than triple the number from the same time period in 2011. Of these 25 students, four were diagnosed as chemically dependent, 15 were diagnosed with depression, anxiety or mood disorder, one was

diagnosed with an eating disorder, and the remainder either withdrew from school completely or did not disclose their diagnosis. Nine of the 25 were identified as special education students and were already receiving therapeutic services in school at the time of their hospitalizations. The remainder included general education students at the time of their hospitalization. All of these students displayed significant social-emotional difficulties at school, including maintaining appropriate peer and adult relationships and lack of involvement in school activities.

Compounding these difficulties is the general societal perception of people with mental illness; children and adults with disabilities have experienced—and continue to experience—discrimination in society. Many organizations such as Special Olympics and Easter Seals have successfully worked to sensitize and inform the public about people with physical and intellectual disabilities, and the social stigma for people with physical and cognitive disabilities has decreased as human services for this population has increased. The Americans with Disabilities Act (ADA) and its educational counterpart, the Individuals with Disabilities Education Act (IDEA), which has been systematically implemented in schools, have helped increase understanding and social acceptance for people with physical and intellectual disabilities. Nevertheless, a stigma against people with mental disabilities still exists. Link and Phelan (2006) detail the social implications of this stigma: They note that people with mental illness routinely experience discrimination and a loss of status. Along with this come employment discrimination, structural discrimination (when treatment facilities are located in isolated, poor, or dangerous neighborhoods), and chronic stress. Fear of being labeled mentally ill prevents those not yet diagnosed from seeking medical attention, and causing those who have

already been diagnosed to distance themselves from their 'label' and become non-compliant with treatment. This stigma can also affect parents and caregivers of students exhibiting symptoms of mental illness.

At the school level, parents are often hesitant to seek mental health support for their children. According to Hinshaw (2005), this is because parents are often unjustly blamed for their children's mental illnesses, which in turn precipitates hesitation in pursuing assessment and treatment. Schools have not typically taken responsibility for the long-term treatment of children with mental illness and are not required to do so by law. Some school districts with the financial resources to do so have engaged in limited partnerships with community mental health providers such as private psychiatrists, clinical psychologists, and social workers. However, the vast majority of school districts across the country continue to treat mental health disabilities differently and separately from physical and cognitive disabilities. Educational support services have been limited to physical and cognitive disabilities, while the growing number of diagnosed mental illnesses in children under the age of 18 is rising dramatically. It is time to recognize and close this educational gap.

Political Analysis

The Americans with Disabilities Act (ADA) and the Individuals with Disabilities Education Act (IDEA) are the most comprehensive and systematic laws enacted to protect students and adults with disabilities in the United States. In the *Journal of Law and Health*, Professor of Law Michael Perlin (1993) defines what he calls 'sanism' as "… the irrational prejudice that causes, and is reflective in, prevailing social attitudes toward persons with mental disabilities" (p. 29). Perlin notes that despite Senator Jesse

Helms's unsuccessful attempt to exclude mentally ill persons from the ADA, commentators have generally limited their analysis and application of the statute to cognitively disabled persons rather than mentally ill persons. Perlin notes that even within the community of disabled persons, persons with mental illness "are often the poor stepchild, and remain the last hidden minority" (p. 20). Perlin's explanation for the continued exclusion of mentally ill persons from the application of the law is the 'sanism' (prejudicial attitude) of the public. He suggests that if prevailing social attitudes toward persons with mental illness are not changed, then the impact of the ADA on American society will continue to be more limited than the law intended.

At the educational level, the school district or Local Educational Agency (LEA) is responsible for the implementation of the IDEA. More narrowly defined than the ADA, this law was first enacted by Congress in 1975 to ensure that children with disabilities have the opportunity to receive a Free Appropriate Public Education (FAPE). The law is implemented through special education services in a public school setting, and is designed to protect and serve all students with disabilities. However, mental illnesses are not mentioned in the in exhaustive list of disabilities that require support within the public school system. To remedy this oversight, the National Association of School Psychologists (NASP) provided guidance to Congress for the re-authorization of IDEA in 2002. The following was included in this guidance:

> Increasing access to related services is crucial to children with mental health needs. Although required, psychological services and counseling are often not available to children in special education. Addressing mental health and behavioral disorders aids in the removal of barriers to learning and enhances classroom management. Current research demonstrates that when a comprehensive range of school and community-based services, including quality mental health services, is provided, students achieve superior outcomes and improved educational performance. The lack of qualified providers, such as

> school social workers, school counselors, child and adolescent psychiatrists, school psychologists, and other qualified psychologists, must be addressed in order to provide these services most effectively. (NASP, 2000, para. 8)

This guidance, though supported by several professional organizations including the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association (NASP, 2002), was not included in the reauthorization of IDEA. Currently at the local level, schools continue to support students with physical and intellectual disabilities as required by law, while students with mental illnesses do not receive the same level of support. Due to this continuing reluctance by Congress to provide educational supports for mentally ill students, the existing policies do not fully support their entire educational experience.

Stafford School District has been hesitant in the past to engage in conversations about mental illness in the community. In this mostly wealthy community of professionals, it has proven difficult for people who are living with mental illness to share their experiences openly within their families without fear of judgment. However, there has been recent conversation among community coalitions to shift from 'mental illness' to 'mental health' in order to soften the language and open the door for more people to express their need for help. While community members in this wealthy district may have been afraid in the past of the social consequences and stigma of admitting to mental illness within their family, there are signs this perspective may be changing.

It is my belief that educators and community members alike in Stafford School District support providing mental health services for students who are either suspected of having mental health disabilities or who have already been diagnosed. However, we need to ensure that these students' educational needs are being met as well. Difficulties in

serving these students arise when the students are frequently absent from school. Current attendance and homebound tutoring policies at Stafford were not written with students with mental illness in mind, and these policies currently work against students with mental disabilities. As Perlin (1993) has noted, an unjustified social prejudice toward students with mental illness has excluded them from adequate treatment, care, and protection under the law.

Moral and Ethical Analysis

Mental illness though incurable, is treatable. As with many other disorders and disabilities, the earlier it is identified and treated, the greater the chance of success in treatment. The education system in the United States has recognized the value of early intervention and supports, as evidenced in state mandated early intervention special education programs (birth to three years old), early childhood at-risk and special education programs (three to five years old), implementation of section 504 of the Americans with Disabilities Act (ADA), and a wide range of therapeutic services that are offered at the elementary school, middle school and high school levels. These programs are all mandated by federal laws designed to protect students with disabilities from discrimination, and which ultimately safeguard their civil right to a Free Appropriate Public Education (FAPE).

There is an almost inexhaustible list of disabilities that are considered under these laws and statutes. School policies guiding the work of educators are created based on these laws. Unfortunately, as lamented by Perlin (1993), mental illnesses, though acknowledged in the ADA, are not provided equal supports within the school system due to the unfunded mandate of Section 504. As discussed in the political and economic

analyses, there are personal and societal repercussions for failing to adequately provide equal educational opportunities for these persons. The stigma attached to mental illness that leads to discrimination is no excuse for doing what's right for students diagnosed with mental illness.

Within the education system, school districts have been allocated money to adequately provide for students with physical and cognitive disabilities that significantly impact their learning. However, there has been no similar allocation for psychiatric services within the school system for students suffering from mental illnesses. The matter of financial equity was addressed within the economic analysis, but the lack of financial equity is also a moral issue to be considered. Due to the high costs of adequate mental health care including diagnosis and treatment, most families are unable to provide this level of care simply through their private insurance. In wealthier communities, students from families who can afford to supplement coverage with their own financial capital are frequently able to receive care. Students from families who cannot afford the cost forego the treatment they require. However, this need not be so.

Guidelines from the Office of Civil Rights (OCR), which oversees implementation of Section 504 of the Americans with Disabilities Act states:

> Under this law, individuals with disabilities are defined as persons with a physical or mental impairment, which substantially limits one or more major life activities. People who have a history of, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. Some examples of impairments which may substantially limit major life activities, even with the help of medication or aids/devices, are: AIDS, alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addiction, heart disease, and mental illness. (OCR, 2006, para. 3)

While accommodations and specific plans are created and updated regularly for students who qualify under the protections of section 504, no federal or state funds are allocated for implementation of this law. School districts are left to provide minimal services that are often inadequate, especially for students stigmatized as “mentally ill”. If Perlin (1993) is right, and Congress continues to underestimate or even ignore the impact of mental illness on American society, ten percent of all American youth (the number of children estimated by the NAMI who suffer significant mental illness) will continue to be left behind educationally. Currently, without funds for school districts to provide adequate care, students with mental illnesses who qualify for protections under section 504 are underserved. If Congress and professional organizations have given their support to providing equal educational opportunity to all disabled students, including those with mental illness, then as a nation we have a moral and ethical obligation to make this a reality.

SECTION THREE: ADVOCATED POLICY STATEMENT

Introduction

There are several implications for inadequately addressing mental illness in students. Students who suffer from mental illness miss a large amount of academic instruction as well as the benefits of social interactions with their peers. Upon graduation from the school system, there are many direct and indirect costs imposed on society when these young adults, not having received an adequate formative education, continue to struggle with mental illness. High school students who do not receive adequate mental health care may experience controlling behavior and difficulties with family and peer interactions or relationships, as well as increased involvement with law enforcement and the juvenile justice system. Additionally, they are at higher risk for struggles with chemical dependency, self-harm and suicide-related behaviors. Moreover, there are unresolved moral and ethical issues for both educators and the general American society in terms of financial equity and unfunded mandates.

The goal of creating a comprehensive policy that addresses mental illness in students was to ensure that such students would not be penalized for lack of attendance in school, and that access to an appropriate education while undergoing the process of diagnosis and treatment could be maintained. It would require a reintegration plan with treating physicians so that these students, when ready, would have the opportunity to re-join their peers in the least restrictive setting while continuing to benefit from the range of services offered within their home school setting. Such a comprehensive policy would serve students who are suspected of having a mental illness as well as those who are already diagnosed and require ongoing treatment.

The primary beneficiaries of a policy addressing mental illness are the students struggling with mental illness and their families. However, there are also benefits for the education system and society at large. Under such a comprehensive policy, educators would have the opportunity to connect with community service providers and thus widen the umbrella of supports for students. It would enhance these professionals' repertoire of skills as they deepen their abilities for intervening with students in need. As discussed in the economic analysis, there is a conservative estimate of 193.2 billion dollars lost in annual earnings attributable to mental illness. There are financial and professional benefits to society when students receive early and adequate mental health care.

Section 504 of the ADA was implemented to protect the rights of students with disabilities, including those with mental disabilities. While action at the federal level is necessary to allocate funds to this unfunded mandate, a local school district policy that affirms and provides further support to this law would allow more students with mental illness to receive treatment and ongoing care while receiving their education. As a consequence, more students would graduate from the school system with a better chance at leading a productive life.

Because current policies often lead to truancy intervention and possible court involvement when students are non-compliant with school attendance, school officials typically work with school therapeutic teams to help students who are undergoing diagnosis and treatment. Sometimes the policies are relaxed on their behalf; however, relaxing the policy is different from creating a proactive policy that would comprehensively support a student's recovery. A comprehensive policy would include attendance forgiveness, continued academic instruction opportunities, a plan for

educating and supporting parents and teachers about the student's illness, and facilitating increased partnership between school staff and outside mental health service providers.

Policy Statement

Toward a more comprehensive method of supporting students with mental illness at Stafford High School, I propose the following four-part policy:

Attendance

Students who are suspected of having a mental illness, or diagnosed as having a mental illness and actively seeking medical attention, may be exempt from regular school attendance policies while undergoing medical intervention. Such a student must be actively enrolled in continuous mental health treatment, and attendance forgiveness must be approved by either a Section 504 team or Individualized Education Plan (IEP) team. Any student who is suspected of having a mental illness or diagnosed as having a mental illness shall be allowed to drop a class without penalty as determined by the Section 504 team or the IEP team.

Credit Recovery

Students suspected of having a mental illness, or diagnosed as having a mental illness and actively seeking and receiving continuous mental health attention, may be enrolled in a credit recovery program offered by the school district for a period of time as determined by the Section 504 team or IEP team. Participation in such a program should be considered temporary, and must be accompanied by a reintegration plan designed to facilitate reentry into the regular school day, or the least restrictive environment as determined by the Section 504 team or the IEP team.

Reintegration

Special services team members (Section 504 team or IEP team) in active consultation with parents and mental health professionals who are serving the student with mental health needs are required to present a reintegration plan that provides details for a proposed return to the typical school day.

Staff Professional Development

The teacher of a student receiving mental health support will receive special training regarding the diagnosis and treatment of the illness as well as practical strategies for implementation that will benefit the student upon return to the classroom.

SECTION FOUR: POLICY ARGUMENT

Current policies are disconnected and punitive for Stafford High School students struggling with mental illness. The series of policies currently drawn upon to problem solve situations were not specifically designed for students with mental illness, nor do students with mental illness currently have any policies created specifically to address their unique needs. Educators have a moral and ethical responsibility to support all students, regardless of their disabilities. The purpose of this section is to examine the supportive and counterarguments for the proposed comprehensive policy addressing students struggling with mental illness.

Supportive Arguments

The suggested policy is not only written specifically with students with mental illness in mind, but actively supports their right to an appropriate education under the guidelines of the ADA. There are four parts to this policy, which addresses all areas that impact students with mental health disabilities.

The first part of the policy addresses poor school attendance characteristic of students who are living with mental illness. It prevents school staff, and classroom teachers in particular, from penalizing students with mental illness for sporadic attendance (e.g., lower grades due to missed school days) and lack of participation in class and homework completion as a result of their current disability.

The second part of the policy, credit recovery, allows students who are mentally ill but actively seeking and receiving treatment to maintain access to academic instruction. Students who are hospitalized automatically have access to tutors as a part of their hospital care. However, for those students who are unable to afford

hospitalization—particularly those without private insurance—regular academic performance continues to be expected, even though they are not receiving any instruction. Because they are unable to maintain attendance, often they are equally unable to produce academic results. Under the recommended policy, providing interim academic instruction in a smaller, more controlled environment would allow students equal access to curriculum while they are seeking therapeutic intervention.

Part three of the policy, reintegration support, addresses the expectation that students will reenter the least restrictive learning environment. The goal is for mentally ill students to be educated with their typically developing peers whenever possible. Without a plan for this to happen, this goal is almost never achieved or monitored. For more severely mentally ill students, reintegration into the regular classroom may not be possible, but a reintegration plan will compel the Section 504 team or the IEP team to continually consider the best placement for each student.

The final part of the policy, professional development for teachers, is designed to support students by supporting those who educate them. General education teachers are typically knowledgeable only about their content area, thus relying heavily on support staff to direct them on current laws and acts and to provide strategies and accommodations they can use to support students with disabilities. A professional development component of the proposed policy, which will provide specifics of the students' mental illnesses, is crucial for helping teachers modify the curriculum for mentally ill students.

Counterarguments

For each component of the proposed policy, there are possible counterarguments from stakeholders. This stems mainly from the fact that the proposed policy is an unconventional approach within the current educational system. Students' mental health struggles have been largely left for parents to manage, while educational staff, teachers, and administrators have the means to intervene only superficially. For every component of the proposed policy comes increased responsibility for a particular stakeholder, as well as inertia toward changing the system.

There are two components of the proposed policy that have the potential to cause concern for district administration and staff. The second section of the proposed policy allows access to a credit recovery program for students who are suspected of or diagnosed with mental illness. This would require the district to provide additional resources or reallocation for staffing, physical space, technological support, and an individualized curriculum for mentally ill students in order to maximize educational support. School therapists would need to be assigned to this credit recovery program so as to integrate therapeutic support into academic instruction while maintaining communication with outside medical doctors.

Providing a physical space for participating students would also be necessary. Students with significant school refusal and anxiety often have difficulties even entering the school building, and while a credit recovery program would need to be physically house within the school building, it must be strategically designed to decrease anxiety for these students so as to allow easy and stress-free maneuvering in and out of the building. These logistical concerns would also require time and extended discussion among district

administration. Implementing credit recovery would mean the creation of a new program within the high school and all of the complex issues that accompany such an endeavor.

Part four of the proposed policy, professional development for teachers and staff, is another component of the policy that may raise concern. Teachers have many obligations and responsibilities in addition to their regular contractual duties, and participating in professional development on mental illness would be yet another requirement to an already extensive list of things to do. The key for building and district administrators is to provide professional development opportunities for teachers and staff in such a way that they feel supported: a major goal would be to provide teachers and staff with simple, practical strategies they can use to support and teach students with mental disabilities.

A final counterargument is the possibility that some parents may not find the proposed policy to be helpful as they seek support for their children; current policies have sometimes created more difficulties for parents instead of opening paths to support for their children. While the proposed policy would provide better support to students and their families, there are occasions when parents are in disagreement with school district teams about their child's need for services. The proposed policy does not help students or their families in these situations. However, educators have a moral, ethical, and legal responsibility to offer an appropriate education to students, even though it is a parent's right to decline.

SECTION FIVE: POLICY IMPLEMENTATION PLAN

The purpose of this section is to provide a plan for implementation of the proposed policy. A comprehensive and systematic plan would include an overview of mental illness in students, an introduction to the policy, a professional development timeline, budget considerations, and progress monitoring. A core team would also need to be established in order to ensure the integrity of implementation.

Introducing the Policy to Stakeholders

Educational activities designed to introduce the new policy should start at the high school level. Even though there has been an increase in the number of mental illness hospitalizations at the elementary and middle school levels, the most immediate concern and target for staff development, along with implementation of the proposed policy, is at the high school level. After the first year of rollout, implementation should then turn to the middle and the elementary school levels.

Prior to introducing the new policy to faculty and staff, there would be a presentation of data to the community via a board of education meeting regarding the increase in mental health diagnoses within the district, including the short and long-term implications for students. Having a thorough understanding of the problem is the first step for all those who will be affected or called upon to take action to effect change. This would include an overview of the most common mental health disorders encountered at the high school level, best practice interventions, and a presentation of supports for students, families, and staff. A synopsis of the potential consequences of inadequate treatment of students with mental illness would be provided to staff. Faculty and staff educational responsibilities would be clearly explained, along with any legal culpability.

These added responsibilities for faculty and staff members may cause apprehension, particularly for teachers; the additional work that may accompany the new policy should be acknowledged. Therefore, teachers should be shown the practical ways in which they will be supported by school therapists and administrators on this journey to meet the needs of all students.

Professional Development Timeline

There must be systematic staff development for all educators who will be affected by the new policy. After the initial rollout of the policy, an annual plan for updating and reviewing the policy with faulty and staff would be created.

While there is a slight turnover of staff every year at the high school, it is important to keep all staff consistently informed. At Stafford School District, there is an annual orientation for all new district staff and teachers that occurs the week before the first week of school. This new policy deals with issues with profound implications for students and families. Along with the supports provided for new teachers, revisiting the policy annually at the new teacher orientation ensures that information is systematically and consistently shared with new staff entering the district.

For veteran faculty and staff throughout the school year, there are regularly scheduled in-service professional development days for certified and classified staff. These in-service days are planned separately for high school staff; elementary and middle school staff have their own in-service days. District administration may consider designating a portion of the high school in-service days throughout the first year of the new policy implementation for professional development specifically geared toward understanding mental illness. During the fall in-service time, a particularly intense focus

should be devoted to developing awareness and intervention skills. This would prepare faculty and staff for the spring, when there is typically a heavier occurrence of mental health-related incidents, such as depression and suicide, among students.

A plan for continued professional development and support would also be executed. This could take the form of district psychologists and social workers presenting at monthly professional development meetings within the high school, during which questions and concerns from faculty and staff could be fielded. After the first year of implementation, the professional development plan prepared for the high school would be modified and reproduced for the middle and elementary schools. A comprehensive, district-wide professional development plan would ensure consistency of implementation.

Budget Considerations

At Stafford School District, in-service time is already factored into the budget; as such, there would be no additional costs related to implementing professional development activities. However, as the district looks to educating the whole child, rather than just the academic part, administrators would have to reallocate staff development priorities so that student mental health became a higher priority. External speakers are factored into the existing budget should the administration choose to bring in experts on the subject of educating mentally ill students.

Aside from professional development, the more challenging costs come with the actual implementation of the policy. There would need to be a core educational team whose responsibility would be to provide case management and educational services for students with mental illness. This core team would consist of one or two teachers, a psychologist or social worker, and a counselor. The highest expense associated with the

implementation of this policy, if it is to be implemented with integrity, is the expense for the core staff in the credit recovery program, who would be the main contact with the student. Each of these members would have a distinct role: the school psychologist or social worker would be the mental health link between the school and the student's outside mental health provider, the counselor would track the student's credits and requirements needed for graduation, and the teacher would provide the required educational resources and instruction.

Additional teachers for the credit recovery program may need to be hired depending on the level of need. They would need to be trained on Department of Children and Family Services (DCFS) reporting, behavioral red flags, and procedures for reporting to police and administration. However, because this is a new policy and it is unclear what the actual needs versus the projected needs are, it is suggested that the administration first train and utilize existing staff, examining staffing needs for the first one or two years before hiring new staff.

Progress Monitoring

Close monitoring of existing data on student mental health in the district and current concerns about students with mental illness not being served appropriately led to the proposal of this new policy. As the policy is gradually implemented, it is expected to alleviate some of the current difficulties for students and their families. However, challenges for staff and administration need to be monitored, since attending to the inevitable challenges of implementation is necessary to ensure both the success of students and the support of staff. For example, it is not recommended practice that students suffering from depression, anxiety, and other mental illnesses be provided

homebound tutoring. Because it is often difficult for them to get out of bed or leave the house, they miss school. However, the goal for a healthy functioning student is to be educated with their peers. If they are not required to work through the illness, and homebound tutoring is provided, then staff is essentially enabling the illness.

If a mentally ill student cannot receive homebound tutoring (as do students with a physical illness) and they cannot withstand the stress of a regular daily schedule, a credit recovery program housed at the school in a smaller environment with less transitions to manage would be the best alternative: it would give students access to individualized learning so they can learn at their own pace, while affording them access to the therapeutic care they need to be successful. If the length of time the student is enrolled in the credit recovery program is closely monitored, and a special services team is given the responsibility and flexibility for initiating and terminating services, then a balance between mental health and academic support can be achieved.

A staffing concern that will need monitoring the first year of the policy is the caseload of the psychologist or social worker assigned to students who are serviced by this policy. Psychologist and social worker caseloads are typically high, so it is possible that an additional full-time equivalent (FTE) would need to be hired to help balance the workload.

With the implementation of any new policy, there are unintended consequences. Classroom teachers are generally the first to feel these consequences, along with other staff tasked with the day-to-day execution of the new procedures. It will be important for the building and district administration to maintain communication with general education and special education staff, as they will work directly with the students while

implementing the new policy. Nonetheless, regular communication throughout the year with all involved is recommended.

SECTION SIX: POLICY ASSESSMENT PLAN

Implementation of the proposed policy would have an anticipated impact on students' ability to attend school and recover credits, therapists' (school psychologists and school social workers) caseloads, as well as communication between stakeholders. These areas would be monitored and assessed during implementation.

Credit Recovery and Attendance

By allowing mentally ill students the opportunity to recover credits and instruction, the proposed policy attempts to proactively shift the current procedure, wherein mentally ill students have no access to academic instruction during the period they are unable to attend school.

The new policy would allow credit recovery opportunities to be provided to mentally ill students, but only when appropriate: credit recovery would be initiated and terminated at the discretion of the school team, ideally be for a limited time and in conjunction with the student's private mental health provider. The success of this component's implementation would be measured by academic success of each student. Nevertheless, the duration of this process will vary among each student depending on the severity of his or her illness: some students will be able to return to the general education population after treatment, while others will need more extensive treatment.

The success of the policy is not wholly determined by the student's return to the general education population. Rather, the goal is to ensure equal educational opportunities for the mentally ill student, just as is provided for the physically ill student. The success of the credit recovery component of the policy would be quantitatively

assessed by monitoring students' attendance and acquisition of credits toward graduation. Rather than using assumptions, teams would be using data to make their decisions.

School Psychologist and School Social Worker Caseloads

School psychologists and school social workers operate within the district's special services department, and state and federal laws and guidelines largely govern the special services department's operations in any district. While there is no current maximum caseload number for psychologists and social workers, special education administrators are mindful of the workload of these therapeutic staff members, particularly when it involves time-consuming and emotionally draining cases. This monitoring by administration helps prevent staff burnout and preserve a high level of service for all students and families. Psychologists and social workers with balanced caseloads are able to maintain their creativity, energy levels, and investment in student success. Therefore, it is important that the new policy also include regular monitoring of these professionals' caseloads.

Regular review of caseloads will accomplish two objectives: First, it will allow the special services administrator to track social worker and psychologist caseloads to ensure they are not feeling overwhelmed by their added responsibilities. If this became the case, it would allow for the administrator to advocate for hiring additional staff in a timely way if necessary. Secondly, regular and frequent monitoring demonstrates to this staff that their level of workload is respected.

It is recommended that the special services administrator assess service delivery under the new policy through monthly communication with these school therapists. This could take the form of either a scheduled meeting or informal conversation to obtain

qualitative data. A spreadsheet tracking the caseload numbers of the therapists' individual and collective cases could also be implemented to gather quantitative data.

Communication

The assessment plan would not be complete without an assessment of the comprehensiveness of communication between all stakeholders involved. For example, there is currently very little communication between school and outside medical personnel: Typically, a parent informs the special services department that their child has been hospitalized. The special services department secretary then contacts the student's teachers to gather assignments for hospital-provided tutors. However, once the student leaves the hospital and returns home, no additional academic instruction is provided until they return to school. In preparation for their school return, a hospital intake meeting takes place between the special services team and the hospital team in order to facilitate a smooth transition back to the school environment. The problem arises when the student is not hospitalized but is nevertheless exhibiting major depressive symptoms such as difficulty getting out of bed or self-harming behaviors, like cutting. In such a case the student stays at home until the team sets a meeting date to problem solve the situation. Moreover, if the student does not immediately go into treatment after the meeting, several more weeks of non-attendance (in severe cases, up to one school year) can pass before the student is able to receive any intervention. All the while, little or no academic instruction has taken place.

The proposed policy requires a comprehensive communication approach. To provide the most effective educational opportunities and service to mentally ill students and their families, an unbroken line of communication must exist between school

therapists and families, school therapists and general education teachers, school therapists and credit recovery teachers, school therapists and medical practitioners, school therapists and school administrators, and among school administrators (see Appendix C).

Improving communication among all stakeholders will increase educational services on behalf of students. When school therapists and families communicate, educators gain a better understanding of family issues that may be impacting students; the educational needs of the family can also be addressed as they relate to the student's disability. The same applies to communication between school therapists and general education teachers: school therapists who communicate with general education teachers provide the teacher with a better understanding of the student's needs, and can also assist teachers in providing appropriate accommodations and strategies necessary for the student's success.

School therapists in communication with credit recovery teachers can provide direction and training for working one-on-one with the mentally ill student, including detecting behavioral warning signs and knowing when to call emergency medical professionals. School therapists in communication with medical professionals can obtain a more complete understanding of the student's medical treatment and prognosis, as well as assist the special services team as they make therapeutic decisions. School therapists need to communicate frequently with building administrators so that the day-to-day implications of implementation can be successfully monitored; building administrators need to communicate with district administration regarding the progress and challenges of the implementation.

Comprehensive communication between policy stakeholders will be key to increasing the level of educational service received by students. The goal of the policy is not to reduce mental illness in the population, but rather to ensure that students with mental illness receive the same attention and treatment as students with other disabilities.

SECTION SEVEN: SUMMARY IMPACT STATEMENT

This section is a summary of the impact of the proposed policy. Even though the proposed policy has the potential to provide a positive impact on students with mental illness, there are also implications that need to be considered, such as equity in service delivery for students as well implications for educators.

The proposed policy is atypical of most approaches taken on behalf of students with mental illness. The prevailing school of thought among the general public and educators is that schools exist solely to provide an education in academics. However, given the data regarding the pervasiveness of student mental illness and the related significant impact this has on their families and society in general, it is equally important our schools provide equitable and comprehensive educational services to all students, including those with mental illness. While both physical and mental disabilities are medical conditions protected under federal and state laws, in particular the ADA and the IDEA, students with mental illnesses are not treated in the same way as students with physical disabilities. The purpose of the proposed policy is to ensure equitable educational services for students with mental disabilities while supporting their right to quality medical care.

All stakeholders—students, their families, educators, and the community in general—are served by this comprehensive policy. Students with significant mental illnesses who miss entire quarters, semesters, or even years of school will be able to receive equal academic opportunities and services in a similar time frame as students with physical illnesses. Parents currently struggling to seek medical support for their children while trying to maintain academic learning will also feel the benefits of this policy.

At the school district and professional level, educators would work more collaboratively with students, their families, and the medical community. At the school level, teachers and school therapists would gain greater insight into the individual needs of mentally ill students as they increase their repertoire of instructional strategies to enhance their instruction for all students.

At the societal level, the community as a whole benefits when students comprehensively treated for a mental illness graduate not only with an earned high school diploma, but with a prospect for a future either in higher academia or the workforce. When students enter the community with maladaptive coping skills and limited academic skills, there exists a higher propensity for crime and other societal burdens related to chemical dependency, suicidal and homicidal behaviors, and financial taxpayer costs. Assisting mentally ill students as comprehensively as possible while they are still in school can avert these issues.

Providing equal educational opportunities for mentally ill students is the right thing to do. However, it comes with a cost: resource allocation staffing, physical space provisions, and curricular support will need to accompany the credit recovery program.

Teachers will need support and professional development, and there is potential for an increase in caseloads for school therapists. To mitigate potential problems, a regular communication cycle among stakeholders is imperative: regular communication between teachers and therapists, therapists and administrators, and among administrators will be necessary to provide both effective medical and effective educational services to students. After a year of implementation, administrators would revisit the policy to address revisions.

In the end, the proposed policy is an attempt to address current inequities between the education afforded students with mental illness and students with physical or learning disabilities. For many years students with any disability were denied access to a quality education with accommodations and supports to help level the playing field. Today, students with physical and cognitive disabilities have federal and state laws and local policies that protect their right to an equitable education, such as Public Law 94-142, Free Appropriate Public Education. As the implementation of such laws has evolved, so have the procedures guiding individual school districts. The proposed policy would continue the evolution of society's as well as educators' desire to provide equal educational opportunities for all students.

In most districts this proposed policy might be harder to implement, since many school districts do not have the resources Stafford School District possesses. However, in Stafford School District, where resources are available and the need is proportionate, the proposed policy not only has the potential to make a profound difference in the lives of mentally ill students but also fulfill the original promise of the Americans with Disabilities Act.

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Appendix A

Students Hospitalized At Stafford High School: First Day of School Through October 2011-2012

Name	***GE**	***SPED**	**Begin Date**	**End Date**	**Hospitalized for:**
Student 1		X	Summer	8/25/11	Substance Abuse
Student 2	X		8/30/11	10/11/11	Depressive Disorder
Student 3	X		9/16/11	9/26/11	Bipolar
Student 4		X	9/24/11	10/4/11	Episodic Mood Disorder
Student 5	X		9/30/11	11/10/11	Depressive Disorder
Student 6	X		10/3/11	10/19/11	N/A
Student 7		X	10/4/11	11/9/11	Substance Dependence
Student 8		X	10/28/11	11/28/11	Cannabis Dependence

- GE – General Education
- SPED – Special Education

Appendix B

Students Hospitalized at Stafford High School: First Day of School through October 2012-2013

Name	GE	SPED	Begin Date	End Date	Hospitalized for:
Student 1		X	6/15/2012 - 7/11/2012	8/27/12	Chemical Dependency
Student 2		X	8/21/12	10/10/12	Major Depressive Disorder
Student 3		X	8/21/12	8/27/12	N/A
Student 4		X	8/27/12	9/18/12	Depressive Disorder
Student 5		X	8/31/12	9/20/12	Chemical Dependency
Student 6		X	9/4/12	11/1/12	Chemical Dependency
Student 7	X		9/5/12	11/29/12	Unable to Disclose
Student 8		X	9/5/12	9/12/12	Unable to Disclose
Student 9	X		9/6/12	10/3/12	Unspecified Episodic Mood Disorder
Student 10		X	9/7/12	9/11/12	Unable to Disclose
Student 11	X		9/17/12	10/4/12	Depression
Student 12	X		9/26/12	10/15/12	Unspecified Episodic Mood Disorder
Student 13	X		9/27/12	10/2/12	Unspecified Episodic Mood Disorder
Student 14	X		9/28/12	10/31/12	Depressive Disorder
Student 15	X		10/1/12	10/30/12	Eating Disorder
Student 16	X		10/1/12	10/8/12	Depressive Disorder
Student 17	X		10/8/12	11/26/12	Depressive Disorder

Student 18	X		10/8/12	11/7/12	Depressive Disorder
Student 19		X	10/8/12	11/13/12	Polysynthetic Abuse
Student 20	X		10/12/12	11/20/12	Substance Abuse
Student 21	X		10/16/12	11/14/12	Anxiety
Student 22	X		10/17/12	11/7/12	Unspecified Episodic Mood Disorder
Student 23	X		10/25/12	10/25/12	Depressive Disorder
Student 24	X		10/29/12	11/6/12	Depressive Disorder
Student 25	X		10/31/12	12/18/12	Mood Disorder

- GE – General Education
- SPED – Special Education

Appendix C

Communication Chart