



PRACTICE GUIDELINES FOR DELIVERY OF SCHOOL SOCIAL WORK SERVICES:

Promoting the Social-Emotional Competencies of Students —
Linking Families, Schools and Communities

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PREFACE

The State of Connecticut school social work guidelines, *Promoting the Social-Emotional Competencies of Students: Linking Families, Schools and Communities*, are the 2013 revision of the school social work guidelines published in 1989. As a testimony to the relevance and flexibility of school social work services in adapting to changing times, this document reflects the evolution of practice for supporting student success. This document is the result of collaboration between the Connecticut State Department of Education (CSDE); the Connecticut Association of School Social Workers Inc. (CASSW); Southern Connecticut State University, Department of Social Work; University of Connecticut, School of Social Work; and school social workers from urban, suburban and rural Connecticut school districts.

Purpose

These guidelines have been developed to:

1. Ensure high-quality professional services and sound practices.
2. Assist school districts in developing, improving and directing school social work services.
3. Provide assistance school administrators and boards of education that are establishing new school social work programs.
4. Provide a basis for evaluation of school social work services by school districts.
5. Provide pupil personnel services staff with information to guide them in coordinating school social work services with those of other disciplines.

These guidelines are offered as a resource for professionals who are developing and implementing appropriate school social work services for Connecticut's students.

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INTRODUCTION

These guidelines have been developed to assist school social workers in identifying their scope of services; developing and implementing programs and interventions to assist students in meeting their academic goals; and guiding the decision making necessary to meaningfully assess circumstances and prepare supports addressing needs within the school community. It is suggested that the reader make themselves aware of the contents of this guide, as well as the appendices, as there are several important concepts discussed that are relatively new in their application to school-based services. Response to Intervention and the collaborative model of a coordinated approach to school health both rely deeply on the skills and services provided by school social workers, but also require comprehensive collaboration with other school professionals. Through the use of this guide, it is intended that each school social worker will be able to plan, manage and monitor their own professional growth to the extent that their work environment allows.

Schools have long been a practice site for social workers across the country, with New York, Boston and Hartford being among the first to institute social work services in schools during the 1906-07 school year. Jane Colbert, at the National Conference of Charities and Corrections in 1916, defined school social work as “supplementing the teacher’s knowledge of the child, assisting the school, and interpreting to the parents the demands of the school and the needs of the children.” (Constable, et al., 2006). Then known as “Visiting Teachers,” school social workers were hired to facilitate communication between home and school in an effort to promote the successful integration of disadvantaged children into the school community and the daily activities of learning. Later with the passage of compulsory attendance laws, the mission of and need for school social workers expanded as more children were entering schools with significant social, emotional and academic barriers to learning.

In April 2010, the Connecticut State Board of Education (CSBE) issued its *Position Statement on Student Support Services* that includes, among other practice activities, the importance of comprehensive and coordinated behavioral health services for all students. School social workers, by nature of their professional training, are uniquely qualified and empowered to provide significant contributions to the ongoing development of social and behavioral self-management among students. This statement and the included guidance for implementing student support services can be found in appendix A. While the individual contributions of school social workers provide significant impact upon the readiness of students to meet the academic challenges confronting them, these services should be provided within a holistic framework consistent with a coordinated school health approach, using scientific research-based interventions. The CSBE *Position Statement on a Coordinated Approach to School Health*, along with its associated guidelines, can be found in appendix B of this publication.

Due to statutory changes resulting from the passage of the Elementary and Secondary Education Act (ESEA) as reauthorized by the No Child Left Behind Act (NCLB) of 2001 and the Individuals With Disabilities Education Act of 2004 (IDEA), all children, including those with disabilities and other barriers to learning, are entitled to a free, appropriate public education and may be eligible for accommodations to meet their learning needs. School social workers, using an ecological perspective while serving on multidisciplinary teams “bring unique knowledge and skills to the school system and the student services team and are hired by school districts to enhance the district’s ability to

meet its academic mission, especially where home, school and community collaboration is key to achieving its mission” (School Social Work Association of America, 2003).

This dual focus of linking schools, families and communities, as well as of implementing interventions to remove nonacademic barriers to learning, remains the central mission of school social workers to this day. This document is intended to provide school social workers situated in local education agencies with guidance, resources and references to inform their practice and provide assistance in communicating to allied professionals the complex duties associated with school social work.

PHILOSOPHY

At the core of social work practice is respect for the dignity, rights and worth of individuals as they realize their potential to become fulfilled, contributing members of society. School social workers are committed to nonjudgmental acceptance of the student and family, shared decision making, participatory education, helping people take responsibility for their own choices and behavior, and enabling students and families to fully benefit from their school experiences. School social workers function within a culturally responsive framework. School social workers have a commitment to enhancing students' talents, hopes, skills, self-awareness and expectations. School social workers focus on strengths within the life or system in which the student functions.

MISSION

The mission of school social workers is to promote and support healthy development in all children to attain their maximum potential and benefit from the education afforded them in Connecticut's schools. Using an ecological perspective, school social workers foster social-emotional competencies and academic achievement by assisting students, families, schools and communities in identifying and addressing barriers to learning and helping students realize their full potential. Ecological theory in social work practice combines biological and psychosocial perspectives to explore the connection between people and their environment.

Standards for School Social Work Practice in Connecticut



IN THIS SECTION

Standard 1: Foundations of Social Work Practice	Standard 4: Assessment
Standard 2: Education and Learning Systems and Organizations	Standard 5: Intervention
Standard 3: Collaboration	Standard 6: Professional Development

The following six standards are adapted from and are a synthesis of the National Association of Social Work (NASW) Standards for Professional Practice, which can be found in their entirety at <http://www.naswdc.org>. These six standards provide the essential foundations guiding social workers' performance in the school environment consistent with the principles, knowledge and performance practices in delivering school social work services. Fidelity to these most significant standards will help staff remain faithful to the mission and philosophy of their profession in delivering social work services in an educational setting. Each of the following standards is organized by definition, principles for guiding practice, content knowledge and performance expectations.

Standard 1: Foundations of Social Work Practice

As leaders and members of student services teams, school social workers are the liaisons between home, school and community in promoting the success of all students by

supporting their academic and social success. They advocate for students and assist them to reach developmentally appropriate milestones. Thus, students are enabled to attain age-appropriate learning, adapt to multiple environments and realize their full potential and personal value.

PRINCIPLES

School social workers are committed to the importance of the Social Work Code of Ethics, which includes:

- service (help people in need and address social problems);
- social justice (challenge social inequality and injustice and pursue social change);
- respect (value the dignity and worth of the person);
- relationships (use human relationships as key tools in the change process);

- integrity (be aware of the profession's mission, values, ethical principles, standards and practice, and practice in a manner consistent with them);
- confidentiality (be familiar and comply with the various local, state and federal mandates related to confidentiality); and
- advocacy (facilitate change that effectively responds to the needs of students, families and school systems).

These principles serve as the basis for all standards that follow.

KNOWLEDGE

School social workers have knowledge and understanding of:

- human behavior in the social environment, including theoretical perspectives related to human growth and development, learning, systems, communications, social learning and behavior;
- the broad range of experiences that shape a student's approach to learning, such as socioeconomic status, gender, culture, disability and sexual orientation;
- the needs of at-risk children and children with disabilities;
- child development and biological factors that affect student functioning;
- local state and federal mandates related to confidentiality and ethical decision making; and
- research- and evidence-based practices.

PERFORMANCE

School social workers demonstrate the ability to:

- develop helping relationships with diverse populations and cultural groups, students, families and communities;
- facilitate, engage in and demonstrate a variety of prevention, intervention and educational activities;
- provide student services in ways that build students' individual strengths and offer students maximum opportunity to participate in the planning and direction of their own learning experience;
- protect the legal rights and confidentiality of students, their families and other vulnerable groups; and
- possess and use professional judgment in order to adhere to the NASW Code of Ethics, which results in ethical decision making.

Standard 2: Education and Learning Systems and Organizations

School social workers understand the nature and scope of education systems and learning organizations. They are able to facilitate processes and engage in practices that promote healthy growth and development in the learning environment.

PRINCIPLES

School social workers are committed to the importance of:

- improving the quality and effectiveness of the learning environment; and
- supporting activities to overcome institutional barriers to the equitable treatment of all individuals.

KNOWLEDGE

School social workers have knowledge and understanding of:

- the organization and structure of the local education system;
- the relationship between practice and policies affecting students;
- the financial base of the local education agency, the nature and scope of its authority, and the politics of school-community relations; and
- the uses of technology to enhance communication, facilitate programs, organize information and demonstrate accountability.

PERFORMANCE

School social workers demonstrate the ability to:

- identify areas of need that are not being addressed by the local education agency and community and work to create services that address these needs;
- improve educational programs through decisions and actions based on assessment, data collection and empirical evidence;
- develop and provide services that address the goals and mission of the educational institution and its academic standards;
- respect and work within the constraints established by the organizational system; and
- assist in the development of school improvement plans that include the expansion of school resources.

Standard 3: Collaboration

School social workers work with other professionals within the educational setting to promote student development and learning. They collaborate with families and work with community resources to minimize risk factors, promote resiliency and respond to student needs.

PRINCIPLES

School social workers are committed to the importance of:

- broad-based collaboration and cooperation both within the school and the community;
- incorporating family input into developing plans and interventions to address student needs;
- expanding the availability of resources to enhance student and family functioning;
- enhancing the functioning of the individual/family within the community; and
- promoting comprehensive prevention programs.

KNOWLEDGE

School social workers have knowledge and understanding of:

- community resources and their availability to provide appropriate services;
- the reciprocal influences of home, school and community;
- the importance of appropriate and culturally sensitive modeling of behavior by school staff and

- administrators;
- the diverse cultures and cultural factors that influence student and family relationships with schools; and
- preventive practices and programs.

PERFORMANCE

School social workers demonstrate the ability to:

- develop and maintain positive, constructive relationships with school- and community-based professionals;
- facilitate trusting and cooperative relationships between parents, the school, and the community;
- work collaboratively to mobilize resources in the local education agencies and communities to meet the needs of students and families;
- empower families to effectively use and gain access to educational and community services; and
- communicate with school personnel regarding family and community influences on student performance.

Standard 4: Assessment

School social workers individually, or as part of a multidisciplinary team, systematically gather data using various methods and sources to assess the needs, characteristics and interactions of students within the school, family and community settings.

PRINCIPLES

School social workers are committed to the importance of:

- objective assessment

KNOWLEDGE

School social workers need knowledge and understanding of:

- methods of systematic assessment needed to plan and implement interventions and evaluate the results;
- the learning process as it relates to developmental stages, learning styles and special learning needs;
- ecological perspective that focuses on the individual student in the context of the social environment in school, at home and in the community;
- the functional approach to assessment as it relates to behavior and interventions;
- the potential biases in assessment approaches with students of diverse racial, ethnic and cultural experiences;
- the state and federal laws and regulations regarding students with special needs (e.g., Section 504 of the Rehabilitation Act of 1973, Individuals with Disabilities Education Act, etc.); and
- the state and federal laws and mandates pertaining to bilingual education.

PERFORMANCE

School social workers demonstrate the ability to:

- collect and analyze data systematically through standardized instruments, records review, interviews and observations, etc.;
- write a comprehensive bio-psychosocial history (e.g., eating, sleeping, leisure time and study habits, social relations, problem solving skills, etc.) based on multiple informants — data collection should include appropriate information enabling the understanding of the various social influences that affect a child’s learning and particular learning styles and needs;
- incorporate bio-psychosocial data into reports that include educationally relevant recommendations with outcome measures; and
- analyze existing data systems (e.g., attendance, disciplinary and academic records), to craft appropriate interventions that will assist students in their overall functioning.

Standard 5: Intervention

School social workers develop and implement intervention plans with individuals, groups, families, the school and the community. They apply empirically validated intervention methods to enable and enhance students’ educational experiences.

PRINCIPLES

School social workers are committed to the importance of:

- supportive adult relationships to successful student outcomes;
- students and families as major stakeholders in intervention plans;
- interventions based upon the student’s existing strengths;
- clinically appropriate interventions; and
- culturally and linguistically competent practice.Knowledge

School social workers have knowledge and understanding of:

- levels of service (individual, group, family or system interventions);
- scope of service (primary, secondary and tertiary prevention and intervention efforts); and
- theoretical perspectives such as behavioral, cognitive, psychodynamic, family systems, strength-based, ecological, crisis intervention and conflict resolution.

PERFORMANCE

School social workers demonstrate the ability to:

- develop positive working relationships with students, their families, school staff and administration;
- ensure that students and their families are provided services within the context of a multicultural awareness and competence to enhance the family support of students’ educational success;
- select, implement and evaluate appropriate intervention methods based on assessments and empirical evidence that will enhance a student’s learning capacity;
- run psycho-educational groups within the school setting;

- recognize and intervene with students' mental health problems, such as depression, anxiety and self-injurious behavior;
- assess and intervene with students exhibiting behavioral problems, such as disruptive behavior, substance abuse and bullying;
- intervene in crises and offer appropriate counseling services or community referrals for all those affected;
- recognize and intervene appropriately with traumatized children, their families, and school staff;
- design interventions to promote positive educational experiences and involve the student, family, school personnel and community services when appropriate; and
- use collaboration and consultation with other professionals to assist in designing and evaluating intervention plans.

Standard 6: Professional Development

School social workers are committed to lifelong learning and they contribute to the professional development of others.

PRINCIPLES

School social workers are committed to the importance of:

- keeping current with developing educational and social trends affecting the lives of children;
- keeping skills current with best practices in school social work;
- maintaining credentials and knowledge base in school social work;
- continuing self-assessment, evaluation and professional development; and
- contributing to the advancement of the profession.

KNOWLEDGE

School social workers have knowledge and understanding of:

- reforms in education, school social work and evidence-based models of practice;
- limits and boundaries of professional roles within the educational system and the community; and
- opportunities for continuing education.

PERFORMANCE

School social workers demonstrate the ability to:

- actively use supervision, collaboration, consultation and professional development to support areas of professional growth;
- provide educational opportunities for students, parents, other professionals and the community;
- contribute to the development of the profession by educating and supervising school social work interns and other social workers; and
- actively participate in professional associations.

Code of Ethics



IN THIS SECTION

Confidentiality

GENERAL RULES PERTAINING TO
PRIVACY, CONFIDENTIALITY AND
COMMUNICATION

*Confidentiality Practices Within
Schools*

*Confidentiality Practices Among
Agencies*

*Exceptions to the General Rules
Prohibiting Disclosure*

Personal Notes and Confidentiality

School social workers must be knowledgeable of the ethical principles and codes of professional conduct described in the *National Association of Social Work's Code of Ethics*, which can be found at <http://www.naswdc.org>. In addition, because the CSDE certifies school social workers as educators, they are also bound to the State of Connecticut's *Code of Professional Responsibility for Teachers* (appendix D). Finally, as school employees, school social workers must comply with the *Family Educational Rights and Privacy Act (FERPA)* and the *Health Insurance Portability and Accountability Act (HIPAA)*. Due to the obligations these professional conduct codes, statutes and regulations impose, a school social worker must balance the systemic needs of the school with the privacy needs of students served. Ethical codes may be broad and may not pertain to all situations, leaving social workers with the responsibility of using their professional judgment in keeping with the standards of the profession. In this section addressing ethical issues confronting school social workers, particular attention will be paid to matters of privacy and confidentiality. Due to the nature of collaborative communication present among

school staff and the necessity to meet the varied needs of a school's student body, school social workers will often be confronted with conflicting needs arising from a student's disclosure. Striking a balance between protecting student privacy and confidentiality, while remaining an important source of contextual information for other school staff, is a necessary responsibility for school social workers.

Confidentiality

GENERAL RULES PERTAINING TO PRIVACY, CONFIDENTIALITY AND COMMUNICATION

It is illegal to disclose strictly confidential information without specific written request. Such information includes a diagnosed learning disability, previous status as a special education student, any other type of diagnosed physical or mental disability, a diagnosed medical condition, use of prescription drugs, history of drug/alcohol abuse and/or treatment, HIV/AIDS status, and official transcripts, including GED scores.

Confidentiality of student information is based on legal and ethical precepts derived from constitutional law, federal and state mandates related to health and education, and social work ethical standards. See NASW, Code of Ethics, 1996; NASW Position Statement: The School Social Worker and Confidentiality, 1991. The general rules addressing disclosure of student information include:

1. *The right to privacy*

The right to privacy is founded on federal and state constitutional law, statutes, common law principles, and the belief that personal information belongs to the individual who has the right to decide whether that information should be disclosed to others.

Family and student privacy: Student health information that any school personnel have recorded and health information that outside health care providers have provided to the school are considered “education records” within the protection of FERPA.

- a. *FERPA*, a federal law, protects the privacy of students and parents by restricting access to, and protecting the confidentiality of, education records. FERPA defines specific rights of parents and students who are 18 years or older regarding their access to, and the confidentiality of, education records. FERPA applies to public schools and other education agencies that receive federal funds.
- b. *HIPAA privacy rule*. The HIPAA privacy rule governs how health care providers use and disclose “protected health information.” <http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html>

As FERPA protects health information in a public school education record, HIPAA’s privacy rule specifically exempts it. Even though HIPAA generally does not govern public school health records, school social workers need to be aware of HIPAA regulations and how the privacy rule affects their ability to obtain protected health information from outside providers for their students. Such disclosures generally require proper authorization to release the information to schools.¹ Only the parent or guardian of a student or students themselves if they are 18 or older can provide such authorization. Urgent or emergency situations allow sharing of essential information with emergency responders assisting the student in question. Depending on the level of care emergency responders need to provide, this might include information such as current medications, ongoing or recent treatment, and other necessary medical or psychiatric information that privacy and confidentiality laws might otherwise protect.

2. *Provider-client confidentiality*

A confidential communication to a school social worker made in the context of a client relationship should not be revealed without the consent of the client (i.e., student), unless required by law. The belief that a client is more likely to disclose all the relevant information necessary for proper diagnosis and treatment if he or she knows that private facts will be held in confidence was derived from practice in the medical profession. This concept guides the practice of maintaining confidentiality of verbal communications and forms the basis for the client-confidentiality standards incorporated into:

- the social work ethical codes of practice;
- standards for health care institutions and agencies;
- relevant state mandates, including a minor’s right to seek treatment for certain conditions, and

1. HIPAA includes provisions for allowable disclosures by health care providers under certain circumstances, including, but not limited to, treatment, public health, state law, and child abuse.

- common law principles; and
- relevant federal statutes and regulations regarding treatment, counseling or assessment and referral law principles of persons, including students, who are receiving alcohol and drug abuse services.

In the course of their responsibilities, school social workers have access to confidential student and family information. They have a responsibility to ensure that such information is maintained according to the ethical and legal standards of confidentiality. As certified personnel, school social workers' requirements to adhere to confidentiality are governed by the same codes of professional conduct as are teachers and school administrators (State of Connecticut's Regulations Concerning State Educator Certificates, Permits and Authorizations, Sections 10-145d-400a and 10-145d-400b). In addition, there are state and federal laws that restrict the disclosure of specific information, such as the HIV or substance-abuse status of a student.

3. *Privileged Communications*

Although certification is the only requirement to practice in schools, many social workers are also licensed as clinical social workers (LCSW) by the Department of Public Health (DPH). Established through specific state statutes, privileged communication is the right of the client in a judicial proceeding to exclude from evidence confidential communications made to a social worker in the course of diagnosis or treatment. In Connecticut, statute prohibits LCSWs from disclosing confidential communications without the explicit consent of the client, except in specific circumstances (Connecticut General Statutes (C.G.S.) Section 52-146f [see appendix JJ]).

Confidentiality Practices Within Schools

Under FERPA, school officials may disclose personally identifiable information from an education record to other school personnel who have a "legitimate educational interest." FERPA includes many requirements for safeguarding student information. Nondirectory information about students may only be disclosed — unless otherwise prohibited by law — to other school personnel who have a legitimate educational interest. School officials may only disclose or re-disclose information that is necessary to provide appropriate services to a student. Information about one student may not be disclosed to another student or another student's parent unless such disclosure is necessary to protect the health and safety of others. Finally, the school district must provide its policy regarding confidentiality of student information to students and parents each school year.

Although not explicit in FERPA, school personnel should employ the following practices regarding confidential student information:

1. Discussions concerning confidential information should take place in secure locations.
2. Confidential written documentation or notes of oral confidential communications should be marked "confidential" and stored in secure locations. When in use, such documentation should be shielded from the view of others and should not be left unattended.
3. Confidential information should not be left as a message with a secretary, on a voice mail or on an electronic mail system.
4. Confidential information that must be mailed or carried should be placed in an envelope marked "Confidential."
5. Confidential information to be discarded should be shredded or otherwise disposed of securely.

Confidentiality Practices Among Agencies

Appropriate practices related to confidentiality between school personnel and another institution, such as a school-based health center or community mental health center include, but are not limited to, the following:

1. School officials must obtain prior written consent of the parent or, where applicable, the student, before requesting from or disclosing to representatives of outside institutions or third parties any student or family information unless otherwise allowed by law.
2. It is acceptable to discuss the situation of a particular student with outside professionals, (e.g., professional development, LCSW supervision and case consultation) if this communication is conducted in a manner that protects the identity of the student and the family (e.g., by withholding the student's name, address, birth date, and other identifying data). In other words, relevant information must be presented in a manner that is reasonably calculated to ensure that the identity of the student cannot be determined. Furthermore, information should be disclosed only to the extent necessary to fulfill the purpose of the professional consultation.
3. Confidential information received by the school that was not requested or is not needed should not be made part of the student's record, and should be returned to the sender or shredded. The school district should notify the parent if this occurs.

An outside party, such as a private health care provider, must obtain proper authorization to disclose protected health information to schools. Such authorization must contain the core elements specified in the HIPAA privacy rule.

Exceptions to the General Rules Prohibiting Disclosure

School social workers are faced with ethical dilemmas when ethical principles and the laws converge, when the needs of their client systems (school, student and families) diverge, or when colleagues are unaware of the ethics and practice standards of the social work profession. The particulars of a situation may require expert clinical judgment to determine whether or to what extent, confidentiality should be maintained. To minimize such potential conflicts, social workers are encouraged to work collaboratively with school administrators to develop written policies and procedures concerning confidentiality, as well as professional development opportunities, so that all building staff members are kept informed. Furthermore, it is important to educate students and their parent or legal guardians about their confidentiality rights and the limitations of such rights.

There are instances when maintaining confidentiality is not appropriate:

1. *Written consent:* Confidential information may be disclosed to designated individuals when informed, prior written consent is obtained from the parent, legal guardian, surrogate parent or when appropriate, from the student. The consent may limit the information to be disclosed and the time to which it is applicable.
2. *Health or safety emergency:* Confidential student information may be disclosed without consent when a student is, or others are, in danger of imminent harm. If the school district determines that there is a clear and significant threat to the health and safety of others, it may disclose information from education records to any person whose knowledge is necessary to protect others. A health or safety emergency generally refers to the high probability of suicide, homicide or risk of a life-threatening injury, condition or illness.
3. *Abuse:* Pursuant to C.G.S. Section 17a-101, school social workers are mandated reporters of

suspected child abuse. Instances of suspected child abuse and neglect or imminent danger of abuse must be reported as required by law.

Personal Notes and Confidentiality

Social workers may maintain personal notes on students separate from the official student record as a personal memory aid when the following conditions are met:

- the notes are in the sole possession of the social worker; and
- the notes are not accessible nor the content revealed to any other person.

If the content of the notes is discussed with others, the notes lose their “sole possession” status and they become part of the student’s permanent record. As with all confidential materials, personal notes should be kept in a secure location.

Scope of Practice: Addressing Barriers to Learning



IN THIS SECTION

**Scope of Practice
Overview**

Prevention

SUPPORTING
HEALTHY
DEVELOPMENT

**Barrier
Identification**

Evaluation

**Measurement of
Treatment**

**Scientific
Research-
based
Interventions**

Collaboration

Consultation

Advocacy

**Linkages to
Community**

Scope of Practice Overview

As implementers of behavioral health services, school social workers make unique contributions to a coordinated approach to school health through prevention, barrier identification, assessment and evaluation, and treatment and intervention services. They provide these services through collaboration, consultation and advocacy. As a consequence of their education, which focuses on the reciprocal interaction of person and environment, school social workers are particularly well suited to address and clarify barriers to learning. School social work encompasses a wide variety of services and approaches that correspond to the barriers to learning affecting the lives of students. The scope of practice includes the following: prevention; barrier identification; evaluation; intervention/treatment; collaboration/consultation; advocacy; and linkages to community resources. These procedures, actions and processes ensure for students, parents and educators that a holistic approach to student achievement is used.

Prevention

SUPPORTING HEALTHY DEVELOPMENT

School social workers implement prevention programs to simultaneously support healthy growth and development for all children and provide early intervention services for students at risk. School social workers use multimodal strategies and approaches to foster student growth and development, including individual counseling; small group activities; focused group interventions; classroom-based activities; schoolwide initiatives; and parent education. While prevention programs may take many forms, evidence-based practice supports a resiliency perspective that links together school, home and community. Effective practices include:

- promoting a positive school culture or environment that is characterized by positive relationships among faculty, staff and students, a sense of safety, honoring of diversity, and a respect for learning;

- fostering resiliency by developing protective factors (e.g., social-emotional learning curricula that teach skills in self-awareness, social-awareness, self-management, responsible decision making, and skills in building and maintaining relationships) (for an example, see <http://www.CASEL.org>);
- minimizing risk factors through interventions across the student’s environments;
- enhancing the school community system through education on such topics as cultural diversity, race, gender, the impact of poverty and disenfranchised/disengaged individuals and families;
- ensuring that children have health insurance by providing appropriate application materials for the HUSKY insurance program and the Sustinet Health Partnership;
- developing with district approval contractual relationships with outside agencies that can contribute to accommodating the needs of students and their families (e.g., the local youth service bureau to target extended learning opportunities and positive youth development);
- establishing formal relationships with providers in the Community Collaborative System of Care <http://www.ct.gov/dcf/cwp/view.asp?a=2558&q=314376>; and
- creating an annual list of licensed behavioral health service providers that includes information relating to the populations served, the application and intake process, types of services, etc.

The school social worker may assume a variety of roles to initiate, implement, and sustain appropriate prevention programs and develop and sustain a schoolwide climate of understanding and support. In districts where the need for prevention has not been established, a school social worker begins by working with administration to establish a rationale connecting students’ needs and the district’s mission. Further conversations with administrators and other support service providers address the development of policies and structures to support such programming. Regarding implementation, the school social worker is highly qualified to provide service delivery that is contextualized to the diverse needs of the specific student population. Finally, responsible practice includes program evaluation as a natural aspect of professional accountability.

Barrier Identification

School social workers identify nonacademic barriers to a student’s educational success. Historically, social work services in the schools grew out of concern for underprivileged students. In a 1966 amendment, Congress added Title VI (Aid to Handicapped Children) to the ESEA. As a result, funding was made available to school districts to provide staff training for teaching students with disabilities. With the passage of the Rehabilitation Act of 1973 and the Education of the Handicapped Act of 1974, the educational rights of students with disabilities were first codified into law. These rights and the supports, services and legal protections available to children with disabilities were further delineated with the passage of the IDEA (2004) and the enactment of NCLB . Because of these statutory changes, all children, including children with disabilities and other barriers to learning, are entitled to a free appropriate public education and may be eligible for accommodations to meet their learning needs. School social workers, working as part of the multidisciplinary team, “bring unique knowledge and skills to the school system and the student services team” and are “hired by school districts to enhance the district’s ability to meet its academic mission, especially where home, school and community collaboration is key to achieving its mission” (SSWAA, 2003).

Presently, state and federal guidelines identify 13 specific handicapping conditions that make a student eligible for special education and related services as a child with a disability. These identified educational disabilities include: *autism; deaf/blind; deafness; hearing impaired; intellectual disability; multiple disabilities; orthopedic impairment; serious emotional disturbance; specific learning disabilities; speech or language impairment; traumatic brain injury; visual impairment, including blindness; and other*

health impairment. As an identified special education student, a child with a disability is entitled to special education and related services, in addition to any modification or accommodations necessary to promote student learning and achievement.

In the event that a child with barriers to learning does not qualify for special education and related services, the supports and services available to special education students may be available through the provision of Section 504 of the Rehabilitation Act of 1973. In addition, school social workers are committed to providing services to students within the general population who exhibit need and may benefit from such services. A primary service in barrier identification is performing a comprehensive evaluation that includes planning with parents, academic and behavioral screening and assessment, and engaging other members of the student support service team to ensure coordinated and consistent service delivery. These efforts should be initiated at the earliest indications of poor academic adjustment, and consider the student's social and emotional development, and cognitive or other peer-matched functional performance. These needs may be triggered by family, community or school-based issues, but will require support to ensure that the student remains able to access the educational program.

Evaluation

School social workers use evidence-based practices in evaluating student needs. Comprehensive evaluations provide a broad contextual perspective from which to view the students' functioning and are essential for developing intervention/treatment plans that contribute to students' success. School social workers perform evaluations that identify the existence, nature and extent of students' problems, as well as their strengths and coping skills. Evaluations are used for all events and conditions that affect a student's functioning in school, such as trauma, disabilities, mental health disorders, substance abuse or grief, among others. School social workers carefully explore variables affecting students' performance that may not be readily apparent, known or understood by others. Essential elements of a thorough evaluation include assessment of the impact of multiple factors, such as family dynamics, socioeconomic, culture, ethnicity, gender, sexual orientation, race, religion and other factors. An effective student evaluation will include consideration and analysis of: reason for referral;

- parents' concerns;
- school's concerns;
- current level of function — social, emotional, academic, familial, community;
- school history;
- family history;
- developmental history;
- medical/health history;
- adaptive functioning; and
- student's view of self — strengths, difficulties.

Evaluation is a dynamic process that may involve the use of standardized and nonstandardized instruments. Assessment tools can augment the clinician's professional training and expertise but should not be used in isolation from other measures to identify student needs or formulate clinical impressions and treatment plans. Assessment tools include:

1. **Standardized Instruments**

Standardized instruments may be used to collect information and enable the assessment of the student's learning needs and contribute to the eligibility determination of children with special needs. Frequently, school social workers use standardized instruments to assess students' social and emotional status in areas such as:

- anxiety;
- adaptive behavior;
- depression;
- aggression;
- attention/hyperactivity/impulsivity; and
- social competence.

Examples of standardized tests for which the school social worker is appropriately trained and certified to perform that might be used in the collection of data are:

- Attention-Deficit/Hyperactivity Disorder Test;
- Children's Depression Scale;
- Vineland Adaptive Behavior Scales, Adaptive Behavior Assessment System;
- Conners Rating Scales-Revised;
- Scale for Assessing Emotional Disturbance;
- Behavior Rating Scales;
- Motivation Assessment Scale;
- Functional Assessment Screening Tool;
- Behavior and Assessment System for Children, Second Edition;
- Achenbach, Child Behavior Checklist;
- Burks Behavior Rating Scale; and
- Preschool Behavior Questionnaire, Preschool & Kindergarten Behavior Scale.

2. **Nonstandardized Instruments**

Nonstandardized information is another important element to develop effective student evaluations and social workers are often called upon to use information derived from:

School Records

Record reviews that include:

- attendance and retention history;
- number and type of schools attended;
- standardized and curriculum based test scores/grades;
- disciplinary actions;
- Planning and Placement Team and Individualized Education Program reports;
- parent conference notes;
- previous evaluations and referrals;
- regular education interventions and supports; and
- cumulative health records (*check your district's policy and procedures manual regarding access to health records).

Consultations (with)

- school personnel;
- community service providers;
- school nurse;
- physicians; and
- family members.

Clinical interviews (with)

- student; and
- family/guardians.

Observations

- across school settings (classroom, cafeteria, library/media center); and
- home/community when appropriate.

3. **Functional Behavioral Assessment**

The Functional Behavioral Assessment (FBA) is a mechanism for determining the social or behavioral gains that a student obtains from the exhibition of problematic behavior. It includes:

- problem identification/definition;
- description of the target behavior;
- problem analysis;
- collecting baseline/academic information;
- describing environment/demands;
- determining the function of the target behavior;
- direct and indirect assessment;
- hypothesis formation (specific and global);
- hypothesis testing through experimental design;
- plan development (Behavioral/Intervention Plan Implementation);
- evaluation/progress monitoring; and
- follow-up/modifying the plan when necessary due to progress or continued problematic behavior.

School social work evaluations are an integral component of a multidisciplinary evaluation.

Measurement of Treatment

School social workers continuously measure and assess the effectiveness of their student evaluation and intervention practices. In school settings, the primary focus of data collection is student assessment. Additionally, school social workers will also need to evaluate the rigor and effectiveness of the services being provided to students. To measure the value of professional interventions, school social workers use a variety of formal and informal tools. These tools may include, but are not limited to:

FORMAL TOOLS

Pre & Post Test Measures
Qualitative Research Design

INFORMAL TOOLS

Observations, Data Collection
Charts of Progress
Teacher/Student/Parent Report

Scientific Research-based Interventions

School social workers assist the educational mission of their school and district through tiered interventions designed to meet the needs of all students. Scientific Research-based Interventions (SRBI) is the Connecticut framework for Response to Intervention (RTI) and is a comprehensive, multistep process that uses progress monitoring to determine how the student is responding to different types of services and instruction and provides tiered interventions of increasing intensity when necessary. While engaging the student with specific strategies and supports, SRBI is essentially a prevention model directed toward alleviating further academic failure for students requiring additional assistance. Through initial screening, universal supports and interventions proven to be successful through scientific inquiry, SRBI is the foundation for tracking and supporting student adjustment and achievement within the school setting. SRBI describes not only the use of evidence-based programs and interventions but also provides direction for the development and implementation of tiered instruction and student support services. Tier I describes those elements of school instruction and support that are universal in application and are provided for all students. Should a student or group of students continue to have needs in accessing their academics as a result of social-emotional or academic barriers to learning, the students receives Tier II interventions *in addition to* those already provided in Tier I. Throughout this period of intervention, ongoing evaluation is necessary to ensure the fidelity of intervention, measuring positive response to intervention and determining next steps. If a student continues to exhibit lagging performance in the desired goal area, Tier III interventions are then applied *in addition to* the Tier I and Tier II interventions. It is important that providing a support in higher tiers does not supplant those provided through earlier intervention, but is intended to be provided in addition to those supports already being provided. Determination for special education services can be made at any tier, and it is not necessary for a student to first be exposed to all three tiers if there is clear and compelling evidence that the student might qualify for services and protection under the IDEA. Special education services should continue to use a multistep process for meeting student needs that is consistent with SRBI.

Evidence-based practice is an attempt to respond to our need as a profession to implement best practices in our work. Evidence based practice is present in both of the fields of mental health and education (see: What Works Clearinghouse, <http://www.w-w-c.org>). While school social workers must ensure the internal validity of the interventions that are used to address student needs, they should also monitor the impact that these interventions have on the school environment. One example of a measure for evaluating impact is the School Success Profile (SSP) (Bowen et al, 2005) (see: http://www.schoolsuccessprofile.org/publications/intervention_package.pdf). It is a comprehensive tool for evaluating and monitoring the effects of interventions in school settings. Paula Allen-Meares describes other available measurements in *Social Work in Schools*, 5th Edition. Incorporating evaluation in the process of school social work verifies results for interventions not only to ourselves, but to the educational systems and clients we serve.

The CSDE has identified 10 underlying principles and critical features that should be included in the implementation of SRBI: 1) the assumption that scientific research should be used to inform educational practice as much as possible; 2) a belief in collective responsibility, accountability and

the power of education; 3) a willingness to be transparent with a relentless focus on continuous improvement; 4) a focus on prevention and early intervention; 5) schoolwide or districtwide high-quality core curricula instruction and comprehensive social/behavioral supports; 6) monitoring fidelity of implementation; 7) culturally responsive teaching and service delivery; 8) a comprehensive assessment plan with universal common assessments and progress monitoring; 9) data analysis, not just data collection; and 10) data-driven decision making with clear decision rules.

For school social workers, behavioral assessment will be critical in their contributions to SRBI implementation within their schools and districts. Behavioral assessment should define the type of behavior being targeted and the function that the behavior serves in the student's life. Assessment should include the influence of social, cultural, familial and ecological elements within the student's environment and result in a clear plan for sensitive and responsive intervention to reduce the barriers in social and academic functioning resulting from the targeted behaviors. While behavioral assessment should be closely linked to the interventions, it provides additional benefits to the school environment, such as improved school climate and culture, maintaining students in the least restrictive environment, decreased identification of behavioral disorders, and the over identification of males and people of color. Benefits of providing services within an SRBI model include cost effectiveness and early identification of emerging behavioral and developmental problems that respond to intervention more robustly when addressed early. For additional guidance, see *Addressing the Needs of the Whole Child: Social, Emotional, Behavioral, and Physical Health, as well as Academic Achievement, in Connecticut's SRBI Process* in appendix F.

Tier I activities include examining and tracking discipline referrals, understanding school climate/norms, identifying at-risk students and monitoring behavior patterns within the school. Identifying at risk students should include universal health screening, universal screening for social skill competencies/social behaviors, Systematic Screening for Behavior Disorders (SSBD) (Walker & Severson, 1992), classroom observations (through teacher or MH consultant), parent-reported child risk factors and student-reported risk indicators (Barnett et al., 2006). Some examples of universal interventions for behavioral health that benefit from the guidance and participation of the school social worker include positive behavioral supports, Positive Behavioral Interventions and Supports, classroom programs, character education/curriculum, parenting programs, staff development (classroom management, noncompliant students), modification of school policy, schoolwide discipline procedures and reinforcements (weekly/monthly).

The Center for Mental Health in Schools has identified six defined aspects of components that enable the delivery of learning supports. School social workers, both by education and professional responsibility, are particularly well suited to reduce barriers to learning. Tier I interventions include:

1. **Classroom focused enabling.** Social workers help enhance the ability of teachers both to motivate all students and to re-engage those students who have “tuned out” and become disengaged from classroom instruction. They can do this by providing comprehensive in-service training for teachers and other staff; helping develop the capacities of paraeducators and volunteers; and enhancing the classroom resources of the teachers to foster a caring context for learning, accommodating a wide range of individual differences, and preventing and addressing a wide range of problems.
2. **Family involvement in school and schooling.** Social workers help develop strategies that foster student learning and support needs of the adults in the home (e.g., improving communication and connections between school and home, educating families about the important role parents play in their children's education, and increasing parental understanding of school policies,

- procedures and practices).
3. **Support for transitions experienced by students and families.** School social workers develop schoolwide activities to welcome new arrivals and provide ongoing social supports; provide ongoing support for students re-entering after out-placement or institutionalization; and facilitate support groups for students experiencing death or divorce, etc.
 4. **Crisis assistance and prevention of violence, bullying and substance abuse.** School social workers, in accordance with district policy, work as part of a crisis team educated in emergency response procedures. Social workers assist with the implementation of the emergency response plan at school or in the educational community at large. Social workers cultivate individual protective factors and help to minimize those risk factors that may contribute to violence, suicide and child abuse.
 5. **Specialized student and family assistance.** While students and families may need community-based services and supports, the school social worker works collaboratively with community providers to maximize social, emotional and academic growth. Social workers are knowledgeable about community resources and trained to help the family access, use and benefit from multisystemic services.
 6. **Enhance community involvement in the school.** Social workers are knowledgeable about community services and programs that can be brought into the schools to augment existing school-based services and provide services not addressed by school staff to better meet the educational and noneducational needs of students and their families. Community outreach enhances the resources available to school staff and students.

These enabling components are essential to a school's ability to accomplish its instructional mission; they do not represent an agenda separate from that mission. School social work is the key profession for the development of programs that focus on reducing barriers to learning.

Tier II activities include detecting nonresponders at Tier I; addressing teacher needs through consultation, collecting baseline data of behavior and conducting initial assessment (e.g., teacher interview, behavior charting/frequency count, rating scales, direct observation, etc.); assessing the environment (observations of environmental factors, developing a checklist to assess classroom management plans); and assessing social skills, motivation and contingencies. Particularly when addressing behavioral and developmental needs at Tier II, the school social worker should use standardized social skills assessments to determine if it is a skill, knowledge or performance deficit. To answer this question, a brief FBA may provide direction in determining the most effective intervention.

Behavioral interventions based on functional assessment lead to more effective and strategic involvement. In most Tier II actions, school social workers will be targeting those social skills students need for school success, such as self-confidence, capacity to develop positive relationships, concentration/persistence with difficult tasks, ability to effectively communicate emotions, ability to listen to instructions and skills in solving social problems (Hemmeter et al., 2006).

Tier II interventions might also include social skills training (group/classroom); targeted group counseling (homogeneous); modifying the classroom program; consulting with teacher and associated environmental modifications; positive reinforcement for using skills; mentoring; modeling; structured play; after school clubs; parent/family contact; and the use of embedded interventions to provide additional opportunities to practice skills (Barnett et al., 2006).

Tier III provides the most intense level of intervention outside the special education framework. This level is triggered when there is no or inadequate response to intervention on Tier II. Assessment at

Tier III begins with reviewing the student's records (discipline referrals); interviewing all teachers and the student (formal/structured); gathering a detailed family/social history from parents; use of standardized rating scales (specific/diagnostic) along with observations to gain understanding of the antecedents, behaviors and consequences contributing to the student's continued problems; and putting together a formal FBA and developing individualized goals and interventions through a behavior intervention plan (BIP).

Tier III interventions might include: individual counseling (academic/behavioral at point of learning); individual behavior modification/positive reinforcement program at the point of learning; and use of direct and explicit instruction. In addition, Tier III interventions can include parent consultation; increased involvement of support staff; the promotion of the transferability of skills; behavioral contracting (goals, consequences and rewards); cognitive-behavioral interventions; self-management strategies; experimental analysis; and finalization of the FBA and the creation of a BIP.

School social workers are part of a larger system addressing the needs of young people in the community and, as such, need to collaborate with a broad network of educators, service providers, parents, administrators and others. Whether working with an individual student or advocating at a policy level, the school social worker aligns the intervention with the unique needs of the student and the situation. The school social worker provides services individually, in small groups or through classroom-based psycho-educational activities. These services are designed to foster the social emotional competencies of school-age children. The school social worker is available to classroom staff as a consultant for developmental norms and effective practices to meet student needs in the classroom setting. The school social worker collaborates with community-based service providers and mental health practitioners to coordinate intervention plans and other services. The school social worker educates families about students' needs and assists families in accessing necessary services, thereby maximizing the potential for educational success.

Intervention/Treatment

When preventative efforts provided through Tier I practices fail to meet student needs, school social workers use comprehensive and strategic interventions in providing Tier II and Tier III services. SRBI provides organization for developing and monitoring individual and group-based progress for students, but to ensure that social and developmental needs are being met social workers identify goals, objectives, methods and timeline, and these elements are incorporated into a treatment plan. The school social worker sets treatment goals and interventions after assessing a student's strengths, weaknesses and social-emotional functioning. The school social worker employs a strengths-based, ecological perspective when developing treatment plans, which maximize the potential for successful outcomes. Within school settings, treatment plans should be developed with cognizance of the need to share related information with other educational staff. Unlike their counterparts in purely clinical settings, school social workers are part of an interdisciplinary team focused on addressing the educational needs of students. Those aspects of a student's life that produce barriers to education are addressed through multiple interventions provided by individuals from varying professional training and perspective. While school social workers may use terms such as "treatment plan" to describe their activities in supporting student needs, school personnel are more familiar with the term "intervention plan." Wherever possible, school social workers should use language consistent with the other professions operating in the school setting. Central to school social work intervention is respect for an

individual's strengths, dignity, uniqueness and capacity for growth.

The school social worker identifies the resources in the student's environments when developing treatment plans. When the student is identified as having special education needs, all plans should be developed through the Individualized Education Program (IEP) and any associated planning, intervention and data collection should be provided for review by the Planning and Placement Team. The IEP drives the intervention plan. Some students who may be struggling academically but do not have special education supports in place may benefit from an early intervention program that provides specific structure and priorities that meet the individual student's needs. Social work interventions should also be implemented as part of the early intervention plan for a general education student. Intervention plans are student focused and/or system-focused using the strengths perspective. Student-focused interventions include casework, group work and referral services for students and their families, with the goal of maximizing school success. One obstacle that may arise is that some of the information shared by the student while receiving services may be information protected by privacy and confidentiality laws. School social workers must protect student privacy and confidentiality, but must also understand that information pertinent to a student's educational needs may be shared with other educational staff in the school. School personnel may recommend school social work services when students are exhibiting internalized or externalized behavior difficulties or social maladjustment, or demonstrating behaviors that indicate academic, psychological or social difficulty. Systems-focused interventions are provided in the environments in which the student is functioning and that are affecting his or her life. Such system-level intervention is typically directed toward the whole classroom, whole school, community level or a subgroup within the larger systems.

Collaboration

School social workers are part of the education team and engage in collaborative activities addressing student needs. As professionals specifically trained in interpersonal relationships, school social workers effectively function in a collaborative role because they are adept at supporting and recognizing the strengths and skills of other professionals. School social workers value the role that other team members, including the student's family, can and must play to ensure successful outcomes.

School social workers use their skills in the collaboration process with staff, students and their families, and community providers. In collaborating with staff, school social workers share their skills and incorporate the skills of others in helping a student. Optimally, each team member is fully supported and respected, while the intervention plan is carried through by all members, each according to his or her assigned role. While team members might not agree on the best way to intervene, school social workers use their consensus-building skills to help the team work toward a common goal.

With their knowledge of family dynamics, school social workers engage the student and the family in the collaborative process. Using their eco-systemic focus, school social workers help other team members understand family situations and dynamics and treat the family as equal partners in developing educational plans and interventions. Having built a trusting relationship with families, school social workers are able to interpret the school policies and procedures for families so that families can communicate with school staff more effectively. The school social worker also brings an understanding and a respect for families' culture, and these dispositions enable families and school staff to better understand and respect each other's perspectives.

The school social worker is also highly qualified to collaborate with community resource professionals. The school social worker's systems skills make outside professionals a part of the child success team by incorporating their assessments in planning for the student's needs. Following the guidelines delineated within FERPA on page 18 in this document, the school social worker shares with the outside professionals the student's functioning in school and assists him or her in understanding the school's policies and procedures. Before sharing any information concerning student functioning, a release of information should be obtained from the parents to allow this communication.

Consultation

School social workers provide education, guidance and assistance to other school staff, families and community agency staff. "Consultation has evolved into one of the most significant forms of intervention in school social work practice," (Constable, et al., 2006). Friend and Cooke (2002) describe consultation as "a strategy in which a teacher requests another professional to assist in problem solving concerning specific student needs." They further point out that "consultation might be used in a segregated school or a mainstreaming program, or to support students who are fully included and receive all services in the general education classroom." Because school social workers have training and expertise in child behavior and behavior plans, family dynamics, mental health, multiculturalism, and micro- and macro-systems, they can provide school staff, families and community resource providers with the necessary consultation to arrive at a solution.

Since the school social worker is skilled in understanding and assessing the student's school and home environment, he or she can tailor the style of consultation most likely to ensure success. Friend and Cooke delineate three styles of consultation: directive; collaborative and nondirective; and supportive or empathic (Friend and Cooke, 2002). The school social worker is sensitive to others' perspectives as they consult with staff, families and outside professionals. As they consult, school social workers share in a collaborative way those skills and knowledge that can improve student progress. For example, when a teacher needs different strategies to manage a child's behavior, the school social worker can help develop a behavior plan better suited to the student in light of his or her strengths, individual needs and family background (directive consultation). At other times, a teacher or parent may need support to implement an existing plan, build capacity and develop confidence in their efforts (supportive/empathic consultation).

Advocacy

School social workers advocate for their students and the mission of their school and district. Consistent with the overarching mission of social work, school social workers advocate for individual students whose needs are not being met in the school setting. Advocacy may be client-specific or system focused. Advocacy skills are vital to optimal professional outcomes for social workers and their clients. To effect system change to better meet the needs of the student, social workers need to understand and master organizational theory and concomitant practice strategies. As Carel Germain says, "political skills of influencing are needed, including persuasion, bargaining, mediation, negotiation and conflict resolution. Knowledge of a specialized kind is required in order to understand and to utilize the formal and informal systems within the school, its seats of power and decision making, channels of communication, its norms, customs, rules and policies" (Gitterman and Germain, 2002). Although this source addresses students with IEPs, it nonetheless offers solid practices that can be generalized to all students.

Linkages to Community

School social workers develop strong linkages with community agencies and staff. School social workers will be unable to address every emotional, developmental, psychological and behavioral need of the student body. Treatment dynamic and characteristics will necessitate collaboration with external social service agencies to meet all of the needs present within the student body. While obstacles exist, including the cost of services, waiting lists, and regional limitations for available resources, school social workers should develop, in consultation with the school and district administrations, memoranda of understanding (MOU) that help to clarify the means by which schools can facilitate referral for students to receive services through external agencies. For a sample template of what may be included in an MOU, go to http://www.ct.gov/cct/lib/cct/SAMPLE-Memorandum_of_Understanding.doc.

MOUs should be developed within the guidelines developed for both FERPA and HIPAA. They should include policies and procedures for referral; releases of information allowing disclosure of information between the school and the external agency; accelerated access to services when possible; and participation of external agency staff in student assistance or planning and placement teams addressing the student's education and care plan. If there is a cost to the school, a memorandum of agreement (MOA) that describes costs, billing and payment schedules should be used instead. Special care should be taken for maintenance of records and associated referral information so that the student's privacy is safeguarded and that personal health information is not stored with educational records.

Schools in general and school social workers in particular should maintain updated listings of local social service, child guidance and community health agencies that include information about costs, hours of operation, emergency access and treatment modalities. These listings can be made available to parents, as well as other school staff. School social workers should keep, at minimum, aggregated records of referrals, agency access (e.g., how long the student and his or her family had to wait to receive services), disaggregated and anonymous student data reflecting outcomes and other indicators that may assist schools in anticipating student need trends (e.g., an increase in students needing assistance to manage anxiety as the end of the school term draws near).

In Connecticut, a number of community agencies may contribute to the supports for students and their families who may benefit from targeted interventions. These agencies and their programs include:

1. Youth Service Bureaus (YSBs) serve every community in Connecticut and have staff trained in providing extended learning opportunities and positive youth development supports to students with behavioral issues. A listing of the 100-plus Connecticut YSBs and their coverage areas can be found at <http://www.ctyouthservices.org/listysb.htm>.
2. System of Care is a consortium of the Department of Children and Families' funded child guidance and family service clinics that provides psychological counseling for mental health issues. The clinics have the capacity to address more complex psychiatric issues with the support of medical staff. A listing of agencies participating in the System of Care, along with their respective service areas, can be found at <http://www.ct.gov/dcf/cwp/view.asp?a=2558&q=314352>.
3. Local Regional Action Councils or Local Prevention Councils have programs or activities available to assist schools and their students. These programs are funded through the Department of Mental Health and Addiction Services and serve every community in the state. A listing of Local Prevention Councils can be found at <http://www.ct.gov/DMHAS/cwp/view.asp?a=2912&q=335152#Statewide%20Assistance>.
4. Connecticut Infoline is a United Way program that provides referral, contact information and is an excellent source for finding answers to specific needs. Infoline can be contacted on the Internet

- at <http://www.infoline.org/> or by telephone by dialing 211.
5. Connecticut Clearinghouse located at Wheeler Clinic in Plainville and supported through funding provided by the Department of Mental Health and Addiction Services has an excellent library of training and program resources available for loan. The available resources provide information about prevention and intervention strategies to address problems that children, youth and families face in confronting substance use and abuse, depression and suicide, and developing resiliency, among others. The clearinghouse can be contacted through <http://www.ctclearinghouse.org/> or at 800-232-4424.

Credentialing and Professional Development



IN THIS SECTION

State Certification

Licensing

Supervision

State Certification

As of July 1, 2003, the following certificates and their requirements are required for anyone serving in the employ of a board of education as a school social worker. Proposed changes to the requirements for certification standards pertaining to school social workers can be found in appendix C.

Sec. 10-145d-564. Initial educator certificate requirements

To receive an initial educator certificate to serve as a school social worker, the applicant shall hold a master's degree in social work from a school of social work accredited by the Council on Social Work Education, and has completed a course of study in special education comprised of not fewer than 36 clock hours, which shall include study in understanding the growth and development of exceptional children, including handicapped and gifted and talented children and children who may require special education, and methods for identifying, planning for and working effectively with special needs children in the regular classroom.

Sec. 10-145d-565. Provisional educator certificate requirements

To receive a provisional educator certificate for school social worker, an applicant shall present evidence of meeting the preparation and eligibility requirements for an initial educator certificate, as well as having completed within 10 years prior to application at least 30 months of successful service as a school social worker in a public school; one school year of successful service under the initial educator certificate, interim educator certificate or durational shortage area permit at an approved nonpublic school or a nonpublic school approved by the appropriate governing body in another state.

Sec. 10-145d-566. Professional educator certificate requirements

To receive a professional educator certificate for school social worker, an applicant shall present evidence of 30 school months of successful service under the provisional educator certificate, interim provisional educator certificate or provisional teaching certificate.

All applicants who do not currently hold a valid Connecticut educator certificate must meet the following requirements:

- A passing score on the Praxis I Pre-Professional Skills Tests (PPST) or a waiver. A waiver is an alternative to taking and passing the PPST. A waiver may be granted by furnishing official proof of having met one of the following:
 - a total score of 1,000 on the SAT, with neither the mathematics nor the verbal subtest scores below 400 points from any test administration on or before March 31, 1995, or a combined score of 1,100 or more with no less than 450 on either the verbal or mathematics subtests from test administrations on or after April 1, 1995;
 - no less than 22 on the English subtest and no less than 19 on the mathematics subtest on the American College Testing (ACT) program assessment from test administrations on or after October 1989, or the equivalent ACT scores of no less than 20 on the English and 17 on the mathematics from test administrations before October 1989; or
 - a total score on the Prueba de Aptitud Academica (PAA) equivalent to a combined score of 1,000 on the SAT with neither the mathematics nor the verbal subtest score below the equivalent of 400 points. In addition, a minimum score of 510 on the English as a Second Language Achievement Test or the Test of English as a Foreign Language.

If you require further information, please contact:

Bureau of Certification and Professional Development
Connecticut State Department of Education
P. O. Box 150471
Hartford, Connecticut 06115-0471
Telephone: 860-713-6969
Fax: 860-713-7017

Licensing

School social workers are not required to obtain licensure through the DPH and, in the performance of the school-related duties, do not work under their license should they hold one. However, many school social workers may desire to obtain their clinical license as a means of identifying their clinical skill set and competency.

An applicant for licensure by examination shall meet the following requirements:

- hold a master's or doctorate degree from a social work program accredited by the Council on Social Work Education (CSWE);
- successfully completed 3,000 hours of post-master's social work experience including not less than 100 hours of work experience under professional supervision by a licensed clinical or certified independent social worker;
- successfully completed the Clinical Level Examination of the Association of Social Work Boards (ASWB).

If you have further questions, please see <http://www.aswb.org/pdfs/handbook.pdf> for a copy of the ASWB Examination Candidate Handbook. This handbook contains information on the examination, registration, admission to the examination and Americans with Disabilities Act accommodations.

For additional information, review related information the Connecticut DPH provides at <http://www.ct.gov/dph/cwp/view.asp?a=3121&q=389604>.

Supervision

Supervision remains an important requirement for the professional growth of school social work staff. “The administrative structure established by the LEA [local educational agency] shall provide for appropriate school social work supervision” (NASW Standards for School Social Work Services, 2002, p. 25). Because a school setting is educational and not clinical, except in residential educational/mental health facilities, the term, “supervision” incorporates activities at two levels: administrative and professional.

Administrative supervision refers to operational supervision, which includes the on-site, day-to-day, nonclinical supervision of staff as they perform their regular duties in adherence to local, state and federal regulations. Such supervision does not require clinical proficiency in the practice of social work and can be provided by an appropriately credentialed individual knowledgeable about school social work, such as a school principal or school district administrator.

Professional supervision of school social workers involves both clinical supervision, which is the oversight of the therapeutic interventions provided by the school social worker and discipline-specific supervision, which provides context of the delivery of social work services within the structure of the educational setting. Professional supervision requires a specialized knowledge base and experience in the practice of school social work. Credentialed, experienced social workers optimally should provide clinical supervision and consultation to all school social workers working within the district. A social worker with the LCSW license or the advanced certified social worker certification (ACSW) is an appropriate person to perform supervisory duties. NASW also has a specialty certification, the credentialed school social worker specialist certification, C-SSWS, which some districts may prefer as an appropriate requirement for a person to serve in a school social work supervisory position. While other social workers or members of other therapeutic professions (e.g., school psychologists) may provide clinical supervision, only an individual holding an advanced degree in social work can provide discipline-specific supervision.

Discipline-specific supervision is *essential* during a newly graduated school social worker’s first two years of practice. Ideally, such supervision is “face-to-face” and provided on a weekly basis. Such supervision promotes professional competence and ensures that high-quality social work services are provided to students, families, school staff and the community. In addition, discipline-specific supervision contributes to and guides the professional growth and development of the school social worker.

Absent discipline-specific supervision, districts may appoint a lead school social worker who could facilitate peer supervision or serve the role of a “mentor” for existing and new school social workers. The lead school social worker should have at least three years of experience in a school setting, an LCSW license or ACSW credential, and have completed coursework in social work supervision, such as the Field Work Supervision course. The Field Work Supervision course is accredited by the Council on Social Work Education and is required when a social worker is a field-work supervisor of a student enrolled in a master’s level social work program.

Supervision is the primary tool for staff development. However, staff meetings, conferences and workshops are additional resources that can be used to enhance staff awareness of relevant developments in the profession and to provide training in new methodologies and techniques. “The local education agency shall provide opportunities for school social workers to engage in professional development activities that support school social work practice. Funding support and an adequate number of professional leave days enable school social workers to strengthen and broaden skills required to better serve students, families, the local education agency, and the community” (NASW, 2002).

Coordinators and supervisors of school social work staff may have additional responsibilities beyond supervision and staff development. Such coordinator/supervisor should also assume the following roles and responsibilities:

- provide information regarding available community resources;
- be an interpreter and liaison to other administrators, helping them understand school social work programs and practices;
- be a support for school social work staff;
- be a teacher of methods to enhance the school social worker’s ability to function effectively as a member of an educational team;
- provide a link between school social workers, as well as a link between school social workers and other support and special education staff;
- develop procedures that standardize practice;
- interpret and advocate school social work practice within the school and within the community; and
- provide direction through determination of priorities and program evaluation. (CSDE, 1989).

For institutional supports related to the duties of school social work coordinators and supervisors, please refer to [Evaluating School Social Workers](#) on page 35 of this document.

Supports and Opportunities



IN THIS SECTION

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District Supports

ADMINISTRATIVE STRUCTURE AND SUPPORT

Previous sections of this document delineate the school social worker's responsibilities to the school systems in which they work. This section delineates the school district's responsibilities to the social workers they employ. NASW's "Standards for School Social Work Services" (NASW, 2002) identifies guidelines that local education agencies should follow in creating and maintaining their school social work programs. An overarching theme in both documents is that "school social work services are aligned with educational goals and integrated with other school support services" (NASW, Standard 31).

School social workers are integral members of the student support network within each school and within each district. Thus, it is imperative that their roles, expertise and professional responsibilities are fully incorporated into the comprehensive framework of the school system.

To meet the standards for administrative structure and support of its social work program, each LEA should ensure that:

1. Realistic job descriptions, working conditions and workload standards are available to assist the school social worker in understanding and explaining the nature of their work in their particular school and are commensurate with their advanced education, training, experience and duties.
2. Supervision is provided on a regular basis (weekly, if possible) by experienced masters of social work and includes administrative, clinical and profession-specific supervision. In addition, evaluation of school social workers should be systematic, appropriate to meet the individual needs of staff members and consistent with discipline-specific standards of practice. Only a supervisor with credentials and expertise in school social work should evaluate clinical practice. School social workers should have a job-specific evaluation form that reflects the scope of their practice.
3. The necessary material and organizational supports are available to help school social workers perform their duties. Such a work setting would include basic resources that ensure privacy and confidentiality for students and support the social worker's daily activities in the performance

of their jobs. Basic resources include an office; computer; ongoing professional development; and an appropriate space for meeting with students and their families. In addition, school social workers should be afforded the opportunity to attend both regularly scheduled building-level and department meetings.

4. Profession-specific professional development opportunities that support school social work practice are available. A range of relevant and timely professional development activities should include those that assist social workers in broadening their clinical and educational knowledge. Not only does professional development apply to social workers receiving training to strengthen their own skills, but also to their providing training to other school personnel in areas such as child development, children's mental health, crisis intervention, and behavior management.
5. The goals, objectives and tasks of a school social work program are clearly and directly related to the mission of the local education agency. Social workers, as members of a student support team, must assist districts in addressing nonacademic barriers to academic achievement and providing supports and interventions assisting students in developing the necessary skills for social and emotional competency.
6. That the level of need for social-emotional and developmental support within the student population is adequately addressed through appropriate staff to student ratios. Appropriate ratios for school social work staff to students should be based upon the unique characteristics and needs of the student population, as well as the available mental health services in the larger community.
7. The school social work program's annual budget is sufficient to support department and school district priorities. The annual budget process should provide opportunities for cross-disciplinary planning to promote cost-effective administration and delivery of services.

School districts should also ensure that their own policies and procedures do not jeopardize school social workers' standards of professional practice. School social work programs should have:

1. Vision and mission statements that maintain consistency with those of the NASW and relate to all students, not special education students alone and complement the vision and mission statements of the school district. These statements should be the guide from which departmental goals and measurable objectives are derived.
2. Policies and procedures that are consistent with the NASW Code of Ethics. These policies and procedures should reflect current professional standards of practice and legal mandates. School social workers should collaborate, as appropriate, to develop, review and revise department policies and procedures. Policies and procedures should allow school social workers to exercise appropriate professional judgment and autonomy in delivering services and ensure effective response to individual and schoolwide crisis situations.
3. Practices that are monitored to ensure that they are consistent with, and serve the intended purposes of, school district confidentiality policies and procedures. Practices for obtaining informed consent to share student and family information with outside parties are consistent with legal and professional standards. Student and family information used by school social workers is shared among school personnel only as needed for the benefit of the student. Resources to assist with confidentiality issues (e.g., supervisors, outside experts, written guidelines) are available to, and appropriately accessed by, school social work staff.
4. School social workers who provide services only within the limits of their individual preparation and expertise. In order to provide services in other areas, they acquire the requisite competencies through additional education (e.g., coursework, in-service training and supervised practice).
5. Similar provisions for contracted school social work services. A contractual agreement for such services requires compliance with district policies and procedures, and the district should monitor these services to ensure such compliance. Contracted school social work services encompass the same

continuum of services as those provided by regularly employed school social work staff and should not be used to decrease the amount and quality of school social work services provided by the district.

The school social work program should have written procedures for evaluating its effectiveness. The results of program evaluations should be documented and, when indicated, result in changes or modifications.

Data, Record Keeping and Personal Notes

School social workers should maintain data that assists the school administration in recognizing the need for and contributions of social work services. Such data may be used to determine resource deployment, staffing assignments and the development of policies and procedures that streamline services for students. Data may include:

- number of sessions held with students;
- number of individual students seen, including:
 - length of treatment, e.g., number of sessions and frequency; and
 - examples or evidence of problem resolution;
- types of issues identified for services;
- classroom observations;
- staff consultations;
- team participation (number, type and frequency);
- listing of administrative responsibilities;
- parent consultations;
- home visits;
- parent training sessions;
- any professional development provided within or outside the district that is related to district responsibilities; and
- any special education-related activities, including time for paperwork.

All student records associated with mental health services provided by school social work staff should be kept in a locked cabinet, away from routine student information, should be clearly marked “Confidential” and cannot be shared with district teaching, support or administrative staff without written consent. Best practice would be for the district to identify secured storage and that access is obtained to these records only by the person who generated them or, in the case of signed releases, to the individuals specifically so named.

Personal notes are not records but to meet the standard of being personal notes, the following requirements apply:

- are developed to prompt memory about previous discussion with the individual;
- do not include diagnostic or verbatim information;
- have not been previously released or transmitted to a receiving agency, as in the case of outside referral;
- are only for the personal use of the individual making the notes (and a designated temporary substitute, such as in the case of illness); and
- are in the sole possession of the individual who generated them and are not typically accessible

to others.

Personal notes generally are not subject to subpoena, however the material can be demanded under a bench order (court order) issued by a presiding judge. Most records can be obtained by subpoena and these include:

- any record made available to other staff;
- diagnostic data or information from which a diagnosis might reasonably be made; and
- content that has been used to substantiate referral to other services.

Requirements for Professional Development

Providing meaningful and effective services for students requires school social workers to maintain and update their knowledge of best practices and emerging trends in treatment and collaboration. It is necessary that school social workers obtain regular and formal training, in addition to ongoing consultation and supervision. This training must be discipline specific to ensure that the individual school social worker is able to provide optimal service within the job expectations that the school and community hold for such a position. School social workers should also receive ongoing training in collaborative models of service delivery. Certification regulations require the completion of 9.0 continuing education units (CEUs) (90 contact hours) every five-year period that a professional educator certificate holder is employed (full-time or part-time) in a Connecticut public school, serving under a professional educator certificate. If you are not serving under a professional educator certificate in a Connecticut public school, then you are not required to complete CEUs to apply for continuation of a professional educator certificate.

It is additionally important that the school social worker be appropriately informed in current educational practices such as data-driven decision making, common formative assessments, improving school climate and school improvement planning. The aforementioned examples are part of the Connecticut Accountability for Learning Initiative and contribute to school districts' improvement plans. Because of their integration with other school staff in addressing the barriers that students must overcome to succeed in school, school social workers must participate in any macro effort within the school and district to address student learning needs.

School social workers should strive to maintain within their district, centralized information related to the physical, communication, psychological and social-emotional development of children and youth. This resource should be used to help all social workers within the district 1) to inform best practice; 2) to provide the means and motivation for sharing success stories related to best practices and to assist in providing background information to non-social-work staff; and 3) to help them understand how school social work services can contribute to the other supports provided to students who are struggling academically, socially, behaviorally or emotionally.

The contributions of SRBI and evidence-based practices to professional efficacy require that social workers continue to develop their knowledge and understanding of the variety of tools available for intervention. The expansion of Internet resources has provided a vast number of opportunities to receive training in various modalities from the comfort of office or home. School social workers should consider using these available resources only when research of the material is adequate and legitimate. An example of straightforward and legitimate introductory material that can be reviewed on line is the trauma-focused cognitive-behavior therapy training found at <http://tfcbt.musc.edu/index.php>.

Evaluating School Social Workers

School social workers are committed to the delivery of quality professional services to students and school systems in which they work. School social workers function in different capacities based on the needs of the district and client populations they serve. School social workers are assigned a variety of administrative, prevention and intervention tasks. The principal or the principal's designee evaluates school social workers, like most other employees within the school. However, these individuals typically do not have clinical and social services training that can inform their assessment of the school social workers' skills. School social workers should seek professional supervision and consultation that enables them to expand existing skills and develop new areas of knowledge.

For administrative oversight, a fully comprehensive evaluation should be adapted to the specific responsibilities that the school social worker has assigned to them. Several areas of performance should be considered during an annual evaluation. Administrative supervisors should consider the school social workers' professional and ethical responsibilities; knowledge of the theory and practice of school social work, human growth and development, and related policies and practices; ability to accurately and effectively assess student needs and progress and help students develop positive self-concept and independence; effective implementation of programs and interventions; ability to meet the needs of students with disabilities; effective communication with students, families and other school personnel; development of appropriate plans with meaningful goals and objectives, clear timelines and meaningful methodology; organization of time, space, materials and equipment and effective use of available resources; adherence to policies, procedures and practices, as defined within the LEA; and promotion of a positive learning environment to meet student needs, including responsibility and respect within the school environment and advocacy for students and families.

The following expanded competencies and indicators of school social work practice should be considered when evaluating staff members. A straightforward rubric identifying that the staff member "has not met," "has met," "exceeds expectations," or has had "no opportunity to practice," will facilitate constructive feedback while assisting the staff member to develop future professional development goals.

1. **The school social worker meets or exceeds professional and ethical responsibilities.**
 - a. Demonstrates responsibility for self-growth, professional improvement and ongoing self-evaluation.
 - b. Works cooperatively with colleagues and administrators.
 - c. Follows the policies and procedures of the school district or works to change those policies and procedures when necessary for the benefit of students and families.
 - d. Adheres to and demonstrates a commitment to, the values and ethics of the social work profession.
 - e. Protects the confidentiality of student and family information to the greatest extent possible while complying with local, state and federal mandates.
 - f. Obtains informed consent to disclose confidential information or to provide services in accordance with professional and ethical standards and legal mandates.
2. **The school social worker demonstrates knowledge of various school systems and learning modalities of various cultures, including the Connecticut system of public school education.**
 - a. Demonstrates knowledge and understanding of the governance of school systems at the local, state and federal levels.
 - b. Demonstrates understanding of special services available to students and families.
 - c. Demonstrates understanding of mental health diagnoses and the IDEA and its categories of

- disability to optimize planning and programming for student success in the school setting.
- d. Demonstrates how organization of the district and its initiatives affects the school community.
3. **The school social worker effectively assesses student needs and progress.**
- Systematically conducts record reviews, observations of the student in multiple settings, clinical interviews with students and appropriate family members and consultations with school staff and staff from community agencies, when appropriate, to gather data.
 - Demonstrates the ability to administer, score and interpret formal and informal inventories and evaluations.
 - Assesses and identifies the social-emotional needs of students and makes recommendations to enhance the overall learning environment of the school.
 - Develops measurable treatment goals to address students' educational needs.
 - Evaluates progress toward the achievement of treatment goals and the need for additional or alternative strategies.
4. **The school social worker as counselor.**
- Helps students develop positive self-concept.
 - Recognizes and understands the strengths of each student and the opportunities presented in the diversity of the school environment.
 - Maintains to the greatest extent possible the confidentiality of student information within the counseling relationship.
 - Demonstrates sensitivity to, and respect for, the needs and feelings of all students and families.
 - Demonstrates patience, empathy and enthusiasm with students.
 - Helps students develop problem-solving, decision-making and social interaction skills.
 - Assists staff to implement strategies to foster pro-social skills.
 - Facilitates the development of student independence.
 - Recognizes and encourages students to identify their strengths and interests.
 - Provides opportunities for students to use their personal strengths to advocate for themselves.
 - Engages students in selecting their own learning and counseling objectives and activities.
 - Provides opportunities that assist students in developing thinking, problem solving and self-evaluation skills.
 - Promotes students' ability to communicate effectively with others about ideas, concerns and emotions.
 - Assists students in evaluating their own progress toward achieving treatment and educational goals.
5. **The school social worker as consultant.**
- Provides information and consultation to school personnel, school board members and community representatives to promote understanding and effective use of school social work services.
 - Makes use of a range of treatment interventions, such as consultation, casework, group work, family counseling, crisis intervention and school/community organization skills.
 - Assists parents, staff, administration and the school community to better understand the factors affecting children's educational experiences.
 - Assists students, families, school staff, administration and community representatives to understand and participate in the process of problem resolution.
 - Demonstrates an ability to engage parent and community representatives in school planning to facilitate children's learning and improve the school environment.
 - Effectively meets the needs of students with disabilities.
 - Obtains and uses information concerning student and family history from available

- records.
 - ii. Demonstrates understanding of the behaviors resulting from mental, physical, emotional, sensory, speech or other disabilities.
 - iii. Assists staff, administration, parents and community representatives to better understand special needs and how they affect student learning.
 - iv. Discusses the provision of school social work services as a related service addressing students with disability.
 - v. Provides consultation to school staff, parents, administration and community representatives to help meet a student's special needs.
6. **The school social worker as community liaison.**
- a. Effectively communicates with students, family members, school personnel and members of the community.
 - i. Understands and articulates the purposes and values of social work interventions to school and community.
 - ii. Clearly communicates key information (e.g., social work assessment, treatment goals and objectives, intervention strategies) to family members and community providers.
 - iii. Facilitates communication between home and school.
 - iv. Initiates and maintains a liaison role, as appropriate, with community service providers and school personnel.
 - v. Develops and communicates clearly the IEP component when social work is to be provided as a related service.
 - b. Facilitates the cooperative involvement of parents and the community in the educational process.
 - i. Assists staff to achieve communication with parents based upon mutual respect.
 - ii. Assists staff in conducting effective parent-teacher conferences.
 - iii. Informs parents of community resources and services and assists them in developing independent access to resources and services.
 - iv. Assists parents to communicate their needs and concerns effectively to school and community agency staff.
 - v. Assists in identifying unmet needs in the community that adversely affect student learning and advocates for necessary services.
 - vi. Provides outreach to parents who experience barriers to their involvement in school experiences.
7. **The school social worker as manager.**
- a. Plans programs and interventions to achieve established goals and objectives.
 - i. Organizes case data to develop psychosocial treatment plans for enhancing student learning.
 - ii. Develops action plans that include initial assessment, treatment goals, interventions and, when appropriate, exit criteria when providing services to students referred for social work supports.
 - iii. Evaluates programs and services for effectiveness and develops alternative strategies when existing supports do not meet student needs.
 - b. Effectively organizes time, space, materials and equipment.
 - i. Establishes and maintains service schedules, routines and procedures.
 - ii. Uses treatment time effectively, paces interventions appropriately and maximizes students' time on task.
 - iii. Provides a treatment environment that is inviting and adequate for planned use.
 - iv. Meets deadlines for documentation and related reports.
 - c. Understands the organization, its policies and the impact on student needs.

- i. Incorporates knowledge of the organization, its structure and local policies when planning programs and services for students and their families.
8. **The school social worker as advocate.**
 - a. Promotes a positive learning environment.
 - i. Promotes appropriate and universal standards for behavior for all persons in the learning environment and enhances positive interpersonal relations based upon mutual respect.
 - ii. Promotes an atmosphere fostering self-discipline based on self- concept and self-worth and accountability to others.
 - iii. Supports fair, respectful and consistent practices that promote understanding of personal responsibility and personal choice.
 - b. Promotes understanding of school system policies and procedures, and of the legal rights and responsibilities of students, staff, families and the community.
 - i. Promotes students' understanding of school policies and procedures and student, staff and family roles and responsibilities in the school environment.
 - ii. Promotes parents' understanding of rights and responsibilities under the law and in their child's school setting.
 - iii. Helps students and parents understand the roles and responsibilities of various staff members within the school setting to facilitate cooperative efforts to meet student needs.
 - c. Advocates for students and families regarding equitable access to services.
 - i. Advocates for students' and parents' rights and responsibilities regarding the best interests of the student.
 - ii. Ensures that students and families are provided services within the context of multicultural understanding and competence to optimize family and student learning.
 - iii. Assists the students and family to appropriately advocate for the student's educational needs.
 - iv. Works for increased understanding of problems facing students and families and strives to obtain, leverage or create needed services.
 - v. Advocates, when appropriate, for exceptions to rules, policies and practices on behalf of students and families.
 - vi. Works to change regulations, rules, policies and practices that are barriers to the provision of best services to students.

Appendices

Appendix A:

CONNECTICUT STATE BOARD OF EDUCATION

HARTFORD

POSITION STATEMENT ON STUDENT SUPPORT SERVICES

APRIL 7, 2010

The Connecticut State Board of Education (CSBE), believes that implementation of a comprehensive program of school-based support services will help students to become self-sufficient, healthy and productive adults. Many students face challenges that place them at risk for educational failure, including poverty, family dysfunction, emotional trauma, linguistic differences and community violence. By adopting a preventive, whole-child perspective and providing a wide range of interventions, schools will be better equipped to reduce barriers to learning and enhance healthy development. Studies have shown that schools with a continuum of developmental, preventive, remedial and support services enhance the capacity of all students to achieve academic success and personal well-being.

Need for Student Support Services

Disciplines providing support services include school counseling, school nursing, school psychology, school social work, speech-language pathology and audiology. These services assist the student population, parents and the entire school community in establishing a full range of prevention and intervention systems that promote healthy development, provide early intervention to address problems as soon after onset as possible and assist with chronic and severe problems. To address students' emotional, behavioral, and mental and physical health needs, the Board recommends that every school district develop, adopt and implement a collaborative approach to service delivery that involves effective use of student support services personnel, parental involvement and community-based resources.

Benefit to Students

Student support services specialists: (1) help educators, administrators, other staff members and parents understand and respond effectively to the health and social factors that affect students' learning; (2) identify risk factors, such as physical deficiencies, speech pathologies or emotional challenges that impede learning; and (3) provide prevention and intervention strategies. Often, these interventions are described in students' individualized plans, such as their individualized health care plans, individualized education programs (IEPs) and student success plans. Districts must employ appropriately qualified student support services specialists to provide the requisite evaluations and interventions for students with special needs.

The Board believes that the use of scientific, research-based interventions benefits the entire student body by providing clear standards and replicable results. Therefore, it is critical that student support services staff members utilize approaches wherein data collection and analysis are important components in determining efficacy of support services. Offering a streamlined system for delivery of services requires student support services personnel to work within school teams (e.g., data, child

study, student support) to examine health and behavioral health trends and respond by developing priorities and strategies to address the needs of students and families.

Benefit to Families and the Community

The Board recognizes that the home and community are critical environments that influence students' well-being and educational progress. The involvement of family members should be a primary component in the delivery of services. In partnership with teachers, administrators and other school staff, student support services specialists build connections between home and school, especially when parents need help in understanding their children's educational needs and their own role in encouraging learning. These professionals maintain open lines of communication while they interpret school requirements and assist families in expressing their concerns. Student support services specialists understand the community and its impact on the lives of students and families and can link the home and school to community resources, expedite appropriate referrals and facilitate communication among home, school and community services.

Guidance for school-based student support services that fosters prevention and intervention systems is outlined in the corresponding document.

POLICY GUIDANCE FOR POSITION STATEMENT ON STUDENT SUPPORT SERVICES

APRIL 7, 2010

The Connecticut State Board of Education, in its 2010 *Position Statement on Student Support Services*, calls for every school district to develop a full range of school-based support services that foster prevention and intervention systems addressing health and social factors for student success. The Board offers the following guidance to support the implementation of Student Support Services.

State Department of Education Responsibilities

Provide leadership informed by science-based guidelines.

- Use data collection to increase the fidelity of interventions used by student support services staff to address existing and emerging needs among children and youth.
- Advocate on state and federal levels for expanded student support services addressing the physical, developmental, psychological and social-emotional needs of students.
- Promote best practices by issuing state summaries of district efforts resulting in significant or promising results.

Provide training, technical assistance and resources.

- Encourage professional development of student support services staff through discipline-specific training and technical assistance.
- Provide technical support and training to school district staff on data-driven decision making, recordkeeping and referral processes.
- Maintain and publish information related to the physical, communication, psychological and social-emotional development of children and youth.

Develop and maintain partnerships.

- Develop and strengthen relationships between student support services staff and community organizations to address preventive, whole-child directed activities.

School Districts' Responsibilities

Student support personnel frequently provide services in more than one school within a district. Consistent application of district-level policies across all schools will ensure uniform and equitable delivery of student support services.

Develop and implement policies and practices that consistently promote delivery of meaningful and responsive student support services.

- Implement prevention-oriented programs and services promoting a positive school climate in which individuals feel connected, safe and supported.
- Develop strategies effective in reducing the prevalence of risk behaviors such as alcohol, tobacco and other drug use, sexual activity, violence, truancy and school avoidance.
- Implement a comprehensive prekindergarten through Grade 12 life skills curriculum that delineates goals and competencies in the areas of personal, social, career and academic development, and prepares students for success in school, at work, in the community and in personal relationships.
- Support the implementation of integrated support services in all schools including student success plans addressing the academic, career, social-emotional, physical and communicative wellness and capacity of students.

- Implement special education related services consistent with each student's individualized education program.
- Utilize a continuum of interventions and strategies addressing the management of behavioral problems using the CSDE *Guidelines for In-school and Out-of-school Suspensions*.
- Expand coordination and collaboration among staff providing regular education and special education services through scientific, research-based interventions and tiered supports addressing primary, secondary and tertiary efforts.

Provide ongoing professional development for staff.

- Provide for discipline-specific staff development that ensures ongoing skill development for student support services staff.
- Provide continuing education for all school professionals on collaborative models of service delivery to prepare them to recognize and appropriately support students at risk for educational or social failure.
- Provide and encourage use of culturally competent curricula and practices.
- Use student support services staff to provide staff training around issues of student development, typical developmental milestones, identifying at-risk characteristics and appropriate referral for student needs.

Regularly communicate with students, families, staff and community partners.

- Engage parents, youth and community members in identifying community-specific risk behaviors and supporting effective strategies to target such concerns.
- Develop whole-school and classroom-based positive behavioral supports that encourage appropriate role modeling among adults; responsibility, initiative and integrity among students; and an atmosphere of mutual respect and consideration for one another.
- Arrange home visits or alternate means of communicating with those families unable to meet at school.
- Use culturally responsive language that respects families, cultures, backgrounds and strengths.

Develop and maintain partnerships.

- Establish school-based and district wide teams to assess the health and mental health needs of the school community and coordinate the delivery of an array of services that includes prevention, early intervention and crisis response. These teams should include student support specialists, school administrators and representatives of community agencies, e.g., police, Department of Children and Families, and health and mental health care providers. The CSDE *Guidelines for a Coordinated Approach to School Health*, 2007, provides recommendations to address the physical, social and emotional health needs of the school community.
- Use Memoranda of Understanding to establish agreements with community agencies that identify and streamline mechanisms for student referrals to external support services.

Regularly evaluate progress and revise policies and programs as needed.

- Adopt discipline-specific criteria for evaluating support services specialists, using the competencies and indicators developed by the CSDE.
- Evaluate current service models and specific interventions to standardize successful service delivery throughout the district.

Student Support Services Staff Responsibilities

Regularly evaluate progress and revise practices and interventions as needed.

- Develop recordkeeping that supports consistent service delivery and is compliant with federal, state, and district policies on records management.
- Maintain appropriate outcome-based data to support the effectiveness of interventions used with students.
- Use tiered approaches that increase the focus and intensity of interventions when a student fails to respond as needed.
- Engage in evidence-based prevention and intervention activities that can be generalized, as appropriate, to the whole student population.
- Analyze existing research to identify best practices in the provision of student support services and design evaluation studies to assess effectiveness of district programs and services.

Communicate positive and accurate messages to students and families that reinforce positive family engagement.

- Engage parents as partners in meeting the needs of individual students and the student body as a whole, e.g., demonstrate commitment to families and expect and support all staff in creating a respectful, inclusive and family-friendly environment.
- Avoid educational jargon when communicating with parents and provide opportunities for two-way communication focused on student learning and success.
- Engage students as partners in advocating for their own individual needs, including participation in the development of their academic, social-emotional, physical, communication and career goals.

Collaborate with professional colleagues in developing and implementing services.

- Participate in regular education intervention teams (e.g., early intervention team, student assistance team, school-based data team and school health team) providing professional consultation and support to both school staff and parents.
- Engage in ongoing supervision as one component of professional development.
- Provide classroom observation and consultation to school staff to facilitate delivery of appropriate supports in the students' school environment.

Provide appropriate role modeling for students.

- Model prosocial behaviors and provide daily reinforcement of classroom lessons and school climate priorities, e.g., encourage caring behavior toward others, allow for and encourage shared responsibility for tasks, and exhibit problem solving and conflict resolution skills.

Students' Responsibilities (as developmentally appropriate)

Take responsibility for personal growth and healthy decisions.

- Share goals, interests, concerns and fears with a trusted adult, e.g., student support services specialist, parent and teacher.
- Develop academic and adaptive skills to promote positive career and social-emotional development.
- Recognize and exercise student rights and responsibilities by engaging in activities that develop critical thinking, problem solving and conflict resolution skills.
- Participate in activities that promote positive youth development and school wide positive behavioral supports, e.g., engage in learning as a participant rather than a recipient, provide feedback to others in constructive ways, explore and reflect on personal values, interests and strengths, and develop and practice skills for success in academic and social achievements.
- Participate as a partner in personal academic, social-emotional, physical, communication and career goals.
- Ask questions, become familiar with the goals and objectives of the educational plan and read

the student handbook on an annual basis.

Be respectful of the strengths and differences of others.

- Respect and appreciate diversity in others and model prosocial behaviors.
- Be aware of relevant policies addressing student responsibilities and behaviors.
- Become familiar with the school's culture and environment by participating in school functions and extracurricular activities of interest.

Use student support services appropriately.

- Learn how to access needed services and who the student support services staff members are in the school, e.g., school nurse, school psychologist, school social worker, school counselor and speech language pathologist.
- Practice lessons provided by teachers, student support services specialists and parents.

Families' Responsibilities

Create a home environment that supports all aspects of a student's education.

- Provide a positive home environment that facilitates optimal growth and development by modeling prosocial behaviors and providing support for learning at home and in the community.
- Talk to children about school and help them think about and plan for their future.

Build a relationship with teachers to support children's health and well-being.

- Share values and expectations for student achievement and school success through regular contact with the child's teachers and student support services personnel.
- Monitor children's academic and social-emotional progress through participation in multidisciplinary teams when appropriate, e.g., child study team, planning and placement team and student assistance team.
- Assist in developing children's educational plan, e.g., student success plan, individualized education program and transition plan, as appropriate.
- Become familiar with the school by participating as a partner in school committees, in the development of school wide positive behavior supports and school improvement planning.

Participate in school efforts supporting a safe, healthy and developmentally appropriate environment at school.

- Participate in school-sponsored learning opportunities and review school communications such as the school Web site and newsletters.
- Be aware of relevant policies addressing student responsibilities and behaviors.
- Participate in school functions and extracurricular activities.

Communities' Responsibilities

Work with school districts to support and promote students' social and emotional development.

- Use Memoranda of Understanding to establish agreements with local schools that identify and streamline the mechanisms for student referral to social service agencies.
- Develop and strengthen relationships between student support services staff and their counterparts in the community to address preventive, whole-child directed activities.
- Assemble, archive and broadly disseminate information related to the physical, psychological and social-emotional development of children and youth.
- Provide staff to attend and participate in interagency meetings to address local youth risk factors,

- strengths and needs, and develop systematic responses regarding these issues.
- Ensure that community agencies use evidence-based interventions to address current and emerging needs in the community.
- Invite appropriate school personnel to participate in staff development opportunities in the community.

References

Connecticut State Department of Education (1999). *Developing Quality Programs for Pupil Services: A Self-Evaluative Guide*. <http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/special/QPPupilSrves.pdf>

Connecticut State Department of Education (2008). *Using Scientific Research-Based Interventions: Improving Education for all Students*. http://www.sde.ct.gov/sde/lib/sde/pdf/pressroom/SRBI_full.pdf

Connecticut State Department of Education (2008). *Comprehensive School Counseling: A Guide to Comprehensive School Counseling Program Development*. <http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/counseling.pdf>

Connecticut State Department of Education (2008). *Guidelines for In-School and Out-of-School Suspensions*. http://www.sde.ct.gov/sde/lib/sde/pdf/pressroom/In_School_Suspension_Guidance.pdf

Connecticut State Department of Education (2007). *Guidelines for a Coordinated Approach to School Health*. http://www.sde.ct.gov/sde/LIB/sde/PDF/deps/student/Guidelines_CSH.pdf

Connecticut State Department of Education. *Connecticut School Health Survey*. <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388104>

Connecticut State Department of Education (2004). *Guidelines for Suicide Prevention: Policy and Procedures*. http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Student/PsychSocial/SP_Guidelines.pdf

Hamilton Fish Institute on School and Community Violence and Northwest Regional Educational Laboratory (2008). *The Role of Mental Health Services in Promoting Safe and Secure Schools*. <http://www.hamfish.org/>

Marx, E., Wooley, S., and Northrop, D. (Eds.). (1998). *Health is Academic: A Guide to Coordinated School Health Programs*. New York, NY: Teachers Press.

U.S. Department of Education, OSEP Center on Positive Behavioral Interventions and Supports (2004). *School-wide Positive Behavior Support: Implementers' Blueprint and Self-Assessment*. <http://www.osepideasthatwork.org/toolkit/pdf/SchoolwideBehaviorSupport.pdf>

Appendix B:

CONNECTICUT STATE BOARD OF EDUCATION

HARTFORD

POSITION STATEMENT ON A COORDINATED APPROACH TO SCHOOL HEALTH

SEPTEMBER 2, 2009

The Connecticut State Board of Education believes that a coordinated approach to school health effectively aligns health and education efforts and leads to improved physical, mental and developmental outcomes for students. Research studies over the past decade have consistently concluded that student health status and student achievement are directly connected and, in fact, that student health is one of the most significant influences on learning and achievement. Additionally, studies have shown that a coordinated approach to school health can reduce absenteeism and classroom behavior problems, improve classroom performance, better prepare students to be productive members of their communities, establish life-long healthy practices, make schools more engaging, as well as address staff wellness needs.

Prominent health concerns such as asthma, injuries, obesity, teen pregnancy and depression are contributing factors to loss of instructional time including absenteeism, dropping out of school and chronic illness. In turn, these lead to significant social and economic issues. The Connecticut School Health Survey data indicate that over the past decade many high school students continue to engage in higher risk behaviors, including sexual intercourse, drug and alcohol use and attempted suicide. Students engaging in higher risk behaviors and those with chronic physical and mental health needs are, in many cases, the same students who face the greatest health and educational disparities.

To address the physical and mental health needs of students, the Board recommends that every school district develop, adopt and implement a comprehensive plan for a well-coordinated approach to school health. A coordinated approach to school health provides the framework for families, community-based partners and schools to work together to improve student achievement. It incorporates eight components: physical education; nutrition; school-family-community partnerships; health services; mental health services; healthy physical and emotional school environment; staff wellness; and comprehensive health education. In developing district plans, data-driven decision making is an essential element to help prioritize efforts that promote health-enhancing behaviors and positive outcomes for youth. A coordinated approach to school health reduces fragmentation, duplication of services and provides a streamlined system for service delivery that is cost effective.

Students must acquire the essential knowledge, skills and attitudes that will guide them to make healthy and responsible choices. Families and schools must work together in providing students with this basic foundation. Therefore, it is imperative that comprehensive health and physical education, including developmentally appropriate comprehensive sexuality education, supported by a school-family-community partnership be offered in prekindergarten through Grade 12. A coordinated approach to school health can be built upon these core principles which are embedded in the CSDE *Healthy and Balanced Living Curriculum Framework for Comprehensive School Health Education and Comprehensive Physical Education* (2006). Additionally, the CSDE *Guidelines for a Coordinated Approach to School Health* (2007) will assist each local school district in building capacity

to implement policies, practices and programs that reduce health and educational disparities for all students. These guidelines are outlined in the corresponding document.

POLICY GUIDANCE FOR THE POSITION STATEMENT ON A COORDINATED APPROACH TO SCHOOL HEALTH

The Connecticut State Board of Education, in its 2009 Position Statement on a Coordinated Approach to School Health, calls for a systematic and comprehensive delivery of services, programs and practices to meet the physical and mental health needs of students. This approach will help reduce the health and educational disparities facing Connecticut students and ensure that all students have the opportunity to achieve academically and become healthy productive citizens.

The Board offers the following guidelines to support the implementation of a coordinated approach to school health among various stakeholders.

State Department of Education Responsibilities

- Strengthen and expand partnerships with state and local agencies, higher education, local businesses, health centers, families and schools to address health and educational disparities for all students.
- Develop new and use existing program guidelines, sample policies, resource lists, state and local student physical and mental health data and other information useful for program planning and improvement.
- Provide leadership in identifying and disseminating research and best practice related to coordinated school health to ensure that the physical and mental health needs of all students are addressed, including, but not limited to: those who are at greater risk for chronic disease; Human Immunodeficiency Virus (HIV); other sexually transmitted diseases (STDs); and teen pregnancy. These students include, but are not limited to: youth of color; lesbian, gay, bisexual, transgender and questioning youth; youth identified with special needs; incarcerated youth; youth in alternative education programs; and youth who have been sexually abused.
- Augment the alignment of comprehensive school health education and physical education standards, assessments and instruction to the *Healthy and Balanced Living Curriculum Framework*.
- Provide job-embedded professional development opportunities for school and community partners regarding coordinated school health and the health needs of students.
- Provide direct technical assistance to districts, schools and community partners to enhance their ability to implement a coordinated approach to school health.
- Build support among various stakeholders to leverage funding to sustain coordinated school health efforts at the state and local levels.
- Recognize and promote districts and schools that are successfully implementing model coordinated school health approaches.
- Evaluate annual progress made to improve the health and well-being of children at the school, district and state levels.

School District Responsibilities

- Ensure full compliance with all state and federal legislation that supports healthy and safe schools.
- Implement the policies, practices and strategies outlined in the CSDE *Guidelines for a Coordinated Approach to School Health* (e.g. recommended number of instructional hours in comprehensive health education and physical education).
- Strengthen and expand partnerships with local agencies, businesses, health centers, families, and schools to address health and educational disparities for all students.

- Provide effective leadership for districts and schools to create a climate that supports student achievement and well-being through the implementation of district wide integrated services and individual student success plans that address physical health, mental health and wellness.
- Assess and utilize current health policies, practices and multiple data sources to ensure that the physical and mental health needs of all students are addressed, including, but not limited to: those who are at greater risk for chronic disease; HIV; STDs; and teen pregnancy. These students include, but are not limited to: youth of color; lesbian, gay, bisexual, transgender and questioning youth; youth identified with special needs; incarcerated youth; youth in alternative education programs; and youth who have been sexually abused.
- Develop, adopt and implement a data-driven comprehensive plan for a coordinated school health approach that includes all eight components: physical education; nutrition; school-family-community partnerships; health services; mental health services; healthy physical and emotional school environment; staff wellness; and comprehensive health education.
- Utilize guidelines, frameworks and other publications developed by the CSDE to build and strengthen the coordinated school health approach.
- Establish or build upon an existing district-level school health or wellness council that includes a diverse representation of school staff, families, students and members of the community to oversee and evaluate the coordinated school health approach and make recommendations to the local board of education.
- Designate a district-level director to assist with implementing and evaluating the district's coordinated school health approach.
- Ensure compliance with all state mandates related to school physical and mental health issues (e.g., requirements for proper immunization and physical assessments for all students).
- Ensure that comprehensive school health education and physical education are taught by certified, highly qualified health and physical education teachers.
- Plan, adopt, implement and evaluate a prekindergarten through Grade 12 comprehensive school health education program including a science-based sexuality education component that focuses on abstinence as well as ways to protect oneself from diseases and teen pregnancy.
- Ensure that each program is age, gender, developmentally and culturally appropriate.
- Support on-going job-embedded professional development for school staff regarding coordinated school health and the physical and mental health needs of students.
- Conduct regular evaluation and reporting on the implementation of school health programs including the impact on student health and well-being.
- Make available nutritious meals and snacks and allow opportunities for daily physical activity breaks for students and staff.

School Responsibilities

- Provide effective leadership to create a climate that supports student achievement and well-being.
- Support the implementation of integrated systems and student success plans that address the physical health, mental health and wellness of students.
- Organize building-level school health and wellness teams to provide the structure for coordinating activities. Teams should include a diverse representation of school staff, families, students and members of the community to oversee and evaluate the coordinated school health approach.
- Assign a staff member to serve as the director for the coordinated school health approach to assist with implementing and evaluating the school's coordinated school health efforts.
- Conduct an assessment to determine what services are in place and what gaps exist to address the physical and mental health needs of students.
- Create a coordinated school health action plan that sets priorities, develops implementation strategies and evaluates progress.

- Develop a communication plan that involves school, family, business and community-based partners.
- Ensure that health- and wellness-related messages and actions are integrated into instruction and activities throughout the building.
- Utilize a positive youth development approach that builds resiliency to address student physical and mental health needs.
- Deliver comprehensive school health education and physical education instruction taught by certified, highly qualified health and physical education teachers.
- Implement and evaluate a prekindergarten through Grade 12 comprehensive school health education program which incorporates a science-based sexuality education component that focuses on abstinence as well as ways to protect oneself from diseases and teen pregnancy.

Teachers'/Staff Responsibilities

- Participate in all professional development activities offered to promote health and wellness.
- Communicate with families about health and wellness activities they can do at home with their children.
- Collaborate with peers to improve health outcomes for students.
- Increase awareness of and participate in the implementation of the coordinated school health action plan.
- Utilize timely science-based resources to inform instruction, programs and services.
- Integrate health- and wellness-related messages and actions into instruction and activities throughout the building.
- Deliver high-quality comprehensive school health education and physical education instruction.
- Analyze student work to inform curriculum, instruction and assessment.
- Participate in health enhancing activities with students (e.g., daily physical activity and creating a safe and welcoming classroom environment).

Families' Responsibilities

- Support school policies designed to improve the health and well-being of children including participation on health and wellness committees in schools.
- Take children to community or school-based healthcare providers for yearly health physicals and immunizations.
- Use school and community-based health resources, such as the 211 Infoline, family resource centers, school-based health centers and local health departments for information and services regarding health.
- Promote positive healthy relationships with respect and appreciation for one another.
- Discuss health and wellness issues at home with children and incorporate health and wellness activities into the daily life of children.
- Work with teachers to support children's learning of health-related issues.
- Participate in learning activities at home and in the community including interactive homework and other health-linked enrichment activities.
- Engage in dialogues with children around health-related issues including sexuality education.
- Participate in educational open house opportunities and become familiar with the comprehensive school health education and physical education curriculum.
- Ensure that children are prepared for school by getting adequate sleep, healthy meals and daily physical activity.

Students' Responsibilities (as developmentally appropriate)

- Examine personal health status and assume responsibility for personal health behaviors (e.g.,

- abstaining from sexual activity; refraining from alcohol and tobacco use; protecting oneself from pregnancy, HIV and STDs).
- Make good decisions to enhance health and encourage and support others in making positive health choices.
 - Communicate with family members regarding healthier lifestyles.
 - Promote positive healthy relationships with respect and appreciation for one another.
 - Express opinions about health issues based on accurate health information.
 - Analyze how families, school communities, media and peers influence health-related decisions.
 - Use effective verbal and nonverbal communication skills as a means of enhancing health and promoting healthy relationships, such as refusal and conflict resolution skills.
 - Locate and use resources and services from home, school and local communities that provide valid health information, products and services.
 - Plan and engage in school-sponsored wellness activities, including participation on health and wellness committees in school.
 - Actively participate in comprehensive school health education and physical education.
 - Advocate for the inclusion of personal health goals into Individual Student Success Plans.
 - Attend annual check-ups and other important appointments with health care providers.
 - Advocate for healthier, more nutritious meal and snack options both at home and at school.
 - Accurately complete school health surveys.

References

Centers for Disease Control and Prevention Division of Adolescent and School Health. (n.d.). *Student Health and Academic Achievement*. http://www.cdc.gov/HealthyYouth/health_and_academics/index.htm. Retrieved on February 19, 2009.

Connecticut School Health Survey (2007). <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388104>. Retrieved March 13, 2009.

Connecticut State Department of Education (2006). *Healthy and Balanced Living Curriculum Frameworks*. <http://www.sde.ct.gov/sde/LIB/sde/PDF/deps/student/Healthy&BalancedLiving.pdf>. Retrieved March 13, 2009.

Connecticut State Department of Education (2007). *Guidelines for a Coordinated Approach to School Health: Addressing the Physical, Social, Emotional and Mental Health Needs of Students*. http://www.sde.ct.gov/sde/LIB/sde/PDF/deps/student/Guidelines_CSH.pdf. Retrieved March 13, 2009.

Connecticut State Department of Education (2006). *Action Guide for School Nutrition and Physical Activity Policies*. <http://www.sde.ct.gov/sde/cwp/view.asp?a=2626&q=320754&sdePNavCtr=|45534|#Action>. Retrieved March 13, 2009.

Connecticut State Department of Education (2005). *Position Statement on Nutrition and Physical Activity*. http://www.sde.ct.gov/sde/LIB/sde/pdf/board/nutrition_phys_activity.pdf. Retrieved March 13, 2009.

Society of State Directors of Health, Physical Education and Recreation & Association of State and Territorial Health Officials. (2002) *Making the Connection: Health and Student Achievement*. <http://thesociety.org/pdf/makingtheconnection.ppt>. Retrieved February 19, 2009.

Appendix C:

CONNECTICUT STATE DEPARTMENT OF EDUCATION

BUREAU OF EDUCATOR STANDARDS AND CERTIFICATION

SPECIAL SERVICES ENDORSEMENT – SCHOOL SOCIAL WORK

ALL APPLICANTS WHO DO NOT HOLD A VALID CONNECTICUT EDUCATOR CERTIFICATE MUST MEET THE FOLLOWING REQUIREMENTS:

PRAXIS I PRE-PROFESSIONAL SKILLS TESTS (PPST): PAPER-BASED
OR
PRAXIS I PRE-PROFESSIONAL SKILLS TESTS (PPST): COMPUTERIZED
OR
WAIVER

AND

HOLD A MASTER'S DEGREE IN SOCIAL WORK FROM A SCHOOL OF SOCIAL WORK ACCREDITED BY THE COUNCIL ON SOCIAL WORK EDUCATION.

AND

A course of study in special education comprised of not fewer than 36 clock hours, which shall include study in understanding the growth and development of exceptional children, including handicapped and gifted and talented children and children who may require special education, and methods for identifying, planning for and working effectively with special-needs children in the regular classroom. For a list of pre-approved courses, see: <http://www.sde.ct.gov/sde/cwp/view.asp?a=2613&xq=321380>

Proposed Certification Regulations for 2014

School Social Worker

Sec. 10-145d-932. When required

This endorsement is required for anyone serving in the employ of a board of education as a school social worker in pre-kindergarten through grade 12.

Sec. 10-145d-933. Initial educator certificate requirements

To receive an initial educator certificate to serve as a school social worker, the applicant shall meet the following requirements, in addition to meeting the assessment requirements, as appropriate:

- (a) Holds a bachelor's degree from an approved institution;
- (b) Holds a master's degree in social work from a school of social work accredited by the Council on Social Work Education;

(c) 300 direct practice hours of school-based social work or 10 months of full-time supervised experience as a school social worker in the employ of a public school in another state, approved nonpublic school in Connecticut or nonpublic school approved by the appropriate governing body in another state;

(d) A graduate level course focused on social work practice in educational settings with study in school culture and collaboration, student assessment, student academic or behavioral interventions, and crisis interventions and mental health that impact learning;

(e) Has completed coursework that fulfill the following areas:

(1) Educational psychology and characteristics of learners, which shall include a combination of the following preparation and successful application of child and adolescent development research into educational practice:

(A) The growth and development of typical and atypical students pre-kindergarten through grade 12 including the characteristics and functioning of students with disabilities, English language learners, and gifted and talented learners;

(B) The impact of cultural, linguistic and environmental issues on the learning needs of students;

(C) Typical and atypical cognitive, emotional, language and behavioral development of school aged children; and

(D) The impact of nutrition, first aid, disease, community health, mental health, youth suicide, child abuse, and alcohol and drug abuse on children.

(2) Federal and state education laws including, but not limited to, the Individuals with Disabilities Education Act (IDEA), Americans with Disabilities Act section 504, professional ethics and code of professional responsibility for educators, Family

Educational Rights and Privacy Act (FERPA), and statutory requirements for mandated reporting, suspensions/expulsions, and school/district accountability; and

(3) Strategies for communicating and collaborating with families about students' progress including communicating assessment results.

Sec. 10-145d-934. Provisional educator certificate requirements

To receive a provisional educator certificate for school social worker, an applicant shall present evidence of meeting the preparation and eligibility requirements for an initial educator certificate, in addition to completing the following requirements:

(a) 10 months of successful service under the initial educator certificate or interim educator certificate; or

(b) Has completed at least 30 school months of successful service within 10 years prior to application for the provisional educator certificate in the subject area or field appropriate to the subject area or

field for which the provisional educator certificate is sought in the public school system in another state, or an approved nonpublic school.

Sec. 10-145d-935. Professional educator certificate requirements

To receive a professional educator certificate for school social worker, an applicant shall present evidence of the following:

(a) 30 school months of successful service under the provisional educator certificate or interim provisional educator certificate in the employ of a board of education; and

(b) A minimum of 20 hours of training in design, assessment and implementation of behavioral support and analysis services for students with behavioral disabilities or autism spectrum disorders.

Appendix D:

CONNECTICUT CODE OF PROFESSIONAL RESPONSIBILITY FOR TEACHERS

SECTION 10-145D-400A

(a) PREAMBLE

The Code of Professional Responsibility for Educators is a set of principles which the education profession expects its members to honor and follow. These principles set forth, on behalf of the education profession and the public it serves, standards to guide conduct and the judicious appraisal of conduct in situations that have professional and ethical implications. The Code adheres to the fundamental belief that the student is the foremost reason for the existence of the profession.

The education profession is vested by the public with a trust and responsibility requiring the highest ideals of professionalism. Therefore, the educator accepts both the public trust and the responsibilities to practice the profession according to the highest possible degree of ethical conduct and standards. Such responsibilities include the commitment to the students, the profession, the community and the family.

Consistent with applicable law, the Code of Professional Responsibility for Educators shall serve as a basis for decisions on issues pertaining to certification and employment. The Code shall apply to all educators holding, applying or completing preparation for a certificate, authorization or permit or other credential from the State Board of Education. For the purposes of this section, “educator” includes superintendents, administrators, teachers, special services professionals, coaches, substitute teachers and paraprofessionals.

(b) RESPONSIBILITY TO THE STUDENT:

(1) The professional teacher, in full recognition of his or her obligation to the student, shall:

(A) Recognize, respect and uphold the dignity and worth of students as individual human beings, and, therefore, deal justly and considerately with students; (B) Engage students in the pursuit of truth, knowledge and wisdom and provide access to all points of view without deliberate distortion of content area matter; (C) Nurture in students lifelong respect and compassion for themselves and other human beings regardless of race, ethnic origin, gender, social class, disability, religion, or sexual orientation; (D) Foster in students the full understanding, application and preservation of democratic principles and processes; (E) Guide students to acquire the requisite skills and understanding for participatory citizenship and to realize their obligation to be worthy and contributing members of society; (F) Assist students in the formulation of worthy, positive goals; (G) Promote the right and freedom of students to learn, explore ideas, develop critical thinking, problem solving, and necessary learning skills to acquire the knowledge needed to achieve their full potential; (H) Remain steadfast in guaranteeing equal opportunity for quality education for all students; (I) Maintain the confidentiality of information concerning students obtained in the proper course of the educational process, and dispense such information only when prescribed or directed by federal or state law or professional practice; (J) Create an emotionally and physically safe and healthy learning environment for all students; and (K) Apply discipline promptly, impartially, appropriately and with compassion.

(c) RESPONSIBILITY TO THE PROFESSION:

(1) The professional teacher, in full recognition of his or her obligation to the profession of teaching, shall:

(A) Conduct himself or herself as a professional realizing that his or her actions reflect directly upon the status and substance of the profession; (B) Uphold the professional educator's right to serve effectively; (C) Uphold the principle of academic freedom; (D) Strive to exercise the highest level of professional judgment; (E) Engage in professional learning to promote and implement research-based best educational practices; (F) Assume responsibility for his or her professional development; (G) Encourage the participation of educators in the process of educational decision-making; (H) Promote the employment of only qualified and fully certificated, authorized or permitted educators; (I) Encourage promising, qualified and competent individuals to enter the profession; (J) Maintain the confidentiality of information concerning colleagues and dispense such information only when prescribed or directed by federal or state law or professional practice; (K) Honor professional contracts until fulfillment, release, or dissolution mutually agreed upon by all parties to contract; (L) Create a culture that encourages purposeful collaboration and dialogue among all stakeholders; (M) Promote and maintain ongoing communication among all stakeholders; and (N) Provide effective leadership to ensure continuous focus on student achievement.

(d) RESPONSIBILITY TO THE COMMUNITY

(1) The professional educator, in full recognition of the public trust vested in the profession, shall:

(A) Be cognizant of the influence of educators upon the community-at-large; obey local, state and national laws; (B) Encourage the community to exercise its responsibility to be involved in the formulation of educational policy; (C) Promote the principles and ideals of democratic citizenship; and (D) Endeavor to secure equal educational opportunities for all students.

(e) RESPONSIBILITY TO THE STUDENT'S FAMILY

(1) The professional educator in full recognition of the public trust vested in the profession shall:

(A) Respect the dignity of each family, its culture, customs, and beliefs; (B) Promote, respond, and maintain appropriate communications with the family, staff and administration; (C) Consider the family's concerns and perspectives on issues involving its children; and (D) Encourage participation of the family in the educational process.

UNPROFESSIONAL CONDUCT*

(f) The professional educator, in full recognition of his or her obligation to the student, shall not:

(A) Abuse his or her position as a professional with students for private advantage; (B) Discriminate against students; (C) Sexually or physically harass or abuse students; (D) Emotionally abuse students; or (E) Engage in any misconduct which would put students at risk; and

(g) The professional educator, in full recognition of his or her obligation to the profession, shall not:

(A) Obtain a certificate, authorization, permit or other credential issued by the state board of education or obtain employment by misrepresentation, forgery or fraud; (B) Accept any gratuity,

gift or favor that would impair or influence professional decisions or actions; (C) Misrepresent his, her or another's professional qualifications or competencies; (D) Sexually, physically or emotionally harass or abuse district employees; (E) Misuse district funds and/or district property; or (F) Engage in any misconduct which would impair his or her ability to serve effectively in the profession; and

(h) The professional educator, in full recognition of the public trust vested in the profession, shall not:

(A) Exploit the educational institution for personal gain; (B) Be convicted in a court of law of a crime involving moral turpitude or of any crime of such nature that violates such public trust; or (C) Knowingly misrepresent facts or make false statements.

* Unprofessional conduct is not limited to the descriptors listed above. When in doubt regarding whether a specific course of action constitutes professional or unprofessional conduct please seek advice from your school district or preparation institution.

(i) Code revision This Code shall be reviewed for potential revision concurrently with the revision of the Regulations Concerning State Educator Certificates, Permits and Authorizations, by the Connecticut Advisory Council for Teacher Professional Standards. As a part of such reviews, a process shall be established to receive input and comment from all interested parties.

Appendix E:

SCHOOL BEHAVIORAL HEALTH SERVICES GUIDELINES FOR A COORDINATED APPROACH TO SCHOOL HEALTH

Definition

Behavioral health services (which may be more generically referred to as mental health) refers to developmental, behavioral, cognitive, emotional, psychological and medical needs associated with optimal human functioning. Behavioral health typically addresses individual, family, social and environmental systems and their inter-relatedness. Services are provided by professionals with training in counseling, psychology, social work, nursing, medicine or, to a lesser extent, the social sciences and related programs. Staff may be exclusively school-based or may be associated with local community agencies.

Addressing behavioral health includes providing safe, supportive environments that encourage self-examination and inquiry, leading to growth as an individual and as a member of society. Although approaches to providing comprehensive behavioral health services to young people may differ, methods are likely to include individual or group counseling, student assistance or child study teams and actions to have a positive effect on the school climate. Although each of these program types has strengths and limitations, they can be most effective when combined within a coordinated plan of services and policies. To foster behavioral health schools need to be safe; ensure academic readiness, including appropriate nutrition, academic supports, health and mental health services, and intellectual challenge; support the validity of an individual's uniqueness; and respect differences.

Rationale

Mental health is an essential component of overall general health, and mental health disorders are genuine health conditions (President's New Freedom Commission on Mental Health, 2003; U.S. Public Health Service, 1999). Mental health treatment is efficacious, meaningful, and, when delivered consistently and comprehensively, reduces economic, social and psychological costs to individuals, their families and society. A study by the World Health Organization, in collaboration with the World Bank and Harvard University, of the impact of mental health disorders on established market economies during the 1990s found that mental health impairment is the second leading cause of disability and premature death (World Health Organization, 2001).

The costs of mental illness, both personal and economic, attest to the need for preventive services throughout the lifespan and targeted interventions as soon as issues emerge. Most schools provide some level of mental health-related service. These services commonly include referral (89 percent), assessment (80 percent), crisis intervention (78 percent) and screening (77 percent) (Lear, Isaacs, & Knickman, 2006). On any given school day, about 20 percent of the U.S. population is in a public school setting. Schools, therefore, have the unique potential to provide screening, prevention and early intervention services along with long-term oversight and follow up to a significant proportion of our society. Without investing in a significant number of additional resources, schools could extend these prevention and support services to their adult staff.

The traditional approach to behavioral health services provision in schools is based on the assumptions that schools must (1) identify those students who may have emotional, social, behavioral or psychiatric conditions that will predispose them to ongoing vulnerability and incapacity; and (2) provide support

services to address those issues identified to enable students to benefit from their educational program. The results of the 2005 Connecticut School Health Survey (Connecticut's version of the national Youth Risk Behavior Survey) clearly identify the hazards confronted by young people, as well as some factors that effectively reduce risk:

- more Connecticut students report dating violence than is reported nationally;
- more Connecticut students report attempting suicide than is reported nationally;
- 23 percent of high school students have smoked marijuana in the last 30 days;
- 45 percent of high school students drank alcohol in the last 30 days;
- nearly 30 percent of students reported having ridden in an automobile where the driver had been drinking alcohol; and
- students who say that their parents usually know where they are are about 30 percent less likely to attempt suicide, experience dating violence, have sexual intercourse or smoke marijuana. They are also 50 percent less likely to drink alcohol or smoke cigarettes.

School behavioral health personnel can contribute to the reduction of these trends through carefully and consistently focusing prevention and intervention efforts on these and related risk factors. The No Child Left Behind Act has increased focus on academic achievement with pressures on schools to achieve adequate yearly progress. At the same time that schools, in response to NCLB, are moving from a deficit model of educational evaluation and toward assessments based on a student's capacity to respond to teaching interventions, schools are also moving away from identifying social, emotional and behavioral deficits toward models based on normative development. The New Freedom Commission's recommendations emphasize the need for mental health in schools to focus on the following:

- promoting social-emotional development, preventing mental health and psychosocial problems, and enhancing resiliency and protective buffers;
- intervening as early as feasible after the onset of emotional, behavior, and learning problems and addressing severe and chronic problems;
- addressing systemic issues at schools that affect both student and staff well-being, such as practices that engender bullying, alienation, student disengagement from classroom learning and staff burnout;
- establishing equitable guidelines, standards and accountability for mental health in schools; and
- building the capacity of all school staff to address emotional, behavioral and learning problems and promote healthy social-emotional development, drawing on all empirical evidence as an aid to developing a comprehensive, multifaceted and cohesive continuum of school-community interventions (Center for Mental Health in Schools & Center for School Mental Health Assistance, 2004).

This section presents policy recommendations, policy rationale, implementation strategies and resources for school behavioral health services.

Policy Recommendations

Policy recommendations for school behavioral health services address the following ten areas.

1. *Eliminate stigma.* Stigma related to mental health disorders shall be eliminated.
2. *Informed consent.* The district shall develop protocols, policies, and procedures to obtain parental consent for children to participate in clinical assessment and treatment services.
3. *Mental health screening.* Early and ongoing screening shall be provided for existing and emerging

- conditions that affect social-emotional development, behavior and psychological functioning.
4. *Community-based linkages.* The district shall develop proactive linkages to local community services that provide supports for target conditions.
 5. *Economically disadvantaged families.* The district shall, in collaboration with local community providers, develop and increase its capacity to provide appropriate services for young people whose family's economic circumstances may be a barrier to accessing best-practice services.
 6. *Crisis intervention.* Capacity to provide crisis intervention and brief treatment services shall be strengthened.
 7. *Staff development.* All school staff shall be informed about normative development, common potential stressors that may interfere with learning and behavioral health (e.g., bereavement, parental divorce), atypical emotional responses, classroom-based interventions that positively affect school climate, systems-based interventions that improve quality of life in school settings, and mechanisms for referring students for more extensive behavioral health services.
 8. *Parent-school linkages.* Parent-school linkages related to the behavioral health needs of young people throughout childhood and adolescence shall be strengthened.
 9. *Reduce risk behaviors.* Child and adolescent risk behaviors, including but not limited to tobacco use, unsafe sexual behaviors, drug and alcohol use, and suicide, shall be reduced.
 10. *School climate initiatives.* Personal and systems-based programs to improve school climate shall be established.

Policy Rationale and Implementation Strategies

1. *Eliminate stigma.* Stigma related to mental health disorders shall be eliminated.

Most professionals agree that mental illness has historically been viewed with confusion, suspicion and judgmental bias. Lack of understanding and fears coupled with a desire to distance oneself from the harsh reality of affected persons' lives have led society to reject individuals suffering from common and debilitating mental health conditions. Current estimates of the incidence of mental health disorders indicate that about 20 percent of the adult population suffers from some form of mental illness at any given time (U.S. Department of Health and Human Services, 1999). Surveys among school-aged populations offer similar results.

Although 1 in 5 children, adolescents and adults experience some form of mental illness, stigma associated with such conditions results in secretiveness and a reluctance to seek treatment, which in turn reduces the ability of support systems to reach their target populations. Schools, whose principal mission is to inform and educate, are uniquely positioned within their communities to confront stigmatization and promote understanding through dissemination of age-appropriate and developmentally informed communication.

Schools, families and other societal systems have the responsibility to teach positive social values associated with optimal functioning. Literature suggests that historical ignorance concerning mental illness and behavioral health disorders has led to intergenerational misunderstanding and a continued prejudice against individuals with these conditions. School staff should proactively and consistently confront these misunderstandings and provide in their place compassion, understanding and empathy. Through these means, the next generation of unaffected individuals will be able to assist those with behavioral health disorders to engage more fully in society.

Implementation strategies include:

- Use considerate and respectful language when discussing mental health conditions.
- Focus on the abilities and capacities of individuals, rather than limitations.
- Avoid derogatory and inaccurate labels such as “crazy,” “psycho,” or “mental” when discussing these conditions or the individuals that suffer from them.
- Furnish information, available through SAMHSA, National Institute of Mental Health and the World Health Organization, among others that corrects mistaken impressions about mental illness in our society, i.e., provide evidence-based information to rectify misconceptions directly associating mental illness with violence.
- Provide to any parent whose child presents with a mental health disorder a copy of a “Consumer’s Bill of Rights” (available from the Substance Abuse and Mental Health Services Administration (SAMHSA) website at http://www.hcqualitycommission.gov/final/append_a.html).
- Monitor local press reports regarding individuals with psychiatric disabilities and write letters to the editor to correct any misconceptions or negative portrayals of individuals with these conditions.
- Help the school community make the link between stigma and discrimination.

2. *Informed consent.* The district shall develop protocols, policies and procedures to obtain parental consent for children to participate in clinical assessment and treatment services.

Schools should attempt to obtain active parental consent for clinical evaluations and treatment services. In certain circumstances, crisis intervention services may be required before obtaining such consent; parents should be contacted as early as reasonably possible. Policies and procedures should clearly and completely address privacy and confidentiality issues before any conflicts arise.

Although there may be concern that a requirement for parental consent and involvement may create a barrier for serving adolescents, establishing these practices in the earliest grades can reduce this concern from the student’s perspective and can promote understanding of behavioral health services as common practices from which many can benefit.

Implementation strategies include:

- Publish information about policies and procedures for obtaining parental consent, including privacy and confidentiality, in student and/or parent handbooks.
- Provide parental consent forms written in the parents’ dominant language and avoid ambiguous, confusing or nonstandard terms. Forms should explain the purpose, intent and process in which the student will be participating, including alternative assessment or treatment options, procedures, risks, benefits and specifics of what will be maintained as confidential, as well as costs or compensation.
- Avoid technical terms whenever possible and provide clear, straightforward explanations of technical terms whenever they must be used.
- Frame the permission statement in the consent form as the parents themselves would state it.

3. *Mental health screening.* Early and ongoing screening shall be provided for existing and emerging conditions that affect social-emotional development, behavior and psychological functioning.

Schools have developed the capacity to identify early conditions that impede academic achievement, such as autism and other developmental and learning disabilities. Although school counselors, psychologists and social workers commonly participate in these assessments, their expertise has not

always been incorporated into the broader structure to screen for conditions that may emerge later in a student's development.

When schools face more complex behavioral health issues, such as childhood disintegrative disorder, depression, schizophrenia or other dysfunctional conditions, they frequently address them on a case-by-case basis, which can result in a wide disparity in services provided to children and their families. Schools and districts must develop within their structures more comprehensive, cohesive systems of care to provide early detection and screening, as well as thorough evaluation of need and subsequent treatment.

Behavioral issues are often viewed from the perspective of how they disrupt school and classroom activities. School staff needs to distinguish between disciplining students for normative behaviors, such as sloppiness, competitiveness and risk-taking that may temporarily interfere with classroom management, and problematic behaviors that require professional assessment.

Implementation strategies include:

- Require principles of informed consent to guide administration of screening tools.
- Screen children, while planning collaboratively with their parents, at the first indication of poor academic adjustment in relation to social, emotional, developmental, cognitive or other peer-matched functional measures. Additional screening may be appropriate as children encounter significant developmental or chronological stressors that may affect their education, such as changing family or school circumstances.
- Use developmental norms, when appropriate, in screenings to establish thresholds for additional services.
- Use screening to identify functional areas that may benefit from additional supports, rather than establishing diagnostic data.
- When school personnel participate in statewide or national surveys, provide staff and administration with disaggregated data, when available and appropriate, to inform them of local trends.
- Use principles of Response to Intervention cited in the 2004 Individuals with Disabilities Education Act (IDEA) to address social-developmental-behavioral learning.

4. *Community-based linkages.* The district shall develop proactive linkages to local community services that provide supports for behavioral health conditions.

Schools need to improve the integration of services with outside community agencies through creative mechanisms that are not dependent on funding. For example, providing space for a local mental health agency to meet with children during the school day would eliminate scheduling and transportation barriers that often prevent children from receiving necessary services. Linkages should focus on early identification, referral and follow up. Collaboration between schools and local agencies should adhere to guidelines that address confidentiality, informed consent and the inclusion of parents as partners.

Implementation strategies include:

- Build linkages that accommodate the needs of individuals, their families and organizational systems.
- Consider providing space for local mental health agencies to meet with client children during the school day.
- Ensure that collaboration between schools and local agencies adheres to guidelines addressing confidentiality, informed consent and the inclusion of parents as partners.
- Ensure that any request for release of information clearly indicates what information will be

shared, with whom, and for what period of time.

- Develop contractual relationships (memoranda of understanding or agreement) with outside agencies rather than collaborating on a case-by-case basis.
- Engage in coordinated, collaborative case planning that includes representation from multiple associated disciplines, e.g. nursing, social work, counseling, psychology.

5. *Economically disadvantaged families.* The district shall, in collaboration with local community providers, develop and increase its capacity to provide appropriate services for young people whose family's economic circumstances may be a barrier to accessing best-practice services.

Lack of funding and inadequate insurance coverage are among the most significant barriers to support for families and children who need it. Through the Health Insurance for Uninsured Kids and Youth (HUSKY) plan, children and their families who meet eligibility criteria can receive insurance coverage either free or at reduced cost. Although this plan meets the needs of some of the more vulnerable members of our society, the cost of mental health treatment is still prohibitive for a significant portion of the public. These families often also have incorrect information or the impression that mental health needs are less important than other health concerns.

Implementation strategies include:

- Work with parent groups and through information mechanisms, such as letters to the home, websites, and parent and student handbooks, to communicate the contributions that healthy social-emotional, developmental and psychiatric status make to academic and overall functioning.
- Help parents advocate for more expansive, coordinated services for children and families.
- Assist families with ensuring that their children have health insurance and provide appropriate application materials when needed.
- Review and catalogue, in collaboration with local health providers, free or reduced-cost services available in the community and develop protocols to ensure that those with greatest need receive priority.
- Establish formal relationships with providers in the *Community Collaborative System of Care* (<http://www.ct.gov/dcf/cwp/view.asp?a=2558&q=314352>).
- Create and annually update a listing of all licensed providers in your community, along with any special instructions related to enrollment, application for services, types of treatment, etc.
- Develop resource packets for families that include listings of relevant community and state services with explanations of the services, intake mechanisms, approximate costs, and alternative resources for families with economic limitations that may affect students' access to necessary services.

6. *Crisis intervention.* Capacity to provide crisis intervention and brief treatment services shall be strengthened.

Childhood and adolescence is a period in human development when one experiences many changes in functioning within a short time frame. As a result of these ongoing, normative challenges, young people frequently require brief interventions to help them develop and improve their coping and problem-solving skills. Although many schools offer high-quality, meaningful supports for such intermittent crises in students' lives, many of these services are provided in a reactive mode. Schools will respond more effectively and strategically by developing protocols and procedures for addressing such predictable needs. Overarching philosophies related to the milestones, challenges and skills development that affect the healthy growth of young people should govern the provision of crisis-related and brief treatment services.

Implementation strategies include:

- Develop appropriate protocols with a decision tree that indicates how, when, and by whom services are to be delivered, what the follow-up plan will be, and how the family will be included in assisting students through transitional periods.
- Establish in each school a safety committee, as suggested by CGS 10-220f, to increase staff and student awareness of health and safety issues and to review the adequacy of emergency response procedures. Each school should have comprehensive emergency response plans that anticipate relocation, temporary isolation from other support services, and mental health triage and brief treatment, in addition to other challenges to typical school operations.
- As allowed by CGS 10-231, substitute every three months a crisis drill in place of the required fire drill. Use these opportunities to practice “lockdown” and evacuation drills.
- Establish a crisis team that considers the physical plant, the student and community population, capacity of external agencies, and their involvement with municipal emergency management services. This team should be able to respond to the individual and group needs of the student body.
- Establish proactive relationships and agreements with the regional agency overseeing Emergency Mobile Psychiatric Services (<http://www.ct.gov/dcf/cwp/view.asp?a=2558&q=314354>) for effective facilitation of urgent referrals for services.
- Gather and analyze data on urgent requests for support services to ensure that interventions, protocols and deployment of behavioral health staff are responsive to current and emerging trends in the student body.
- Ensure full implementation of the Connecticut Comprehensive School Counseling Program (<http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/counseling.pdf>).
- Ensure that mental health staff employed by the school applies evidence-based techniques and practices that address specific goals and outcomes.
- Facilitate transfer to community mental health specialists those youngsters who might benefit from more long-term interventions.

7. *Staff development.* All school staff shall be informed about normative development, common potential stressors that may interfere with learning and behavioral health (e.g., bereavement, parental divorce), atypical emotional responses, classroom-based interventions that positively affect school climate, systems-based interventions that improve quality of life in school settings, and mechanisms for referring students for more extensive behavioral health services.

Teachers’ pre-service education includes little information about the normative development of young people and behaviors that might emerge throughout a student’s educational career. Schools should ensure that each staff member has adequate information about normative development.

Implementation strategies include:

- Provide staff orientation and training that addresses the typical developmental milestones, emotional needs and activities that affect young people. Staff should be particularly knowledgeable about the age group with whom they interact but should also be familiar enough with general development to recognize how their students fit within the continuum of growth during the school years.
- Schedule regular in-service workshops provided by behavioral health services staff that address typical development, anomalous development, and strategies to assist students in their passage through the school system.
- Ensure that mental health personnel receive relevant professional training that increases their

- skills and capacity to meet the behavioral health needs of students.
 - Collaborate with colleagues in higher education to incorporate more comprehensive education about child development and age-appropriate education into pre-service training.
8. *Parent-school linkages.* Parent-school linkages related to the behavioral health needs of young people throughout childhood and adolescence shall be strengthened.

The involvement of parents is essential for creating a supportive, social behavioral health program. Students who receive high quality support services in a school setting but return to a home with an uninformed or uninvolved environment will not benefit as fully as they might from supports that have been put into place. Moreover, parents as taxpayers may be the school's best ally in leveraging financial and municipal support for the expansion of behavioral health services. Involvement of parents in the overall planning for and oversight of behavioral health needs and programming can be another method for reducing stigmatization and encouraging socially informed curriculum and services. Although in some rare occasions parents may not be able to play a beneficial role in addressing a youngster's mental health needs, the inclusion of parents closes the loop on assisting students within all the environments that affect them.

Schools can be one of the most powerful and meaningful sources of information for successful parenting. School staff members receive constant exposure to emerging developments and policies affecting young people. Schools should become information centers for the families they serve using, along with other strategies, resource packets that include information about normative development, local resources, areas of concern and advocacy around emerging or existing needs.

Implementation strategies include:

- Ensure that all staff members and students use considerate and respectful language.
 - Ensure that conversations are two-way, that each person is heard and understood, and that structures for these conversations remain flexible.
 - Become an information center for the families you serve, using along with other strategies, resource packets that include information about normative development, local resources, areas of concern and advocacy around emerging or existing needs.
 - Assist parents in becoming actively involved in their child's education.
 - Create "action teams" that are made up of parents, school staff and administrators, and students to develop comprehensive plans to increase family and community involvement.
 - Conduct regular, ongoing information and training sessions addressing childhood development, limit-setting, positive reinforcement, homework skills, new math, etc., for parents and other concerned adults.
 - Create and annually update a listing of licensed providers in your community, along with any special instructions related to enrollment, application for services, types of treatment, etc.
 - Develop resource packets for families that include listings of community and state services with explanations of the services, intake mechanisms, the approximate costs of services, and alternative resources for families with economic limitations that might affect students' access to necessary services.
 - Develop scheduling that accommodates family schedules as well as organizational staff schedules.
9. *Reduce risk behaviors.* Child and adolescent risk behaviors, including but not limited to tobacco use, unsafe sexual behaviors, drug and alcohol use, and suicide, shall be reduced.

Young people need to test external boundaries and realize their own internal capacities as part of their normal development. Unfortunately, modern society offers innumerable risks and hazards that can have fatal consequences. Drugs, alcohol and violence remain the greatest threats to young people and their successful transition into adulthood. Schools need to work with the community to identify hazards and risks, offer alternatives and recommend strategies to reduce the hazards associated with risk-taking behaviors.

Implementation strategies include:

- Ensure that staff is familiar with the content and recommendations in *Guidelines for Suicide Prevention: Policy and Procedures*, 2nd Edition, 2004 published by the CSDE (http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Student/PsychSocial/SP_Guidelines.pdf).
- Provide to all staff the most recent results of the Connecticut School Health Survey, which informs the public about the rates of risk-associated behaviors.
- Use curricular materials that are evidence-based and replicable between groups. For examples, see the CDC Registries of Programs Effective in Reducing Youth Risk Behaviors at <http://www.cdc.gov/HealthyYouth/AdolescentHealth/registries.htm>.

10. *School climate initiatives*. Personal and systems-based programs to improve school climate shall be established.

Schools themselves must become safer, more predictable, and increasingly responsive to the needs of young people and their families. Staff members need support to strengthen their capacity to support others. Systemic consideration must include the physical, emotional and humanistic needs of the school community. Violence must be reduced. Acceptance of differences should guide interpersonal interaction, pro-social and non-judgmental values should guide decision making, and responsibility should be taught and modeled.

Implementation strategies include:

- Develop structures that provide safety while encouraging the involvement of students, families and the community in school-based activities.
- Identify for each student an adult who will serve as mentor, aide, adviser and guide. Encourage the development of long-term relationships between students and staff that endure while the student attends the school.
- Use schoolwide contingency programs that provide reinforcement for positive behaviors and consistent consequences for errors. The State Education Resource Center, in collaboration with the University of Connecticut and the State Department of Education, provides training and consultation on incorporating schoolwide positive behavioral supports.
- Advise your school's student government to consider and respond to climate issues related to accountability and responsibility.
- Increase students' willingness to listen respectfully and responsively to one another.

Guidelines for a Coordinated Approach to School Health

Connecticut State Department of Education, July 2007

Appendix F:

ADDRESSING THE NEEDS OF THE WHOLE CHILD:

***SOCIAL, EMOTIONAL, BEHAVIORAL, AND PHYSICAL HEALTH, AS WELL AS ACADEMIC
ACHIEVEMENT, IN CONNECTICUT'S SRBI PROCESS***

TOPICAL BRIEF #3

SCIENTIFIC RESEARCH-BASED INTERVENTIONS

CONNECTICUT'S FRAMEWORK FOR RESPONSE TO INTERVENTION

CONNECTICUT STATE DEPARTMENT OF EDUCATION

SEPTEMBER 2011

This topical brief is the third in a series designed to clarify and assist the work of Connecticut educators engaged in implementing Scientific Research-Based Interventions (SRBI). The term SRBI was adopted by the Connecticut State Department of Education (CSDE) in August 2008 (Connecticut’s Framework for Response to Intervention [RTI]) and is synonymous with the term RTI. RTI is the term used nationally to describe the practice of providing high-quality instruction and interventions matched to student needs, monitoring progress frequently to make decisions about changes in instruction or goals, and applying data to inform educational decisions (National Association of State Directors of Special Education, 2008). The purpose of RTI or SRBI is, of course, to ensure that all students learn and acquire the behavioral and academic competencies that they will need to be successful in school and in society.

Studies over the past decade have consistently demonstrated that in order for students to achieve at high academic levels, schools, families and communities must focus on the child’s social, emotional, physical and behavioral health as well as the acquisition of academic skills, strategies and content. These studies have shown that a coordinated approach to school health can reduce absenteeism and classroom behavior problems, improve classroom performance, better prepare students to be productive members of their communities, establish lifelong health practices, make schools more engaging, and address staff wellness needs (Connecticut State Board of Education Position statement on a Coordinated Approach to School Health, 2009). The focus of this brief is on using the SRBI process to address the needs of the **whole child** to remove non-academic barriers to academic achievement and ensure that students achieve their full potential.

In 2008, the CSDE convened Department and State Education Resource Center (SERC) representatives to develop a plan for addressing student needs in the areas of social, emotional, physical and behavioral health. After meeting and discussing how best to move forward, the committee decided to draw upon existing practices rather than to develop an entirely new and different initiative. Connecticut districts were already becoming familiar with, and committed to, the SRBI process and were at various stages of implementation. The “Underlying Principles and Critical Features of SRBI” (Connecticut’s Framework for Response to Intervention [RTI], 2008, pp. 14-19) were consistent with “assumptions that provide a solid foundation for addressing the needs of the **whole child** for successful learning.” Furthermore, upon examination, it was clear that the SRBI framework provided precisely the kind of continuum for developmental, preventative, remedial and support services that research has shown to enhance the capacity of schools to address the affective and health domains effectively (Connecticut State Board of Education Position statement on Student Support Services, 2010). Integrating evidence-based practices that address the development of the social, emotional and physical health areas into the three-tiered SRBI framework was the next appropriate step for developing supporting documents to assist schools in developing comprehensive SRBI programs for their students.

To better understand the vision of the committee, it is helpful to examine the SRBI framework. The framework is based on a multistep approach to providing services and interventions through increasing levels of intensity, as needed. The progress that students make at each stage of intervention is closely monitored using data and data teams (see Topical Brief 1 at http://www.sde.ct.gov/sde/lib/sde/pdf/curriculum/cali/topical_brief_1.pdf). Data teams meet regularly to monitor student progress using a five step process that includes: 1) conducting universal screening and ongoing collection of data; 2) analyzing assessed strengths and challenges to determine root causes; 3) establishing, reviewing and revising SMART (Specific, Measurable, Attainable, Realistic and Timely) goals; 4) selecting scientific, research-based interventions; and 5) progress monitoring through the use of assessment and data. The results of this monitoring are used to make decisions about the need for further research-based

interventions, changes in setting, frequency and intensity in the delivery of the interventions, and to ensure that the process is cyclical. A more comprehensive description of the SRBI process can be found in Connecticut's Framework for RTI at http://state.rti4success.org/index.php?option=com_resource&view=single&cid%5B%5D=207.

SRBI is not new. It simply provides a framework for ensuring successful student learning, and opportunities to refine and improve much of what districts and schools are already doing. As previously highlighted, it is essential to focus on the **whole child**. The concept of a child's "wholeness" includes not only academic functioning but also all the components affecting the child's well-being and overall health—specifically the social and emotional, behavioral and physical health of the child.

If you have begun to implement SRBI in academic areas, you will already have the structures of the framework in place to incorporate social, emotional, behavioral and physical health into the SRBI framework. In addition, by keeping good data, as the SRBI process requires, you may find that some of the services you are presently providing are not as effective as anticipated. By identifying the most effective services, your efforts will have greater impact. Addressing student needs in these areas can, and should, be incorporated into district-level, building-level, and grade-level data team meetings. Data team members for each of these levels, and in each of the tiers, may include administrators, teachers, specialists (e.g., health educator, special education teacher, behavioral health specialist, nutritional consultant, and nurse), parents, and when appropriate, a dietician and noncertified staff members. With respect to grade-level data team meetings, while it is not possible for every staff member to be at every data team meeting for all grade levels, all specialists and teachers should be a member of at least one data team that meets on a regularly scheduled basis, and attend others on an as-needed basis.

The following provides a more detailed description of the SRBI tiers and practical application examples that address the development of social-emotional, physical, and behavioral health in students.

Tier 1

Tier 1 refers to the general education core curriculum and instruction, the overall school climate, and the system of schoolwide social-emotional learning and behavioral and physical health supports for all students. High-quality, evidence-based practices that build foundational skills and knowledge for all students must be provided in Tier 1. If districts and schools effectively implement appropriate programs and services in Tier 1, there will be fewer students who need the additional supports offered through Tier 2 and Tier 3. While it is beyond the scope of this brief to provide a detailed description of what a high quality Tier 1 looks like in each of the areas being discussed, some key components will be highlighted. A more detailed description can be found in the corresponding Connecticut State Board of Education policy guidance and position papers (see references).

Tier 2 And Tier 3

Tiers 2 and 3 are the newest parts of the process for parents and for many teachers. Tier 2 and Tier 3 are for students who, based on the data, do not attain important benchmarks despite the services that have been provided in Tier 1. In the event of a large number of students not attaining the expected benchmarks through Tier 1 services, teams should review their data carefully and consult with subject matter experts to improve the supports and programming delivered in Tier 1.

Tier 2 interventions are short term (e.g., eight to 20 weeks) and remain part of the general education system with supports from specialists. Interventions must be research-based as much as possible, be reasonably feasible for educators to use, and accurately target the student’s area(s) of difficulty” (Connecticut’s Framework for RTI, 2008, pp. 34). Tier 3 interventions may be different and more specialized; however, “the primary difference between Tier 2 and Tier 3 interventions generally involves the intensity and/or individualization of the intervention. Greater intensity can be achieved with a smaller teacher-student ratio, a longer duration of instruction/services and more frequent progress monitoring” (Connecticut’s Framework for RTI, 2008, p. 41). As in Tier I, obtaining and analyzing solid data, on a highly regularized schedule, are the underpinnings for all decision-making in both Tier 2 and Tier 3. If at any point it appears that the student is making little or no progress, the team needs to make appropriate modifications to the intervention and/or initiate a new intervention.

The frequency and intensity of the collaboration between the school and parents increase at these levels. The characteristics of good communication should have been established in Tier 1, and must continue in Tier 2 and Tier 3. Such communication is characterized by creating authentic two-way communication; using plain language; focusing on strengths; remaining positive, upbeat and success-oriented; building on families’ desires for their children to succeed; and perhaps most importantly, recognizing the invaluable knowledge that families can bring to the school.

Practical Application Examples

Physical Health

With the exception of the physical education program, physical health is an area that has not generally been thought about when implementing SRBI. The framework, however, is an excellent vehicle to ensure that appropriate programs and services in this area are in place for all students, and to provide more individualized interventions when needed. The district and school-based data teams can play an important role in evaluating the effectiveness of existing physical health programs and services at the Tier 1 level.

Tier 1 (physical activity): Tier 1 in the physical education arena is similar to other academic areas in that one of the most important features is the implementation of a regularly scheduled physical education curriculum that is aligned with state standards for physical education. Differentiated instruction using small flexible grouping is essential to provide additional practice or explicit instruction to students of varying skill levels. Providing additional age-appropriate times for physical activity (e.g., classroom instruction, recess, and before- and after-school programs) and encouraging students to participate in physical activities in ways that promote self-discipline and personal responsibility are also important elements in Tier 1. Schools and districts should provide parent education programs about the importance of physical activities and encourage adults to model healthy behavior by participating in wellness programs, and in physical activity programs with their children or students. Besides the school-based programs, districts and schools should encourage community partners and families to provide structured physical activity programs and opportunities for unstructured physical activity for students outside school.

Typically, the data from strategic school profiles, physical fitness benchmark assessments, teacher assessments and body composition indicators, in pertinent situations, may be used at the Tier 1 level by data teams to evaluate and make decisions about the progress of students.

Tier 2 (physical activity): Examples of Tier 2 interventions for students who have problems due to physical inactivity include small groups of students who meet weekly or bi-weekly during school hours with a physical education teacher for physical activity (PA) goal setting and progress monitoring, PA incentives, social support, and point-of-decision reinforcement (e.g., during recess and before/after school activities); provision of special assignments/challenges related to PA, such as ways to be more active outside school; more individualized and intensive instruction related to PA and nutrition; assistance with accessing appropriate after-school facilities and programs; and family collaboration to assist in ways for students to be more active outside school.

Interventionists may include members of a coordinated school health team, including but not limited to administrators, teachers, nurse, noncertified staff members (e.g., cafeteria workers) and family. Examples of assessments may include pedometer steps, Perceived Levels of Physical Exertion Scale, body composition indicators and behavioral referral data.

Tier 3 (physical activity): Examples of Tier 3 interventions for students who are experiencing challenges as a result of physical inactivity include implementation of before- and after-school programs to engage identified students in PA three to five times per week; implementation of programs in which students and parents are involved together in extensive training and PA activities; individual counseling; and implementation of adapted physical education strategies.

Interventionists and assessment data might be similar to data used in Tier 1 and Tier 2, with more frequent and targeted progress monitoring.

Tier 1 (health and wellness): In Tier 1, district and school data teams need to implement and assess health policies and practices to ensure that the physical health needs of all students are addressed, including but not limited to those who are at risk for chronic diseases and health conditions such as overweight, obesity, diabetes and asthma; HIV; sexually transmitted diseases; drug and alcohol use and abuse; and teen pregnancy (Policy Guidance for the Position Statement on a Coordinated Approach to School Health, 2009). A comprehensive prekindergarten through Grade 12 school-health education curriculum with well-established standards and benchmarks should be in place and taught by certified, highly qualified health education teachers. School grounds should be smoke free, meet air quality standards and be regularly checked for potential safety hazards. Information should be provided to school staff members so they understand triggers and early warning signs of special health needs (e.g., asthma), and have action plans to implement in emergencies. The school nurse should be available to work with teachers to assist them in making appropriate modifications to accommodate health issues (e.g., opportunities for frequent rest intervals in the form of static skill stations for students with asthma). Programs and protocols should be available to help students to learn and apply self-care management skills, when appropriate, and a two-way family communication system should be in place regarding school health/nursing services to coordinate information.

The data teams must be able to evaluate the impact of Tier 1 programs in these areas to add, delete or modify programs and to plan interventions for individual students, as needed. Examples of assessments that might be used include attendance data, health services referrals, parent and child questionnaires, physical education performance data, self-medication assessments, and assessments developed for specific medical conditions (e.g., asthma).

Tier 2 (health and wellness): Examples of Tier 2 interventions for students with special health needs such as asthma include developing protocols for students to make up schoolwork due to absence from school; working with the school medical adviser and school nurse to plan school health programs on asthma; enlisting community partners (e.g., American Lung Association, local physicians) to

provide appropriate after-school programs; and implementing weekly or bi-weekly small group sessions with the physical education educator and school nurse to develop self-management skills, PA goal-setting, and progress monitoring.

Interventionists may include members of a coordinated school health team, including but not limited to administrators, teachers, nurse, health assistants, respiratory therapists, noncertified staff, and family. Examples of assessments may include health service referrals, attendance data, physical education performance, PA data, self-medication assessments, asthma action-plan assessments, asthma assessment sheets and Students with Asthma Tracking Form.

Tier 3 (health and wellness): Examples of Tier 3 interventions for students with special health needs such as asthma include referrals of students who exhibit signs of unmanaged asthma to primary care physician; implementation of before- and after-school programs to engage students in weekly asthma self-management skill-building programs; implementation of student and parent together programs for skill-building and individualized healthcare plan development; individual counseling; and implementation of asthma family support groups.

Interventionists and assessment data might be similar to data used in Tier 1 and Tier 2, with more frequent and targeted progress monitoring.

Tier 1 (nutrition): In Tier 1, district and school data teams need to ensure that the school health education curriculum includes nutrition education and specifically addresses the importance of all meals, including breakfast. Federally funded school breakfast programs and national school lunch programs should be implemented in eligible schools to provide age appropriate, nutritionally balanced meals. Individualized modifications of foods offered in the school nutrition program should be available to meet the medical requirements of students, and culturally appropriate food selections should be available to all students. A two-way family communication system should be established to support healthy meals at home and to provide opportunities for families to contribute nutritious food selections to various school events.

Tier 2 (nutrition): Examples of Tier 2 interventions for students with special nutrition requirements include implementation of an alternative meal delivery method to increase participation in the school breakfast program (e.g., breakfast in the classroom, grab and go breakfast, breakfast after first period); provision of specific nutrition or ingredient information to students with identified medical and/or nutritional needs; school staff collaboration to provide safe food environment throughout the school setting for students with special nutritional needs (e.g., allergies); implementation of small group meetings with the food services director, dietitian or school nurse on food selection and meal management; provision of resources for supplemental nutrition programs such as food bank and food stamps; and assist families with identification of community resources available to help with acquiring healthy foods for the household.

As with other areas, the data teams must be able to evaluate the impact of Tier 1 programs in these areas in order to add, delete or modify programs and to plan interventions for individual students, as needed. Examples of assessments that might be used include attendance data, health services referrals, parent and child questionnaires, breakfast and lunch meal counts, physical education performance data, self-medication assessments and assessments developed for specific medical conditions (e.g., asthma).

Interventionists may include members of a coordinated school health team, including but not limited to food services director or staff, dietitian administrators, teachers, nurse, social worker, noncertified

staff, and family. Examples of assessments might include breakfast meal counts, lunch meal counts, production records (which record the specific foods selected by students in the school meal programs), attendance data, nurse visits and behavioral referral data.

Tier 3 (nutrition): Examples of Tier 3 interventions for students with special nutrition requirements include provision of specialized educational opportunities for students and families with specific nutritional needs (e.g., obesity, eating disorders, diabetes, food allergies); implementation of before- and after-school program to engage students in nutrition self-management programs; individual nutritional and/or psychological counseling; parent support groups; and training for parents and students regarding the development of an individualized health care plan.

Interventionists and assessment data might be similar to data used in Tier 1 and Tier 2, with more frequent and targeted progress monitoring.

Social and Emotional Health

Tier 1: As stated in Connecticut’s Framework for RTI, “school and district personnel not only must provide teachers with high-quality curriculums and specific academic benchmarks for students, but also with a comprehensive, schoolwide system of social-emotional learning and behavioral supports” (2008, p. 24). This kind of comprehensive system is not limited to addressing overtly disruptive, noncompliant behaviors. It must also be designed to ensure a safe and secure educational environment and a positive school climate, so that nonacademic barriers to learning are removed and students can develop the prosocial skills that positively affect their motivation to achieve.

Several essential elements must be included in Tier 1. In order to establish a safe and secure educational environment, schools need to ensure that their school safety and emergency response systems are reviewed regularly and updated, as needed, to meet current needs. Codes of conduct delineating behavior/social standards and expectations, including strict prohibitions regarding bullying and harassment, should be clear, concise and consistently enforced in the school and classroom environments. Discipline policies and practices should be designed and implemented to encourage students to stay in school rather than excluding them, and should include specific procedures for prevention as well as intervention. Professional development for school personnel should be provided to assist them in addressing behavioral issues effectively, explicitly including those associated with bullying and harassment.

To create a positive school climate of warmth and mutual respect, districts and schools should engage in practices that foster understanding and respect for cultural diversity and celebrate the contributions of diverse groups. Educators should implement research-based and culturally competent/responsive curriculums that support student engagement, involve students as decision makers and problem solvers, and promote the acquisition of prosocial behaviors. Reinforcement activities that support behavioral and social development (i.e., self-awareness, self-regulation, decision-making, respect for others) can be co-taught with social workers, psychologists, school counselors, health educators, school nurses or others, as deemed appropriate. Adults in the school should take care to model the behaviors they are teaching when they interact with each other and with the students.

Finally, as in all other areas, schools should be engaging in a two-way communication with families and communities in supporting the development and maintenance of these social and emotional health skills. Initiatives should foster information sharing, as appropriate, and encourage the building of peer relationships and support networks.

Some of the assessments that data teams can use to develop and evaluate the effectiveness of these programs and interventions in this area are school climate questionnaires, suspension and expulsion rates, incidence of bullying and harassment, as well as other disciplinary data, schoolwide or classroom rating scales and checklists, attendance rates, work completions rates, and classroom observations.

Tier 2: Examples of Tier 2 interventions for students who need improvement in social behaviors include: implementation of small group instruction using research-based programs that support behavioral and social development; behavior management programs targeting specific behaviors; behavior contracts; check-in, check-out activities, and implementation of home-school collaboration activities. Interventionists may include general education teachers, school psychologists, school social workers, school counselors, school nurses, administrators and/or other support service specialists trained in specific intervention strategies. The interventions may take place in the general education classroom or a non-classroom setting, if appropriate.

Some examples of assessments in Tier 2 include pre and post measures of behavior checklists, observations, discipline referrals, student self-monitoring records of goals and progress and parent information data.

Tier 3: Examples of Tier 3 interventions for students who need improvement in social behaviors include more frequent implementation of small group instruction using research-based programs that support behavioral social development; more frequent monitoring and feedback with behavioral contracts; individual counseling; collaboration with community providers; more intensive home-school collaboration; and additional parent support services.

Interventionists may include school psychologists, school social workers, school counselors, administrators and/or other support service specialists trained in specific intervention strategies. The interventionists work in collaboration with general education teachers and in some instances community providers. The interventions generally take place in a nonclassroom setting.

In addition to the type of assessments used in Tier 1 and Tier 2, a functional behavior analysis might be a typical example of an assessment at this level.

Summary

Both school personnel and families can embrace SRBI as an opportunity to make a substantial improvement in a child's learning and health when needed. Clearly, additional questions will arise as schools and parents become increasingly experienced, sophisticated and proficient in their implementation of SRBI. Most often, there will not be one "right answer" to these questions, as resolutions are often situation specific and there may be many paths to the same goal. Using those practices with research-based foundations will ensure the effectiveness of interventions adapted to the individual needs of students. Ideally, as teams become more experienced in considering the needs of the **whole child**, the teams themselves will generate responses and effective solutions to the questions that arise during efforts to individualize programs, practices and services through a collaborative problem-solving process. For your convenience, a planning template illustrating the development of comprehensive programming to address the needs of the whole child that includes social, emotional, behavioral, and physical health, as well as the academics has been included in Appendix B of this document. Several references have also been included within this template that teams will find useful as they implement the SRBI framework to address the needs of the whole child.

References

Connecticut State Department of Education, (2010). *Topical Brief 1: The Use of Data Teams in Connecticut's SRBI Process*. http://www.sde.ct.gov/sde/lib/sde/pdf/curriculum/cali/topical_brief_1.pdf. Retrieved April 1, 2011

Connecticut State Department of Education, (2010). *Topical Brief 2: Communication and School-Family Partnerships in Connecticut's SRBI Process*. http://www.sde.ct.gov/sde/lib/sde/pdf/curriculum/cali/srbi_topical_brief_2_99_5.pdf. Retrieved April 1, 2011 .

Connecticut State Department of Education, (2010). *Position Statement on Creating a Healthy Learning Environment that is Physically, Emotionally and Intellectually Safe*. http://www.sde.ct.gov/sde/LIB/sde/pdf/board/Creating_Learning_Environment.pdf. Retrieved April 1, 2011 .

Connecticut State Department of Education, (2010). *Position Statement on Nutrition and Physical Activity*. http://www.sde.ct.gov/sde/LIB/sde/pdf/board/nutrition_phys_activity.pdf. Retrieved April 1, 2011 .

Connecticut State Department of Education, (2010). *Position Statement on Student Support Services*. <http://www.sde.ct.gov/sde/LIB/sde/pdf/board/stusuptserv.pdf>. Retrieved April 1, 2011 .

Connecticut State Department of Education, (2009). *Position Statement on a Coordinated Approach to School Health*. http://www.sde.ct.gov/sde/LIB/sde/pdf/board/csh_position_statement.pdf. Retrieved April 1, 2011 .

Connecticut State Department of Education, (2009). *School-Family-Community Partnerships for Student Success Position Statements and Policy Guidance*. <http://www.sde.ct.gov/sde/cwp/view.asp?a=2678&q=320732&sdePNavCtr=|45493|#45544>. Retrieved April 1, 2011 .

Connecticut State Department of Education, (2008). *Using Scientific Research-Based Interventions: Improving Education for all Students: Connecticut's Framework for RTI*. http://state.rti4success.org/index.php?option=com_resource&view=single&cid%5B%5D=207. Retrieved April 1, 2011 .

Appendix G:

REPORTING CHILD ABUSE AND NEGLECT: AN OVERVIEW FROM THE DEPARTMENT OF CHILDREN AND FAMILIES

The following is an outline of the legal requirements of “mandated reporters,” those professionals who, because their work involves regular contact with children, are mandated by law to report suspected child abuse and neglect. For a complete copy of the law, refer to Sections 17a-101 through 17a-103a, inclusive of the Connecticut General Statutes.

Who Must Report

Connecticut law requires certain citizens to report suspected child abuse and neglect. These mandated reporters are people in professions or occupations that have contact with children or whose primary focus is children. The law requires that they report suspected child abuse or neglect. Under Section 17a-101 of the Connecticut General Statutes, the following are considered mandated reporters:

- Any person paid to care for a child in any public or private facility, child day care center, group day care home or family day care home which is licensed by the State.
- Battered Women’s Counselors
- Chiropractors
- Dental Hygienists
- Dentists
- Department of Children and Families Employees
- Department of Public Health employees responsible for the licensing of child day care centers, group day care homes, family day care homes or youth camps.
- Foster Parents
- Licensed/Certified Alcohol and Drug Counselors
- Licensed/Certified Emergency Medical Services Providers
- Licensed Marital and Family Therapists
- Licensed or Unlicensed Resident Interns
- Licensed or Unlicensed Resident Physicians
- Licensed Physicians
- Licensed Practical Nurses
- Licensed Professional Counselors
- Licensed Surgeons
- Medical Examiners
- Members of the Clergy
- Mental Health Professionals
- Optometrists
- Parole Officers (Juvenile or Adult)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Police Officers
- Probation Officers (Juvenile or Adult)
- Psychologists
- Registered Nurses

- School Guidance Counselors
- School Paraprofessionals
- School Principals
- School Teachers
- Sexual Assault Counselors
- **Social Workers**
- School Coaches or Coaches of Intramural or Interscholastic Athletics
- The Child Advocate and any employee of the Office of the Child Advocate.

What Must Be Reported

Mandated reporters are required to report or cause a report to be made when, in the ordinary course of their employment or profession, they have reasonable cause to suspect or believe that a child under the age of 18 has been abused, neglected or is placed in imminent risk of serious harm. (Connecticut General Statutes §17a-101a)

Child abuse occurs where a child has had physical injury inflicted upon him or her other than by accidental means, has injuries at variance with history given of them, or is in a condition resulting in maltreatment, such as, but not limited to, malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional maltreatment or cruel punishment. (Connecticut General Statutes §46b-120)

Child neglect occurs where a child has been abandoned, is being denied proper care and attention physically, emotionally, or morally, or is being permitted to live under conditions, circumstances or associations injurious to his well-being. (Connecticut General Statutes §46b-120)

When making a report, a mandated reporter is required to provide the following information, if known:

- names and addresses of the child and his parents or responsible caregiver(s);
- child's age and gender;
- nature and extent of injury, maltreatment or neglect;
- approximate date and time the injury, maltreatment or neglect occurred;
- the circumstances in which the injuries, maltreatment or neglect became known to the reporter;
- previous injury, maltreatment or neglect of the child or siblings;
- name of the person suspected to have caused the injury, maltreatment or neglect;
- any action taken to treat or help the child; and
- any other information the reporter believes would be helpful

Mandated reporters who, outside the ordinary course of their employment or profession, have reasonable cause to suspect or believe that a child under the age of 18 is in imminent risk of being abused or has been abused or neglected, can and should make a report to the Hotline.

How to Report

Mandated reporters must report orally to the Department of Children and Families' (DCF) Hotline or a law enforcement agency within 12 hours of suspecting that a child has been abused or neglected and must submit a written report (DCF-136 form) to DCF within 48 hours of making the oral report. DCF is required to tape record all reports to the Hotline.

Special reporting requirements may apply for staff members of a public or private institution or facility that cares for such child, or a public or private school. Police must report to DCF immediately upon receipt of any oral report of abuse or neglect.

Upon receipt of any oral report alleging sexual abuse or serious physical abuse or serious neglect, DCF must report to the appropriate state or local law enforcement agency within 12 hours.

Anonymity

Mandated reporters are required to give their name when they make a report to DCF, however, reporters may request anonymity to protect their privacy. This means that DCF would not disclose their name or identity unless mandated to do so by law (Connecticut General Statutes, Sections 17a-28 and 17a-101). Unless a reporter gives written consent, his or her name will not be disclosed except to:

- a DCF employee
- a law enforcement officer
- an appropriate state's attorney
- an appropriate assistant attorney general
- a judge and all necessary parties in a court proceeding
- a state child care licensing agency, executive director of any institution, school or facility or superintendent of schools

If DCF suspects or knows that the reporter knowingly makes a false report, his or her identity shall be disclosed to the appropriate law enforcement agency and the person may be subject to the penalty described in the next section.

Immunity and Penalty

Immunity from civil or criminal liability is granted to people who make required reports in good faith. Immunity is also granted to people who in good faith have not reported. However, failure to report could result in fines, which range from \$500 to \$2,500 and the individual will be required to participate in an educational and training program. In addition, mandated reporters could also be sued for damages if further injury is caused to the child because they did not act.

Anyone who knowingly makes a false report of child abuse or neglect shall be fined up to \$2,000 or imprisoned for not more than one year, or both. The identity of any such person shall be disclosed to the appropriate law enforcement agency and to the perpetrator of the alleged abuse.

Employers may not discharge, discriminate or retaliate against an employee for making a good faith report or testifying in an abuse or neglect proceeding. The Attorney General can bring a court action against any employer who violates this provision, and the court can assess a civil penalty of up to \$2,500 plus other equitable relief.

Informing the Family

Mandated reporters are under no legal obligation to inform parents that they have made a report to DCF about their child. However, depending on the circumstances, it may be necessary and/or beneficial to do so.

- When a child is suspected of being abused, neglected or placed at imminent risk of serious harm

by a member of the staff of a private or public school or an institution that cares for the child, the person in charge of the school or facility must notify the child's parent or other person responsible for the child's care that a report has been made. It is DCF's responsibility to notify the head of such school, facility or institution that a report has been made.

- Health care professionals may need to talk with parents to assess the cause of the child's injury(ies). Mental health professionals or members of the clergy may want to talk with the parents to offer support and guidance.

However, in cases of serious physical abuse or sexual abuse, it may not be wise to talk with parents before reporting the case to DCF. This may put the child at greater risk and could interfere with a potential criminal investigation.

Investigation of Abuse or Neglect Report

DCF is responsible for immediately evaluating and classifying all reports of suspected abuse/ neglect/ imminent risk. If the report contains information to warrant an investigation, DCF must make its best effort to begin an investigation within two hours if there is an imminent risk of physical harm to a child or another emergency; and within three days for all other reports. In all cases, DCF must complete the investigation in 30 calendar days. When conducting a child abuse or neglect investigation, DCF or a law enforcement agency must coordinate activities to minimize the number of interviews with any child. DCF must obtain consent from the parent, guardian or person responsible for the child's care for any interview, unless DCF has reason to believe such person or a member of the child's household is the alleged perpetrator. When such consent is not required, the interview must be conducted in the presence of a 'disinterested adult' (typically, a person who is impartial and has no self-interest in the case). If a disinterested adult is not available after reasonable search and immediate access is necessary to protect the child from imminent risk of serious harm, DCF or a law enforcement agency will still interview the child. If, after the investigation has been completed, serious physical abuse or sexual abuse is substantiated, DCF must notify the local police, and either the Chief State's Attorney/designee or a state's attorney in the judicial district in which the child resides or in which the abuse occurred. A copy of the investigation report must also be sent.

Suspected Abuse By a School Employee

Mandated reporters are required to report any suspected child abuse, neglect or imminent risk of serious harm directly to DCF or the police. This includes situations when the alleged perpetrator is a school employee. DCF must notify the head of the school that a report has been made, unless such person is the alleged perpetrator. Investigations of suspected child abuse, neglect or imminent risk of serious harm by a school employee are conducted by DCF. If, after such investigation, DCF has reasonable cause to believe that a child has been abused by a certified public school employee (in a position requiring a certificate), DCF shall notify the Superintendent of such finding and shall provide him or her with records concerning such investigation. The Superintendent must suspend such employee. The suspension shall be with pay and will not diminish or terminate the employee's benefits. Within 72 hours after such suspension, the Superintendent shall notify the local or regional board of education and the Commissioner of Education of the reasons for and conditions of the suspension. The Superintendent shall disclose the DCF records to the Commissioner of Education and local or regional boards of education or their attorney for purposes of review of employment status or certification. The suspension must remain in effect until the local Board of Education takes action.

If the employee's contract is terminated, the Superintendent shall notify the Commissioner of Education or his representative within 72 hours. The Commissioner of Education may then commence certification revocation proceedings. The Superintendent may suspend any other school staff member in similar circumstances. The State's Attorney must notify the Superintendent, or supervising agent of a non-public school, and the Commissioner of Education when a certified school employee, or any person holding a certificate issued by the State Board of Education, is convicted of a crime involving an act of child abuse or neglect.

Suspected Abuse By a Member of An Institution or Facility Providing Child Care

Mandated reporters are also required to report when they have reasonable cause to suspect or believe that any child has been abused or neglected by a member of the staff of a public or private institution or facility that provides care for children. DCF must notify the head of the institution or facility providing child care that a report has been made, except in circumstances when such person is the alleged perpetrator. Whenever DCF, based on the results of an investigation, has reasonable cause to believe that a child has been abused or neglected by a staff member of a public or private institution or facility providing child care, DCF shall notify the institution, school or facility and provide records concerning the investigation to the executive director. If the facility is licensed by the state for the caring of children, DCF shall notify the state agency that licenses it and provide records concerning the investigation. The institution may suspend the employee. The suspension must be with pay, not diminish or terminate the employee's benefits and remain in effect until resolved by the person's employer.

Where to Call

The Department has a single point of contact statewide for the reporting of suspected child abuse and neglect. This Child Abuse and Neglect Hotline operates 24 hours a day and seven days a week. Anyone who suspects that a child has been abused or neglected or is in danger of abuse or neglect is strongly encouraged to call the Hotline.

DCF Child Abuse and Neglect Hotline: 1-800-842-2288

TDD Number: 1-800-624-5518

The Hotline is staffed by full-time, highly-skilled professionals of the Department who receive and process reports of alleged child abuse and neglect. The Hotline worker gathers critical information from the caller to determine if a report meets Connecticut's statutory criteria for child abuse or neglect. Those reports that meet the criteria are forwarded to a DCF case investigator for prompt and appropriate action.

Appendix H: Report of Suspect Child Abuse/Neglect (reporting form)

REPORT OF SUSPECTED CHILD ABUSE/NEGLECT

DCF-136
10/01/02 (Rev)



HOTLINE
1-800-842-2288

Within forty-eight hours of making an oral report, a mandated reporter shall submit a written report (DCF-136) to the Hotline.
See the reverse side of this form for a summary of Connecticut law concerning the protection of children.

Please print or type

CHILD'S NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	AGE OR BIRTH DATE
CHILD'S ADDRESS		
NAME OF PARENTS OR OTHER PERSON RESPONSIBLE FOR CHILD'S CARE	ADDRESS	PHONE NUMBER
WHERE IS THE CHILD STAYING PRESENTLY IF NOT AT HOME?	PHONE NUMBER	DATE PROBLEM(S) NOTED
NAME OF HOTLINE WORKER TO WHOM ORAL REPORT WAS MADE	DATE OF ORAL REPORT	DATE AND TIME OF SUSPECTED ABUSE/NEGLECT
NAME OF SUSPECTED PERPETRATOR, IF KNOWN	ADDRESS AND/OR PHONE NUMBER, IF KNOWN	RELATIONSHIP TO CHILD

NATURE AND EXTENT OF THE CHILD'S INJURY(IES), MALTREATMENT OR NEGLECT.

INFORMATION CONCERNING ANY PREVIOUS INJURY(IES), MALTREATMENT OR NEGLECT OF THE CHILD OR HIS/HER SIBLINGS.

LIST NAMES AND AGES OF SIBLINGS, IF KNOWN.

DESCRIBE THE CIRCUMSTANCES IN WHICH THE INJURY(IES), MALTREATMENT OR NEGLECT CAME TO BE KNOWN TO THE REPORTER.

WHAT ACTION, IF ANY, HAS BEEN TAKEN TO TREAT, PROVIDE SHELTER OR OTHERWISE ASSIST THE CHILD?

REPORTER'S NAME AND AGENCY	ADDRESS	PHONE NUMBER
REPORTER'S SIGNATURE	POSITION	DATE

WHITE COPY: TO DCF HOTLINE, 505 Hudson Street, Hartford, CT 06106

YELLOW COPY: REPORTER'S COPY

SUMMARY OF LEGAL REQUIREMENTS CONCERNING CHILD ABUSE/NEGLECT

PUBLIC POLICY OF THE STATE OF CONNECTICUT

To protect children whose health and welfare may be adversely affected through injury and neglect; to strengthen the family and to make the home safe for children by enhancing the parental capacity for good child care; to provide a temporary or permanent nurturing and safe environment for children when necessary; and for these purposes to require the reporting of suspected child abuse, investigation of such reports by a social agency, and provision of services, where needed, to such child and family.

WHO IS MANDATED TO REPORT CHILD ABUSE/NEGLECT?

Battered Women's Counselors	Optometrists
Chiropractors	Parole Officers (Juvenile or Adult)
Dental Hygienists	Pharmacists
Dentists	Physical Therapists
Department of Children and Families Employees	Physician Assistants
Licensed/Certified Alcohol and Drug Counselors	Podiatrists
Licensed/Certified Emergency Medical Services Providers	Police Officers
Licensed Marital and Family Therapists	Probation Officers (Juvenile or Adult)
Licensed or Unlicensed Resident Interns	Psychologists
Licensed or Unlicensed Resident Physicians	Registered Nurses
Licensed Physicians	School Coaches
Licensed Practical Nurses	School Guidance Counselors
Licensed Professional Counselors	School Paraprofessionals
Licensed Surgeons	School Principals
Medical Examiners	School Teachers
Members of the Clergy	Sexual Assault Counselors
Mental Health Professionals	Social Workers

Any person paid to care for a child in any public or private facility, child day care center, group day care home or family day care home which is licensed by the State. Department of Public Health employees responsible for the licensing of child day care centers, group day care homes, family day care homes or youth camps. The Child Advocate and any employee of the Office of the Child Advocate.

DO THOSE MANDATED TO REPORT INCUR LIABILITY?

No. Any person, institution or agency which, in good faith, makes or does not make a report, shall be immune from any civil or criminal liability provided such person did not perpetrate or cause such abuse or neglect.

IS THERE A PENALTY FOR NOT REPORTING?

Yes. Any person, institution or agency required to report who fails to do so shall be fined \$500.00 - \$2,500.00 and shall be required to participate in an educational and training program.

IS THERE A PENALTY FOR MAKING A FALSE REPORT?

Yes. Any person, institution or agency who knowingly makes a false report of child abuse or neglect shall be fined not more than \$2,000.00 or imprisoned not more than one year or both. The identity of such person shall be disclosed to the appropriate law enforcement agency and to the alleged perpetrator of the abuse.

WHAT ARE THE REPORTING REQUIREMENTS?

- An oral report shall be made by a mandated reporter by telephone or in person to the DCF Hotline or to a law enforcement agency as soon as practicable, but not later than 12 hours after the mandated reporter has reasonable cause to suspect or believe that a child has been abused or neglected or placed in imminent risk of serious harm. If a law enforcement agency receives an oral report, it shall immediately notify Hotline. Oral reports to the Hotline shall be recorded on tape.
- Within forty-eight hours of making an oral report, a mandated reporter shall submit a written report to the DCF Hotline.
- When the report concerns an employee of a facility or institution which is licensed by the State, the mandated reporter shall also send a copy of the written report to the executive head of the state licensing agency.

DEFINITIONS OF ABUSE AND NEGLECT

Child Abuse: any child or youth who has a non-accidental physical injury, or injuries which are at variance with the history given of such injuries, or is in a condition which is the result of maltreatment such as, but not limited to, malnutrition, sexual molestation, deprivation of necessities, emotional maltreatment or cruel punishment.

Child Neglect: any child or youth who has been abandoned or is being denied proper care and attention, physically, educationally, emotionally, or morally or is being permitted to live under conditions, circumstances or associations injurious to his well-being.

Exception: The treatment of any child by an accredited Christian Science practitioner shall not of itself constitute neglect or maltreatment.

Child Under 13 with Venereal Disease: a physician or facility must report to Hotline upon the consultation, examination or treatment for venereal disease of any child not more than twelve (12) years old.

DO PRIVATE CITIZENS HAVE A RESPONSIBILITY FOR REPORTING?

Yes. Any person having reasonable cause to suspect or believe that any child or youth under the age of eighteen (18) is in danger of being abused or has been abused or neglected, may cause a written or oral report to be made to the Hotline or a law enforcement agency. A person making the report in good faith is also immune from any liability, civil or criminal. However, the person is subject to the penalty for making a false claim.

WHAT IS THE AUTHORITY AND RESPONSIBILITY OF THE DEPARTMENT OF CHILDREN AND FAMILIES (DCF)?

All children's protective services are the responsibility of the Department of Children and Families.

Upon the receipt of a child abuse/neglect report, the Hotline shall cause the report to be classified, evaluated immediately and forwarded to the appropriate investigation unit for the commencement of an investigation within timelines specified by statute and policy.

If the investigation produces evidence of child abuse/neglect, the Department shall take such measures as it deems necessary to protect the child, and any other children similarly situated, including, but not limited to, immediate notification to the appropriate law enforcement agency, and the removal of the child or children from his home with the consent of the parents or guardian or by order of the Superior Court, Juvenile Matters.

If the Department has probable cause to believe that the child or any other child in the household is in imminent risk of physical harm from his surroundings, and that immediate removal from such surroundings is necessary to ensure the child's safety, the Commissioner or designee shall authorize any employee of the Department or any law enforcement officer to remove the child and any other child similarly situated from such surroundings without the consent of the child's parent or guardian. The removal of a child shall not exceed ninety-six (96) hours. If the child is not returned home within such ninety-six hour period, with or without protective services, the Department shall file a petition for custody with the Superior Court, Juvenile Matters.

WHAT MEANS ARE AVAILABLE FOR REMOVING A CHILD FROM HIS HOME?

- 96-Hour Hold by the Commissioner of DCF (see above)
- 96-Hour Hold by a Hospital – Any physician examining a child with respect to whom abuse or neglect is suspected shall have the right to keep such child in the custody of a hospital for no longer than ninety-six hours in order to perform diagnostic tests and procedures necessary to the detection of child abuse or neglect and to provide necessary medical care with or without the consent of such child's parents or guardian or other person responsible for the child's care, provided the physician has made reasonable attempts to (1) advise such child's parents or guardian or other person responsible for the child's care that he suspects the child has been abused or neglected and (2) obtain consent of such child's parents or guardian or other person responsible for the child's care. In addition, such physician may take or cause to be taken photographs of the area of trauma visible on a child who is the subject of such report without the consent of such child's parent's or guardian or other person responsible for the child's care. All such photographs or copies thereof shall be sent to the local police department and the Department of Children and Families.
- Custody Order – Whenever any person is arrested and charged with an offense under Section 53-20 or 53-21 or under Part V, VI, or VII of Chapter 952, as amended, the victim of which offense was a minor residing with the defendant, any judge of the Superior Court may, if it appears that the child's condition or circumstances surrounding his case so require, issue an order to the Commissioner of the Department of Children and Families to assume immediate custody of such child and, if the circumstances so require, any other children residing with the defendant and to proceed thereon as in cases reported.

WHAT IS THE CHILD ABUSE CENTRAL REGISTRY?

The Department of Children and Families maintains a registry of reports received and permits its use on a twenty-four hour daily basis to prevent or discover child abuse of children. Required confidentiality is ensured.

DCF CHILD ABUSE AND NEGLECT HOTLINE: 1-800-842-2288

STATUTORY REFERENCES: §17a-28; §17a-101 et. seq.; §46b-120.

Appendix I: Complaint - School Truancy/Defiance Family with Service Needs

**COMPLAINT - SCHOOL TRUANCY/DEFIANCE
FAMILY WITH SERVICE NEEDS**

JD-JM-119 Rev. 4-12
C.G.S. §§ 46b-120, 149, 10-198a, 10-200

STATE OF CONNECTICUT
SUPERIOR COURT
JUVENILE MATTERS
www.jud.ct.gov



Address of Court					Docket number		
Name of child		Address of child		Grade	Sex	Date of birth	Indian tribe/reservation, if any
Child's race							Hispanic
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Black	<input type="checkbox"/> Unknown	<input type="checkbox"/> White	<input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of mother			Address of mother				
Name of father			Address of father				
Name of guardian, if any			Address of guardian				
Mother's home telephone	Mother's work telephone	Father's home telephone	Father's work telephone	Guardian's home telephone	Guardian's work telephone		
Name of complainant			Address of complainant				
Name of school and contact person at school				Telephone	Fax number		

A family with service needs complaint may be filed only after the school has exhausted all available options to rectify the problem.

A complaint may be found insufficient if it does not include the following as required by state law including, but not limited to, Section 10-198a of the Connecticut General Statutes: ("*X*" box if action as been taken)

- A meeting was held with the parent of the truant child and appropriate school personnel reviewed and evaluated the reasons for the child being truant. The meeting was held not later than 10 school days after the child's 4th unexcused absence in a month or the 10th unexcused absence in a school year.
- Coordination of services and referrals for the child were made to community agencies providing child and family services.
- Every year, at the beginning of the school year and upon any enrollment during the school year, the parent was informed in writing of his or her obligations or the obligations of any other person having control of the child under Section 10-184 of the Connecticut General Statutes.
- School personnel made reasonable efforts to notify the parent or other person having control of the child by telephone whenever the child failed to report to school on a regularly scheduled school day and no indication was received by school personnel that the child's parent or other person having control of the child was aware of the pupil's absence.

If records are incomplete or do not exist please attach an explanation for the Court.

Type of Referral

The family is a family with service needs because it includes a child who is (place an "x" in the appropriate box or boxes):

- Truant** (Four (4) unexcused absences in one month or Ten (10) unexcused absences in a school year)
- Habitually Truant** (Twenty (20) unexcused absences in a school year)
- Defiant** (Continuously and overtly defiant of school rules and regulations)

Attendance

List specific dates of unexcused absences in the space below. Do not just reference the included attendance report in this section.

Behavior

If this referral is based on the child's in-school conduct rather than truancy, provide documentation that the child has been continuously and overtly defiant of school rules and regulations. There must be a pattern of defiance over a time. A single incident is not sufficient to establish that a child is defiant of school rules. *(List all dates and description of behavior)*

List date(s) of meeting(s) with parent(s): _____

Parent or guardian did not attend meeting(s) on _____ or otherwise did not cooperate with the school in attempting to solve the truancy problem.

Community Services attempted on: _____

Has the parent or guardian been notified of the filing of this complaint? Yes No

Signed *(Superintendent of School, only)*

Print or type name of person signing

Date signed

Appendix J: Regulation pertaining to Consent Not Required for Disclosure

Sec. 52-146f. Consent not required for disclosure, when. Consent of the patient shall not be required for the disclosure or transmission of communications or records of the patient in the following situations as specifically limited:

(1) Communications or records may be disclosed to other persons engaged in the diagnosis or treatment of the patient or may be transmitted to another mental health facility to which the patient is admitted for diagnosis or treatment if the psychiatrist in possession of the communications or records determines that the disclosure or transmission is needed to accomplish the objectives of diagnosis or treatment. The patient shall be informed that the communications or records will be so disclosed or transmitted. For purposes of this subsection, persons in professional training are to be considered as engaged in the diagnosis or treatment of the patients.

(2) Communications or records may be disclosed when the psychiatrist determines that there is substantial risk of imminent physical injury by the patient to himself or others or when a psychiatrist, in the course of diagnosis or treatment of the patient, finds it necessary to disclose the communications or records for the purpose of placing the patient in a mental health facility, by certification, commitment or otherwise, provided the provisions of sections 52-146d to 52-146j, inclusive, shall continue in effect after the patient is in the facility.

(3) Except as provided in section 17b-225, the name, address and fees for psychiatric services to a patient may be disclosed to individuals or agencies involved in the collection of fees for such services. In cases where a dispute arises over the fees or claims or where additional information is needed to substantiate the fee or claim, the disclosure of further information shall be limited to the following: (A) That the person was in fact a patient; (B) the diagnosis; (C) the dates and duration of treatment; and (D) a general description of the treatment, which shall include evidence that a treatment plan exists and has been carried out and evidence to substantiate the necessity for admission and length of stay in a health care institution or facility. If further information is required, the party seeking the information shall proceed in the same manner provided for hospital patients in section 4-105.

(4) Communications made to or records made by a psychiatrist in the course of a psychiatric examination ordered by a court or made in connection with the application for the appointment of a conservator by the Probate Court for good cause shown may be disclosed at judicial or administrative proceedings in which the patient is a party, or in which the question of his incompetence because of mental illness is an issue, or in appropriate pretrial proceedings, provided the court finds that the patient has been informed before making the communications that any communications will not be confidential and provided the communications shall be admissible only on issues involving the patient's mental condition.

(5) Communications or records may be disclosed in a civil proceeding in which the patient introduces his mental condition as an element of his claim or defense, or, after the patient's death, when his condition is introduced by a party claiming or defending through or as a beneficiary of the patient and the court or judge finds that it is more important to the interests of justice that the communications be disclosed than that the relationship between patient and psychiatrist be protected.

(6) Communications or records may be disclosed to (A) the Commissioner of Public Health in connection with any inspection, investigation or examination of an institution, as defined in subsection (a) of section 19a-490, authorized under section 19a-498, or (B) the Commissioner of Mental Health

and Addiction Services in connection with any inspection, investigation or examination authorized under subsection (f) of section 17a-451.

(7) Communications or records may be disclosed to a member of the immediate family or legal representative of the victim of a homicide committed by the patient where such patient has, on or after July 1, 1989, been found not guilty of such offense by reason of mental disease or defect pursuant to section 53a-13, provided such family member or legal representative requests the disclosure of such communications or records not later than six years after such finding, and provided further, such communications shall only be available during the pendency of, and for use in, a civil action relating to such person found not guilty pursuant to section 53a-13.

(8) If a provider of behavioral health services that contracts with the Department of Mental Health and Addiction Services requests payment, the name and address of the person, a general description of the types of services provided, and the amount requested shall be disclosed to the department, provided notification that such disclosure will be made is sent, in writing, to the person at the earliest opportunity prior to such disclosure. In cases where a dispute arises over the fees or claims, or where additional information is needed to substantiate the claim, the disclosure of further information shall be limited to additional information necessary to clarify only the following: (A) That the person in fact received the behavioral health services in question, (B) the dates of such services, and (C) a general description of the types of services. Information the department receives pursuant to this subdivision shall be disclosed only to federal or state auditors and only as necessary for the purposes of auditing.

Appendix K: Resources

PROFESSIONAL ORGANIZATIONS:

SSWAA – School Social Work Association of America <http://www.sswaa.org>

CASSW – Connecticut Association of School Social Workers <http://www.cassw.org>

NASW – National Association of Social Workers – <http://www.nasw.org>

NASW/CT – National Association of Social Workers/Connecticut Chapter – <http://www.naswct.org>

NIMH – National Institute of Mental Health – <http://www.nimh.nih.gov>

CASEL – Collaborative for Academic, Social, and Emotional Learning – <http://www.casel.org>

SAMHSA – Substance Abuse and Mental Health Services Administration – <http://www.samhsa.gov>

STATE AGENCIES/RESOURCES:

CSDE – State Department of Education - <http://www.sde.ct.gov/>

DCF – Department of Children and Families – <http://www.state.ct.us/DCF>

DDS – Department of Developmental Services – <http://www.ct.gov/dds/>

DSS – Department of Social Services – <http://www.ct.gov/dss>

BRS – Bureau of Rehabilitation Services – <http://www.brs.state.ct.us>

Infoline – <http://www.infoline.org/>

COMMERCIAL RESOURCES:

Community Intervention – <http://www.communityintervention.org>

Wellness Productions – <http://www.wellness-resources.com>

Boys Town Press – <http://www.boystownpress.org>

Free Spirit Publishing – <http://www.freespirit.com>

Hazeldon Publishing and Educational Services – <http://www.hazeldon.org/bookstore>

Research Press – <http://www.researchpress.org>

School Specialty – <http://www.TeachersMediaCompany.com>

At-Risk Resources – <http://www.at-risk.com>

Sunburst Visual Media – <http://www.sunburstvm.com>

Childswork/Childsplay – <http://www.childswork.com>

Positive Promotions – <http://www.positivepromotions.com>

CURRICULUM MATERIALS:

Committee for Children – Second Step Program – <http://www.cfchildren.org>

Committee for Children – Steps to Respect - <http://www.cfchildren.org>

Promoting Alternative Thinking Skills – PATHS – <http://www.modelprograms.samhsa.gov>

Boys Town – Boys Town Model - <http://www.boystownpress.org>

PROFESSIONAL DEVELOPMENT:

State Education Resource Center – SERC - <http://www.ctserc.org/>

Cape Cod Institute – <http://www.cape.org>

New England Education Institute – NEEI – <http://www.neei.org>

References

- Allen-Meares, P. (ed. 2007). *Social work services in schools*. 5th ed. New York: Pearson, Allyn, and Bacon.
- Barnett, D.W., Elliott, N., Graden, J., Ihlo, T., Macmann, G., Nantais, M., & Prasse, D. (2006). *Technical adequacy for Response to Intervention practices*. *Assessment for Effective Intervention*, 32(1), 20-31.
- Bowen, G. L., Rose, R. A., & Bowen, N. K. (2005). *The reliability and validity of the School Success Profile*. Philadelphia, PA: Xlibris Press.
- Center for Mental Health in Schools at UCLA. (2005). *National Initiative: New Directions for Student Support*.
- Collaborative for Academic, Social, and Emotional Learning (CASEL). (2003). *Safe and Sound: An Educational Leader's Guide to Evidence-based Social and Emotional Learning Programs*.
- Connecticut State Department of Education (CSDE). (1989). *Guidelines for School Social Work*.
- Constable, R. T., Rippey Massat, C., McDonald, S. and Flynn, J.P. (2008). *School social work: Practice, policy, and research*. 7th ed. Chicago: Lyceum.
- Evans, D.L., Foa, E.B., Gur, R.E., Hendin, H., O'Brien, C.P., Seligman, M.E. and Walsh, T. (eds. 2005). *Treating and Preventing Adolescent Mental Health Disorders: What we Know and What We Don't Know*. NY: Oxford Univ. Press.
- Franklin, C, Harris, M. B. and Allen-Meares, P. (eds. 2006). *The school services source book: A guide for school-based professionals*. New York: Oxford University Press.
- Fraser, M.W. (2004). *Risk and Resilience in Childhood*. Washington, DC: NASW Press.
- Freeman, E.M. (1998). *School Social Work at Its Crossroad: Multiple Challenges and Possibilities*. *Social Work in Education*. 20(2), 83-89.
- Friend, M. and Cook, L. (2003). *Interactions: Collaboration Skills for School Professionals*. 4th ed. Boston: Allyn & Bacon.
- Hemmeter, M.L., Ostrosky, M., and Fox, L. (2006). *Social and emotional foundations for early learning: A conceptual model for intervention*. *School Psychology Review*, 35, 583-601.
- Gitterman, A. and Germain, C. B. (2008). *Life Model of Social Work Practice: Advances in Theory and Practice*. 3rd ed. New York: Columbia University Press.
- National Association of Social Workers (1996). *Code of Ethics*.

REFERENCES

National Association of Social Workers. (2001) *Confidentiality and School Social Work: a Practice Perspective*.

National Association for Social Workers (2002). *Standards for School Social Work Services*.

New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America - Final report*.

School Social Work Association of America. (2001). *Position Statement: School Social Workers and Confidentiality*.

School Social Work Association of America (2003). *School Social Work as a Career*.

Walker, H. M. and Severson, H. H. (1992). *Systematic Screening for Behavior Disorders (SSBD)*. 2nd ed. Longmont, CO: Sopris West.

Zins, J., Weissberg, R., Wang, M. and Walberg, J. (2004). *Building Academic Success on Social and Emotional Learning*. NY: Teachers College Press.

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