Thursday, September 11, 14

Student Mental Health: An Essential Guide for School Administrators

MASA Video Presentation November 5, 2013

“If you want to build a ship, don't herd people together to collect wood and don't assign them tasks and work, but rather teach them to long for the endless immensity of the sea.”

Antoine de Saint-Exupery

Demographics of Childhood Psychiatric Disorders

18% of children and adolescents have a mental health disorder

5% have a Severe Emotional Disability

Only a small percentage of students in the EBD/SED category (typically about 1.5-2%)

Thus, most emotionally disturbed, and even most severely emotionally disturbed students are not in special education at all, they are in the regular education system.

Mental health disorders in children are often undetected and therefore remain untreated

Unmet MH care needs can have serious consequences for children and their families: strained social relationships, poor academic performance, and serious problems in adulthood

Longitudinal studies of children with mental health disorders have documented an increased risk of dropping out of school, alcohol and drug use, and criminal activity later in life

A higher percentage of boys than girls had difficulties at both levels of severity (severe/definite and minor)

Nearly twice the percentage of poor children had parental reports of severe/definite difficulties as nonpoor children (7 percent vs. 4 percent)

The percentage with severe/ definite difficulties was 9 percent of Medicaid insured children compared with 4 percent of privately insured children and 5 percent of uninsured children

Among boys with severe/ definite difficulties, 59 percent had ever been diagnosed with ADHD, 48 percent with learning disability, and 21 percent with developmental delay

Prevalence of Psychiatric Disorders in Youths Across Five Sectors of Care

Garland, A. et al
Am. Acad Child Adolesc. Psychiatry
40:4 April 2001

The group that had the highest percentage of psychiatric disorders was:
SED students (70.2% diagnosed in the previous year, followed by
Mental Health (60.8%)
Alcohol/Drug (60.3%)
Juvenile Justice (52.1%)
Child Welfare (41.8%)

Schools are the most common settings where youth who have mental health disorders receive any services

School counseling (25%)
Mental health specialists (24%),
General medical providers (11%)
Human Services (7%)
Alternative medicine (5%)
Juvenile Justice (5%)

Only one third of adults who have mental health disorders receive treatment

Only one fifth of children and adolescents who have mental health disorders receive treatment

Manifestations in the Home vs. School Environments

Some disorders manifest differently depending on the situation (e.g. ADHD in highly stimulating, distracting settings vs. low distracting settings)

Other disorders are less reflective of the environment and more reflective of the internal illness (e.g., Schizophrenia, Bipolar disorder, etc.)

Causes of mental health symptoms

1. Adjustment related to life stresses
2. Caused by medical disorder, toxins, or medication side effects
3. Caused by a disorder that has a biological basis (and is affected to varying degrees by life stresses)- e.g., Schizophrenia, Depression, Bipolar Disorder, ADHD, Obsessive Compulsive Disorder, Panic Disorder, Autism, etc.

Addressing the behavioral manifestations of a disorder without understanding the nature of the disorder frequently leads to a failed behavioral plan, and frustrated students, teachers and parents.

Ideally, students would receive treatment for their disorders, and the treatment would be so effective that school problems would disappear

This occasionally happens (e.g., in milder cases of ADHD), but in moderate or severe mental health disorders, even with the best treatments, there are residual symptoms that tend to interfere with educational and social functioning

Some students have ongoing school difficulties because they are not receiving any treatment for their disorders, because they are receiving the wrong treatment, or because they have disorders that, even with the best treatments, symptoms persist.

Most mental health treatment that is provided to children, adolescents and adults is not provided by mental health professionals. It is medication management provided by primary care physicians who have minimal training in mental health diagnosis and treatment

Mental health disorders in children are often undetected and therefore remain untreated

Unmet MH care needs can have serious consequences for children and their families: strained social relationships, poor academic performance, and serious problems in adulthood

Minnesota Student Survey

28% of 9th grade girls reported a history of suicidal thoughts

10% of 9th grade girls reported a history of at least one suicide attempt

Among boys with severe difficulties, 59 percent had ever been diagnosed with ADHD, 48 percent with learning disability, and 21 percent with developmental delay

Among boys with no difficulties, less than 4 percent had parental reports of any of the diagnoses

Chemical Health Issues

Minnesota Student Survey 2004
28% of 12th grade boys and 15% of 12th grade girls reported frequent binge drinking during the last year

17% of 9th grade boys and 18% of 9th grade girls reported use of both alcohol and drugs within the past year. The percentages for 12th graders was 30% and 25%

19% of 12th grade boys and 11% of 12th grade girls reported driving after using alcohol or drugs on three or more occasions

Exclusion from EBD/SED Placement

"...a pattern of unsatisfactory educational progress that is not primarily a result of intellectual, sensory, physical health, cultural, or linguistic factors; ***illegal chemical use***; autism spectrum disorders under part 3525.1325; or inconsistent educational programming."

How is the district to determine that the student's problems are not primarily due to drug and/or alcohol use?

Should a chemical health screen be a part of the pre-referral intervention? If it is positive, should the district recommend a chemical health evaluation and refuse to go further in the special education evaluation until this is clarified?

Special Education

EBD

Psychiatric Characteristics of Students at the First EBD Assessment

Psychiatric Characteristics of Students at Time of First EBD Assessment

(n=33)

Diagnosis	Has been made	Evidence	Total
ADHD	48%	52%	100%
Depression	21%	55%	76%
Dysthymia	3%	0%	3%
Bipolar	6%	12%	18%

PTSD	3%	0%	3%
Other Anxiety Disorders	3%	58%	61%
PDD	3%	9%	12%
Tic Disorder	3%	0%	3%
Bulemia	0%	0%	0%

Bulemia	0%	0%	0%
Adjustment Disorder	0%	48%	48%
Speech and Language Disorders	6%	0%	6%
Learning Disabilities	21%	0%	21%
Developmental Delays	0%	0%	0%
FAE/FAS/ FDE/FDS	0%	0%	0%

100% of student files at the time of the Special Education EBD assessment indicate that a mental health disorder has already been diagnosed or that there is compelling evidence that one is present

Diagnoses of ADHD, Mood Disorders and Anxiety Disorders are common

Other disorders include psychotic disorders, autism spectrum disorders, tic disorders, chemical abuse, etc.

Parental Divorce/Separation,Foster Care, Adoption, History of Physical Abuse, History of Sexual Abuse and Parental Chemical Dependency are common

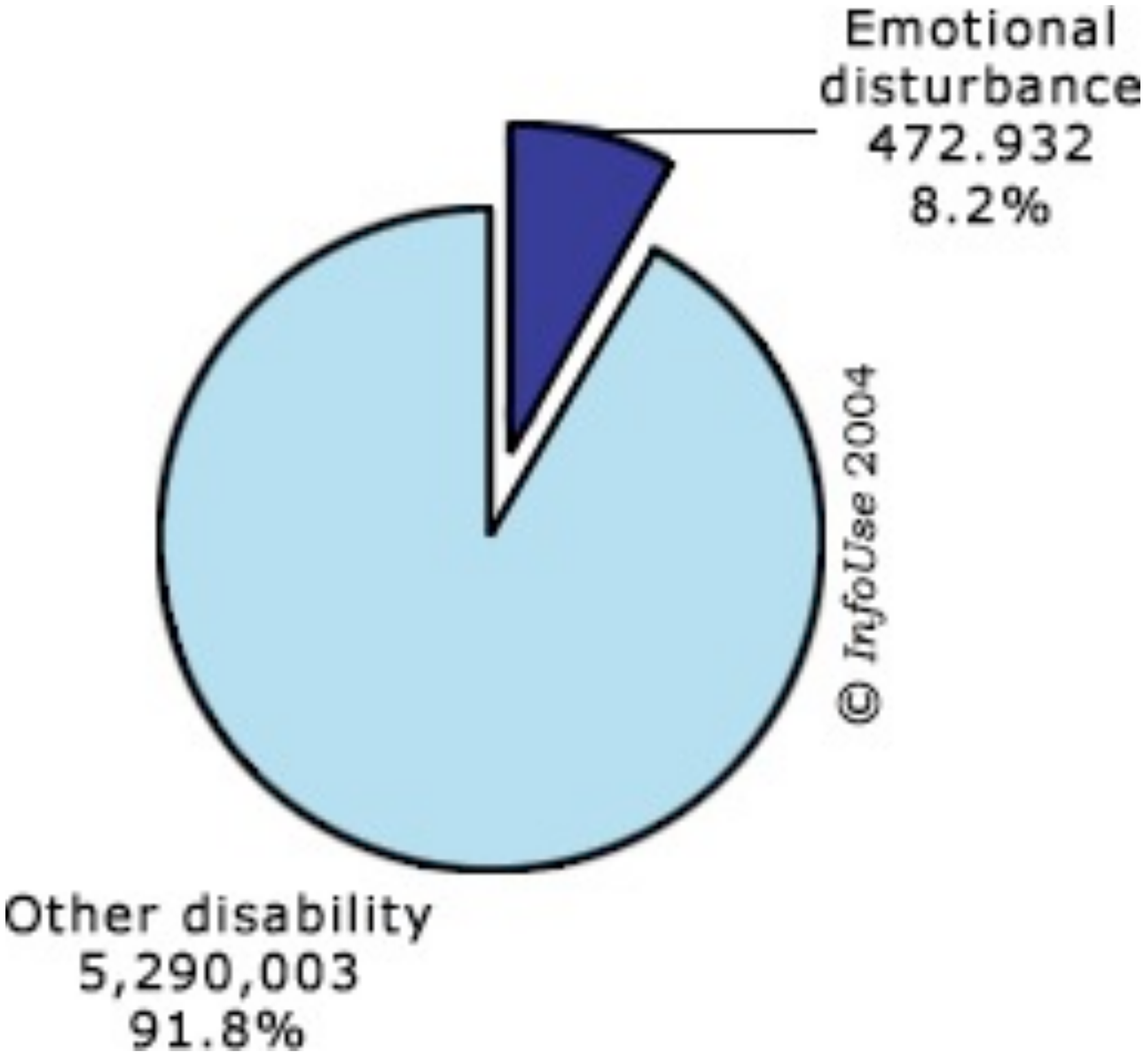
Characteristics of Setting 4 EBD students compared to Setting 4 Day Treatment Students

*= Higher percentage

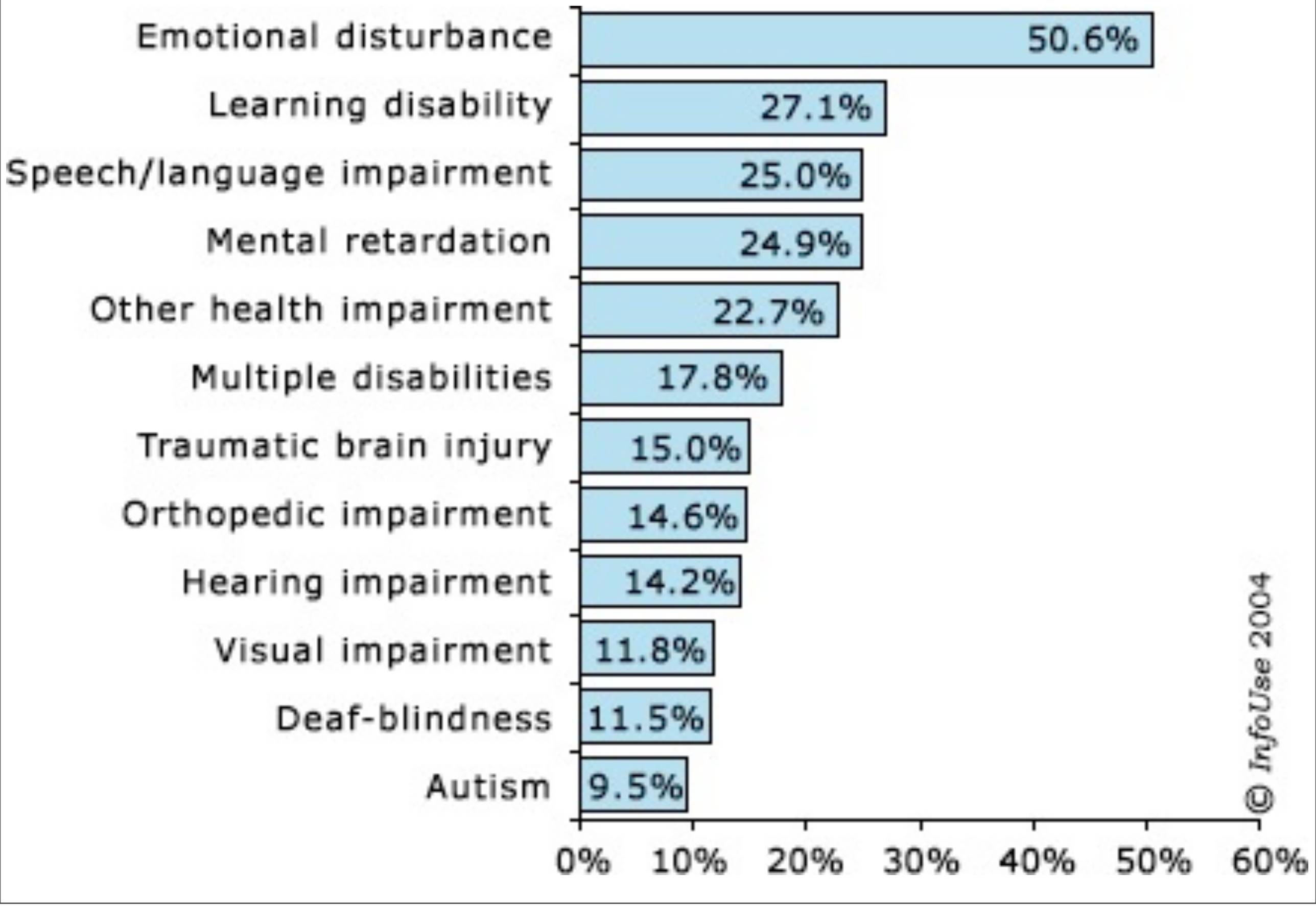
	EBD	Day Rx
# Hospitalizations/Student	*	
# Suicide Attempts/Student	*	
Use of Antidepressant medication	*	
Severity of Mental Health history	*	

A review of records of one such program in a 5000 student district revealed that 85% of these students had already been diagnosed with a mental health disorder, but that only 5% were receiving treatment.

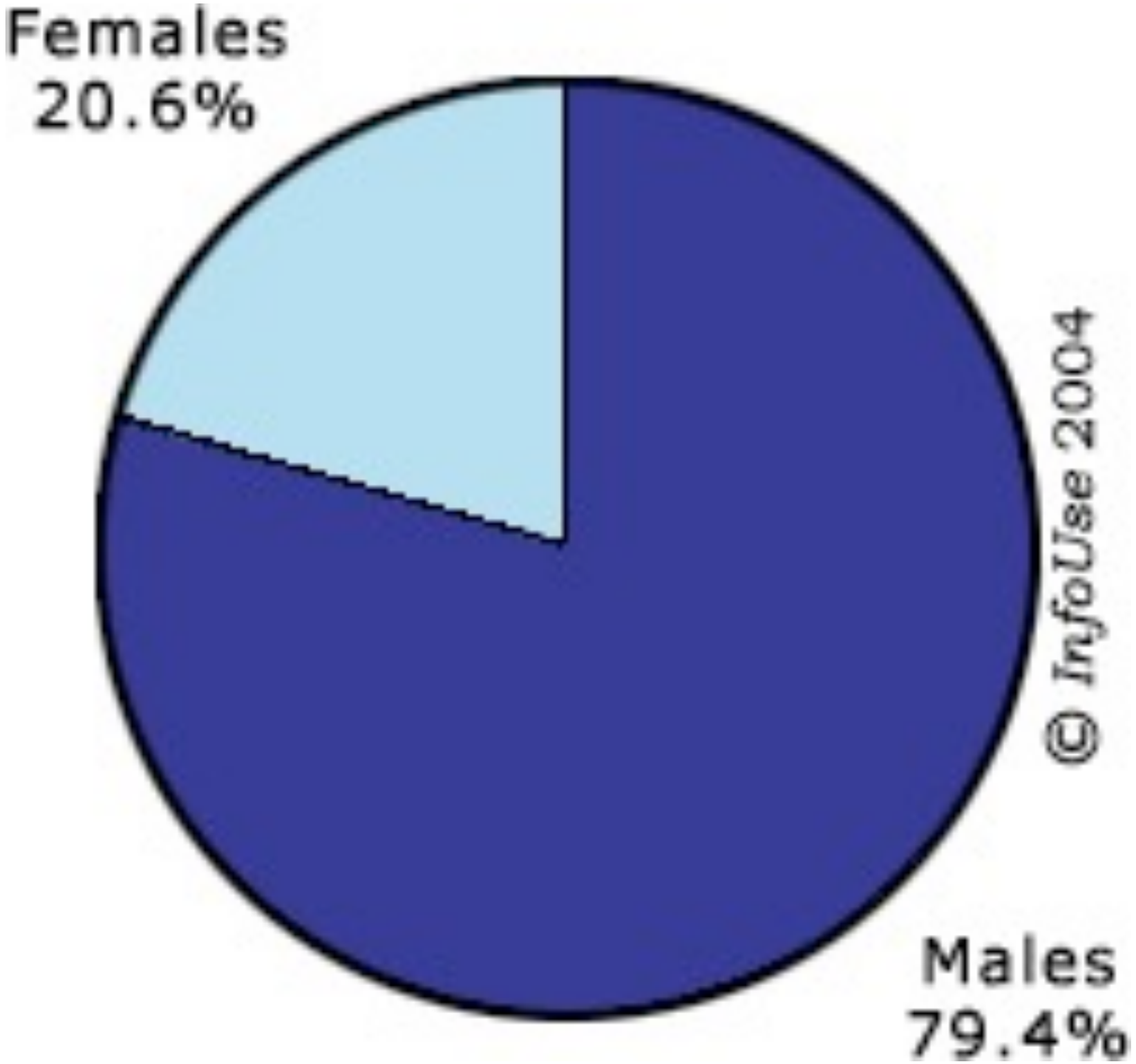
Special Education Categories and Mental Health Disorders


Emotional disturbance
472.932
8.2%
Other disability
5,290,003
91.8%
© InfoUse 2004

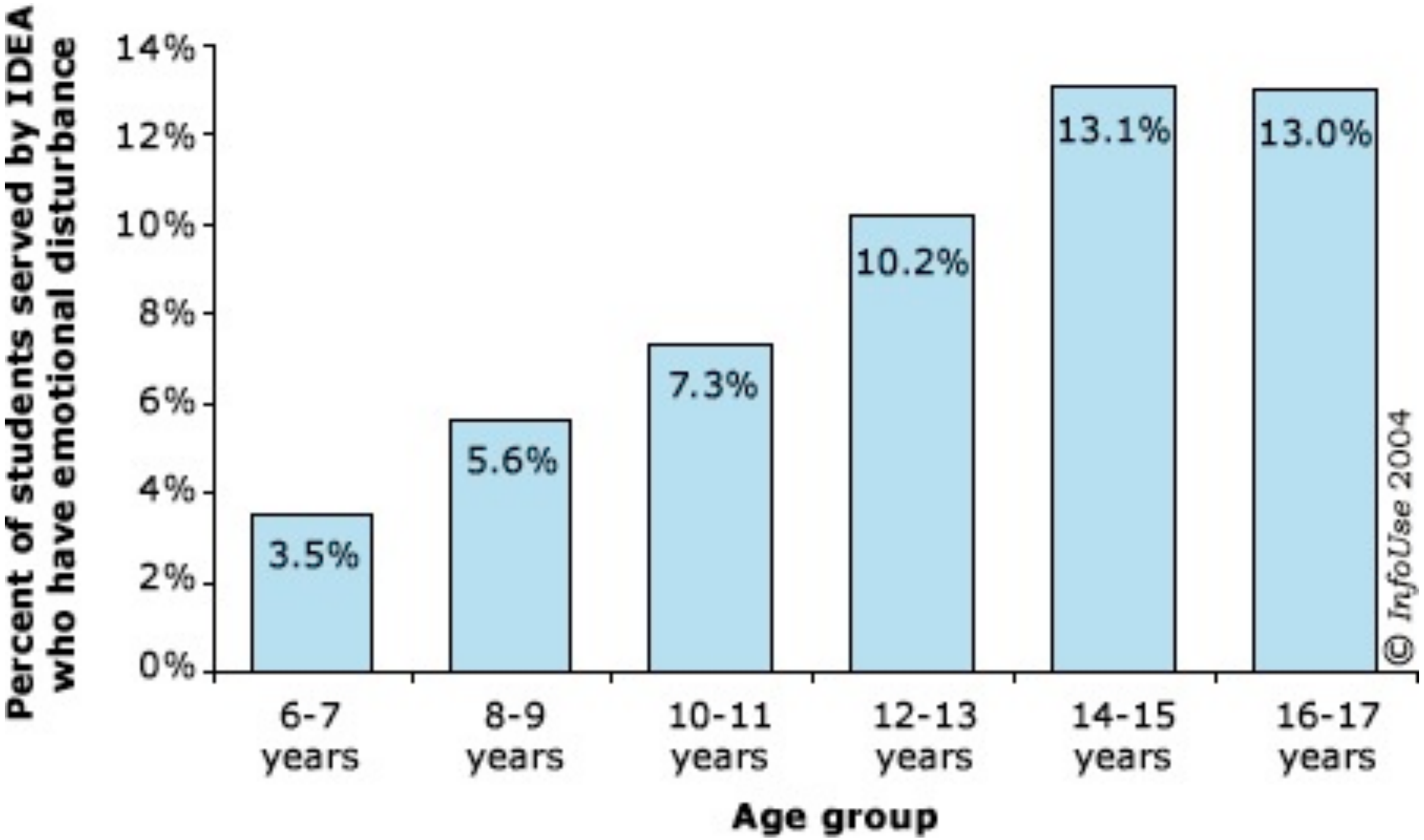
Dropout Rates In Special Education


Emotional disturbance
50.6%
Learning disability
27.1%
Speech/language impairment
25.0%
Mental retardation
24.9%
Other health impairment
22.7%
Multiple disabilities
17.8%
Traumatic brain injury
15.0%
Orthopedic impairment
14.6%
Hearing impairment
14.2%
Visual impairment
11.8%
Deaf-blindness
11.5%
Autism
9.5%
0%
10%
20%
30%
40%
50%
60%
© InfoUse 2004

Male:Female Ratio In Special Education SED/EBD Category


Females
20.6%
Males
79.4%
© InfoUse 2004

Percentage by Age Group of Special Education SED/EBD Students


Percent of students served by IDEA who have emotional disturbance
14%
12%
10%
8%
6%
4%
2%
0%
3.5%
5.6%
7.3%
10.2%
13.1%
13.0%
6-7 years
8-9 years
10-11 years
12-13 years
14-15 years
16-17 years
Age group
© InfoUse 2004

Outcomes for Youths with Serious Emotional Disturbance in Secondary School and Early Adulthood

Mary M. Wagner

http://www.futureofchildren.org/usr_doc/vol5no2ART7.pdf

Percentages of Youths With:	SED	Any Disability	Genl Pop
Ever enrolled in any postsecondary school when out of high school three to five years	25.6	26.7	68.3
Currently competitively employed when out of high school three to five years	47.4	56.8	69.4
Married or living with someone of the opposite sex three to five years after high school	17.2	19.4	29.6
Women who were mothers three to five years after high school	48.4	40.6	27.8
Had ever been arrested One year after high school	25.0	12.2	7.8
Three to five years after high school	57.6	29.5	—

The EBD Special Education system is a failure. The major reason that these students do not succeed is that the "E" in EBD is rarely treated

Ideally, all students with mental health disorders would be screened, identified and treated within the health care system.

In fact, only one in five children and adolescents who have a mental health disorder receive treatment

How does this impact the schools? What is the role of schools in this issue?

Clarifying clinical vs. behavioral issues:

The Clinical/Behavioral Spectrum

Behavioral----Predominately------Mixed------Predominately-----Clinical

Behavioral **Clinical**

Applying behavioral interventions to primarily clinical problems, or providing clinical interventions to primarily behavioral problems is generally ineffective.

Advantages and Limitations of Functional Behavioral Analysis

FBAs are useful if the behavior is learned, and if it responds to behavioral interventions

FBAs are not useful, and may in fact be counterproductive, if the behavior stems from a biological disorder, whether medical or mental health

There is no "function" to the irritability of a diabetic whose blood sugar is low, or to the mood swings of an individual who has Bipolar Mood Disorder

The evaluator needs to recognize that "intrinsic factors", may need to be given as the reasons/functions of a student's behavioral difficulties.

Problems such as youth violence often have multiple clinical and behavioral

contributors. Many of these students are in the "Mixed" part of the spectrum

Youth Violence

Mass media tends to focus on dramatic, very rare events of youth violence such as mass murder school shootings

In fact, most adolescent homicides are committed in inner cities and outside of school. They most frequently involve an interpersonal dispute and a single victim.

On average, six or seven youths are murdered in this country each day. Most of these are inner-city minority youths.

Multiple factors contribute to and shape antisocial behavior over the course of development

Many of these are within the social environment. Peers, family, school, community and neighborhood contexts shape, enable and maintain antisocial behavior, aggression and related behavior problems.

Risk factors in the home environment:
-Weak bonding
-Ineffective parenting (poor monitoring, inconsistent discipline, inadequate supervision)
-Exposure to violence in the home
-An environment that supports aggression and violence

Risk factors in the child or adolescent:

-Early conduct problems

-Attention-Deficit Hyperactivity Disorder and associated impulsivity and poor judgment

-Depression

-Anxiety disorders

-Lower cognitive and verbal abilities

External risk factors:

-Peer rejection

-Competition for status and attention

-Association with antisocial peers who are experiencing academic failure

-Peers who engage in violent activities

Highly adaptive parenting, good verbal ability and success in school are protective factors against antisocial behavior

The earlier the age of onset of antisocial behaviors, the more severe they tend to be and the more likely that they will persist into adulthood

Life course persistent behaviors are correlated with neurological deficits, language deficits, cognitive deficits and are exacerbated by stressful home situations

Youth with conduct problems plus a mental health disorder such as ADHD, Depression or Anxiety Disorders are more likely to engage in aggression than youth who only have conduct problems.

Research indicates that placing violent youth together in programs (e.g., Setting IV sites for Emotionally Disturbed delinquent students) increases the risk of violent behavior

Although students with the characteristics outlined above tend to be at a higher risk of violence, there are also those who are not conduct disordered, but who suffer from mental health problems.

Some of these students have been victims of significant bullying. Their fragile mental health status and severe mental health symptoms may “push them over the edge” into committing violent acts

“Prediction is very difficult-
especially about the future.”

Niels Bohr

Danish Physicist

Nobel Laureate

The best predictor of future violence is past violence

The vast majority of people who are violent do not have psychiatric disorders.

The vast majority of people who have psychiatric disorders are not violent.

Issues that raise the risk of violence in an individual who has a mental health disorder:

-Substance use disorder

-A history of violence, juvenile detention or physical abuse

-Recent severe stressors

In general, mental health disorders do not raise the risk of aggression. Exceptions include individuals who have paranoid delusions, those who have agitated Bipolar Mood Disorder, highly impulsive conduct disordered students who have ADHD and students who are abusing chemicals such as alcohol and PCP.

Predicting Violence
False Positives and False Negatives

Clinical judgment has been shown to be worse than flipping a coin for predicting dangerousness beyond imminent danger.

Research-based screening tools have better predictive value, but are not infallible.

Addressing School Violence

In general, school districts' most aggressive students are in self-contained Setting IV E.D. programs.

Conclusion:

-Violence in the school setting is a real risk

-There are major problems with accurately predicting violent behavior

-Mental health disorders are generally not predictors of violence, but when they occur in the context of other behavior problems and significant stressors, they can lead to violent behaviors

-Proactively addressing students' mental health problems through collaborative efforts can improve behaviors, reduce the risk of violence and cut costs

Roles and Responsibilities

Who works, directly or indirectly with a student who has a mental health disorder?

Teacher

School Psychologist

School Counselor

School Social Worker

School Nurse

Principal

and, if the student is in special education:

Special Education Teacher/Case Manager

Special Education Director

Who does what?

How do you prevent gaps in services?

How do you prevent overlapping roles?

Who decides what the roles are?

Who provides oversight to assure accountability?

What activities need to be done to assure educational success, for a student who has a mental health disorder?

Who should do these activities?

Should there be policies, procedures or guidelines?

Their roles are frequently undefined, with lack of clarity, difficulty in supervision, and lack of accountability.

This can result in overlap of services in some areas and major gaps in others.

-Providing counseling as a related service on IEPs, in certain circumstances

-Providing other related services as needed (social skills groups, help with study skills and organizational skills)

-Conducting Evaluations of Students who have Mental Health Disorders

-Attending IEP meetings

-Providing ongoing documentation of special education interventions and their outcomes

-Monitoring of target symptoms (e.g. off-task behavior, behavioral outbursts, etc.)

-Documenting the nature, frequency and severity of the target behaviors

-Communicating this information to the treating physician and/or mental health professional

-Obtaining diagnostic and treatment information

-Reviewing the information, and translating it into accommodations and modifications specific to the student's disorder

-How much do the mental health staff (social worker, psychologist, counselor, nurse, etc.) know about the student's mental health issues? Have parents been asked to sign releases of information, if the student is receiving medication/ therapy? Have records been obtained? Has there been communication with the treating professional?

-It is very common for a student who has been diagnosed with a disorder (usually ADHD), who is on medication for that disorder.....

to be referred for a special education evaluation because of ongoing symptoms of that disorder....

with no evidence of communication between school staff and the physician who is treating the disorder.

-Assisting teachers in understanding the nature of the student's underlying disorder, and working with the teacher to assure that appropriate modifications take place

-Clarifying whether the student is just beginning treatment and is likely to demonstrate improvement in target symptoms, or is seen as having reached maximum benefit from mental health treatment

-Assuring that the student is not a victim of harassment by peers

-Communicating with the student's parents on a regular basis about both problems and successes in schools

-Communicating to the treating professional about situations where problems continue, despite the student's treatment

-Monitoring of symptoms presenting in the classroom that are not being treated, and communicating these symptoms to the treating professional

-Seeking psychiatric consultation if it appears that the student may be misdiagnosed or if the treatment remains ineffective and the treating professional is not willing to reconsider treatment options.

-Data gathering and outcome analysis

-Conducting Pre-referral interventions

-Screening for mental health and chemical health disorders

-Crisis intervention- who does what?

-Understanding Functional Behavioral Analysis and “Intrinsic” causes of behavior

Appropriate Accommodations and Modifications for students who have mental health disorders

Accommodations and modifications work best when they address the underlying nature of the student's disorders, and are tailored to the criteria of the disorders.

Skills Training: Social Organizational Self-control Etc.

Presentation Accommodations- How the material is presented to the student

Response Accommodations- Helping the student to formulate a response E.g., with organizational devices, etc.

Timing/Scheduling Accommodations

Setting Accommodations- Changing the nature of the student's educational setting

Environmental Adaptations

Many students who have psychiatric disorders are very reactive to their environments

Students who have ADHD may do much better in low stimulation, non distracting environments

Students who have Pervasive Developmental Disorders including Autism and Asperger's Syndrome may be very reactive to touch, sounds, smells and light exposure

They may be particularly sensitive to fluorescent lighting, and may have significant behavioral problems as a result

Payer of last resort issues provide a strong disincentive for school districts to identify and address students' mental health issues

However, they can be addressed by building bridges to mental health systems while maintaining clear legal and financial firewalls for the district.

Four Pronged Approach:

1. Early intervention at pre-referral stage
2. Students at risk for Setting 3
3. Students at risk for Setting 4
4. Students in Setting 4 placements

Example: The special education director of a Suburban West Metro District requested a file review of Setting 4 EBD students.....

85% of them had a history of receiving a psychiatric diagnosis, but only 5% were receiving any psychotherapeutic interventions

He brought many of the students back to the district and provided on-site, co-located mental health services from a local community mental health clinic.

The venture was successful, and this district of approximately 5000 students saved over $800,000.00/year as a result.

District administrators often worry about payer of last resort issues. How much are they already paying (in aides, intensive programming, due process hearings, etc., etc.) by not addressing mental health issues?

Co-located, on-site mental health diagnostic and treatment services in the schools

Counseling vs. Therapy

Counseling is the process of providing information, improving skills, and assisting a student in succeeding within the school environment. Counseling is routinely done by school social workers, psychologists, nurses and counsellors.

Therapy is a clinical service that constitutes treatment of a disorder; for example the treatment of clinical depression.

Many interventions provided by school staff are nurturing, supportive and therapeutic, but the term, "therapy" refers to clinical treatment

For students who have significant mental health disorders, typical school counseling is insufficient to ameliorate the symptoms that are causing emotional and/or behavioral problems in the classroom

Unfortunately, due to access issues, many parents are unable to bring their children to mental health clinics on a regular basis.

One solution is to provide on-site mental health diagnostic and treatment services within the school

Beneficial to the family- many parents can't leave their jobs once a week to transport their child to the clinic. They are often available for phone calls.

Beneficial for the school-improved access to services for the students

Beneficial for the clinician-lower fail/cancel rates, improved ability to understand students' school behavioral issues

Most of all- beneficial for the students- they get the help that they need

Models of services- who should provide the treatment?

Should school district employees be providing mental health diagnostic and treatment activities?

Problems with this model-
Data confidentiality
No malpractice insurance for school districts
Weekend/evening/summer coverage
Billing
etc. etc.

Mental health professional works in the schools but works for an outside agency

This model solves the issues of data confidentiality, malpractice, crisis coverage, psychiatric backup, billing, etc. etc.

Interagency contractual agreements (e.g., with the county) need to guarantee access to county funds when appropriate, clarify fiscal responsibility, designate fiscal agents, and provide a “lease of space”

Need to clarify who will provide treatment, who will supervise, and how boundaries will be maintained (e.g., delegation of interagency roles). Inform the school board of determination of eligibility under IDEA for these services.

Require appropriate licensure

Assure that criminal background checks are done

Clarify which policies will apply

Clarify who will provide administrative control for the site

Establish firewalls between each party's data, and assure that appropriate releases of information are obtained from parents before sharing any data

Hold harmless and indemnification agreements- contractually assuming liability may violate the terms of a school district's insurance policies and void its coverage

If the contractor is a private contractor, there may not be adequate assets to indemnify the school district. Assure adequate malpractice coverage for the provider

What School Districts Can Do

Create a mental health plan for your district. Districts have infectious disease protocols, procedures and guidelines. They rarely have similar mental health plans.

A lack of a mental health plan can lead to unnecessary referrals for Special Education assessments, to restrictive placements, and to student underachievement.

Having a district mental health plan can lead to a significant reductions in behavioral incidents, improved academic achievement and cost savings.

It is essential to recognize disorders when they are present, and to address them according to the functions of each system.

It is the function of the educational system to educate.

It is the function of the mental health and medical systems to treat.

Nonetheless, the educational system needs to recognize and deal accordingly with mental health disorders, in a similar manner that the system deals with medical disorders.

This is a Public Health model of service.

Schools can play an important role in addressing students' mental health issues in the process of educating. They can assist medical and mental health professionals with crucial information to assist accurate diagnosis and effective treatment.

Although school mental health staff are not providing clinical treatment, they can be very helpful in addressing students' mental health needs as they relate to the educational environment.

By clarifying roles, responsibilities and boundaries, school mental health staff can assist students to succeed in school

Address students' mental health disorders from a Public Health perspective

PBIS Three-Tiered Model

Tier 1 (base of pyramid): Universal approaches for all students

Tier 2: Services (e.g. groups) for at-risk students

Tier 3 (tip of pyramid): Individualized services for high-risk students

Co-located mental health treatment services

Educate school staff about mental health disorders

Chemical Health policies

Data practices (what to chart, data privacy, “desk drawer rule”, etc.)

Inservices/ Continuing education for teachers and mental health staff

Encourage school staff to understand the difference between clinical and behavioral issues, and to understand where students are on the clinical/behavioral spectrum

Collaboration with other systems (Social Services, Corrections, etc.)

Collaboration:

“An unnatural act committed between non-consenting adults”

Hypothesis:
Mental Health and/or Chemical Health Disorders are leading contributing factors, or even the causes, of individuals receiving services from Social Services/Child Protection, Corrections and Special Education SED/EBD systems.

Example: Less than 2% of students in a school district are in the SED category, but 50-70% of the adolescents in that county's juvenile probation system are in SED Special Education

How to prevent juvenile crime?

Think “Willie Sutton”

Willie Sutton, the bank robber, was asked why he robbed banks.

He answered, “That’s where the money is”

So, to prevent juvenile crime, some system (ideally not the educational system) should address the unmet needs and untreated mental health disorders of students at risk for SED Special Education services

County Services

Case Management
Crisis Intervention Services
Juvenile Probation
Child Protection
Public Health

Health Plan/HMO Responsibilities Screening for Medicaid Students Crisis Services Accessibility to Diagnostic and Treatment Services

Designing appropriate physical environments

Re-entry from hospitalization, residential treatment, chemical dependency treatment

Maintaining legal and financial firewalls

Maximizing funding streams, obtaining third party billing, CTSS application, etc.

Effective use of consultation

Prevent special education referrals by effectively addressing mental health disorders at the pre-referral stage (e.g., communicating with treating physicians, etc.)

Consider OHI rather than E.D. approach

Monitor target symptoms of mental health disorders, and communicate findings to treating professionals

Review mental health information and translate it into meaningful accommodations and modifications

Is there a way that students can be diverted from special education evaluations by considering a mental health diagnostic evaluation as a pre-referral evaluation?

Can this be done in a way that minimizes the district's financial and legal liabilities?

Can it involve other systems (e.g., health insurance companies, County Public Health, County Collaboratives, etc.?

Can it result in effective treatment and diversion of students from requiring special education services, or from requiring as intensive and restrictive services?

Yes

William Wurt, Superintendent of schools in Gary, Indiana:

"The schools should serve as a clearinghouse for children's activities so that all child welfare agencies may be working simultaneously and efficiently, thus, creating a child world within the city wherein all children may have a wholesome environment"

Thomas Elliot, Sociologist:

"All agencies dealing with neglected or behavior problem children should be closely coordinated under the aegis of the school, including medical inspection, school nursing, attendance control, vocational guidance, placement, psychological testing, visiting teachers, and special schools and classes."

William Wurt quote- 1923

Thomas Elliot quote- 1928

References:

Dikel, W., Bailey, J., and Sanders, D.: "Community Support Services in a Special Education Setting" Behavioral Disorders, 1994, 20(1), 69-75

Dikel, W.: "Mental Health and the Schools: What Educators Need to Know", Minnesota Department of Education, 1999, http://www.nasponline.org/advocacy/MentalHealth.PDF

Dikel, W.: “Mental Health and Public Health” Metro Doctors, Vol. 4, No. 3 May/June 2002

Ratwik, P. and Dikel, W: “Bridges and Firewalls: Contractual Relationships for Mental Health Services Provided in School Settings” Inquiry and Analysis, (Journal of National School Board Association Council of School Attorney’s) April 2009

Ruff, S. and Dikel, W: “Mental Health Related Services In IEPs” Inquiry and Analysis, November 2009

Waldspurger, M. and Dikel, W. “Drugs and Disabilities: Conducting Special Education Evaluations of Students Who Abuse Drugs or Alcohol” Inquiry and Analysis July, 2010

Stewart, D. and Dikel, W. “Emotional/Behavioral Disorders and Special Education: Recommendations for System Redesign of a Failed Category” Hamline Law Review, pending publication 2011

Waldspurger, M. and Dikel, W. “Mental Health Data in School Files” Inquiry and Analysis pending publication 2011

Dikel, W. and Ostrom, J. “The Behavioral/Clinical Spectrum” Encyclopedia of School Health, pending publication

Dikel, W.

"Providing Mental Health Services in Public Schools"
Leadership Insider: Practical Perspectives on School Law and Policy
May, 2012

Dikel, W.

"School Shootings and Student Mental Health: What Lies Beneath the Tip of the Iceberg"
National School Board Association Website:
http://www.nsba.org/SchoolLaw/Issues/Safety/School-Shootings-and-Student-Mental-Health.pdf, December, 2012

Dikel, W.

"The Teacher's Guide to Student Mental Health" (book, in press)

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