Evaluation of Student and Family Well-being in the Minnetonka School District

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Introduction

The Minnetonka School District is well known for its success in promoting academic excellence. District leaders have also recognized the importance of students' social/emotional functioning, and the Minnetonka school board has placed student and family well-being as its highest priority for the past 3 years. Student well-being is defined as the positive sense of self and belonging that students feel when their cognitive, emotional, social and physical needs are met. Well-being reflects resiliency and self-awareness, empowering students to make positive, healthy choices in and out of the classroom.

The Minnetonka school board defined the goal of creating and implementing a plan that supports parents' desires to have their students be socially and emotionally strong and that provides the appropriate level of support to students for their academic, social and emotional well-being. District leaders have been encouraged to strengthen internal supports and to develop a hub of resources for families

The District's resource map identifies structural components including staff training, clear program goals, an established referral process and monitoring program efficacy.

In response to the goal of effectively monitoring program efficacy, I have been asked to provide an evaluation of District programs and activities as they relate to students' well-being.

The District has adopted numerous students supports, including some that are specifically directed toward improving well-being, and others that impact well-being indirectly. The Minnetonka District is committed to provide the best possible environment for development of academic and social/emotional skills. "Serving students well and inspiring them to reach their highest level of personal and academic achievement is the essence of our quest to be a world-class public-school district. We will identify and respond to unique learning needs as early as possible. We will also strive to help students avoid self-limiting labels and focus on their unique talents and gifts…. Minnetonka teachers will recognize that they must address emotional and developmental issues during the learning experience in order for effective learning to take place."

Dr. Peterson has noted, "Although we still have a firm commitment to parents having responsibility for their children's mental health, the District can be very supportive of students and parents in areas where there are multiple students facing specific challenges…. Sufficient time can be devoted to the development of social skills and emotional skills to enable students to be even more successful academically… the lack of emotional skills and social skills can actually hinder the academic development of students. So, that balance is important, and could be managed by teachers, counselors and principals."

This report is comprised of two major sections. The first section focuses on the methodology of targeting improvements in well-being. It describes techniques of fostering wellness, resiliency and stress reduction. Skill building activities are directed to all students, and build on the numerous and valuable tier 1 activities already taken place in the District.

The second section focuses on present and potential future District activities as they relate to students who clearly have a lack of well-being. Information was gathered from a variety of sources, including numerous interviews with school district staff. Every effort was made to gather data in order to establish clarity regarding topics related to mental health supports in the District. The data are summarized in the body of the report, with full reports outlined in the appendices to the report.

Part One: Fostering Wellness, Resiliency and Stress Reducing Activities

How is Well-being Different from Wellness?

Wellness is a concept signifying optimal health. Health is not simply the absence of disease; it is a state in which physical and mental health are optimal. The concept of well-being overlaps the concept of wellness, but it also includes having a positive attitude towards oneself, one's peers and family and the community. In fact, an individual who has a serious illness, but who has social, emotional and spiritual supports may still have a positive sense of well-being.

Facets of well-being include how people think and feel about their lives, such as the quality of their relationships, their positive emotions and resilience, the realization of their potential, or their overall satisfaction with life. Well-being generally includes global judgments of life satisfaction.

Well-being tends to be measured by self-report. Objective data obtained from surveys and screening tools can also help clarify the degree of an individual's well-being.

The Changing Student Population

The nature of the student population is perceived by many school staff as changing in very significant ways. They have a cell phone culture, with students spending numerous hours a week on their phones. They spend an increasing amount of time on social media and a decreasing amount of time in actual social interactions with their peers. One staff

noted that a lunchroom observation indicated that half of the students were not interacting with peers, but rather with their handheld electronic devices.

Students appear to be more sensitive to societal stressors than they have been in the past. They carry the burden of dealing with many competing demands. One educator described the situation as being a profound shift in the complexity of students' responsibilities. Students today, more than ever, require interventions that improve well-being.

Social Emotional Learning

Many students have the types of problems that respond well to learning techniques within the framework of Social Emotional Learning (SEL). Many school districts utilize these techniques, and are experiencing positive outcomes in academic success and reduction of behavioral difficulties. SEL interventions are designed to result in improved well-being.

Minnetonka's student well-being curriculum are aligned with the five core competencies of the CASEL framework and the National Health Education standards. From their website: "Social and emotional learning (SEL) enhances students' capacity to integrate skills, attitudes, and behaviors to deal effectively and ethically with daily tasks and challenges. Like many similar frameworks, CASEL's integrated framework promotes intrapersonal, interpersonal, and cognitive competence. There are five core competencies that can be taught in many ways across many settings. Many educators and researchers are also exploring how best to assess these competencies."

Please refer to Appendix 1 for a full description from the CASEL website of the model of service provided.

Evidence-based SEL programs in pre-K through 12 teach the skills of self-awareness, self-management, social awareness, relationship skills, and responsible decision-making; they provide a foundation that has a buffering and resiliency impact as students face new challenges following graduation.

SEL programming, when embedded in schools that have Multi-Tiered System of Support (MTSS) and school-linked mental health supports in place, also promote the skills of persistence, problem solving, conflict resolution, self-regulation, getting along with others, asking for help, and living a healthy lifestyle. These programs are also shown to significantly improve academic achievement.

A significant percentage of Minnetonka students reported ongoing symptoms of anxiety and/or depression. Many of these students demonstrate significant improvement through learning techniques of social emotional learning (SEL).

Some students have major psychiatric disorders such as post traumatic stress disorder, obsessive compulsive disorder, major depression, etc. Those students also can benefit

from (SEL) techniques, but may also require additional mental health interventions including psychotherapy and possibly medication.

School/Parent Partnerships in Promoting Students' Healthy Lifestyles and Building Resilience

Lifestyle Interventions

Having a healthy lifestyle and learning resilience are key factors in promoting well-being. Especially in light of the COVID-19 pandemic, interventions that promote health and well-being are all the more important for students who are experiencing stress. A focus on a positive lifestyle and the development of resiliency can help protect an individual from the stresses of life. Teaching and promoting these interventions through a partnership between parents and schools can result in the development of healthy students who have optimal coping mechanisms for life stressors

Lifestyle is a key contributor to developing and maintaining health and well-being. In fact, if one wants to live to a healthy old age, one should realize the lifestyle is the most important contributor to that end. Schroeder (SA (2007) We Can Do Better: Improving the health of the American people, New England Journal of Medicine, 357(12): 1221-1228.) noted the behavioral patterns had a health contribution of 40%, followed by genetic disposition (30%), social circumstances (15%), healthcare (10%) and environmental exposure (5%). (Please see Appendix 2).

Lifestyle behavioral patterns include diet, exercise, adequate sleep, use of tobacco, alcohol or other intoxicants and social connectedness. The Minnetonka District promotes healthy behaviors through endorsement of positive lifestyle factors, encouragement of sports, providing healthy foods on lunch menus, teaching of the dangers of drugs, alcohol and nicotine and encouraging social connections. Overall, the Minnetonka District, through its Health curriculum and student activities, is very supportive of healthy lifestyle promoting activities that lead to health and well-being.

Unfortunately, the Minnesota Student Survey indicated that most Minnetonka High School students are not getting adequate sleep, a problem that is noted nationwide. Sleep is an important factor in lifestyle management. Causes of inadequate sleep include electronic media use, caffeine consumption and early school start times. Inadequate sleep has health-related consequences, such as depression, increased obesity risk, and higher rates of drowsy driving accidents. Ironically, I recently consulted to a school district that adopted late start times to address this issue. Unfortunately, the result was that students stayed up later and still did not get enough sleep.

Parents play a crucial role in supporting healthy lifestyles for their children. The positive effect of lifestyle curriculum taught to students at school is amplified when parents partner with the school district by encouraging healthy lifestyle activities for their children and themselves. *Because lifestyle issues are so crucial to health and well-being, I would recommend fostering these partnerships between parents and educators. Activities could include bringing in speakers, developing webinars and encouraging discussions of lifestyle and health during teacher conferences*.

Healthy lifestyle behaviors are best taught from an early age. Adoption of healthy lifestyle activities by parents has the best chance of adoption by their children. Ultimately, a healthy lifestyle contributes to success at home, at school and in the community.

Cultivating Resilience

A key aspect of student's well-being is the self-esteem that results in mastering one's response to life stressors. This results from learning resilience. Schools can build effective partnerships with students' parents to help foster the development of crucial life skills. Holding students accountable for their behaviors, encouraging independence and positive social interaction with peers and helping them to develop useful coping mechanisms fosters character development and helps to lay the foundation to becoming a responsible adult. Students need effective role modeling and support from adults, both at home and at school. It is important for students to have consistency in the messages that they receive from parents and teachers, and it is important to identify and address situations in which there is a clear disagreement between parents and school personnel. In many cases, agreement can be reached when parents and school personnel have a better understanding the overall issues, including mental health issues, that are affecting these students.

The Minnetonka District has sponsored presentations on the topic of effective parenting, and these have had a positive response. *I would encourage the District to expand its partnership with parents on addressing this topic, as the development of self-control and resilience are so crucial to having a successful life and optimal well-being. I would recommend the development of additional in-service presentations including the possibility of webinars in which effective methods of parenting can be described for parents of elementary, middle and high school students.* Given the challenges facing students and their families, the District can be very helpful in providing parent education utilizing expertise of professionals working for the District or in the community. There are many professionals in the Twin Cities who would be excellent choices in the development and presentation on the topic of building resiliency in Minnetonka students.

Students' Health curriculum addresses the topic of lifestyle choices. *I would recommend expanding the topic of parenting in the Health curriculum. Increased exposure to the topic of child rearing can raise students' awareness of their future potential to effectively parent children, as well as being more receptive to understanding the issues that their own parents face in parenting them.*

Learning the Skills of Self Mastery

Children and adolescents have a remarkable ability to self regulate their bodies and minds. They can learn to control their autonomic nervous systems (Dikel, W. and Olness, K., "Self-Hypnosis, Biofeedback, and Voluntary Peripheral Temperature Control in Children" Pediatrics 1980 66(3): 335-340). They can learn techniques that result in self-relaxation, increased focus and concentration, improved productivity and overall increases in well-being.

There are a variety of techniques that students can learn that result in these improvements. Unfortunately, many of these techniques are associated with a public perception of "new age", religious, non-scientific and/or fringe activities. In fact, techniques such as mindfulness and yoga have abundant research data to support their effectiveness. Increased self mastery clearly can contribute to student well-being. *I would note that, if these techniques are to be taught in the school setting, they need to be completely secular and based on evidence-based best practices research.*

Mindfulness- Benefits for Students

Mindfulness is defined as "increased, purposeful, nonjudgmental attention to the present moment."

The study, "Mindfulness in the Classroom: Learning from a School-based Mindfulness Intervention through the Boston Charter Research Collaborative" from the Center for Education Policy Research, Harvard University, found that students assigned to the mindfulness intervention condition showed a reduction in perceived stress and significant improvements in sustained attention. These students also showed a reduced response of the amygdala, a brain structure associated with emotion and stress, to negative stimuli. Together, these findings suggest the potential value of mindfulness interventions for alleviating stress and enhancing sustained attention.

Research suggests that mindfulness practices may be one way to foster self-control, or the ability to plan, control, direct, and sustain one's attention, emotions, and behavior. Self-control enables students to regulate their behavioral, emotional, cognitive, and attentional resources so that they can accomplish a learning goal by facilitating persistent focus, reduced stress, decreased aggressive behavior, improved cognitive performance, and enhanced resilience.

Another program involving mindfulness found significant improvements in executive function, mental well-being, and prosocial behavior among 4th and 5th graders. (Schonert-Reichl, K. A., et. al (2015). Enhancing cognitive and social-emotional development through a simple to administer mindfulness-based school program for elementary school children: A randomized controlled trial. Developmental psychology, 51(1), 52.)

Caballero et. al. found that higher levels of mindfulness were associated with better grades, higher standardized test scores in Math and English language arts, better attendance, and fewer suspensions. (Caballero et. al. (in press). Greater mindfulness is associated with better academic achievement in middle school. Mind, Brain, and Education.)

Studies find that youth benefit from learning mindfulness in terms of improved cognitive outcomes, improved attention and focus, social-emotional skills, behavior in school, empathy and well-being. In turn, such benefits may lead to long-term improvements in life. For example, social skills in kindergarten predict improved education, employment, crime, substance abuse and mental health outcomes in adulthood.

Mindfulness- Benefits for Educators

In randomized controlled trials, teachers who learned mindfulness experienced reduced stress and burnout, greater efficacy in doing their jobs, more emotionally supportive classrooms and better classroom organization.

Yoga

Yoga is an ancient system of physical and mental practices that originated in the Indus Valley civilization in South Asia. The fundamental purpose of yoga is to foster harmony in the body, mind, and environment.

School districts are increasingly utilizing yoga as one of their social emotional learning techniques. A study from 2015 noted that 36 programs were identified that offered yoga in more than 940 schools across the United States, and more than 5400 instructors had been trained by these programs to offer yoga in educational settings. These programs are designed to address stress and anxiety, and promote social and emotional learning, physical and emotional health and well-being, all basic requirements for readiness to learn and a positive, healthy school climate.

Research suggests that school-based yoga cultivates competencies in mind-body awareness, self-regulation, and physical fitness. Classroom teachers benefit as well. Taken together, these competencies lead to improvements in students' behavior, mental state, health, and performance, as well as teacher resilience, effectiveness and overall classroom climate.

Providing educators with training in yoga and mindfulness-based skills may have several beneficial effects for educators, including increases in calmness, mindfulness, well-being, and positive mood, improvements in classroom management, emotional reactivity,

physical symptoms, blood pressure, and cortisol awakening response, and decreases in mind and body stress. Providing teachers with skills and practices to enhance their own self-care is a crucial step toward improving classroom climate, teacher effectiveness and student outcomes.

The Minnetonka District has adopted a number of social emotional learning interventions. *I am recommending significant expansion of self-mastery techniques to be provided to both students and staff. Best practices evidence-based activities would have multiple beneficial results in well-being, in my opinion.*

I would recommend that the District leadership meet with Charlene Myklebust, Psy. D. and Kari Palmer M.A., CCC-SLP to explore possibilities of expanding social emotional learning in the District. Dr. Myklebust has trained educators in 22 states in social emotional learning, and is widely recognized as an expert in the SEL field. She assists schools in achieving high levels of social and emotional support for staff and students, evidence-based teaching about mindfulness, self-care, brain-based learning strategies and achieving well-being. Ms. Palmer is a speech and language pathologist/social cognitive therapist at her private practice, Changing Perspectives, in Excelsior, MN. She has co-authored, with Michelle Garcia Winner, Ryan Hendrix, and Nancy Tarshis "The Incredible Flexible You: A Social Thinking Curriculum for the Preschool and Early Elementary Years". Additionally, she consults with local school districts on implementing Social Thinking into their programming.

Part Two: Well-Being and Mental Health Disorders

It is normal for students and their families to experience typical life stresses that challenge their sense of well-being. The COVID-19 pandemic is an unprecedented stressor that is presenting significant challenges to even the most resilient individuals, and is especially problematic for those who are already grappling with significant deficits in their well-being.

The latter group includes many individuals who have pre-existing mental health challenges that put them at increased risk of deterioration in the face of major life stressors. This makes it all the more important for these mental health issues to be identified and addressed.

Mental health symptoms can arise from a reaction to life stressors, from medical disorders, medication side effects, deficiencies in the diet, toxins in the environment, or from biologically-based psychiatric disorders such as such as autism spectrum disorder, major depression, bipolar mood disorder, schizophrenia, panic disorder, obsessive compulsive disorder, etc. These categories are not mutually exclusive, and an individual may have symptoms from more than one of these categories.

When children and adolescents have emotional and or behavioral problems, it is important to avoid a sole focus on their mental health pathology. It is essential to identify their positive qualities and to foster these qualities through skill building and positive reinforcement. It is also appropriate to identify aspects of the child's or adolescent's environment that are lacking, and to encourage addressing these environmental deficits in order to promote mental health.

At the same time, it would be a mistake to avoid making a diagnosis of a mental health disorder in an attempt to focus on the child or adolescent's positive factors. Obsessive compulsive disorder, panic disorder, mood disorders, psychotic disorders, etc. need to be identified and treated appropriately.

Mental Health Disorders

The symptoms of mental health disorders can have a negative impact on student well-being. For example, students who suffer from anxiety or depression may have significant difficulty in coping with even mild to moderate everyday life stressors. For this reason, much of this report focuses on identifying and quantifying the mental health symptoms experienced by Minnetonka students, and on interventions that are likely to the most effective for them. The report will focus on both general and special education populations of students.

Interviewees noted that in kindergarten classrooms, often one student in each class dominates the room due to behavioral difficulties. They tend to be general education rather than special education students.

Setting 3 students are noted to have multiple mental health problems. These include eating disorders, sleep disorders, ADHD, anxiety disorders, depression, oppositional defiant disorder, panic attacks and dissociative disorders. Anxiety is described as being overwhelming for many of them to the point that they can't walk into the lunch room due to their anxiety. Some of them manifest their anxiety as anger, thus intimidating staff and other students.

Several interviewees noted their opinion that 100% of the District's EBD students have been diagnosed with mental health disorders or have evidence of having them.

The Minnesota Student Survey

Measures of well-being are often identified through self-report. The Minnesota Student Survey is helpful in this regard, both for identifying students with optimal well-being and those who are having serious problems in that area.

Unfortunately, the survey has few questions specifically related to positive well-being. Some of them have low percentages of positive responses.

Positive Well-being Responses on the Minnesota Student Survey

Between 70 and 89% of students answered “very much” in “regard to how much their parents cared for them. Regarding friends caring for them, “very much” applied to 37% to 53%. Responding to “my teacher is very much caring very much” ranged from 15% to 41%, and “adults in the community caring very much” ranged from 18% to 30%.

Those answering “no” to the question, “do you have any long-term mental health, behavioral or emotional problems lasting six months or more ranged from 58% in 11th grade females to 85% of 8th grade males.

“Not at all” answers ranged from 41% to 55% regarding little interest or pleasure in doing things, 39% to 72% for feeling down, depressed or hopeless, 22% to 59% feeling nervous, anxious or on edge and 29% to 73% for not being able to stop her control worrying. In all cases, 11th grade females reported the least amount of well-being.

Negative Well-being Responses on the Minnesota Student Survey

Many questions identified a large percentage of students whose answers indicated a significant lack of well-being. For example:

As high as 42% of 11th grade females and 26% of 11th grade males reported that they had long-term mental health behavioral or emotional problems lasting six months or more.

Seriously considering attempting suicide within the last year ranged from 5% of 8th grade males to 17% of 11th grade females. “More than a year ago” ranged from 5% for 8th grade males to 20% of 11th grade females.

“Have you ever actually attempted suicide during the last year” ranged from 1% of 8th grade males to 4% of 11th grade females. For “more than a year ago”, it ranged from 1% of 8th grade males to 7% of 11th grade females.

Answering “not at all rarely” or “somewhat or sometimes” to the question “I feel in control of my life and future” was at 37% in 11th grade females.

Among those who missed part or all of a full school day of school due to feeling very sad, hopeless, anxious, stressed or angry ranged from 3% of 5th grade males to 31% of 11th grade females.

As many as 37% of 11th grade females reported feeling down, depressed or hopeless several days in the last two weeks. 15% of them reported more than half the days and 9% of 11th grade females and 10% of 9th grade females reported feeling down, depressed or hopeless nearly every day.

Feeling nervous, anxious or on edge was reported as high as 23% in 11th grade females more than half the days and 22% of 11th grade females nearly every day.

Not being able to stop or control worrying more than half the days ranged from 4% in 8th grade males to 18% in 11th grade females. "Nearly every day" ranged from 2% of 8th grade males to 18% of 11th grade females.

Emotional well-being and distress in 5th graders indicated under the item "I worry a lot" that 22% of 5th grade females and 15% of 5th grade males agreed, and 14% of 5th grade females and 6% of 5th grade males strongly agreed.

Reporting that "I don't have any adults that I can talk to about problems I am having" ranged from 3% of 5th grade females to 10% of 11th grade males.

"Fair to poor" responses to the question, "How would you describe your health in general?" ranged from 2% of 5th grade males and females to 9% of 11th grade females reporting "fair". Reporting "poor" ranged from 0% of 5th grade males to 2% of 11th grade males and females.

From 11% of 9th grade males to 19% of 11th grade females reported any physical disabilities or long-term health problems. From 11% of 8th grade males to 20% of 11th grade females reported having been diagnosed with asthma.

The majority of high school students reported getting seven hours of sleep or less per night. Teenagers optimally would sleep nine hours a night.

In answer to the item "I feel good about myself" 13% of ninth grade females noted "not at all or rarely".

7% of 11th grade females and 8% of 11th grade males noted "not at all or rarely" to the item "I feel good about my future".

Over 30% of all gender and age groups noted that, several days a week they experienced little interest or pleasure in doing things. 9% of 11th grade females and 11% of 11th grade males reported this "nearly every day"

Self-injurious behavior not intended to be suicidal ranged from 1% of 8th grade males to 9% of ninth grade females.

Use of alcohol in the past year ranged from 4% of 8th grade males to 21% of 11th grade females.

Binge drinking one day in the last 30 days was reported in 5% of 11th grade males and 10% of 11th grade females

In Depth Data Analysis of Minnesota Student Survey Results

The Minnesota Student Survey is a valid self-report instrument that clearly indicates that a large portion of Minnetonka students display evidence of very significant psychiatric difficulties. It is normal to have some anxiety or changes of mood corresponding with life events, but not being able to stop or control worrying most of the time, feeling suicidal, or even attempting suicide are serious symptoms of significant concern. Further data analysis would be necessary to clarify the scope of this problem. It is necessary to identify the degree of overlap of answers in order to clarify the total percentage of students who answer "yes" to any of the critical items regarding lack of well-being. An in-depth analysis can clarify whether and to what degree students who report one type of problem also report other types of problems. The alternative would be a situation in which students only report one type of problem. In the latter case, the total percentage of students who qualify for having any significant problems would be substantially higher than for the percentage of students who report several problems. I would suspect that the number is somewhere in between. *It is important to understand how mental health disorders cluster in the Minnetonka student population in order to address these problems effectively. I would recommend that this analysis be done in order to establish a baseline as a first step towards future outcome analysis.*

One way to accomplish a needs assessment of students who have significant evidence of a lack of well-being is to do an in-depth analysis of Minnesota Student Survey results. Clearly, thoughts of suicide, suicide attempts and symptoms of anxiety impacting daily functioning would indicate that a student has a lack of well-being. As the survey only addresses one item at a time, a more in-depth analysis is necessary to quantify the number and percent of students who would meet the criteria of a lack of well-being. This can be a starting point for interventions with this high-risk population. The next step in an in-depth analysis of the survey results would be to correlate any one item on the survey with other items that have a much higher frequency if the first item is positive.

Unfortunately, the survey does not ask whether the student is receiving mental health services. This information would be helpful in a cross correlation in order to strategize whether the students' problems are more likely due to lack of treatment or due to the failure of treatment. Research that indicates that most children and adolescents who have mental health disorders do not receive treatment would suggests that the former explanation is more likely.

Thanks to the efforts of Matt Breen and Matt Rega, a thorough, in-depth analysis of Minnesota Student Survey results was accomplished. Data analysis provided two-variable cross comparisons in order to identify risk factors associated with symptoms of concern. The full analysis can be found in Appendix 3.

Following are some highlights:

-In terms of considering suicide, ninth-graders were most negatively impacted (amongst 8th, 9th and 11th grade) when they did not agree with the following statement: “most teachers at my school are interested in me as a person.”

-In terms of considering suicide, eleventh-graders were most negatively impacted (among 8th, 9th and 11th grade) when they responded “no” to the following statement: “is there an adult at school you can talk to about problems you are having.”

-In terms of considering suicide, eighth-graders were most negatively impacted (amongst 8th, 9th and 11th grade) when they did not agree with the following statement: “I feel safe at school.”

-Based on strength of relationship and numbers reporting such instances of bullying, being bullied based on physical appearance or gender expression were most impactful to both grades and considering suicide.

-Based on strength of relationship and numbers reporting such mental health struggles, feeling good about oneself or feeling valued or appreciated by others were most impactful for considering suicide. Planning ahead and making good choices and feeling good about one’s future were most impactful on grades.

-Students who disagreed or strongly disagreed, versus agreeing or strongly agreeing, with the statement “I feel safe at home” were 3 times more likely to consider suicide. (68.8% with n = 16 to 24.8% with n = 509)

-Students who reported being sexually assaulted by an adult outside of the family were 6.5 times more likely to attempt suicide. (38.7% with n = 31 to 5.9% with n = 490)

-Students who reported having run away from home at least once versus never were 6.5 times more likely to attempt suicide. (40.7% with n = 27 to 6.1% with n = 493)

This data analysis is helpful in informing mental health support staff regarding risk factors for the District’s most vulnerable students. These students may not be willing to talk about suicidal thoughts, but might be willing to disclose risk factors for suicide that would alert support staff regarding potential danger to self or others.

I would recommend that District leadership continue conducting data analyses in order to identify the relationships and risk factors in comparisons of other variables.

Additional Evidence of Lack of Well-being in Minnetonka Students

Overall, interviewees noted that 50%-90% of all students referred to the SST were referred for behavioral reasons and/or concerns for mental health needs: anxiety, school avoidance, discipline referrals, attendance concerns and referrals to treatment. Most

referrals had multiple areas of concerns. Most attendance problems were related to mental health concerns.

The PHQ noted up to 21% of students in grade 11 required further depression screening.

On the ACES Adverse Childhood Experience tool, almost 17% of students reported one incident of abuse and neglect or other traumatic experiences, nearly 6% experienced two, nearly 3% experienced three and nearly 2% experienced four or more.

Long-term mental, behavioral or emotional problems are estimated at:
Grade 8 15%
Grade 9 20%
Grade 10 23%
Grade 11 22%
Grade 12 24%

Recommendations for student needs indicates that over 25% struggle with anxiety or depression "making it paramount to have a well-rounded and robust program that is focused on prevention and early intervention and the builds resiliency and coping skills".

Mental Health Screening

In Medical Settings

Screening tools are used in the health context as a method of identifying evidence of health or mental health disorders, and then providing further assessment if the screening is positive.

Mental health screening would ideally be done in the pediatric medical setting on a regular basis. In fact, all children and adolescents age 0 to 21 who are on Medical Assistance or Minnesota Care are entitled to early, periodic screening, diagnosis and treatment (EPSDT), an entitlement that includes mental health screening. (See https://mn.gov/omhdd/assets/why-do-we-wait_tcm23-27780.pdf for details). Also, pediatricians and family physicians are increasingly becoming aware of children's and adolescents' mental health difficulties, and are conducting universal mental health screens with their patients.

In Schools

Screening for emotional/behavioral disorders is mandated in some circumstances in Minnesota. Minnesota rules require a mental health screen for students who are placed in the EBD category of special education (Minn. R. 3525.1329 Subp. 3 (A) (7)). Many school districts including Minnetonka use the BASC screening tool for this purpose. I would note that results of screening in the EBD population tend to identify as many as 100% of students as having evidence of mental health disorders.

The EBD eligibility criteria also requires that the IEP team rule out chemical use as a factor primarily causing the student's unsatisfactory educational progress. (Minn. R. 3525.1329 Subp. 2a (B) (2)).

The SAEBRS Screening Tool

The Minnetonka District is using the SAEBRS screening tool to identify elementary students who have evidence of mental health difficulties. SAEBRS is the Social Academic and Emotional Behavioral Risk Screening tool. It is comprised of sections covering:

Social: (e.g. Arguing, temper outbursts, disruptive behavior) that might be considered "externalizing" problems
Emotional: (e.g. Sadness, anxiety, withdrawal, lack of resilience) that might be associated with "internalizing" problems
Academic: (e.g. Academic engagement, production of acceptable work, preparedness). Academics enable learning
It takes one to three minutes per student, and should be done three times per year for all students.

Observable trends indicate that, at most grade levels, the District is below or near the goal of having 20% or less of the student population identified as "at-risk". At the first-grade level, there appears to be a trend of identifying the highest percentage of students meeting the "at-risk" threshold on the total score. Across the course of an academic year, the percentage of students identified as "at-risk" decreases from the beginning of the school year to spring screening. (See Appendix 4 for details).

In the second year, the time commitment needed to organize and analyze the data decreased notably, making the time demands involved in oversight of the project implementation more manageable.

Mental health supports for identified students include:

TIER1:

- Classroom lessons (Health SEL, Social Thinking, Peace Site, Responsive Classroom, Counselor lessons)
- Behavior Plan/intervention consultation and set-up

TIER2

- Groups: Emotional Regulation, Self-Regulation, Social Skills/Friendship, Family Change
- Self-Monitoring
- Daily Check-ins
- Individual push-in classroom support

- Body Breaks
- Exercise Intervention
- Relaxation Group
- Homework Club

TIER 3

- Individual counseling/intervention
- 2 or more group interventions per week
- Daily Check-ins

An important aspect of supporting student wellbeing is continuity and embedding of supports/strategies across settings. District staff provide the families of participants with regular communication on common language, content, and strategies used in the intervention groups to empower families to support learning across home and community settings.

The SAEBRS team describes the process of a continuing efforts to refine methods of progress monitoring to focus on efficiency and responsiveness, and looks forward to the opportunity to pilot a tool to help sort and match appropriate interventions to identified student needs. The pilot and operational model will need continued support in terms of staffing to maintain the current level of support offered to students. The team will consider adjusting the screening period to slightly earlier in the spring to better inform the spring intervention period.

In my opinion, this is a very useful program. I would recommend a pilot project of expansion to the sixth-grade population.

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The Minnesota Student Survey includes several items that would make it a useful screening tool if it were not anonymous. However, an in-depth analysis can provide valuable information regarding risk factors of vulnerable students. These are described elsewhere in this report. Given that many students would be willing to discuss risk factors (e.g., grades, being bullied, etc.), but might not be willing to discuss severe problems such as suicidal thoughts, awareness of the risk factors can be a valuable tool for mental health support staff in identifying students who will require more intensive mental health services. As counselors meet with every high school student at least once, knowledge of risk factors can lead to more successful interventions for the most vulnerable students. For example, when counselors meet with 11th grade young women, the powerful fact that 22% of them reported on the Student Survey that they felt nervous, anxious or on edge nearly every day, 18% reported considering attempting suicide within the last year, 4% reported having attempted suicide within the last year and 7% reported having attempted suicide more than a year ago provides motivation to identify and intervene with these students. Methods of identifying high risk students can be of great help to this vulnerable population.

I would recommend that the Student Survey in depth analysis results be communicated to District educators, social workers, counselors, psychologists and nurses.

Given the prevalence of evidence of mental health disorders in Minnetonka students, *I would recommend that asking students about problems such as anxiety and depression be done by school counselors, social workers, psychologists and nurses. Students would need to be informed that providing such information is purely voluntary. I would recommend that questions be taken directly from the Minnesota Student Survey, and be a combination of questions about risk factors and questions about experiencing symptoms such as generalized anxiety, feeling depressed most of the time, suicidal thoughts and suicidal behaviors. I would suggest that this be done at the initial appointments with counselors. I would recommend that the mental health support staff take part in the process of creating a protocol for questioning students about symptoms that suggest a lack of well-being. Asking students about symptoms needs to be done in a very sensitive manner, but if done correctly, can result in interventions that improve well-being and that can save lives*.

Some school districts provide universal mental health screening tools. For example, the Columbia Depression Screening Tool:

(https://www.thereachinstitute.org/images/columbia_depression_scale_teen_parent.pdf) is used to identify at-risk and high-risk students. (See Appendix 5).

I would not recommend the use of this tool at this time, as it tends to focus mostly on depression rather than a wider range of mental health symptoms. I am providing it as an example of a widely used screening tool.

I would note that mental health screening of students can be a controversial topic. On the one hand, universal mental health screening is seen as a powerful tool in addressing a significant public health problem. On the other hand, critics of screening view it as an intrusive activity which is beyond the scope of the public education system. It is noteworthy that the SAEBRS screening tool has been well received by families.

Mental health screening results in an increase in the number of students who are identified as having needs for mental health diagnostic and treatment services. In my opinion, this supports expansion of on site, co-located metal health services in the District.

Academic Success in the Minnetonka School District

The Minnetonka school District is highly regarded for its success in improving student academic outcomes. An examination of academic success rates and the relationship between success and student well-being can be assisted through the use of data analysis.

A complete overview of academic gains is provided in Appendix 6. A few examples are listed here:

There are several key academic achievement highlights for Minnetonka students in the English and Immersion programs. NWEA Math and Reading Test results show that by fourth grade, the differences in performance among English, Chinese, and Spanish Immersion students is virtually the same, a trend that has been consistently observed for the past eight years.

By the end of Fifth Grade, the average Minnetonka student is performing beyond the Eleventh-Grade level on the NWEA Reading and Math assessments.

The majority of Spanish and Chinese Immersion students in Minnetonka are now performing beyond the national targets for Immersion students in Sixth and Eighth Grades.

ACT results show that since the 2001-02 school year, the average ACT Composite score has increased from 23.1 to 27.7.

Prior to the new SAT version in 2017-18, SAT results indicated an upward trend in performance between the 2006-07 school year and the 2016-17 school year with improvements in Reading, Writing, and Math prior to the change in SAT. In 2006-07, the average Reading score was 618, while in 2016-17, the average score was 654. Math average scores increased from 618 to 665 during the same time-frame, with Writing performance improving from 599 to 609 respectively.

The High School continues to have students take higher level Math courses through the AP and IB programs. More students who have never taken an honors level course in the past are taking honors level courses such as AP Statistics.

The American Indian population out-paced their state counterparts by a significant margin of 35.4 percent, the same as last year. The African American population scored 18.6 percentage points higher than African American students statewide compared to 27.0 percentage points higher a year ago. Hispanic students out-performed their counterparts by 35.9 percent compared to a 28.5 percent difference from 2016 to 2017.

By the time students reach high school, they are typically performing well above their peers across the state and out-performing most students across metro area districts. Various instructional strategies to help students improve their critical thinking skills in Reading and strategies to help students build stamina to read independently, not only has aided with increasing test results, but it has also helped to create a passion for reading in students. Students are expected to read every night at a young age, and schools implement Reading initiatives that recognize students for their hard work in this area. It is evident that schools are helping to create life-long readers and critical thinkers at all grade levels.

Academic Success and Student Well-being

The Minnetonka School District offers numerous opportunities for high achieving students including advanced learning, gifted programing, the Navigator and Honors programs, Advanced Placement and International Baccalaureate classes. These are exceptional opportunities for many students.

During my interviews, several staff expressed the opinion that, although Minnetonka students may be high achievers, they pay the price by experiencing significant anxiety in their attempts to get high grades.

This opinion is not substantiated by the Minnesota Student Survey analysis. In fact, it indicated that there is an inverse relationship between high grades and problems with anxiety. In other words, students in grades eight, nine and eleven who reported earning mostly C's, D's or F's had a higher percentage of reporting feelings of significant anxiety than those earning A's or B's. As noted below, the same is true for feelings of depression and suicidality.

The data supporting this conclusion are outlined below. Please note that the numbers in the various boxes are raw data; when translated into percentages they provide useful data that can be used in comparisons of student groups.

Grades and Mental Health Symptoms

Grades: Out of about 2330 students in grades five, eight, nine, and eleven who answered the question regarding their typical grades, about 229 reported earning mostly C's, D's or F's.

Reported Feelings of Anxiety Correlated with Grades

Below is a chart of the 1802 students in grades 8, 9, and 11 who answered a question regarding their feelings of anxiousness or nervousness over the last two weeks as well as a question regarding their typical grades in school this year. Note: C's, D's and F's were condensed because of smaller sample sizes in the D and F groups.

Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge? - All Grades				
Frequency	**Mostly A's**	**Mostly B's**	**Mostly C's, D's or F's**	**Total**
Not at all	425	240	46	**711**
Several days	365	196	74	**635**
More than half the days	111	84	35	**230**
Nearly every day	106	81	39	**226**
Total	**1007**	**601**	**194**	**1802**

Summary:

- 12.5% (226 out of 1802) reported feeling anxious “nearly every day” over the last two weeks
- 10.5% (106 out of 1007) of students reporting mostly A’s noted feeling anxious “nearly every day”
- 13.5% (81 out of 601) of students reporting mostly B’s noted feeling anxious “nearly every day”
- 20.1% (39 out of 194) of students reporting mostly C’s, D’s or F’s noted feeling anxious “nearly every day”

  60.5% (1091 out of 1802) reported feeling anxious <u>at least</u> “several days” over the last two weeks
- 57.8% (582 out of 1007) of students reporting mostly A’s noted feeling anxious <u>at least</u> “several days”
- 60.1% (361 out of 601) of students reporting mostly B’s noted feeling anxious <u>at least</u> “several days”
- 76.3% (148 out of 194) of students reporting mostly C’s, D’s or F’s noted feeling anxious <u>at least</u> “several days”

<u>Below is the same data broken down by grade in school</u>

<u>Grade 8:</u>

Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge? - 8th				
Frequency	Mostly A's	Mostly B's	Mostly C's, D's or F's	Total
Not at all	166	100	18	**284**
Several days	120	59	19	**198**
More than half the days	23	19	12	**54**
Nearly every day	22	20	7	**49**
Total	**331**	**198**	**56**	**585**

Summary:

- 8.4% (49 out of 585) reported feeling anxious “nearly every day” over the last two weeks
- 6.6% (22 out of 331) of students reporting mostly A’s noted feeling anxious “nearly every day”
- 10.1% (20 out of 198) of students reporting mostly B’s noted feeling anxious “nearly every day”
- 12.5% (7 out of 56) of students reporting mostly C’s, D’s or F’s noted feeling anxious “nearly every day”
- 51.5% (301 out of 585) reported feeling anxious <u>at least</u> “several days” over the last two weeks
- 49.8% (165 out of 331) of students reporting mostly A’s noted feeling anxious at least “several days”

- 49.5% (98 out of 198) of students reporting mostly B's noted feeling anxious at least "several days"
- 67.9% (148 out of 194) of students reporting mostly C's, D's or F's noted feeling anxious at least "several days"

Grade 9:

Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge? - 9th				
Frequency	Mostly A's	Mostly B's	Mostly C's, D's or F's	Total
Not at all	163	85	17	265
Several days	148	74	21	243
More than half the days	45	28	13	86
Nearly every day	43	32	16	91
Total	399	219	67	685

Summary:

- 13.3% (91 out of 685) reported feeling anxious "nearly every day" over the last two weeks
- 10.8% (43 out of 399) of students reporting mostly A's noted feeling anxious "nearly every day"
- 14.6% (32 out of 219) of students reporting mostly B's noted feeling anxious "nearly every day"
- 23.9% (16 out of 67) of students reporting mostly C's, D's or F's noted feeling anxious "nearly every day"
- 61.3% (420 out of 685) reported feeling anxious at least "several days" over the last two weeks
- 59.1% (236 out of 399) of students reporting mostly A's noted feeling anxious at least "several days"
- 61.2% (134 out of 219) of students reporting mostly B's noted feeling anxious at least "several days"
- 74.6% (50 out of 67) of students reporting mostly C's, D's or F's noted feeling anxious at least "several days"

Grade 11:

Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge? - 11th				
Frequency	Mostly A's	Mostly B's	Mostly C's, D's or F's	Total
Not at all	96	55	11	162
Several days	97	63	34	194
More than half the days	43	37	10	90
Nearly every day	41	29	16	86
Total	277	184	71	532

Summary:

- 16.2% (86 out of 532) reported feeling anxious “nearly every day” over the last two weeks
- 14.8% (41 out of 277) of students reporting mostly A’s noted feeling anxious “nearly every day”
- 15.8% (29 out of 184) of students reporting mostly B’s noted feeling anxious “nearly every day”
- 22.5% (16 out of 71) of students reporting mostly C’s, D’s or F’s noted feeling anxious “nearly every day”
- 69.5% (370 out of 532) reported feeling anxious at least “several days” over the last two weeks
- 65.3% (181 out of 277) of students reporting mostly A’s noted feeling anxious at least “several days”
- 70.1% (129 out of 184) of students reporting mostly B’s noted feeling anxious at least “several days”
- 84.5% (60 out of 71) of students reporting mostly C’s, D’s or F’s noted feeling anxious at least “several days”

Correlation Between Grades and Self-reports of Depression and Suicidality

As noted in Appendix 7, “Associations Between Grades and Mood”, the findings described above for the association between grades and anxiety are paralleled in the analysis of the correlations between grades and depression/suicidality. There is a clear trend for both genders in 8th, 9th and 11th grade, to have an inverse correlation between grades and symptoms of depression and/or suicidality. In fact, there is only one exception in the data trend of “Reported Grades this Year Versus Feeling Down, Depressed or Hopeless Nearly Every Day”, in which there was an affirmative response from 7% of 11th grade males receiving mostly A grades, compared to 5% of B and C students. Otherwise, the correlations for depression and suicidality are strong and dramatic.

An analysis of the findings provides useful information regarding students at high risk for self-harm. For example, 22% of 8th grade females, 44% of ninth grade females and 36% of 11th grade females who had C averages reported having considered suicide in the last year. In general, students receiving mostly D’s or F’s were the highest risk groups. Thus, if a school counselor is interviewing a ninth-grade female who has a C average, he or she needs to recognize that this ninth grader has a nearly 50% chance of considering suicide.

Lower Academic Achievement, Well-being and Student Mental Health

Lower academic achievement is correlated with decreases in well-being. It is also correlated directly or indirectly with mental health issues. Based on the literature, the following risk factors are predictive of lower levels of academic achievement:

Poverty
Special learning needs (sped)
Identified learning gaps (non- sped)
Truant or transient characteristics with poor attendance
Disruptive or antisocial behavior
Homelessness
Mental health
Family crisis
Substance use and abuse
Fear for personal safety
Chronic illness

Although “mental health” is only one item on the list, the other items overlap with mental health in a variety of ways.

I would note that a successful emphasis on assisting students to boost their academic achievement is likely to improve mental health symptoms for many of them. The Minnetonka School District has shown significant success in promoting high academic achievement. As noted above, higher academic achievement boosts self-esteem and well-being for many students. Some of these students may have thought of themselves as being “average”, and, through perseverance, resilience and “grit”, succeeded in advanced classes.

There may be a sub population of students who are vulnerable to developing anxiety symptoms for a variety of reasons. As noted on the Minnesota Student Survey, many students report feelings of generalized anxiety much of the time. It is likely that this anxiety impacts many areas of their life including academic performance.

Interventions using techniques of social emotional learning can be very helpful in reducing anxiety symptoms for many of the students. Please refer to the section, “Fostering Wellness, Resiliency and Stress Reducing Activities” for details.

Disciplinary Activities, Mental Health and Well-being

Disciplinary activities can provide information and insight about issues related to mental health and well-being.

Last year, Minnetonka High School had approximately 1000 disciplinary actions for a variety of issues including attendance, classroom behavior, parking and drug use. There were 180 suspensions last year from the high school.

Vaping of nicotine and cannabis has decreased due to placement of detectors in the bathrooms, and from student education in Health and other classes.

Patterns of disciplinary actions shed light on student mental health issues and lack of student well-being. For example, attendance issues often reflect underlying social and emotional problems. It is not unusual for students to be truant because they can't get themselves to school. Mental health problems often underlie truancy issues. Research indicates that, if a student is truant and that has no other evidence of behavioral problems, there is at least a 70% chance that he or she has an underlying mood or anxiety disorder. These students are better characterized as school refusers rather than truants, as their behaviors in general are not delinquent. It is helpful for truancy interventions to identify evidence of mental health disorders such as anxiety and depression, as school refusing students do not respond well to behavioral interventions that target conduct disordered students. When their underlying anxiety or depression is addressed, students have a much more successful likelihood of returning to school. This problem can be very challenging, especially if it has gone on for an extended period of time. The best results are obtained when there is a coordinated team effort between mental health professionals, parents and school professionals.

Parents, Their Mental Health and Well-being

For the last three years, the Minnetonka school board has placed well-being of students and their families as their highest priority.

Some interviewees noted concern that student and family well-being were problematic when students and/or parents struggled with mental health issues. This is obviously a sensitive topic, but if parent well-being is going to be addressed, issue of mental health disorders needs to be discussed.

Several interviewees noted frustration about the difficulties that they were having helping parents, who appeared to have mental health problems of their own, effectively deal with the challenges that their children were presenting in the school environment. They noted poor attendance at parenting information meetings. One noted, "the ones who need to come the most don't show up".

From the public health perspective, many adults experience significant mental health disorders in a given year. I would note that this applies to students' parents (and to educators as well). If stigma were not such an issue, mental health disorders could be discussed in the same light as high blood pressure, asthma or diabetes. However, due to stigma, it is a topic that needs to be discussed with great sensitivity.

Approximately 20% of US adults experience a mental health disorder in a given year, and 5% experience a serious mental illness. Approximately 4% have coexisting substance-abuse and mental health disorders. Major depressive episodes among US adults have an annual prevalence rate of over 7%.

Several interviewees noted concern the mental health treatment of individual students was not likely to be effective if family interventions were not taking place concurrently.

It is my understanding that the Relate clinic has the capability of providing services to families which include consultation with child and adult psychiatrists. As noted elsewhere in this report, *I am recommending expansion of partnerships between mental health clinics and the school district, with services available to children, adolescents and adults, including both family therapy and individual treatment as indicated.*

Raising awareness to students and their families about mental health issues can be a first step in improving family well-being. Some interviewees noted that parents were interested in in-service presentations on topics such as autism spectrum disorder. These meetings could be a combination of education about specific topics and support for parents who experience the difficulties of parenting challenging children. Some parents would be more likely to attend educational meetings if transportation, childcare and a meal was available. I would encourage the District to continue in its efforts to provide information and support to parents who may be struggling with their own mental health issues. As there is a stigma attached to mental health disorders, some families may be reluctant to attend public meetings on the topic of mental health. The District may have better success through providing online information through the use of webinars. These could be tied into other webinars discussed previously that focus on lifestyle issues and building resilience.

Special Education and Mental Health

Significant mental health problems, with associated difficulties in well-being, are noted in many special education students in the OHD, ASD and EBD categories, as well as in many students with 504 plans. In fact, several studies indicate that the vast majority of EBD students either have been diagnosed with a mental health disorder or demonstrate evidence of having one. Keeping track of mental health data, and using this information in designing effective interventions, can result in improved academic functioning and behavioral improvement. The knowledge of a student's mental health characteristics can also be applied to the provision of effective tier 2 services that have the potential to act in some situations as a pre-referral intervention, eliminating the need for a special education evaluation. Obtaining pertinent mental health data from a school file is often a tedious activity, due to the various places where crucial mental health information is located in a file. For this reason, I suggested the use of a mental health database that can organize crucial data in an efficient manner. It can be analyzed for each individual student, and also for the entire group of students. This can provide valuable information in designing effective accommodations, modifications and other interventions.

The database is designed to organize data which is already present, for the most part, in school files. Mental health data obtained from parents are private information, and a Tennessen warning is necessary when requesting such data. Use of a database makes the process more efficient, and helps to shed light on mental health issues which

otherwise might not be as obvious. It can be a “living database”, in that it can be added to when changes occur that are pertinent to a student’s success. An example would be documenting a new medication when it is started, or when adjustments in dosage take place. This can improve communication between the school district, parents and treating professionals.

Following my recommendation to computerize input on the mental health database, District staff created the electronic database. (See Appendix 8). This was used to conduct a special education file review, in order to clarify the nature and extent of mental health problems in students who qualified for placement in the EBD category. Please refer to Appendix 9 for complete results. Please refer to Appendix 10 for an overview of total special education student counts by disability category.

A summary of the data indicates that 17 student files of 6 females and 11 males were reviewed. They represented grades K-11 except for grade 2. 14 were involved with a mental health professional, 11 with a medical professional and 1 with a Child Protection worker. In addition to the EBD category, 3 were in the OHD, 1 in the SLD and 1 in the SPL category. 3 students had academic disabilities in reading, 3 in written expression, 1 in math and 1 with speech difficulties.

6 students had releases of information allowing communication with treating mental health or medical professionals.

Full scale IQs varied from 81 to 149.

Functional behavioral analysis included a variety of postulated functions of behavior including escaping task demands, seeking attention, avoidance of non-preferred social interactions and gaining control. Some students’ FBAs indicated functions related directly to mental health issues, such as underdeveloped skills for self-regulation, inattention, anxiety and depression.

17 of the students were having behavior problems at home, 15 were having behavior problems at school and 5 were having behavior problems in the community. 10 displayed aggressive behavior, 10 displayed oppositionality/defiance, 2 had destruction of property and 2 were noted to have problems with lying.

Medical conditions were noted, including 1 student with allergies, 1 with celiac disease, 1 with diabetes, 2 with a migraines/headache and 1 with skin concerns.

Mental health conditions included 10 students with a history of ADHD, 5 with anxiety, 3 with depression, 1 with obsessive compulsive disorder, 1 with an unspecified mood disorder and 1 with a sensory processing disorder.

Nine of the 17 students were taking psychiatric medications including stimulants (7), antidepressants (4), mood stabilizers (2) and antipsychotics (2).

11 of the students were receiving mental health psychotherapy.

The BASC-3 is a widely used multidimensional tool that assesses evidence of child and adolescent emotional disabilities including aggression, anxiety, and depression. It identified numerous mental health symptoms that were consistent with the diagnoses that had been made. 100% of the students had evidence of significant mental health disorders on the BASC-3.

None of the students had had screening done in order to rule out substance use as the primary cause of the students' behavior.

2 of the students' files had documentation of a Tennessen warning being given to the parents when private information such as mental health information was requested.

In cases where a student had been diagnosed with a mental health disorder, 7 had documentation that indicated the severity of symptoms and the student's level of functioning.

When there was a change in medication or other therapies, 2 had documentation that clarified the nature and degree of changes in symptoms.

7 students' IEPs included mental health treatment as a related service.

It is clear that the EBD population is comprised of students who have a variety of mental health disorders that manifest at school, at home and in the community. Most are involved with the mental health system already, and some are involved with the medical system as well.

Based on the information revealed in the special education file review, I would recommend the following:

As Minnesota rules mandate that students are not to be placed in the EBD category if the primary source of the problem is substance use, I would recommend screening for chemical health issues. I would note that the presence of substance abuse does not in itself prove that the abuse was the primary cause of emotional/ behavioral difficulties. I would refer the interested reader to the article, "Waldspurger, M. and Dikel, W. "Drugs and Disabilities: Conducting Special Education Evaluations of Students Who Abuse Drugs or Alcohol" Inquiry and Analysis July, 2010" for more details.

Similarly, as a Tennessen warning is mandated in situations where government (including public school) employees are seeking private information, I would recommend that this be done with appropriate documentation.

It would be very useful to track students' severity of symptoms and level of functioning, especially following changes in medication or other therapies. Use of the CGAS would help facilitate this process. *I would recommend that a CGAS rating be done at the time of*

assessment, as it provides an objective measure of a student's level of functioning. This is not a diagnostic tool; it is simply a level of function rating that covers many items already covered during a special education evaluation. It can be done periodically in order to provide an objective measure of a student's improvement as a result of the provision of services. The CGAS rating reflects the level of student well-being or lack thereof. (Please refer to Appendix 11 for a description of this tool). The information gathered can be sent, with a release of information, to the treating clinician in order to provide useful data regarding treatment efficacy.

Less than half of the students receiving medical and/or mental health treatment had releases of information in their files that would allow communication between school staff and clinicians. It is not clear how many of the students who did not have releases of information had parents who had been asked to sign a release but declined doing so. *I would recommend that attempts to be made to obtain releases of information on all students being seen for special education evaluations who have treating clinicians, as communication between clinicians and educators can be very helpful for the students.*

I would also recommend using the database in all new and follow up special education evaluations of students in the OHD (mental health), ASD and EBD categories, as well as in assessments of students with 504 plans resulting from mental health disabilities, as it provides information that can be easily accessed and used for both individual and group program planning and development activities.

Tiers

The pyramid model utilizes the concept of three tiers of intervention. Tier 1 at the base of the pyramid, focuses on universal prevention activities, comprising approximately 80% of the student population. Tier 2 provides services to approximately 15% of the population, generally providing services such as skill building in a group setting. Tier 3 provides individual interventions for significantly at-risk students.

Tier 1 includes classroom lessons, behavior plan/intervention consultation and setup.
Tier 2 utilizes groups including emotional regulation, self-regulation, social skills/friendship and family change.
Tier 3 utilizes individual counseling/intervention, generally with one or two interventions per week and daily check-ins.

A review of Minnetonka's District tier 1-3 services indicates:

Tier 1 Elementary services include responsive classroom, bullying prevention, emotional health curriculum, social thinking curriculum, buddy lunches, character education, elementary emotional health curriculum and culture/climate.

Tier 1 Secondary services include advisory services, the web program, Do the Right Thing, Health class, embedded health, counselor check-in, FACS class, Schoology

counseling course, courage retreat, career day, team building, principal talks, counseling lessons, climate initiatives, junior first mates, anti-bullying curriculum and clubs/after school activities.

Tier 2 Elementary services include direct instruction groups (social skills, emotional regulation and family change), ADHD coaching, behavior paras, K–2 primary project, confident kids, social worker classroom lessons, mentor program, collaborative and proactive solutions, classroom interventions resulting from SST findings, support for students with financial needs, morning check-ins, consultation with families, bike clubs, fitness interventions and the K-2 winning team.

Tier 2 Secondary services include the Voyager program, ADHD learning lab, behavior plans, scheduled consultation with a therapist, behavioral or emotional check ins, the Ambassador program, student leadership initiatives, specialized intervention student groups (DBT, grief, compass, adoption, men and women of color) and attendance check-ins and interventions.

Tier 3 Elementary services include individual skill instruction, grief counseling, individual counseling/ therapy, informal individual behavior planning, behavior charts, responsive services and functional behavior assessment and individual behavior planning.

Tier 3 secondary services include school based mental health counseling/ therapy, individual student support, targeted student support, quiet lunch, targeted support groups for adoption, grief, family change, men and women of color, anxiety, sojourner, Treehouse, family friends, boys to men, compass program, 504 check-ins, individual student meetings and chemical health support services.

Tier 1 Elementary services are provided by classroom teachers, school counselors, outside providers and in some cases all school staff.

Tier 1 Secondary services are provided by classroom teachers, student leaders, counselors, school and community resources, administrators, paraprofessionals, advisory and immersion teachers and all staff.

Tier 2 Elementary services are provided by social workers, paraprofessionals, classroom teachers, administrative support, ADHD coach, SST team, school psychologists and student support specialists.

Tier 2 Secondary services are provided by classroom teachers, paraprofessionals, counselors, Social workers, administrators, Park Nicollet staff, student deans and student management coordinators.

Tier 3 Elementary services are provided by social workers, paraprofessionals, classroom teachers, co-located Relate and Park Nicollet staff, student support teams, grief counselors, principals, administrative support staff, school counselors and school psychologists.

Tier 3 secondary services are provided by the Relate therapist, school counselors, social workers and paraprofessionals.

Problems with the Pyramid Model

The Minnetonka school District has been successful in its use of the Multi-Tiered System of Support (MTSS) model of educational services. It serves the "whole child" through academic, behavioral, social and emotional interventions. Services are provided according to students' needs.

MTSS is a useful model in the educational setting, but has its drawbacks as a public health approach when dealing with the issue of lack of well-being due to psychiatric disorders. MTSS is designed as a stepwise approach with students who have problems at school. Visualizing a pyramid, the base of the pyramid (Tier 1) provides universal instruction for all students. At-risk students (Tier 2) receive targeted services, often in the form of group interventions. Students at the tip of a pyramid (Tier 3) receive intensive, individualized interventions. Tier 3 is comprised of a small percentage (e.g., 5%) of students who require individual attention, assessment, treatment, etc.

Clearly, the high numbers of students who report evidence of poor self-worth and poor well-being far surpasses the approximately 5% estimates of the number of students requiring tier 3 supports and individual attention.

One reason may be that some of these students may not be having academic or behavioral problems in the school environment and therefore don't fit into the MTSS model. The MTSS model is an educational model rather than a public health model. It is designed to address the needs of students who are having educational difficulties. It is a very useful model for the educational setting. A public health model addresses the needs of all students regardless of whether or not they are having educational difficulties.

Thus, only a small percentage of students may need specialized individual attention for school difficulties, but a significantly larger percentage may require individualized mental health interventions.

The Minnesota student survey illustrates this problem. For example, approximately 4% of 11th grade females reported attempting suicide during the last year. 7% of 11th grade females reported attempts more than a year ago. 17% of 11th grade females reported frequent thoughts of suicide. 22% of 11th grade females reported feeling nervous, anxious or on edge nearly every day. 10% of 9th grade females reported feeling down, depressed or hopeless nearly every day.

These numbers exceed the percentage of Tier 3 students described in the MTSS model.

The educational model and the public health model overlap when considering students who have both educational needs and mental health symptoms. As the Minnesota Student Survey has an item regarding whether a student has an IEP, correlating special education status and mental health symptoms is possible to some extent.

The Search Institute identifies 40 developmental assets that can be developed to encourage success. This is a useful model, but I would note that a student could have all of the external assets (focusing on the relationships and opportunities they need in their families, schools, and communities), and still develop debilitating psychiatric disorders such as depression, bipolar disorder, panic disorder, obsessive compulsive disorder, schizophrenia, etc. This is because these disorders have a medical basis and can manifest even in individuals who have multiple developmental assets. The developmental assets are clearly beneficial, but are not sufficient to prevent mental health difficulties for many students. Using a medical analogy, diet and exercise may prevent the development of diabetes for some individuals, but others may develop the disease despite healthy lifestyle interventions due to other contributing factors such as a genetic disposition to diabetes.

It is important to recognize this fact in order to have priorities to cover both bases, namely encouraging assets while recognizing the necessity of a public health approach to psychiatric disorders that is essentially the same as a public health approach to medical disorders.

A public health approach to prevention is somewhat similar to a three-tier model of intervention. However, it differs in an important respect.

Primary prevention is the prevention of disorders before they ever manifest. An example of this in the world of medicine would be the polio vaccine. Some mental health disorders can be prevented, especially if they stem from trauma such as bullying or child abuse. Preventing the use of alcohol during pregnancy can prevent fetal alcohol syndrome. Mental health, social service and medical interventions can successfully target individuals at risk for these problems and thus be effective primary prevention activities. Unfortunately, for the majority of psychiatric disorders such as obsessive-compulsive disorder, autism spectrum disorder, bipolar mood disorder, schizophrenia, etc., we do not have effective primary prevention approaches.

Secondary prevention is the same as early intervention, namely identifying and intervening early in the course of a mental health disorder. For example, identifying and treating a student's depression when it first manifests results in much better outcomes than a delay in diagnosis and treatment.

Tertiary prevention utilizes interventions for individuals who have already had extensive interventions, in an attempt to prevent the need for future intensive interventions. Providing wraparound services to individuals who have experienced multiple hospitalizations is an example of tertiary prevention. Another example would be the

provision of intensive case management and mental health interventions to setting three special education services in order to prevent the need for setting four services

There is great value in encouraging positive lifestyle choices to students. For example, the Minnetonka District's Wellness Guide offers quick tips for improving well-being and mood. These include talking to others, smiling, laughing, thinking positively, exercising, sleeping well, eating well, playing with your pet, listening to happy music and finding gratitude. Unfortunately, there are some students who may experience no improvement in their mood despite these lifestyle changes, due to the fact that they suffer from a chemical imbalance that manifests as major depression or other biologically-based psychiatric disorders. A two-pronged approach can combine school district prevention approaches with the recognition that a substantial number of students suffer from disorders that do not tend to significantly improve with tier 1 and tier 2 services. Mental health training for both educational staff and for students can assist in this process.

School districts that are interested in playing a role in helping students and their families address issues of well-being and mental health face a challenge in regard to their role with students who are not having major academic or behavior problems in school but who clearly suffer from mental health disorders.

The crux of the problem is the fact that schools are educational institutions and not public health institutions. Educational models are very appropriate for the school setting, but they fall short of meeting the goal of well-being for all students.

Answering the question, "What is a school district's role in addressing the needs of students who are not having problems in school?" is a complex task. I would note that, from a public health perspective, these problems need to be owned by the community. School districts can partner with community systems to address public health issues, but in my opinion, it would be inappropriate to expect them to carry the whole load themselves.

In my opinion, the most important thing that a County collaborative can provide is not LCTS funding, but rather true collaboration from multiple systems such as county mental health, county case management, juvenile corrections, public health, etc. that can share in a plan that clearly identifies their respective roles regarding interventions for students who have mental health disorders.

I would note that interagency collaboration for special education students is mandated (Federal statute 300.154: Methods of ensuring services (a)Establishing responsibility for services) which includes an identification of, or a method for defining, the financial responsibility of each agency.

I would recommend that the Minnetonka District address these issues with the family service collaborative members in order to gain clarity regarding each member's roles and responsibilities in addressing mental health problems from a public health perspective.

Nurses, School Counselors, Social Workers and Psychologists

Nurses

Based on a discussion with several nurses, the majority of nursing time is spent on students' mental health issues. A typical nursing visit for a routine medical problem lasts approximately 20 minutes. Mental health problems are time consuming, and include parent contacts, phone calls, emails, etc. It is estimated that 15% of the students take up 85% of the nurses' time due to mental health problems.

Thus, nurses play a vital role in supporting students' physical and emotional well-being. They generally do not provide direct counseling regarding students' mental health difficulties: they make referrals to counselors who provide that service.

Students with mental health problems may present with physical complaints. It is not unusual for an anxious child to come to the nurses' office five times in a two-week period with vague somatic complaints.

The 2019 Minnetonka Health Services report indicated that emotional/social concerns were noted in 488 visits. However, a significant number of students with physical complaints appeared to have underlying mental health concerns. Possible mental health concerns include" not feeling well" 3342 visits, stomachache, 5459 visits, pain 3935 visits and headache, 4373 visits. Elementary school students were more likely to present with physical problems when anxious, and older students were generally more able to identify their emotional discomfort.

The vast majority of medications that the nurses deal with are psychiatric medications. One nurse noted that all but one of the medications that she handed out was for psychiatric symptoms. These are compelling statistics, especially given the fact that many psychiatric medications are long acting and are taken at home before school and not taken at school at all.

I was told by several educators that there are a significant number of students who seek help for social/emotional problems who would rather be seen for an initial appointment by a school nurse than a school counselor due to issues of stigma. The district model that has the school counselors being the point of entry for social/emotional services is possibly problematic, given the fact that a number of students would choose to first seek help in the nurses' office rather than seeing a counselor.

I would recommend expanding the point of entry model to include the option of using nursing services as an alternative entryway. Based on the information provided to me, this would increase the likelihood of self-referral for students who are uncomfortable being seen entering the counselor's office. This would likely increase the nurses' workload, and might require additional staffing and training. I would note that school nurses have already been receiving mental health training including the eight-hour mental health first aid curriculum.

In my opinion, school nurses play a vital role in addressing student mental health issues, and their medical knowledge is a great asset in addressing the issue of well-being. In my opinion, flexibility regarding this issue could result in more students receiving necessary services. However, I would note that, following the initial appointment with a nurse, a referral will be made to a school counselor for follow-up services.

I would recommend that a protocol be developed for referring students to counselors when students present to the nurses' office with multiple visits where there is no evidence of an actual physical problem. This is already been done to some extent. A protocol would be helpful and quantifying the extent of the problem.

I would recommend that a time study be conducted in order to clarify in greater detail the percentage of mental health interventions related to nursing activities in the elementary, middle and high school population. It is possible that some of their time-consuming case management activities could be done by County mental health case managers in some circumstances.

Counselors

At this time, school counselors provide an entryway for students who require social/emotional interventions, and are the first stop for these services.

Counselors provide a variety of groups including self-regulation, social thinking, social skills, school readiness, family change and grief groups. Counselors' time is split up with approximately 40% of the time providing direct service and the remainder of the time working with parents, teachers, and in administrative activities. Counselors, depending on grade level, split their time between social emotional support and academic guidance. In general, elementary and middle school counselors provide a higher ratio of mental health support services versus academic counseling than do high school counselors. Some counselors noted that students receiving academic guidance often have significant social/emotional issues as well.

Some counselors noted that, although their ideal situation would be to provide preventative and proactive services, time constraints put them in a more reactive position in dealing with students' problems. To my knowledge, I am not aware of prioritization of counselor activities to clarify whether all of them are essential.

Social Workers

Students who have greater mental health needs are referred to the school social worker when possible. Some social workers are limited to working with special education students, whereas others also see general education students. In schools where, social worker activities are limited to special education students, there tends to be more counselors' time available to see students.

Social workers are involved in a wide variety of interventions. They help support students with needs for social skills and other life skills. They support parents and staff and are involved with the student support team and with special education assessments. They are involved with prevention programs, monetary grants for needy students, interacting with community mental health providers and are involved in the ADHD mentorship program. They assist students who struggle with anxiety and provide parent outreach. They are also involved with crisis risk assessments.

Psychologists

Except for a few psychologists who are contracted to provide general education counseling services, school psychologists noted that approximately 90% of their time was devoted to providing special education assessments. Meetings take up to the remainder of time. They would prefer to have more time available to work with students, parents and teachers. They noted that there has been an increase in parent referrals, with approximately 25% of evaluations being requested by parents who bring in private evaluations.

Chemical Health Services

Judy Hanson is providing chemical abuse services to Minnetonka High School which are partially funded by the Family Service Collaborative LCTS grant.

She is available for initial interventions on a timely basis, with referrals generally coming from students who are apprehended in the use of substances (mainly nicotine and cannabis), or by self-referral.

She does not do chemical health assessments, but makes referrals based on a variety of factors including information gathered from semi-structured interviews/screening tools, the rate of recidivism, co-occurring symptoms and self-referral. She noted that she referred 20% of the students that she saw for vaping THC, 22% of alcohol abusers and 19% of nicotine users.

Outcome measures include recidivism, attendance, grades, comparisons with the student's initial screening results, self-report and collateral information from parents, teachers and counselors.

When asked about recommendations concerning school policies related to students who were caught using substances, she noted that immediate diversion would be preferable to suspension. She did not believe that the overall impact of suspension was positive. *I do not have enough information to form an opinion regarding the positive versus negative consequences of mandating suspension versus providing immediate diversion. In my opinion, this is an important issue which warrants further study.*

Feedback from District staff regarding Ms. Hanson's work is positive. They especially appreciate the timeliness of her services, and wish that similar timeliness would be available from mental health treatment providers.

District Mental Health Supports

The Minnetonka district provides a white variety of mental health supports to their students. They include:

ADHD coaching/Lab
ADHD Mentorship Program
Adoption Group
Anti-bullying curriculum
Anxiety Group
Chemical health specialist
The Child Family Support Program (CFSP)
Emotional Regulation Group
Empower U
Exercise Intervention
Family Change Group
Growing through Grief
IM4 education
Make it Okay
Men and Women of Color Groups
Mental Health Resource Fair
New Student Group
Primary Project
Project Play
Relaxation Group
Relate mental and chemical health programs
Resource Map
Responsive Classroom
SEL small skills groups (SAEBRS)
Self-Regulation Group
Social Skills Group
Suicide awareness and prevention
Well -being Guide
Well-being website
Who are your people?
Winning Team/Goal Getters
Youth Mental Health First Aid

Please refer to Appendix 12 for detailed descriptions regarding the nature of the interventions, who is receiving the interventions, when are they received and outcome information.

Adequacy of Mental Health Support Staff Resources

In my meetings with various school professionals in the Minnetonka District, one common theme was the opinion that the District is a leader in the provision of educational supports, but is an outlier compared to similar districts in the provision of mental health supports for students.

I was also told that, despite very significant increases in enrollment, the number of social work, psychology, counseling and nursing staff have not increased accordingly.

A data analysis was performed in order to clarify these two issues. The questions were:

1.) Compared to other school districts, how does the Minnetonka District fare in regard to the adequacy of mental health support services?

2.) Has the Minnetonka District's hiring of mental health support services staff kept pace with increases in student enrollment?

Adequacy Data

Data were analyzed comparing Minnetonka High School mental health staff ratios with those of the Hopkins, Eden Prairie, Edina, Wayzata, Buffalo, Saint Michael, Albertville, Orono, Mound West Tonka and Chanhassen Districts high school staff. The analysis focused on high school counselors, social workers and psychologists. College counselors were not included in the analysis. Minnetonka also had a 504 counselor who was not initially included in the analysis.

The ratio of students to support staff for the above-mentioned districts averaged 1:372. Minnetonka's ratio was at least 1:376, clearly not an outsider. If the 504 counselors were included in the analysis, the ratio for Minnetonka was 1:340. The District is adding a 10th counselor this year, or, at the latest, in the fall of 2020. In doing so, the ratio will go to 1:340 or, if including the 504 counselors, 1:309. (This does not include the college counselor). If we include the college counselor, the ratio goes to 1: 283. Neither the Advanced Learning Coordinator (a licensed counselor) nor the Compass coordinator, who both serve students, are in the calculation. Please refer to Appendix 13, Support Staff Ratios, for details.

I would thus conclude that the answer to question #1 is that the Minnetonka District is in fact above average compared to other districts in its mental health support staffing numbers for the high school. *I would encourage the District to do a similar analysis for middle schools and grade schools.*

Student Enrollment Numbers and Mental Health Support Staffing

Data were analyzed for the period between 2015 and 2020 for social workers in special ed and general ed, psychologists, school counselors, nurses, behavior strategists and ASD consultants:

Clear Springs enrollment grew from 794 students to 881 students. Special education enrollment increased from 93 students to 117 students. Total FTE Number is declined from 2.45 to 2.3, and student per staff ratio declined from 1:324 to
1:383

Deephaven enrollment decreased from 667 students to 648 students. Total FTE numbers essentially stayed the same, going from 2.03 to 2. Student per staff ratio improved slightly, going from 1:328 to 1:324.

Excelsior's enrollment increased from 746 to 814 students. Total FTE numbers increased from 2.39 to 2.75, and student per staff ratio improved, from 1: 312 to 1: 296.

Groveland's enrollment increased from 784 to 897 students, and total FTE numbers increased from 2.33 to 2.45. Student per staff ratio declined, from 1:336.5 to 1:366.1.

Minnewashta's enrollment increased from 839 to 946 students, and total FTE numbers increased from 2.28 to 2.75. Student per staff ratio improved, from 1:368 to 1:344.

Scenic Heights' enrollment increased from 800 to 905 students, and the total FTE numbers increased from 1.96 to 3.05. Student per staff ratio improved from 409.2 to 296.7.

MME's enrollment increased from 1200 to 1322, and the total FTE numbers increased from 4.87 to 5.6. Student per staff ratio improved from 1:246.7 to 1:236.1.

MMW's enrollment increased from 1040 to 1250, and total FTE numbers increased from 5.3 to 5.95. Student per staff ratio declined from 1:196.2 to 1:210.1.

MHS's enrollment increased from 2987 to 3394, and the total FTE numbers increase from 12.3 to 14.05. Student per staff ratio essentially stayed the same, from 1: 242.8 to 241.6.

District wide enrollment increased from 9857 two 11,057, and a total FTEs increased from 36.1 to 44.35. Student per staff ratio improved, from 1:273 to 249.3. With full staffing and .8 nursing added, the ratio now would be 1:233.8

(Please refer to Appendix 14, Student Support Services Staffing – Historical Data: 2015-2020 for details).

Thus, the hypothesis that student enrollment increased without a concomitant increase in mental health support services is not substantiated by data analysis.

Nonetheless, it was the general consensus of the school professionals who I interviewed that they had inadequate staffing to meet the social and emotional needs of students who were demonstrating problems in well-being. I heard the phrase, “we are spread too thin” numerous times.

It could be argued that, although Minnetonka has at least equivalent mental health supports as the average of other districts, that all the districts are understaffed in regard to student support services. This raises the question, “how much is enough?”

Judging from the Minnesota student survey, there clearly are large amounts of students who have evidence a very significant social/emotional difficulties. In my opinion, it is essential for school districts to clarify their role in providing mental health support services, compared to the roles of other providers including medical and mental health professionals in the community or in co-located relationships with the school district.

Conclusions and recommendations regarding this issue are outlined at the end of this report.

Maximizing the Effectiveness of Mental Health Support Staff

Before considering the addition of mental health support staff, it is important to identify interventions that could result in more efficient use of the support staff in the District.

Several social workers noted that some of their time is used for providing IEP individual counseling that they feel is no longer necessary. The services were at one time necessary, in their opinion, but due to progress made, they believed that the student would function well without these services. However, they noted that some parents are reluctant to discontinue the service due to their concerns that their child may deteriorate as a result.

I am not aware of the various contributors to the situation, which may include the nature of different teams at different schools, and their potential willingness or reluctance to actively advocate the reduction of services which they deem is no longer necessary.

Some social workers described a method that they used to prevent this problem. This was to provide a “burst” of more intensive services at the beginning of service provision, followed by a gradual weaning of services when appropriate. The timeline for these changes would be different for each student. Some social workers noted that parents can be comfortable with this arrangement, especially if they know the services can be increased if problems arise.

In my opinion this issue provides an opportunity for the District to be more efficient in the provision of mental health student support services. *I would recommend that this issue be analyzed in more detail to identify the situations where IEP teams could effectively*

work with parents to ensure that necessary services continue, and unnecessary services be weaned with no harm done to the students.

There is another area in which time could be freed up for mental health staff to provide additional services. School psychologists note that, for the most part, their time is spent performing special education evaluations. They noted that some of these evaluations, specifically those provided for emotionally and/or behaviorally disturbed students, could be prevented by more intensive use of tier 2 pre-referral interventions. There is a perception that there are not enough mental health support staff to provide these interventions, and that additional staff would be necessary to accomplish this goal.

I spoke with Kim Gibbons, Ph.D., who noted that when she was the special education director of the St. Croix River Education District, their district was able to reduce special education evaluations by 50%. She noted that, by providing tailored pre-referral interventions, districts can ultimately free up psychologists' time to provide additional services to districts, such as teacher training and consultation.

Dr. Gibbons now is the director of the Center for Applied Research and Educational Improvement (CAREI) at the University of Minnesota. She noted that she is available to provide expertise to school districts regarding the use of pre-referral interventions that have the potential to reduce the number of special education evaluations. I would encourage the Minnetonka District to take advantage of this consultation.

Other consultants such as Clayton Cook from the University of Minnesota could also be quite helpful in addressing this issue. Dr. Cook is the John and Nancy Peyton Faculty Fellow in Child and Adolescent Wellbeing at the University of Minnesota and Associate Professor in the School Psychology Program. In addition to his research, he consults with several school systems throughout the US to improve the delivery of a continuum of high-quality services to promote better social, emotional, and behavioral outcomes for students.

It is my understanding that there is a variation among different schools regarding the threshold for referral for special education. *Further explanation into the reasons for this could shed light on solutions to this problem*.

A third area to consider in regard to increasing efficiency and freeing up time of the mental health support staff is increasing utilization of County mental health case managers. According to the Hennepin County website, "Children who have serious and long-lasting mental health needs can receive mental health case management services to help them and their families navigate the mental health system. Mental health case managers help children and their families obtain and coordinate therapeutic and supportive services that address the child's mental health issues and related social, recreational, health, educational, and vocational needs. Mental health case management services are provided by community agencies as well as by county social workers. To be eligible for mental health case management services, a child needs to have recently completed a

diagnostic assessment and to be experiencing a "severe emotional disturbance," as determined by a mental health professional.

The definition of “severe emotional disturbance” includes children and adolescents “who, as a result of an emotional disturbance, have significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.”

Few Minnetonka students have mental health case managers, despite several of them meeting the criteria for eligibility. Feedback from a variety of sources indicates a more positive staff impression of Carver County versus Hennepin County. District mental health support staff including nurses, social workers and special education case managers spend a considerable amount of time engaged in activities that could be provided by County-hired or contracted case managers. These activities include such activities as making arrangements for doctor visits, arranging for transportation, etc. This takes time away from school professionals to accomplish their tasks in the school environment.

If there has been a problem with County services in the past, this could be directly addressed through communication with supervisory staff. *A significant number of students, especially those in setting 3 programs, meet the criteria for eligibility. I would recommend that this issue be explored.*

It is my understanding that most Minnetonka students who are receiving mental health case management services are involved in other systems such as County social services. Many Minnetonka students who are not involved with multiple systems may also qualify for case management. *I would recommend expanding the amount of case management services for students who clearly are in need of these services.* Case management does not replace mental health treatment services; it is a service that complements and supports treatment. In order to receive the services, the student’s parents would need to apply for the service and to provide documentation regarding their child’s eligibility. I would reiterate that many of these students are already receiving time consuming mental health case management services which are provided by school staff rather than by County case managers.

Maximizing efficiency of services is the fourth area to explore. The Minnetonka District provides a wide variety of mental health support services. Each has its own history, rationale, target population and methodology. In my opinion, in analyzing the topic of adequacy of services, it is appropriate to consider prioritizing the services already being provided, and determining whether any of them are of low enough priority to justify consideration of discontinuing them. Criteria for prioritization would include whether the service is mandated, the number of students being served, the nature of the students’ mental health difficulties in the population being served, whether other activities overlap the service, and whether outcome measures indicate whether the service is effective. Some mental health support services are described as being inadequate, such as the step-wise provision of tier 2 services as a pre-referral intervention for students at risk of

requiring a special education evaluation for emotional/behavioral difficulties. In order to expand services in one area, it may be necessary to phase out services in another area. *The prioritization of mental health support services into higher versus lower priority activities is a necessary factor, in my opinion, in analyzing the adequacy of services and the potential need to increase staffing.*

In my opinion, prior to considering adding additional staff, it is important for the District to explore all possibilities for maximizing the work that is done by the District's mental health support staff. I would note that prioritizing services and analyzing their benefit may result in continuing all of the services being reviewed. However, given complaints of mental health support staff being "spread too thin", prioritization is clearly indicated, in my opinion.

Mental Health Coordinator

As the Minnetonka District addresses student mental health issues, there will be an ongoing need to coordinate mental health related activities within the District. Coordination could be done by an individual or by several staff working together, splitting the workload.
The job description would include:

-Identifying the activities that need to be performed by various school mental health staff (psychologists, social workers, counselors, nurses), and working with those groups to assure that the activities are accomplished without overlap or gaps in services. Examples of activities include direct counseling with students and their families, obtaining releases of information, communicating with treating professionals, providing consultation to teaching staff, special education assessment, educational testing, skills training, etc.

-Creating a mechanism of oversight and accountability to assure that tasks are completed.

-Creating protocols for mental health related activities that are endorsed throughout the District.

-Coordinating services from the various outside agencies- HMO's, Corrections, Mental Health, Chemical Health, Social Services, Vocational Rehabilitation and Community health and mental health clinics, that serve Minnetonka students.

-Establishing collaborative ventures with outside agencies, for the provision of mentoring, case management, family liaison, etc.

-Expanding on-site mental health services from outside clinics into Minnetonka schools to assure that mental health services are available and easily accessible for diagnostic assessment and mental health treatment.

-Providing oversight for training to teachers, counselors, social workers, psychologists, nurses, behavioral aides, paraprofessionals and administrators about the mental health problems affecting students, and methods of effectively helping students who have mental health disorders succeed.

-Program planning and development, based on needs assessment.

-Assuring that students who have identified counseling needs receive appropriate services.

-Assuring that school staff seek mental health evaluations for students when mental health problems are evident.

-Assuring that IEPS reflect appropriate accommodations and modifications for students' mental health problems.

-Overseeing in-service educational programming for parents about mental health and chemical health topics, methods of obtaining advocacy for health and mental health services, availability of County case management services, etc.

-Culturally sensitive parent outreach and advocacy.

-Data analysis of mental health information from students' special education databases with the goal of tailoring educational services based on students' abilities and disabilities, and in establishing outcome data of interventions.

-Providing easily accessible centralized information to school staff regarding available resources for mental health related services.

On-site Mental Health Services

On site, co-located mental health diagnostic and treatment services provided by community mental health professionals are an ideal method of providing access to services for children and adolescents who may not otherwise be able to utilize them. These services provide bridges to mental health while maintaining appropriate legal and financial firewalls for the school district. Having services provided by a contracted community mental health provider removes problems that could arise from the district hiring its own mental health providers. These problems include data privacy (all therapeutic files become part of the educational record), lack of ability to obtain malpractice insurance for the district, the need for crisis coverage in off hours, etc.

The Minnesota Department of Human Services Legislative Report from February, 2020, "Improving the School-linked Mental Health Program" noted, "Under Minnesota's model of school-linked mental health, community mental health agencies place mental health

professionals and practitioners in partnering schools and school districts to provide direct mental health services to students. These services work to increase access to mental health services for all children, particularly children and youth who are uninsured and underinsured, to improve clinical and functional outcomes for children and youth with a mental health disorder, and improve identification of mental health issues. These mental health providers also support parents, caregivers, consult with teachers, provide care coordination and deliver classroom presentations and school-wide trainings on mental health issues…Youth are 6x more likely to complete mental health treatment in schools than in community settings…Mental health services are most effective when they are integrated into students' academic instruction…School-linked mental health services also eliminate common barriers for families such as taking time off from work, transportation, navigating complex systems, and longer wait times in the community clinic.

A Comprehensive School Mental Health System (CSMHS) builds on existing school resources within a Multi-Tiered System of Support (MTSS) to effectively support all students. By establishing common language and a framework between both student support personnel and school-linked providers, a multidisciplinary team can be more readily attained through the provision of a full array of supports and services that promote positive school climate, social emotional learning, mental health and well-being, while reducing the prevalence and severity of mental illness."

My experience with the Relate clinic dates back to 1996, when Mark Wolak, then special education director for the Minnetonka District, hired me to review the files of students who were in level four programs at District 287. I found that 85% of the students already had a mental health diagnosis, but only 5% were receiving mental health services. The District was able to have students return to the Minnetonka schools with the help of Relate clinic's provision of therapeutic diagnostic and treatment services. The District saved $800,000 per year as a result. The services provided by the clinic were essential to the success of this undertaking.

In my opinion, co-located, on-site mental health services provided by a community mental health clinic are the ideal model of service provision. The Relate clinic has been providing community mental health services for District students for 50 years. They have both a child psychiatrist and an adult psychiatrist who are available to treat students and their parents. Clinicians able to utilize consultation on difficult cases. They make an effort to understand the nature of school districts' unique issues regarding student mental health. They work with high-risk students and families.

The Relate Clinic has a number of sources of income that are paying for on-site services in the District. These include a school-linked grant from the Minnesota Department of Human Services, grants from the Family Service Collaborative, funds from the school district and reimbursement from third-party insurance.

Students identified and referred to the clinic often are from families who are uninsured or underinsured. Mental health treatment is thus available to families who otherwise have a good chance of not receiving these services. By treating a disproportionate percentage

of uninsured and underinsured individuals, the clinic has a greater need for generating income from other sources. This problem is exacerbated by underfunding of mental health services.

Relate clinic is embarking on a three-pronged model designed to improve efficiency in the intake treatment processes.

First, centralized referrals allow for collection of necessary client and family paperwork including family insurance details. This allows for a mix of clients to be seen in the District including families with insurance & families with barriers to service that can be subsidized by collaborative, state & District funds.

Second, the plan allows the clinic to be able to move clinical resources between District buildings if buildings are not providing sufficient referrals to maintain their hours full in that building.

Third, at the end of each month there will be a formal team meeting at the District level to review wins and opportunities to ensure a transparent communication of what is going well & what timely changes may be needed on both sides (clinical or school).

In my opinion, goals for on-site mental health diagnostic and treatment services would include:
-Affordable diagnostic and treatment services.
-Availability in every school in the District
-A short waiting list for intakes, evaluation and treatment
-Clinicians who are experienced in diagnostic and treatment activities
-Low staff turnover
-Clearly defined professional boundaries from both the clinic and the District
-Clinicians understand and appreciate the unique characteristics of school mental health services
-Availability of substance use assessment and treatment
-Availability of in-home family therapy
-Adequate space in the buildings to provide the necessary mental health services
-Availability to treat parents or other family members at the clinic office, if requested
-Availability of adult and child psychiatrists to provide treatment and team consultation

In my opinion, given the results of the student survey, screening tools and feedback from a variety of school staff, the availability of clinical services both within the school and in the community are essential, and in fact need to expand in order to address the significant mental health problems in the student population. Although on-site co-located services are a fraction of the total clinical services provided to Minnetonka students, they fill an essential need for high-risk students.

Unfortunately, financial and other systemic concerns in the mental health system are highly problematic. There is a lack of mental health professionals in the community, and waiting lists can be long. High co-pays and deductibles can make services out of reach

for many families. Many working families cannot find the time to bring their children into clinics in the community on a regular basis. All of these facts support expansion of clinical services provided by community mental health professionals within the District. The challenge is to find a way to be able to financially make this feasible.

In order to understand the complexities of school mental health funding, I spoke with David Senior, executive director and Becky McNattin, director of clinical services at Relate clinic.

They noted that the total cost of a full-time equivalent clinician is approximately $65,000 a year salary with benefits. Including indirect costs, the amount is $80,000-$95,000 a year. The DHS grants have not kept pace with these increases. The school-linked grants were supposed to cover 20% to 30% of the costs. However, insurance deductibles have skyrocketed, and grant amounts have not kept pace with these increases. In the Minnetonka District, 45% to 50% of their clients are uninsured or underinsured. Underinsured clients are defined as having at least a $4000 deductible plan. Relate clinic has a DHS grant of $280,000 per year, which only covers a small fraction of students who they serve in schools.

Clinicians who work at the clinic and not at the school are expected to bill 25 hours per week. School-linked clinicians tend to bill approximately 20 hours per week for the time working in the schools. Clinicians tend to be in the schools part time. It is difficult to have a full caseload during several times of the year. Summers are especially problematic for reimbursement.

Ancillary services such as teacher training, school staff consultation, etc. that cannot be billed to insurance account for 2 to 8 hours per week per full-time equivalent therapist. Funds provided by the Minnetonka District and the Family service collaborative are earmarked for Minnetonka. Relate clinic also serves the Mound, West Tonka, Orono, St. Louis Park, Hopkins, Edina, Wayzata and Chaska/Chanhassen Districts.

They expressed interest in expanding school-linked services in the Minnetonka District, should the District be interested. To provide an extra clinician, they estimated that the full-time equivalent cost beyond the amount that could be generated from insurance would be approximately $40,000 per year.

In my opinion, the Relate clinic has been a valuable mental health resource to the Minnetonka School District for many years, and it is my opinion that an ongoing relationship between the clinic and the District should be strongly encouraged.

Given the extent of mental health problems in the student population, I would encourage expansion of on-site clinical services by the Relate clinic and/or other clinics.

Information regarding on-site, co-located services was requested from several neighboring school districts. It indicated a wide variety of intensity of services and reimbursement methodologies. (Please see Appendix 15 for details). Of particular note

is the Elk River District, which has a total enrollment of approximately 14,000 students. It has 14 full-time equivalent clinicians, provided by Central Minnesota Mental Health Center, Bridging Hope, Rogers Therapy, Greater Minnesota Family Services, Parasol Wellness and Lutheran Social Services. This results in having one full-time equivalent per building. Funding is obtained from insurance billing, LCTS funds, DHS school linked mental health grants and LEA funds. Their District's total cost to fund a full-time equivalent is $7000.00.

The Osseo District, with an enrollment of 20,369 students has 17 full-time equivalent staff provided by Peoples Inc., Saint David's and the Lee Carlson Center. Funding is provided by insurance, DHS grants, LCTS grants and private insurance. Total cost per FTE is $35000.00- $40000.00.

Clearly, there is a wide variety of staffing patterns and practice models for co- located services.

I would recommend that the Minnetonka District explore all available options for the expansion of accessible mental health services in the District.

Mark Sanders, from Hennepin County, was mentioned several times as an expert in financing school mental health programs, and is seen as a resource for school districts. I spoke with him, and he offered consultation regarding school mental health funding, at no cost to the District. I would recommend that District leadership utilize expertise of professionals such as Dr. Sanders.

I would also recommend meeting with professionals from the various districts who oversee the on-site mental health clinic activities and funding streams. This will provide a foundation of information that will allow the Minnetonka District to expand services in a cost-effective and clinically effective manner.

The shortage of accessible services at this time contributes to problems with student and family well-being. Expansion of services would provide additional options for tier 3 services that are designed to improve mental health functioning and well-being.

Communicating with Treating Professionals

Most of Minnetonka students who are being treated for mental health disorders are being seen by physicians rather than by mental health professionals. This is consistent with national norms.

Releases of information allowing District staff to speak with the physician are frequently obtained, but concerns were raised that there is often not enough time available for communication to take place. The District communicator may be a social worker, a counselor, a nurse or a special education case manager. Typically, school staff communicate with parents who then communicate with the treating professional.

Given the time constraints, it may be difficult to communicate effectively with the treating physician when there are concerns that medication is not being effective or is causing side effects.

I would recommend that an effort being made to obtain a release of information and to communicate directly with the treating mental health or medical professional in situations where special education is being considered due to symptoms which are identical to those that are the criteria for a mental health disorder such as ADHD, when the student is taking medication for those symptoms. I have seen a number of instances where the physician was not aware of ongoing problems, and when the medication dosage was adjusted, the problem improved to the point that a special education evaluation was no longer needed. This resulted in improved educational outcomes, cost savings and improved well-being for the student and his or her family.

Another issue related to communication with treating professionals is the concern among school staff that mental health treatment facilities do not communicate adequately when students are being discharged from day treatment or hospital treatment. This makes it difficult to have a smooth transition back to a Minnetonka school, and can ultimately lead to increased stress, anxiety, and a return of symptoms that were the cause of placement in the first place. *I would recommend this should be quantified, with the results clearly communicated to the mental health administrators in question. A mental health program's lack of communication despite efforts made by school personnel to facilitate it is clearly unacceptable, in my opinion.*

Mental Health Consultation

Another request made by school staff was to have access to a mental health consultant who could assist the District in clarification of diagnostic or treatment issues, potential educational interventions, risk assessments or helping the District work more successfully with a student's parents. They noted that Middle School East has some access to a mental health professional in the community. *In my opinion, the judicious use of a mental health consultant can be very helpful in specific situations. Ideally, consultation could be provided by a District mental health support staff professional. In situations where expertise is not available within the District, outside consultants can provide a beneficial service.*

Outcome Measurement

Although many interventions take place in the Minnetonka School District, it is at times difficult to identify the data that indicates whether the services are effective. This is not an unusual problem, as it is frequently encountered in many school districts.

There is a significant amount of anecdotal data indicating that interventions are helpful to students and families. The goal is to have outcome data that are objective and generalized across the population served.

Outcome data are gathered in a variety of ways in the District. Students may provide feedback as to their own perception of progress made in individual or group counseling sessions. Attendance may improve for truant students who have underlying mental health issues. There may be a reduction in incident reports in students with acting out behaviors. Grades may improve when problem such as ADHD are treated. Functioning at the time of three-year reevaluations may be significantly improved compared to the last assessment. Discipline referrals may be reduced over time. Pre-referral interventions may decrease when additional tier 2 services are provided. Self-reports of the effectiveness of calming virtual reality goggles may reflect significant improvement in post-stress versus pre-stress assessments. IEP goals such as increased time on task and time cooperating with peers are measured. Students seen in psychotherapy may demonstrate improvement in academics and behavior.

The District is using outcome measurements for a number of assessments, but they may not be routinely used to measure the effectiveness of other interventions. One of the reasons for this that is mentioned by school staff is the time commitment required for assessing outcomes.

One measurement that reflects a student's level of functioning is the Children's Global Assessment Scale (CGAS) discussed elsewhere in this report, and illustrated in Appendix 11. As noted above, this is not a diagnostic test; it is an assessment of a child's or adolescent's level of functioning. It can be administered by school psychologists. Positive changes over time reflect positive outcomes of interventions.

It is my understanding that District school psychologists report that they already gather the level of functioning data that goes into calculating the numerical indices on the CGAS. *In my opinion, this is all the more reason to utilize this measure of functioning. It provides a useful and quick method of gauging students' level of functioning, and can be easily adjusted overtime as that functioning hopefully improves.*

There are a number of ways that outcomes can be measured. In order to effectively conduct an evaluation of mental health support services and their impact on well-being, outcome measurements can be a valuable resource in determining whether an intervention should continue, should be expanded, or be discontinued. *I would recommend that the District continue in its efforts to systematize outcome measurements of social/emotional interventions for the purpose of effective program planning and development. I would recommend seeking technical support in this process from Matt Rega in the Teaching and Assessment department.*

Matriculation and Persistence

The Minnetonka School District has done an exemplary job of providing opportunities for academic success. Results of the Minnesota Student Survey indicate that Minnetonka students' plans to go to a four-year college range from 80% of 11th grade males to 90% of 11th grade females. National clearinghouse data indicate that Minnetonka's matriculation rates are 80% for students enrolling in four-year colleges and another 12% matriculating into two-year programs.

The most recent data from the Minnetonka District indicate that college persistence, defined as graduating within six years, is approximately 60%.

The national average for college persistence is approximately 40%. The highest rates of college persistence by state are found in Delaware and Virginia, where public four-year colleges graduate over 70%. I do not have the data clarifying the persistence rates of students from these states who attend private colleges. Virginia is one of 34 states to have state mandated college and career preparation for school counselors K through 12 and has outlined outcome of competencies by level.

Common reasons for the college dropout phenomenon include: financial stress; not asking for help; non-attendance; procrastination; social isolation; chemical abuse; overloading one's schedule; excessive video involvement (e.g. social media, gaming); and becoming overwhelmed by pressure. Many of these factors are caused by or contribute to the development of anxiety disorders and depression.

Anxiety and depression are the two most common reasons that college students seek mental health services, according to the Center for Collegiate Mental Health 2017 Annual Report from Penn State University. While the incidence of all other mental illnesses reported by college students has declined or remained flat, these two mental health conditions have shown year-over-year increases.

I do not have a breakdown of data that would clarify whether those students who did not finish college were more likely to have attended expensive private colleges, and who left due to the expense. I would suspect that lack of academic preparation and coursework are not the most significant contributors to problems with college persistence for students in the Minnetonka School District. It is possible that lack of emotional preparation, however, may be a major contributor.

While test scores can predict academic success, self-management and relationship skills may better prepare [college] students to thrive and graduate. Atlantic (Felton, 2016)

In my opinion, if the District develops and expands programs teaching students methods of effective lifestyle management, character development, persistence and self-mastery (described above), that this will have a positive effect on improving college graduation rates. Expanding mental health support services that serve students suffering from

mental health disorders such as anxiety and depression would also have a positive effect on college persistence.

I would recommend that the District conduct a prospective study to determine the contributing factors that increase college persistence and the factors that contribute to lack of persistence. An analysis of these issues could lead to identification of and interventions for high school students who are at risk of not persisting in college. This could lead to increasing success and improve self-worth and well-being for a significant percentage of students in the District.

Evidence Based Teaching Methods

Several evidence based proactive classroom management techniques have been shown to be successful with students who have emotional/behavioral difficulties. They are:

Establishment of clear rules
Use of function-based plans.
Academic support with curricular modifications
Cooperative learning
Specialized instruction study skills
Peer assisted learning
Social emotional learning
Peer mediated behavior
Conflict resolution interventions
Social skills instruction
Anger management
Behavior support management plans
Pre-corrections
Instruction in self-monitoring
PBIS
Peer reinforcement
Behavior contracts
Crisis intervention planning

I reviewed this list with setting 3 teachers and was impressed that they were familiar with all of these interventions and used them to varying degrees as needed.

I would recommend that general education teachers also utilize these techniques, as appropriate, if they are not already doing so. They are interventions that are helpful to individual students who have social/emotional problems, but also benefit the rest of the classroom students as well. This allows the student who has problems to avoid the stigma of being singled out for interventions in the classroom. As academic success is a key indicator of student well-being, the use of evidence-based teaching methods are clearly warranted.

Mental Health Education for Students and Staff

Student Mental Health Curriculum

Health classes in the Minnetonka District cover mental health topics to some degree. Mental health curriculum is approximately 10% of the total health curriculum.

Middle school curriculum does not address specific psychiatric disorders.

The 6th grade curriculum addresses issues such as conflict resolution, stress management, emotional changes in puberty and available resources. There is some discussion about anxiety and depression.

The 7th grade curriculum addresses issues such as friendships and dating relationships that can impact mental health, and self-management. Suicide is not discussed, allegedly because a parent complained it was “too much too fast”.

There is no health class in eighth grade, apparently due to scheduling conflicts with elective classes.

High school curriculum include how lifestyle issues can impact mental and physical health. Anxiety, social media and its impact on mental health, chemical health and the effects of substance use impacting anxiety and depression are discussed. Disordered eating, nutrition, mood boosting foods, exercise and mental health, community resources and the value of effective lifestyle management are reviewed. Disorders such as PTSD stemming from trauma, bipolar disorder and ADHD are not covered. Suicide is discussed, including an overview of what to do if a peer says that he or she is feeling suicidal.

Approximately 50 6th graders and 60 7th graders cannot take health class because it interferes with their schedules. Ironically, most of these students are in special education, many of whom are at-risk or high-risk students.

Regarding the topic of not teaching about suicide in seventh grade, I would note that the Minnesota Student Survey indicates that, for the question “have you ever seriously considered attempting suicide, 5% of 8th grade males and 10% of 8th grade females answered, “yes, during the last year”. 5% of 8th grade males and 7% of 8th grade females answered, “yes, more than a year ago”. In answering the question, “have you ever actually attempted suicide”, 1% of eighth grade males and 3% of eighth grade females answered “yes, during the last year”. 1% of eighth grade males and 2% of 8th grade females answered, “yes, more than a year ago. “

I would recommend expanding mental health curriculum to be a higher percentage of health curriculum (25%) than it is now (10%). This recommendation is based on the pervasiveness of mental health disorders in middle and high school students, and the need for education to assist them and their peers in seeking help when needed. *I would*

recommend that health class be offered in eighth grade, given the needs of eighth grade students to understand the physical and mental health. I would also recommend that all sixth and seventh graders be able to take health class. I would recommend that the topic of suicide be discussed in middle school as well as in high school. Expanding the amount of health class availability in high school would also be helpful in empowering students with the knowledge that they need in order to live a healthy lifestyle and to attain the goal of well-being.

Ideally, students would learn about mental health issues in other classes besides Health. A Physics teacher might point out that Isaac Newton may well have been on the autistic spectrum. An English teacher might point out that the writer, Sylvia Plath, suffered from recurrent depressive episodes. The more that Minnetonka educators learn about mental health issues, the more they will be able to impart this information to the students when appropriate. Mental health education can go a long way in reducing stigma and encouraging individual to seek help when they are experiencing symptoms of mental health disorders. Knowledge can be the first step in the process of attaining well-being.

Continuing Education for Staff

All of the professionals who I interviewed agreed that they have benefited from in-service training on topics such as crisis intervention, mental health first aid, effects of trauma, etc. Not surprisingly, given the severity of mental health difficulties in the student population, staff expressed interest in expanding continuing education activities regarding student mental health.

I received feedback that course work needed to be tailored to the audience's skill sets and backgrounds. Teachers expressed interest in learning more about mental health, but some noted their concerns regarding their lack of expertise and the need to maintain clear boundaries regarding their roles in dealing with students' mental health difficulties. Psychologists, counselors, nurses and social workers all expressed familiarity with various mental health topics, and were interested and expanding their scope of knowledge. All staff were interested in a greater understanding of the types of mental health disorders impacting students, the ways in which these disorders manifest in the classroom, and strategies for interventions that are successful with this population. Given the fact that statistically, every classroom in the District has a likelihood of having at least one student with a severe emotional disturbance, this issue is highly pertinent

Constraints on the availability of time for continuing education services are problematic, but the problem is of such severity as to warrant expanded continuing education in mental health topics. This can also be done through reading books and articles and through the use of webinars. I wrote the book, "Student Mental Health- A Guide for Teachers, School and District Leaders, School Psychologists and Nurses, Social Workers, Counselors and Parents" in order to help meet this need.

Increasing the knowledge of student mental health issues among educators results in more effective interventions with at-risk students, ultimately resulting in improvements in student well-being.

LCTS Funds

Local collaborative time study (LCTS) funds are generated through indirect Medicaid billings resulting from random time studies. This amounts to approximately $300,000 per year that is distributed through the Minnetonka Family Service Collaborative.

Different collaboratives around the state have different philosophies regarding the best use of LCTS funding. Some disperse multiple small grants, whereas others find value in funding a few substantial grants.

Given the severity and pervasiveness of the District's students' mental health problems, and the significant limitation in accessible on-site services at this time, I would recommend the latter approach. In my opinion, funding should go to supporting direct services for at-risk and high-risk students. I would recommend consideration of large grants going to increasing the availability of on-site, co-located diagnostic and treatment services. I would recommend that, in the process of analyzing the interest and availability of clinics including, but not limited to the Relate Clinic, that funding be made available through LCTS grants for expansion of services. This would help fill the need for tier 3 services and would result in increased well-being for vulnerable students.

I would also recommend the use of outcome measures that clearly define students' level of functioning prior to treatment, at some time during treatment and following treatment interventions.

A School Mental Health Plan

The Minnetonka School District, by prioritizing well-being for students and their families, is taking a very positive step in the process of evaluating mental health supports. I am attaching a document, "Creating a School District Mental Health Plan that Meets the Needs of Students who have Psychiatric Disorders" (Appendix 16) It was written with the goal of assisting school districts in organizing their mental health interventions. It is my impression that the Minnetonka District already is utilizing a significant portion of items in the plan. *I would recommend that District leadership review the document in order to clarify whether additional organizational interventions are indicated.*

Student and Family Well-being Interviews

In order to have a clear understanding of the experiences of students and their families in regard to well-being, I would recommend in-depth interviews that explore their experiences with District mental health supports and that seek feedback regarding future District activities and interventions.

I would recommend interviews of elementary, middle and high school students, and separate interviews of parents with children at these levels. The goal of the interviews is to assist the District in having an in-depth understanding of the opportunities and challenges that students and their families experience. Interviewees would have experience in working with District staff who provide mental health supports for at-risk and high-risk students. Their opinions are valuable, and the interview project could identify areas in which the District could improve its interventions.

One outcome of student and parent interviews could be the creation of a family well-being counsel that helps guide the District in its efforts to provide effective mental health supports. The council could also oversee parent and family in-service presentations that combine information and support.

Another outcome could be the creation of a parent advocate role that would focus on assisting parents who could benefit from advocacy around the issue of mental health supports. The parent advocate could act as a liaison between parents in the District.

Constructive input from students and their families could provide valuable information for District program planning and development regarding mental health supports and student and family well-being.

Unfortunately, the COVID-19 pandemic precluded plans for conducting these interviews. I would recommend that they be done when it becomes safe to do so. Best results, in my opinion, would result from in person interviews.

Conclusions and Recommendations

Improving well-being in the Minnetonka population will require a two-pronged approach.

The first prong focuses on improving lifestyles, learning and practicing resilience and acquiring self-mastery skills. The first two of these need to be done as a partnership between the school system and students' parents. Self-mastery skills would be taught to students and staff, and the process would also be available to parents as well. All three interventions are universal tier 1 activities that teach these life skills through the K-12 experience, developing and refining the skills as students mature. Lifestyle, resilience and self-mastery serve students well during their K-12 years, and continue to be highly beneficial into adulthood. For those students who ultimately become parents, their children will benefit as well.

I am recommending adoption of a school-wide effort, working with students and their parents, to achieve these goals. *The topics of lifestyle, resilience and self-mastery will each require curriculum that address the topic throughout each students' K-12 experience.*

By involving parents in adopting healthy lifestyle measures in the home environment, and by mirroring these measures in school curriculum, students will have the best chance of developing healthy lifestyles. Lifestyle management is already taught in health class to some degree; I am recommending that this process be increased and intensified. A healthy lifestyle is a major step in achieving well-being.

Parents play an essential role in the process of helping their children learn perseverance, self-control, responsibility, character building and resilience. The education system can contribute to the success of learning resilience by providing information to parents about research findings and helping parents recognize situations in which they are encouraging resilience. *Curriculum will need to be developed for students and their parents, and parent involvement could take place through in-service presentations, webinars and support groups. I would recommend consideration of tailoring parent involvement to the needs of specific student groups. For example, there has been significant interest in a combination of parenting groups and support groups for parents of children and adolescents who are on the autism spectrum.*

Learning self-mastery is a skill that can be successfully taught in the K-12 environment. It can result in a reduction of anxiety and depression and an increase in self-esteem and well-being as well as improved academic performance. *I would recommend utilizing the expertise of Charlene Myklebust and Kari Palmer to assist in the process of developing the curriculum necessary to provide the necessary skills for learning self-mastery. I would note that teaching these techniques to school staff as well as to students is likely to have the best outcome.*

The District has a number of tier 2 activities for providing services to at-risk students. By providing universal tier 1 activities of lifestyle management, building resilience and learning self-mastery, there may be less of a need for tier 2 activities for some students. In my opinion, teaching these topics will result in improved well-being throughout the student population.

The second prong focuses on students who, because of having mental health disorders, experience a lack of well-being due to symptoms such as anxiety or depression. These students can benefit from learning lifestyle, resilience and self-mastery skills, but generally need more help in the form of counseling or therapy. Some of them may have disorders severe enough to warrant the use of medication. These students require a great deal of attention from teachers, administrators, school nurses, counselors, psychologists and social workers.

Approximately 18% of students are considered by mental health professionals as being "emotionally disturbed" (ED), and 5% are "severely emotionally disturbed" (SED). Thus, most of the ED students, and even most of the SED students are served within the general education environment and are not in special education. Those who are receiving special education services tend to have multiple mental health disorders that impact their emotions and behaviors.

At best, 50% of those students who have mental health disorders are receiving some treatment, which is generally in the form of medication management by primary care physicians. A lack of available skilled clinicians, underfunding of mental health treatment and a significant percentage of families who are under insured or uninsured contribute to the problem. As a result, most child and adolescent mental health services are provided by school professionals.

School professionals (psychologists, social workers, counselors and nurses) who provide mental health supports to students are providing counseling, not therapy. Counseling is the process of providing information and teaching skills such as social skills and organizational skills. A student who suffers from post-traumatic stress disorder due to severe trauma, who is presenting with anxiety, depression and suicidal thoughts, requires more than counseling. Therapy, provided by mental health professionals, focuses on diagnosing and treating disorders. A student in therapy may also benefit from simultaneous counseling that focuses on skill building activities.

As noted above, mental health disorders frequently go untreated. The Minnesota Student Survey indicates high percentages of students suffering from a variety of mental health problems, most notably anxiety and depression.

Looking at the "big picture", it is not surprising that mental health support staff feel "spread too thin". The key question is, "Given the mental health support staff's roles in working with students who have mental health disorders, providing counseling but not therapy, is the best intervention to hire more mental health support staff?".

I am recommending an alternative approach: prioritizing and improving the efficiency of mental health support staff, and increasing the number of mental health professionals providing co-located clinical services from clinics such as Relate. Given that some of the students occupying a great deal of teachers', administrators' and mental health support staff's time are not receiving treatment of their disorders, the ability to more successfully make referrals for diagnosis and treatment should improve time management for school staff.

As noted above, there is a wide variety of funding patterns used by school districts to cover the non-billable ancillary costs are providing mental health diagnosis and treatment services. Further exploration into this issue is clearly warranted.

I would recommend that the District set a goal of having enough co-located clinicians to provide services to at-risk and high-risk students, with no, or a very short, waiting list.

Exploration of funding and treatment patterns at the District's schools will help clarify the number of clinicians that would need to be added. All available options of funding should be explored, in my opinion.

I would recommend interviewing directors of other clinics besides Relate in order to have a larger sample of clinics from which to choose. I would also recommend finding other sources of funding besides school district budgets. I would recommend the family service collaborative LCTS funds focus on facilitating the process of school mental health provision.

Data analysis

During the process of interviewing of a wide variety of school staff, many opinions were expressed that were not substantiated by data. For example, several staff members expressed opinions that the Minnetonka District was an outlier, compared to other school districts, in the provision of mental health support services. The opinion was also expressed that the District has not increased mental health supports commensurate with increases in enrollment. Data analysis did not support either opinion; the Minnetonka District had better than average mental health support staff ratios, and a study of staffing trends from 2015 to 2020 indicated overall increases in staff during that period.

Another misconception was that students who strove to achieve high grades had a price to pay- namely, an increase in anxiety and depression. In fact, a data analysis revealed an inverse correlation between grades and symptoms of anxiety and depression. Students who reported mostly A's had the lowest levels of generalized anxiety and of suicidal ideation. The lower the grade average, the more likely students were to be suffering from these mental health symptoms.

Data analysis for this report provided useful information regarding identification of high-risk student populations. For example, an in-depth analysis of Minnesota Student Survey results of the variables considering suicide and typical grades indicated that 44% of ninth grade females who had a C average reported having considered suicide in the last year. In other words, knowing only the facts that a young woman is a ninth grader with a C average immediately alerts a mental health support staff that this is a high-risk student.

Data was also useful in a chart review of special education evaluations that were entered into a computerized special education database. The database can provide a great deal of information within a few pages, and can yield information both on individual students and on groups of students.

A special thanks goes out to Matt Riga and Matt Breen for their excellent work in providing analysis of these data.

Based on the above information, *I would recommend use of data when providing analysis of reasons for problems within the District. Opinions may abound, but actual data can provide a foundation of information onto which thoughtful planning can take place.*

I would recommend expansion of data analysis of the Minnesota Student Survey to further identify profiles of students who are at significant risk. Mental health support staff can use this information to be more effective working with these populations.

I would recommend utilization of the special education database for future assessments of students in the EBD and ASD categories and in the OHD category for those students who are receiving special education services for a mental health disorder.

…..

I believe that, in adopting a two-pronged approach that focuses on lifestyle management, resiliency and self-mastery on the one hand, and on addressing mental health disorders on the other hand has the best likelihood for success.

The full array of recommendations are highlighted with italics in this report. They are listed here in a condensed version to aid with program planning and development activities:

Lifestyle and partnership with parents:
Because lifestyle issues are so crucial to health and well-being, I would recommend fostering these partnerships between parents and educators. Activities could include bringing in speakers, developing webinars and encouraging discussions of lifestyle and health during teacher conferences

Building resilience and partnership with parents:
I would encourage the District to expand its partnership with parents on addressing this topic, as the development of self-control and resilience are so crucial to having a successful life and optimal well-being. I would recommend the development of additional in-service presentations including the possibility of webinars in which effective methods of parenting can be described for parents of elementary, middle and high school students.

Self-mastery:
I am recommending significant expansion of self-mastery techniques to be provided to both students and staff. Best practices evidence-based activities would have multiple beneficial results in well-being, in my opinion.

Mental health data analysis:
It is important to understand how mental health disorders cluster in the Minnetonka student population in order to address these problems effectively. I would recommend that this analysis be done in order to establish a baseline as a first step towards future outcome analysis…I would recommend that District leadership continue conducting data analyses in order to identify the relationships and risk factors in comparisons of other variables.

The SAEBRS screening program:
In my opinion, this is a very useful program. I would recommend a pilot project of expansion to the sixth-grade population.

Communicating student survey analysis results:
I would recommend that the Student Survey in depth analysis results be communicated to District educators, social workers, counselors, psychologists and nurses.

Interviewing students:
I would recommend that asking students about problems such as anxiety and depression be done by school counselors, social workers, psychologists and nurses. Students would need to be informed that providing such information is purely voluntary. I would recommend that questions be taken directly from the Minnesota Student Survey, and be a combination of questions about risk factors and questions about experiencing symptoms such as generalized anxiety, feeling depressed most of the time, suicidal thoughts and suicidal behaviors. I would suggest that this be done at the initial appointments with counselors. I would recommend that the mental health support staff take part in the process of creating a protocol for questioning students about symptoms that suggest a lack of well-being. Asking students about symptoms needs to be done in a very sensitive manner, but if done correctly, can result in interventions that improve well-being and that can save lives.

Expanding co-located mental health services:
I am recommending expansion of partnerships between mental health clinics and the School District, with services available to children, adolescents and adults, including both family therapy and individual treatment as indicated.

Special education evaluations and substance use:
As Minnesota rules mandate that students are not to be placed in the EBD category if the primary source of the problem is substance use, I would recommend screening for chemical health issues. I would note that the presence of substance abuse does not in itself prove that the abuse was the primary cause of emotional/ behavioral difficulties. I would refer the interested reader to the article, "Waldspurger, M. and Dikel, W. "Drugs and Disabilities: Conducting Special Education Evaluations of Students Who Abuse Drugs or Alcohol" Inquiry and Analysis July, 2010" for more details.

Special education evaluations and Tennessen warnings
Similarly, as a Tennessen warning is mandated in situations where government (including public school) employees are seeking private information, I would recommend that this be done with appropriate documentation.

Special education evaluations and CGAS ratings:
I would recommend that a CGAS rating be done at the time of assessment. It provides a useful and quick method of objectively gauging a student's level of functioning, and can be easily adjusted over time as that functioning hopefully improves.

Special education evaluations and releases of information:

I would recommend that attempts to be made to obtain releases of information on all students being seen for special education evaluations who have treating clinicians, as communication between clinicians and educators can be very helpful for the students.

Using the special education database:
I would also recommend using the database in all new and follow up special education evaluations of students in the OHD (mental health), ASD and EBD categories, as well as in assessments of students with 504 plans resulting from mental health disabilities, as it provides information that can be easily accessed and used for both individual and group program planning and development activities.

Nurses and points of entry for students with mental health problems:
I would recommend expanding the point of entry model to include the option of using nursing services as an alternative entryway.

Nursing referral protocols for somaticizing students:
I would recommend that a protocol be developed for referring students to counselors when students present to the nurses' office with multiple visits where there is no evidence of an actual physical problem.

Nurses and case management:
I would recommend that a time study be conducted in order to clarify in greater detail the percentage of mental health interventions related to nursing activities in the elementary, middle and high school population. It is possible that some of their time-consuming case management activities could be done by County mental health case managers in some circumstances.

Pros and cons of suspension for drug offenses:
I do not have enough information to form an opinion regarding the positive versus negative consequences of mandating suspension versus providing immediate diversion. In my opinion, this is an important issue which warrants further study.

Mental health support staff adequacy data:
I would encourage the District to do a similar analysis for middle schools and grade schools.

Weaning IEP social work services when appropriate:
I would recommend that this issue be analyzed in more detail to identify the situations where IEP teams could effectively work with parents to ensure that necessary services continue, and unnecessary services be weaned with no harm done to the students.

Mental health case management:
A significant number of students, especially those in setting 3 programs, meet the criteria for eligibility. I would recommend that this issue be explored. I would recommend

expanding the amount of case management services for students who clearly are in need of these services.

Prioritizing mental health support services:
The prioritization of mental health support services into higher versus lower priority activities is a necessary factor, in my opinion, in analyzing the adequacy of services.

Communicating with physicians who are prescribing psychiatric medication:
I would recommend that an effort be made to obtain a release of information and to communicate directly with the treating mental health or medical professional in situations where special education is being considered due to symptoms which are identical to those that are the criteria for a mental health disorder such as ADHD, when the student is taking medication for those symptoms.

Dealing with systems that fail to communicate crucial mental health information with school staff:
I would recommend this should be quantified, with the results clearly communicated to the mental health administrators in question. A mental health program's lack of communication despite efforts made by school personnel to facilitate it is clearly unacceptable, in my opinion.

Utilizing mental health consultation:
In my opinion, the judicious use of a mental health consultant can be very helpful in specific situations. Ideally, consultation could be provided by a District mental health support staff professional. In situations where expertise is not available within the District, outside consultants can provide a beneficial service.

Systematizing outcome measurements:
I would recommend that the District continue in its efforts to systematize outcome measurements of social/emotional interventions for the purpose of effective program planning and development. I would recommend seeking technical support in this process from Matt Rega in the Teaching and Assessment department.

Identifying contributors to college persistence:
I would recommend that the District conduct a prospective study to determine the contributing factors that increase college persistence and the factors that contribute to lack of persistence.

Evidence based proactive classroom management techniques:
I would recommend that general education teachers also utilize these techniques, as appropriate, if they are not already doing so.

Student mental health curriculum in health class:
I would recommend expanding mental health curriculum to be a higher percentage of health curriculum (25%) than it is now (10%). I would recommend that health class be

offered in eighth grade, given the needs of eighth grade students to understand the physical and mental health. I would also recommend that all sixth and seventh graders be able to take health class. I would recommend that the topic of suicide be discussed in middle school as well as in high school. Expanding the amount of health class availability in high school would also be helpful in empowering students with the knowledge that they need in order to live a healthy lifestyle and to attain the goal of well-being.

Continuing mental health education for educators:
Increasing the knowledge of student mental health issues among educators results in more effective interventions with at-risk students, ultimately resulting in improvements in student well-being.

LCTS funding:
Different collaboratives around the state have different philosophies regarding the best use of LCTS funding. Some disperse multiple small grants, whereas others find value in funding a few substantial grants. Given the severity and pervasiveness of the District's students' mental health problems, and the significant limitations in accessible on-site services at this time, I would recommend the latter approach. In my opinion, funding should go to supporting direct services for at-risk and high-risk students. I would recommend consideration of large grants going to increasing the availability of on-site, co-located diagnostic and treatment services. I would recommend that, in the process of analyzing the interest and availability of clinics including, but not limited to the Relate Clinic, that funding be made available through LCTS grants for expansion of services. This would help fill the need for tier 3 services and would result in increased well-being for vulnerable students.

Monitoring student functioning:
I would recommend the use of outcome measures that clearly define students' level of functioning prior to treatment, at some time during treatment and following treatment interventions.

Adopting recommendations from the school mental health plan document:
I would recommend that District leadership review the document in order to clarify whether additional organizational interventions are indicated.

Well-being interviews of students and parents:
In order to have a clear understanding of the experiences of students and their families in regard to well-being, I would recommend in-depth interviews that explore their experiences with District mental health supports and that seek feedback regarding future District activities and interventions. I would recommend interviews of elementary, middle and high school students, and separate interviews of parents with children at these levels. One outcome of student and parent interviews could be the creation of a family well-being counsel that helps guide the District in its efforts to provide effective mental health supports. The council could also oversee parent and family in-service presentations that combine information and support. Another outcome could be the creation of a parent advocate role that would focus on assisting parents who could benefit from advocacy

around the issue of mental health supports. The parent advocate could act as a liaison between parents in the District.

Lifestyle, resilience and self-mastery curriculum:
The topics of lifestyle, resilience and self-mastery will each require curriculum that address the topic throughout each students' K-12 experience. Curriculum will need to be developed for students and their parents, and parent involvement could take place through in-service presentations, webinars and support groups. I would recommend consideration of tailoring parent involvement to the needs of specific student groups. For example, there has been significant interest in a combination of parenting groups and support groups for parents of children and adolescents who are on the autism spectrum.

Recommendation of Charlene Myklebust and Kari Palmer for self-mastery service coordination:

I would recommend that the District leadership meet with Charlene Myklebust, Psy. D. and Kari Palmer M.A., CCC-SLP to explore possibilities of expanding social emotional learning in the District. Dr. Myklebust has trained educators in 22 states in social emotional learning, and is widely recognized as an expert in the SEL field. She assists schools in achieving high levels of social and emotional support for staff and students, evidence-based teaching about mindfulness, self-care, brain-based learning strategies and achieving well-being. Ms. Palmer is a speech and language pathologist/social cognitive therapist at her private practice, Changing Perspectives, in Excelsior, MN. She has co-authored, with Michelle Garcia Winner, Ryan Hendrix, and Nancy Tarshis "The Incredible Flexible You: A Social Thinking Curriculum for the Preschool and Early Elementary Years". Additionally, she consults with local school districts on implementing Social Thinking into their programming.

Recommendation of Mark Sanders for school mental health funding consultation:
Mark Sanders, from Hennepin County, was mentioned several times as an expert in financing school mental health programs, and was seen as a resource for school districts. I spoke with him, and he offered consultation regarding school mental health funding, at no cost to the District.

Learning from other districts about their school mental health service models:
I would also recommend meeting with professionals from the various districts who oversee the on-site mental health clinic activities and funding streams. This will provide a foundation of information that will allow the Minnetonka District to expand services in a cost-effective and clinically effective manner.

Summary

The Minnetonka School District is committed to its goals of academic excellence and student and family well-being. All of the staff interviewed for this project shared a vision of a world class school district that effectively addresses both goals. Although this evaluation contains constructive feedback regarding recommended improvements in mental health supports, I would note that the District is already doing an exemplary job of supporting students and their families. Further efforts in that direction will provide ongoing improvements in the well-being of students and their families.

Appendix 1: CASEL

Core SEL Competencies
Social and emotional learning (SEL) enhances students' capacity to integrate skills, attitudes, and behaviors to deal effectively and ethically with daily tasks and challenges. Like many similar frameworks, CASEL's integrated framework promotes intrapersonal, interpersonal, and cognitive competence. There are five core competencies that can be taught in many ways across many settings. Many educators and researchers are also exploring how best to assess these competencies. The competencies are:

Self-awareness
This is the ability to accurately recognize one's own emotions, thoughts, and values and to know how they influence behavior. They include the ability to accurately assess one's strengths and limitations, with a well-grounded sense of confidence, optimism, and a "growth mindset." Self-awareness includes the ability to identify emotions, to have accurate self-perception, to recognize one's strengths, to have self-confidence and self-efficacy.

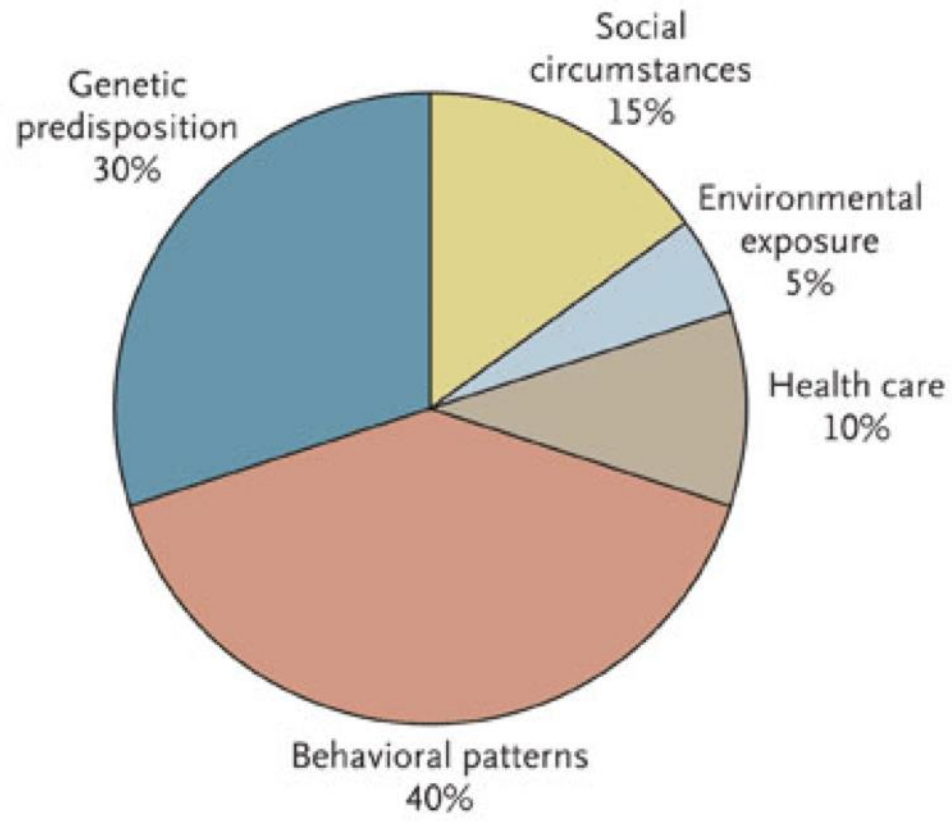
Self-management
This is the ability to successfully regulate one's emotions, thoughts, and behaviors in different situations, effectively managing stress, controlling impulses, and motivating oneself. It includes the ability to set and work toward personal and academic goals. Self-management skills include impulse control, stress management, self-discipline, self-motivation, goal-setting and organizational skills.

Social awareness
This is the ability to take the perspective of and empathize with others, including those from diverse backgrounds and cultures. One has the ability to understand social and ethical norms for behavior and to recognize family, school, and community resources and supports. Social awareness includes perspective-taking, empathy, appreciating diversity and respect for others.

Relationship skills
These are the abilities to establish and maintain healthy and rewarding relationships with diverse individuals and groups. They include the ability to communicate clearly, listen well, cooperate with others, resist inappropriate social pressure, negotiate conflict constructively, and seek and offer help when needed. They also include communication, social engagement, relationship building and teamwork.

Responsible decision-making
This is the ability to make constructive choices about personal behavior and social interactions based on ethical standards, safety concerns, and social norms. They include the realistic evaluation of consequences of various actions, and a consideration of the well-being of oneself and others. Skills include the ability to identify problems, analyze situations, solve problems, evaluate situations, being reflective and taking ethical responsibility.

Appendix 2: Determinates of Health



Appendix 3: In Depth Analysis of Minnesota Student Survey Results

The data below represent the percent of Minnetonka Eleventh Graders who reported having "considered attempting suicide" given their response to the included statement.

Minnetonka Eleventh Grade Students were:

3.5x more likely if they reported feeling down, depressed or hopeless every day, versus anything less often (72.1% with n = 43 to 21.8% with n = 481)

3x more likely if a student disagreed or strongly disagreed, versus agreeing or strongly agreeing, with the statement "I feel safe at home" (68.8% with n = 16 to 24.8% with n = 509)

3x more likely if they answered "not at all or rarely", versus all else, to "I feel good about myself" (68.3% with n = 41 to 22.2% with n = 482)

2.5x more likely if a student disagreed or strongly disagreed, versus agreeing or strongly agreeing, with the statement "I feel safe in my neighborhood" (62.5% with n = 8 to 25.5% with n = 517)

2.5x more likely if they reported someone within their family having molested them, versus not (66.7% with n = 12 to 25.0% with n = 503)

2.5x more likely if they reported being excluded from friends, other students or activities every day versus never (50.0% with n = 8 to 21.9% with n = 392)

2.5x more likely if they reported someone outside of their family having molested them, versus not (61.3% with n = 31 to 23.8% with n = 488)

2x more likely if they reported being bullied at least once, versus never, because of a physical or mental disability (54.2% with n = 24 to 24.8% with n= 501)

The highlighted data below represents the percent of Minnetonka Eleventh Graders who reported having "actually attempted suicide" given their response to the included statement.

Minnetonka Eleventh Grade Students were:

8.5x more likely if they reported that their parents care about them "not at all" or "a little" versus "some" or "very much" (55.6% with n = 18 to 6.5% with n = 508)

6.5x more likely if they reported being sexually assaulted by an adult outside of the family (38.7% with n = 31 to 5.9% with n = 490)

6.5x more likely if they reported having run away from home at least once versus never (40.7% with n = 27 to 6.1% with n = 493)

6.5x more likely if they reported “not at all”, versus anything else, to whether their adult relatives other than parents care about them (50.0% with n = 6 to 7.7% with n = 520)

6x more likely if they reported being sexually assaulted by a stronger or older member of the family (41.7% with n = 12 to 6.9% with n = 505)

5x more likely if they reported being bullied because of being gay, lesbian or bisexual at least once versus never (34.8% with n = 23 to 7.0% with n = 503)

4x more likely if they reported being bullied due to a physical or mental disability at least once versus never (28.0% with n = 25 to 7.2% with n = 501)

4x more likely if they reported consuming alcohol 20 or more times in the last year versus anything less (26.9% with n = 26 to 6.9% with n = 492)

4x more likely if they reported being bullied due to physical appearance at least once versus never (21.5% with n = 93 to 5.3% with n = 433)

4x more likely if they reported being bullied online at least once versus never (25.0% with n = 48 to 6.5% with n = 476)

4x more likely if they reported having other students excluded them from friends other students or activities several times per week or more versus once a week or less (31.3% with n = 16 to 7.5% with n = 508)

3.5x more likely if they reported being bullied due to size or weight at least once versus never (21.9% with n = 73 to 6.0% with n = 453)

3x more likely if they reported spreading rumors or lies about someone else at least once versus never (22.2% with n = 36 to 7.2% with n = 489)

2.5x more likely if they reported being bullied due to their gender at least once versus never (19.0% with n = 21 to 7.7% with n = 505)

2.5x more likely if they reported consuming alcohol in the last month at least once versus never (13.1% with n = 153 to 5.5% with n = 366)

2x more likely if they reported pushing, shoving, hitting or kicking someone at least once versus never (14.3% with n = 14 to 8.1% with n = 509)

2x more likely if they reported using marijuana every day versus anything less (16.0% with n = 25 to 7.8% with n = 475)

Additional Minnesota Student Survey Data Insights:

The following tables are intended to provide additional insight into our Minnesota Student Survey Data, specifically regarding students' responses to certain questions or statements and how each relates to whether or not the student reports having considered suicide. Naturally, each of these responses could and should be connected to additional items outside of suicidal thoughts; however, at this time, the focus remained on these specific relationships for the purpose of identifying areas that may be prioritized for ongoing work. Most of the data in these tables pertains to the responses of Eighth, Ninth, and Eleventh Graders, with some reflecting only Ninth and Eleventh Grade answers based on which groups were asked certain age appropriate questions.

Table 1: Mental health against suicide consideration - Tables 26A-C on the Minnesota Student Survey

Rank	Statement
1	I feel good about myself.
2	I feel valued and appreciated by others.
3	I feel good about my future.
4	I feel in control of my life and future
5	I find good ways to deal with things that are hard in my life.
6	I am given useful roles and responsibilities.
7	I am included in family tasks and decisions.
8	I plan ahead and make good choices.
9	I express my feelings in proper ways.
10	I stay away from bad influences.
11	I deal with disappointment without getting too upset.
12	I say no to things that are dangerous or unhealthy.
13	I build friendships with other people.
14	I resolve conflicts without getting anyone hurt.
15	I am thinking about what my purpose is in life.
16	I am sensitive to the needs and feelings of others.
17	I accept people who are different from me.

Table 2: Reason for bullying against suicide consideration - Tables 10A-B and 28 on the Minnesota Student Survey

_____Note: Because of sample sizes, the varying levels of bullying frequency were condensed into one, thus making the data a "yes" or "no" scenario rather than frequency of occurrence.

Rank	Reason for Bullying
1	Your physical appearance
2	Your gender expression (your style, dress, or the way you walk or talk) [Gr. 9, 11]
3	Your size or weight
4	Your race, ethnicity, or national origin
5	Because you are gay, lesbian, or bisexual or because someone thought you were [Gr. 9, 11]
6	Your gender (being male, female, transgender, etc.)
7	A physical or mental disability
8	Your religion

Table 3: "Most teachers at my school are interested in me as a person" against suicide consideration - Tables 6 and 28 on the Minnesota Student Survey

Rank	Group (By Grade)
1	9
2	11
3	8,9,11
4	8

Table 4: "Is there an adult at school you can talk to about problems you are having" against suicide consideration - Tables 16 and 28 on the Minnesota Student Survey

Rank	Group (By Grade)
1	11
2	9
3	8,9,11
4	8

Table 5: "I feel safe at school" against suicide consideration - Tables 8 and 28 on the Minnesota Student Survey

Rank	Group (By Grade)
1	8
2	9
3	8,9,11
4	11

Table 6: "How would you describe your grades this year" against suicide consideration - Tables 3 and 28 on the Minnesota Student Survey

Rank	Group (By Grade)
1	11
2	9
3	8,9,11
4	8

The remaining two tables replace suicide consideration with reported grades as the effect of mental health and bullying respectively.

Table 7: Mental health against grades - Tables 10 and 3 on the Minnesota Student Survey
_____Note: Because data was spread thin by having 20 groups in each table, "not at all" and "sometimes" were condensed into one group as were "often" and "almost always. Additionally, "A's" and "B's" were condensed, and "C's" through "F's" were condensed.

Rank	Statement
1	I plan ahead and make good choices.
2	I feel good about my future.
3	I feel in control of my life and future
4	I feel good about myself.
5	I say no to things that are dangerous or unhealthy.
6	I stay away from bad influences.
7	I find good ways to deal with things that are hard in my life.
8	I feel valued and appreciated by others.
9	I express my feelings in proper ways.
10	I deal with disappointment without getting too upset.
11	I resolve conflicts without getting anyone hurt.
12	I am given useful roles and responsibilities.
13	I build friendships with other people.
14	I am included in family tasks and decisions.
15	I am thinking about what my purpose is in life.
16	I am sensitive to the needs and feelings and others.
17	I accept people who are different from me.

Table 8: Reason for bullying against grades - Tables 26 and 3 on the Minnesota Student Survey
_____Note: Because of sample sizes, the varying levels of bullying frequency were condensed into one, thus making the data a "yes" or "no" scenario rather than frequency of occurrence.

Also, the grades were condensed into A's and B's for one group and C's, D's and F's for the second group.

Rank	Reason for Bullying
1	Your physical appearance
2	Your gender expression (your style, dress, or the way you walk or talk) [Gr. 9, 11]
3	Your race, ethnicity, or national origin
4	Your size or weight
5	Because you are gay, lesbian, or bisexual or because someonethought you were [Gr. 9, 11]
6	A physical or mental disability
7	Your gender (being male, female, transgender, etc.)
8	Your religion

The following data provides actual numbers in terms of how many students reported concerning responses for both of a pair of statements or questions:

Suicide Consideration: Out of about 1790 students between grades eight, nine, and eleven who answered the question regarding considering suicide, 331 reported "yes," either in the last year, more than a year ago, or both:

Mental Health

Of these 331 students who reported considering suicide, the following numbers answered "not at all or rarely" to the included statement:

- 94 to "I feel good about myself"
- 62 to "I feel good about my future"
- 61 to "I feel valued and appreciated by others"
- 56 to "I feel in control of my life and future"
- 56 to "I find good ways to deal with things that are hard in my life"
- 44 to "I deal with disappointment without getting too upset"
- 41 to "I express my feelings in proper ways"
- 37 to "I plan ahead and make good choices"
- 36 to "I am included in family tasks and decisions"
- 34 to "I stay away from bad influences"
- 29 to "I am thinking about what my purpose is in life"
- 28 to "I am given useful roles and responsibilities"
- 27 to "I say no to things that are dangerous or unhealthy"
- 15 to "I build friendships with other people"
- 13 to "I resolve conflicts without getting anyone hurt"
- 9 to "I am sensitive to the needs and feelings of others"
- 1 to "I accept people who are different from me"

Bullying

Of the students who answered both bullying and suicide consideration questions, 335 noted considering suicide. Of these 335, the following numbers reported being bullied for the included reason at least once in the last 30 days.

- 129 because of their physical appearance
- 95 because of their size or weight
- 65 because they were cyberbullied
- 62 because of their gender expression (includes only 9th and 11th grade)
- 56 because of their race, ethnicity, or national origin
- 41 because of their gender
- 34 because they are gay, lesbian, or bisexual or because someone thought they were (includes only 9th and 11th grade)
- 38 because of a physical or mental disability
- 32 because of their religion

Adult at School with Whom You Can Talk about Your Problems

Below is a breakdown of the percent of students who considered suicide given a certain response to the question "is there an adult at school with whom you can talk about your problems." Overall, 61.0% of all students reported not having such an adult at their school.

Grades 8, 9, 11:

- 1774 students answered both questions
- 13.7% (95 out of 692) who answered "yes" had considered suicide
- 20.9% (226 out of 1082) who answered "no" had considered suicide

Grade 8:

- 574 students answered both questions
- **7.7%** (18 out of 234) who answered "yes" had considered suicide
- **14.7%** (50 out of 340) who answered "no" had considered suicide

Grade 9:

- 680 students answered both questions
- 11.9% (30 out of 252) who answered "yes" had considered suicide
- 20.8% (89 out of 428) who answered "no" had considered suicide

Grade 11:

- 520 students answered both questions
- 22.8% (47 out of 206) who answered "yes" had considered suicide
- 27.7% (87 out of 314) who answered "no" had considered suicide

Most Teachers at My School are Interested in Me as a Person

Below is a breakdown of the percent of students who considered suicide given a certain response to the statement "most teachers at my school are interested in me as a person." Overall, 22.5% of all students disagreed or strongly disagreed with this statement.

Grades 8, 9, 11:

- 1795 students answered both questions
- **14.6%** (203 out of 1392) who agreed or strongly agreed had considered suicide
- **32.0%** (129 out of 403) who disagreed or strongly disagreed had considered suicide

Grade 8:

- 584 students answered both questions
- 10.3% (47 out of 457) who agreed or strongly agreed had considered suicide
- 20.5% (26 out of 127) who disagreed or strongly disagreed had considered suicide

Grade 9:

- 687 students answered both questions
- **12.9%** (68 out of 528) who agreed or strongly agreed had considered suicide
- **34.0%** (54 out of 159) who disagreed or strongly disagreed had considered suicide

Grade 11:

- 524 students answered both questions
- 21.6% (88 out of 407) who agreed or strongly agreed had considered suicide
- 41.9% (49 out of 117) who disagreed or strongly disagreed had considered suicide

Grades: Out of about 2330 students in grades five, eight, nine, and eleven who answered the question regarding their typical grades, about 229 reported earning mostly C's, D's or F's.

Mental Health

Of these 229 students who reported considering suicide, the following numbers answered "not at all or rarely" or "somewhat or sometimes" to the included statement:

- 122 to "I plan ahead and make good choices"
- 121 to "I feel good about myself"
- 120 to "I feel good about my future"
- 119 to "I feel in control of my life and future"
- 115 to "I find good ways to deal with things that are hard in my life"
- 109 to "I deal with disappointment without getting too upset"
- 100 to "I feel valued and appreciated by others"
- 100 to "I express my feelings in proper ways"
- 86 to "I am thinking about what my purpose is in life"
- 85 to "I stay away from bad influences"

- 85 to “I say no to things that are dangerous or unhealthy”
- 78 to “I build friendships with other people”
- 76 to “I am given useful roles and responsibilities”
- 73 to “I am included in family tasks and decisions”
- 71 to “I resolve conflicts without getting anyone hurt”
- 56 to “I am sensitive to the needs and feelings of others”
- 18 to “I accept people who are different from me”

Bullying

Approximately 2425 students answered both the bullying question and the reported grades question (about 1290 when only 9th and 11th grade noted below). Of these 2425 students, about 246 students reported earning mostly C’s, D’s and F’s (about 154 in the 9th and 11th only questions). Of the students reporting C’s, D’s or F’s, the following numbers reported being bullied at least once in the last 30 days for the included reason:

- 70 because of their physical appearance
- 55 because of their size or weight
- 42 because they were cyberbullied
- 40 because of their race, ethnicity, or national origin
- 29 because of their gender expression (includes only 9th and 11th grade)
- 25 because of a physical or mental disability
- 23 because of their gender
- 16 because they are gay, lesbian, or bisexual or because someone thought they were (includes only 9th and 11th grade)
- 14 because of their religion

Reported Feelings of Anxiousness Against Grades

Below is a chart of the 1802 students in grades 8, 9, and 11 who answered a question regarding their feelings of anxiousness or nervousness over the last two weeks as well as a question regarding their typical grades in school this year. Note: C’s, D’s and F’s were condensed because of smaller sample sizes in the D and F groups

Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge? - All Grades				
Frequency	Mostly A's	Mostly B's	Mostly C's, D's or F's	Total
Not at all	425	240	46	**711**
Several days	365	196	74	**635**
More than half the days	111	84	35	**230**
Nearly every day	106	81	39	**226**
Total	**1007**	**601**	**194**	**1802**

Summary:

- 12.5% (226 out of 1802) reported feeling anxious “nearly every day” over the last two weeks
    - 10.5% (106 out of 1007) of students reporting mostly A’s noted feeling anxious “nearly every day”
    - 13.5% (81 out of 601) of students reporting mostly B’s noted feeling anxious “nearly every day”
    - 20.1% (39 out of 194) of students reporting mostly C’s, D’s or F’s noted feeling anxious “nearly every day”
- 60.5% (1091 out of 1802) reported feeling anxious at least “several days” over the last two weeks
    - 57.8% (582 out of 1007) of students reporting mostly A’s noted feeling anxious at least “several days”
    - 60.1% (361 out of 601) of students reporting mostly B’s noted feeling anxious at least “several days”
    - 76.3% (148 out of 194) of students reporting mostly C’s, D’s or F’s noted feeling anxious at least “several days”

Below is the same data broken down by grade in school

Grade 8:

Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge? - 8th				
Frequency	Mostly A's	Mostly B's	Mostly C's, D's or F's	Total
Not at all	166	100	18	**284**
Several days	120	59	19	**198**
More than half the days	23	19	12	**54**
Nearly every day	22	20	7	**49**
Total	**331**	**198**	**56**	**585**

Summary:

- 8.4% (49 out of 585) reported feeling anxious “nearly every day” over the last two weeks
    - 6.6% (22 out of 331) of students reporting mostly A’s noted feeling anxious “nearly every day”
    - 10.1% (20 out of 198) of students reporting mostly B’s noted feeling anxious “nearly every day”
    - 12.5% (7 out of 56) of students reporting mostly C’s, D’s or F’s noted feeling anxious “nearly every day”
- 51.5% (301 out of 585) reported feeling anxious at least “several days” over the last two weeks

- 49.8% (165 out of 331) of students reporting mostly A's noted feeling anxious at least "several days"
- 49.5% (98 out of 198) of students reporting mostly B's noted feeling anxious at least "several days"
- 67.9% (148 out of 194) of students reporting mostly C's, D's or F's noted feeling anxious at least "several days"

Grade 9:

Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge? - 9th				
Frequency	Mostly A's	Mostly B's	Mostly C's, D's or F's	Total
Not at all	163	85	17	265
Several days	148	74	21	243
More than half the days	45	28	13	86
Nearly every day	43	32	16	91
Total	399	219	67	685

Summary:

- 13.3% (91 out of 685) reported feeling anxious "nearly every day" over the last two weeks
  - 10.8% (43 out of 399) of students reporting mostly A's noted feeling anxious "nearly every day"
  - 14.6% (32 out of 219) of students reporting mostly B's noted feeling anxious "nearly every day"
  - 23.9% (16 out of 67) of students reporting mostly C's, D's or F's noted feeling anxious "nearly every day"
- 61.3% (420 out of 685) reported feeling anxious at least "several days" over the last two weeks
  - 59.1% (236 out of 399) of students reporting mostly A's noted feeling anxious at least "several days"
  - 61.2% (134 out of 219) of students reporting mostly B's noted feeling anxious at least "several days"
  - 74.6% (50 out of 67) of students reporting mostly C's, D's or F's noted feeling anxious at least "several days"

Grade 11:

Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge? - 11th				
Frequency	Mostly A's	Mostly B's	Mostly C's, D's or F's	Total
Not at all	96	55	11	**162**
Several days	97	63	34	**194**
More than half the days	43	37	10	**90**
Nearly every day	41	29	16	**86**
Total	**277**	**184**	**71**	**532**

Summary:

- 16.2% (86 out of 532) reported feeling anxious "nearly every day" over the last two weeks
  - 14.8% (41 out of 277) of students reporting mostly A's noted feeling anxious "nearly every day"
  - 15.8% (29 out of 184) of students reporting mostly B's noted feeling anxious "nearly every day"
  - 22.5% (16 out of 71) of students reporting mostly C's, D's or F's noted feeling anxious "nearly every day"
- 69.5% (370 out of 532) reported feeling anxious at least "several days" over the last two weeks
  - 65.3% (181 out of 277) of students reporting mostly A's noted feeling anxious at least "several days"
  - 70.1% (129 out of 184) of students reporting mostly B's noted feeling anxious at least "several days"
  - 84.5% (60 out of 71) of students reporting mostly C's, D's or F's noted feeling anxious at least "several days"

These are examples of a simple two-step analysis. The survey could be analyzed in significantly greater depth regarding identifying pertinent variables. By understanding how problems cluster in high-risk populations, interventions can be designed that are much more effective in serving these students.

The highlighted data below represents the percent of Minnetonka Eighth, Ninth and Eleventh grade students who reported having "been treated for a mental health, emotional or behavioral problem" given their response to the included statement.

3x more likely if they reported being bullied for having a physical or mental disability at least once versus never (67.7% with n = 93 to 24.0% with n = 1752)

3x more likely if a student reported a history of chemical dependency treatment (78.1% with n = 32 to 25.6% with n=1790)

3x more likely if they reported having attempted suicide (71.6% with n = 95 to 23.4% with n = 1680)

3x more likely if they reported pressuring their partner in a relationship to have sex when they did not want to versus never having done so (64.3% with n = 14 to 28.4% with n = 1170)

3x more likely if they reported strongly disagreeing, versus all else, to the statement “I feel safe at school” (76.5% with n = 17 to 25.9% with n = 1821)

2.5x more likely if a student disagreed or strongly disagreed, versus agreeing or strongly agreeing, with the statement “I feel safe in my neighborhood” (67.7% with n = 27 to 24.0% with n = 1817)

2.5x more likely if they reported being sexually abused by an adult not in the household (66.7% with n = 63 to 24.8% with n = 1717)

2.5x more likely if they reported being bullied due to their gender at least once versus never (59.6% with n = 89 to 24.5% with n = 1757)

2.5x more likely if they reported shoplifting “10 or more times” versus anything less (69.6% with n = 23 to 25.6% with n = 1759)

2x more likely if they reported any non-zero frequency of cannabis use versus never (50.9% with n = 167 to 23.7% with n = 1608)

2x more likely if they reported being victims of cyberbullying at least once versus never (48.9% with n = 180 to 23.9% with n = 1664)

2x more likely if they reported using cannabis over 40 times in the last year versus anything less (56.0% with n = 50 to 25.4% with n = 1724)

2x more likely if they reported being physically abused in a relationship (58.7% with n = 46 to 25.3% with n = 1734)

2x more likely if they reported using tobacco (cigarettes or chew) at least once versus never (46.5% with n = 71 to 25.4% with n = 1659)

2x more likely if they reported binge drinking at least once versus never (43.7% with n = 103 to 25.1% with n = 1672)

1.5x more likely if they reported being bullied because of their religion at least once versus never (43.4% with n = 99 to 25.3% with n = 1746)

1.5x more likely if they reported perpetrating physical abuse at least once versus never (35.7% with n = 56 to 26.0% with n = 1783)

Within these tables, the following columns are provided:

1) The rank of each item within its section of the survey. This is based on a calculation we termed "size metric," which will be outlined in element four below.
2) The statement or question posed to the student.
3) A p-value that resulted from a Chi-Square Test for Independence. In this column, note that values less than **.05** are revealing evidence of a relationship between a student's response and whether he or she has considered suicide.
4) The "size metric" is not a formal statistical value. This is a metric we created that is based on the percent of students who considered suicide in "negative" toned responses compared to the overall average, coupled with the actual number of students in these groups who had considered suicide. This value is then normalized if there are notably different sample sizes with each group.

Table 1: Mental health against suicide consideration - Tables 26A-C on the Minnesota Student Survey

Summary:

1) The top 14 items all revealed an extremely strong statistical relationship between a student's response and his or her consideration of suicide, as is evidenced in the p-value column.
2) There is a notable drop in the size metric from **1** to **2** and **5** to **6**. While some of this difference is caused by notably high percentages of students in these "not at all or rarely" groups considering suicide, a bigger factor is simply how many students answered "not at all or rarely" to that particular statement. For instance, the first-ranked item in the table, "I feel good about myself", had **61.8 percent** of "not at all or rarely" answers note that they had considered suicide (compared to **18.5 percent** overall), but it was the fact that this **61.8 percent** was **94 out of 152** that caused this metric to inflate. For comparison, the sixth-ranked item, "I am given useful roles and responsibilities had a **62.2 percent** suicide consideration rate from there "not at all or rarely" group, but this was based off of **28 out of 45**.

Rank	Statement	P-Value	Size Metric
1	I feel good about myself.	3.85E-65	423.8
2	I feel valued and appreciated by others.	1.14E-50	319.5
3	I feel good about my future.	4.46E-43	302.8
4	I feel in control of my life and future	3.7E-40	285.4
5	I find good ways to deal with things that are hard in my life.	7.12E-34	269.5
6	I am given useful roles and responsibilities.	5.84E-35	217.3
7	I am included in family tasks and decisions.	1.69E-34	215.8
8	I plan ahead and make good choices.	7.48E-23	194.9
9	I express my feelings in proper ways.	1.34E-22	194.8
10	I stay away from bad influences.	7.02E-30	192.8
11	I deal with disappointment without getting too upset.	3.54E-14	182.5
12	I say no to things that are dangerous or unhealthy.	4.98E-29	163.5
13	I build friendships with other people.	9.66E-12	112.4
14	I resolve conflicts without getting anyone hurt.	1.43E-09	93.6
15	I am thinking about what my purpose is in life.	0.0535	63.3
16	I am sensitive to the needs and feelings of others.	0.3747	29.5
17	I accept people who are different from me.	0.7006	6.9

Table 2: Reason for bullying against suicide consideration - Tables 10A-B and 28 on the Minnesota Student Survey

_____Note: Because of sample sizes, the varying levels of bullying frequency were condensed into one, thus making the data a "yes" or "no" scenario rather than frequency of occurrence.

Summary:

1) All eight of the bullying scenarios revealed a statistically significant relationship between students' responses and whether they had considered suicide.
2) While all forms of bullying raised concern, physical appearance was atop the size metric rankings because of the high number of students who reported such bullying and had considered suicide (**129**). Size or weight had the next highest number at **95**.

Rank	Reason for Bullying	P-Value	Size Metric
1	Your physical appearance	1.92E-20	246.2
2	Your gender expression (your style, dress, or the way you walk or talk) [Gr. 9, 11]	7.53E-10	173.7
3	Your size or weight	4.63E-11	164.7
4	Your race, ethnicity, or national origin	2.05E-11	119.4
5	Because you are gay, lesbian, or bisexual or because someone thought you were [Gr. 9, 11]	4.57E-08	110.6
6	Your gender (being male, female, transgender, etc.)	3.35E-13	107.5
7	A physical or mental disability	9.60E-09	84.3
8	Your religion	8.09E-05	58.5

Table 3: "Most teachers at my school are interested in me as a person" against suicide consideration - Tables 6 and 28 on the Minnesota Student Survey

Summary:

1) This table covers a single statement against suicide consideration, so the focus below is on Eighth, Ninth, and Eleventh Graders as separate groups and then all combined.
2) Each of the three grades and the combined group revealed a statistically significant relationship between a student's level of agreement with this statement and whether or not they had considered suicide.
3) The size metric shows that this is more of a concern at the high school level. This is largely a result of the higher percentages of students in the "disagree" and "strongly disagree" groups who had considered suicide. (It is not a result of higher numbers of students at the high school disagreeing with the statement as the numbers alone were pretty consistent across all three grades surveyed.)

Rank	Group (By Grade)	P-Value	Size Metric
1	9	4.97E-10	97.7
2	11	6.27E-05	89.3
3	8,9,11	1.02E-16	78.5
4	8	2.46E-04	53.8

Table 4: "Is there an adult at school you can talk to about problems you are having" against suicide consideration - Tables 16 and 28 on the Minnesota Student Survey

Summary:

1) This table covers a single statement against suicide consideration, so the focus below is on Eighth, Ninth, and Eleventh Graders as separate groups and then all combined.
2) The combined group and Eighth and Ninth Grade groups revealed a statistically significant relationship between a student having an adult at school with whom they can talk about problems and whether or not they had considered suicide. For Eleventh Graders, the results were not statistically significant.
3) While the relationship between response and suicide consideration was not significant for Eleventh Graders, it still had the greatest size metric based on the higher overall percentage of students who considered suicide as well as the number in the "no" group.

Rank	Group (By Grade)	P-Value	Size Metric
1	11	0.2123	179.5
2	9	0.0032	155.6
3	8,9,11	0.0001	147.1
4	8	0.0106	108.1

Table 5: "I feel safe at school" against suicide consideration - Tables 8 and 28 on the Minnesota Student Survey

Summary:

1) This table covers a single statement against suicide consideration, so the focus below is on Eighth, Ninth, and Eleventh Graders as separate groups and then all combined.
2) Each of the three grades and the combined group revealed a statistically significant relationship between a student's level of agreement with this statement and whether or not they had considered suicide.
3) The size metric shows that this is more of a concern in middle school than high school, becoming less notable as a student gets older.

Rank	Group (By Grade)	P-Value	Size Metric
1	8	4.44E-14	61.1
2	9	4.48E-09	46.5
3	8,9,11	1.18E-22	43.4
4	11	4.71E-05	38.3

Table 6: "How would you describe your grades this year" against suicide consideration - Tables 3 and 28 on the Minnesota Student Survey

Summary:

1) This table covers a single statement against suicide consideration, so the focus below is on Eighth, Ninth, and Eleventh Graders as separate groups and then all combined.
2) Each of the three grades and the combined group revealed a statistically significant relationship between a student's level of agreement with this statement and whether or not they had considered suicide.
3) Of the three grades individually, Ninth grade had the strongest relationship between grades and suicide consideration, with a notably smaller p-value than the other two grades
4) Even though Ninth Grade had the smallest p-value and had a higher percentage and number of "mostly C's" who had considered suicide, Twelfth Grade ended up with the

greatest size metric because **8** of **10** "mostly D's or F's had considered suicide versus **5** of **10** in Ninth Grade.

Rank	Group (By Grade)	P-Value	Size Metric
1	11	0.0003	61.3
2	9	2.49E-10	56.9
3	8,9,11	2.81E-13	44.6
4	8	0.0296	20.1

The remaining two tables replace suicide consideration with reported grades as the effect of mental health and bullying respectively.

Table 7: Mental health against grades - Tables 10 and 3 on the Minnesota Student Survey
_____Note: Because data was spread thin by having 20 groups in each table, "not at all" and "sometimes" were condensed into one group as were "often" and "almost always. Additionally, "A's" and "B's" were condensed, and "C's" through "F's" were condensed.

Summary:

1) All but "I am thinking about what my purpose is in life" revealed a significant relationship with grades. "I plan ahead and make good choices," "I feel good about my future" and "I say no to things that are dangerous and unhealthy" were notably the strongest relationships.
2) "I plan ahead and make good choices" and "I feel good about my future" had the greatest size metrics because of a combination of the aforementioned strong relationship and the relatively high percentage of C-F's who noted "not at all" or "sometimes" in their response to the respective questions. (For reference, if the response to "I plan ahead and make good choices" were truly independent of grades, the number of C-F grades who reported "poor" on this mental health statement should have been **66** out of **229**. Instead, it was **122** out of **229**.)

Rank	Statement	P-Value	Size Metric
1	I plan ahead and make good choices.	1.3E-17	224.5
2	I feel good about my future.	6.65E-17	219.3
3	I feel in control of my life and future	2.18E-10	186.3
4	I feel good about myself.	1.59E-09	184.0
5	I say no to things that are dangerous or unhealthy.	2.59E-16	179.8
6	I stay away from bad influences.	2.52E-12	160.5
7	I find good ways to deal with things that are hard in my life.	6.14E-06	158.0
8	I feel valued and appreciated by others.	2.76E-07	150.4
9	I express my feelings in proper ways.	0.0001	134.6
10	I deal with disappointment without getting too upset.	0.0074	131.7
11	I resolve conflicts without getting anyone hurt.	7.84E-09	127.2
12	I am given useful roles and responsibilities.	5.32E-06	117.5
13	I build friendships with other people.	1.72E-05	116.8
14	I am included in family tasks and decisions.	1.07E-05	112.5
15	I am thinking about what my purpose is in life.	0.4684	91.3
16	I am sensitive to the needs and feelings and others.	0.0042	77.8
17	I accept people who are different from me.	0.0119	31.0

Table 8: Reason for bullying against grades - Tables 26 and 3 on the Minnesota Student Survey
Note: Because of sample sizes, the varying levels of bullying frequency were condensed into one, thus making the data a "yes" or "no" scenario rather than frequency of occurrence. Also, the grades were condensed into A's and B's for one group and C's, D's and F's for the second group.

Summary:

1) All reasons for bullying, except for "your religion" revealed a statistically significant relationship with reported course grades. The relationships were notably the strongest in ranks #1-4 and #6.
2) Being bullied for "physical appearance" returned the greatest size metric primarily because more students reported being bullied for this reason one or more times in the last 30 days than any other reason (**470** students compared to **397** for the next most common). Of these **470** students, **70** reported having mostly C's, D's, or F's.

Rank	Reason for Bullying	P-Value	Size Metric
1	Your physical appearance	0.0002	102.6
2	Your gender expression (your style, dress, or the way you walk or talk) [Gr. 9, 11]	0.0104	82.3
3	Your race, ethnicity, or national origin	2.77E-06	77.4
4	Your size or weight	0.0075	75.1
5	Because you are gay, lesbian, or bisexual or because someonethought you were [Gr. 9, 11]	0.0055	55.9
6	A physical or mental disability	0.0003	48.5
7	Your gender (being male, female, transgender, etc.)	0.0080	38.1
8	Your religion	0.9178	14.4

Here are some examples of background data and processes used to analyze, in this case, to assess the relationship between certain metrics and consideration of suicide for Eleventh Graders

Is there a relationship between one's self-reported typical grade and whether or not they have considered suicide?

Grade Description	Have Considered Suicide	Haven't Considered Suicide
A's	60	214
B's	53	129
C's	15	43
D's	7	2
F's	1	0

Removing the F's because of the small sample size, a Chi-Square Test for Independence on this data revealed a relationship between one's grades and their consideration of suicide (p-value ≈ .0012). Specifically, the "D" group should have been reversed (2-7 instead of 7-2) if these two variables were truly independent.

Is there a relationship between a student's agreement with the statement "most teachers at my school are interested in me as a person" and whether or not they have considered suicide?

Level of Agreement	Have Considered Suicide	Haven't Considered Suicide
Strongly Agree	25	109
Agree	63	210
Disagree	43	64
Strongly Disagree	6	4

A Chi-Square Test for Independence on this data revealed a strong relationship between one's level of agreement with statement and their consideration of suicide (p-value $\approx$ .000063). Specifically, the "strongly agree" and "agree" groups were 18 under their collective expected total, while the "disagree" and "strongly disagree" groups were 18 over their collective expected total, given the total number of students who noted considering suicide.

Is there a relationship between a student's agreement with the statement "I feel safe at school" and whether or not they have considered suicide?

Level of Agreement	Have Considered Suicide	Haven't Considered Suicide
Strongly Agree	64	248
Agree	61	127
Disagree	9	9
Strongly Disagree	3	0

First, the above data were condensed into two groups, as generally agree and generally disagree based on the strongly disagree having a small, but notable number. A Chi-Square Test on the condensed data revealed a strong relationship between one's level of agreement with the statement and their consideration of suicide (p-value $\approx$ .0010). Specifically, the combined disagree groups had **12** who had considered suicide when that number should have been closer to **5** or **6** if there were no connection between these questions.

Appendix 4: SAEBRS data

Scale	At Risk	Not At Risk
Social	0-12	13+
Academic	0-9	10+
Emotional	0-16	17+
Total	0-35	36+

SAEBRS CUT SCORE KEY (pictured above)

MWA 2017-18 SAEBRS Total Score "At-Risk" Number of Students by Grade Level

Grade	Fall Total	Fall Total minus SpEd	Fall Total in SpEd	Winter Total	Winter Total minus SpEd	Winter Total in SpEd	Spring Total	SpringTotal minus SpEd	SpringTotal in SpEd
K	25	17	8	21	15	6	22	14	8
1st	36	31	5	32	28	4	28	22	6
2nd	16	10	6	7	4	3	8	4	4
3rd	32	27	5	18	17	1	22	18	4
4th	9	7	2	12	10	2	20	13	7
5th	22	13	9	18	12	6	18	11	7

MWA 2018-19 SAEBRS Total Score “At-Risk” Number of Students by Grade Level									
Grade	Fall Total	Fall Total minus SpEd	Fall Total in SpEd	Winter Total	Winter Total minus SpEd	Winter Total in SpEd	Spring Total	SpringTotal minus SpEd	SpringTotal in SpEd
K	29	21	8	22	19	3	21	13	8
1st	38	31	7	33	26	7	28	21	7
2nd	25	19	6	**	**	**	24	15	9
3rd	15	8	7	16	9	7	25	15	8
4th	11	10	1	15	12	3	9	7	2
5th	10	3	7	14	5	9	22	14	8

MWA 2019-20 SAEBRS Total Score “At-Risk” Number of Students by Grade Level									
Grade	Fall Total	Fall Total minus SpEd	Fall Total in SpEd	Winter Total	Winter Total minus SpEd	Winter Total in SpEd	Spring Total	SpringTotal minus SpEd	SpringTotal in SpEd
K	39	36	3	24	21	3	26	20	6
1st	19	17	2	16	14	2	24	19	5
2nd	18	13	5	21	17	4	23	12	11
3rd	26	16	10	24	12	12	25	13	12
4th	10	5	5	16	11	5	15	11	4
5th	12	10	2	16	12	4	11	7	4

MWA 2017-18 SAEBRS Total Score “At-Risk” Percentages by Grade Level			
Grade	Fall 2017	Winter 2017	Spring 2018
Kindergarten	15%	13%	13%
First	25%	21%	18%
Second	11%	5%	5%
Third	22%	13%	15%
Fourth	6%	8%	13%
Fifth	14%	12%	11%

MWA 2018-19 SAEBRS Total Score “At-Risk” Percentages by Grade Level			
Grade	Fall 2018	Winter 2018	Spring 2019
Kindergarten	14%	11%	11%
First	29%	25%	21%
Second	15%	**	14%
Third	10%	11%	17%
Fourth	7%	10%	6%
Fifth	6%	6%	15%

** not calculated due to an early maternity leave starting just before the screening date

MWA 2019-20 SAEBRS Total Score “At-Risk” Percentages by Grade Level			
Grade	Fall 2019	Winter 2019	Spring 2020
Kindergarten	21%	13%	14%
First	11%	9%	14%
Second	13%	15%	16%
Third	15%	14%	14%
Fourth	6%	11%	10%
Fifth	8%	13%	7%

2017-18	Total students served	Total students served with at-risk total score at threshold	Students not served (parent declined or based on teacher input)	Parent only referral	Teacher only referral
Fall	124	58	26	31	19
Winter	129	68	19	25	17
Spring	100	-	4	2	16

2018-19	Total students served	Total students served with at-risk total score at threshold	Students not served (parent declined or based on teacher input)	Parent only referral	Teacher only referral
Fall	130	61	24	7	15
Winter	157	-	10	17	12
Spring	146	62	10	18	20

2019-20	Total students served	Total students served with at-risk total score at threshold	Students not served (parent declined or based on teacher input)	Parent only referral	Teacher only referral
Fall					
Winter					
Spring					

SUPPORTS:

TIER1:

- Classroom lessons (Health SEL, Social Thinking, Peace Site, Responsive Classroom, Counselor lessons)
- Behavior Plan/intervention consultation and set-up

TIER 2

- Groups: Emotional Regulation, Self-Regulation, Social Skills/Friendship, Family Change
- Self-Monitoring
- Daily Check-ins
- Individual push-in classroom support
- Body Breaks
- Exercise Intervention
- Relaxation Group
- Homework Club

TIER 3

- Individual counseling/intervention
- 2 or more group interventions per week
- Daily Check-ins

Appendix 5: Columbia Depression Scale (Ages 11 and over)

Present State (last 4 weeks)
TO BE COMPLETED BY TEEN
If the answer to the question is “No,” circle the 0; if it is “Yes,” circle the 1. Please answer the following questions as honestly as possible.
In the last four weeks ...
1. Have you often felt sad or depressed?
2. Have you felt like nothing is fun for you and you just aren’t interested in anything?
3. Have you often felt grouchy or irritable and often in a bad mood, when even little things would make you mad?
4. Have you lost weight, more than just a few pounds?
5. Have you lost your appetite or often felt less like eating?
6. Have you gained a lot of weight, more than just a few pounds?
7. Have you felt much hungrier than usual or eaten a lot more than usual?
8. Have you had trouble sleeping – that is, trouble falling asleep, staying asleep, or waking up too early?
9. Have you slept more during the day than you usually do?
10. Have you often felt slowed down ... like you walked or talked much slower than you usually do?
11. Have you often felt restless ... like you just had to keep walking around?
12. Have you had less energy than you usually do?
13. Has doing even little things made you feel really tired?
14. Have you often blamed yourself for bad things that happened?
15. Have you felt you couldn’t do anything well or that you weren’t as good looking or as smart as other people?
16. Has it seemed like you couldn’t think as clearly or as fast as usual?
17. Have you often had trouble keeping your mind on your [schoolwork/work] or other things?
18. Has it often been hard for you to make up your mind or to make decisions?
19. Have you often thought about death or about people who had died or about being dead yourself?
20.Have you thought seriously about killing yourself?
21. Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
22. Have you tried to kill yourself in the last four weeks?

Appendix 6: Academic Achievement Analysis

The following sections provide highlights on the historical academic performance of the average Minnetonka student during the past several years on a variety of nationally normed and state normed standardized assessments. These assessments include ACT, SAT, NWEA, MCA, as well as STAMP, AAPPL for the Chinese and Spanish Language Immersion programs.

ACT and SAT Results

Overall, Minnetonka students have made strong academic gains, most notably in that the average ACT Composite score has improved from **23.1 points** during the 2001-02 school year to **27.7 points** in 2018-19.

In addition, SAT results indicate an upward trend in performance between the 2006-07 school year and the 2016-17 school year with improvements in Reading, Writing, and Math. In 2006-07, the average Reading score was **618**, while in 2016-17, the average score was **654**. Math average scores increased from **618** to **665** during the same time-frame, with Writing performance improving from **599** to **609** respectively. After 2016-17, the SAT Test version fluchanged, so the data have fluctuated, however, the results remain strong with students scoring in the **670** range for Critical Reading and Writing, and the **680** range for Math.

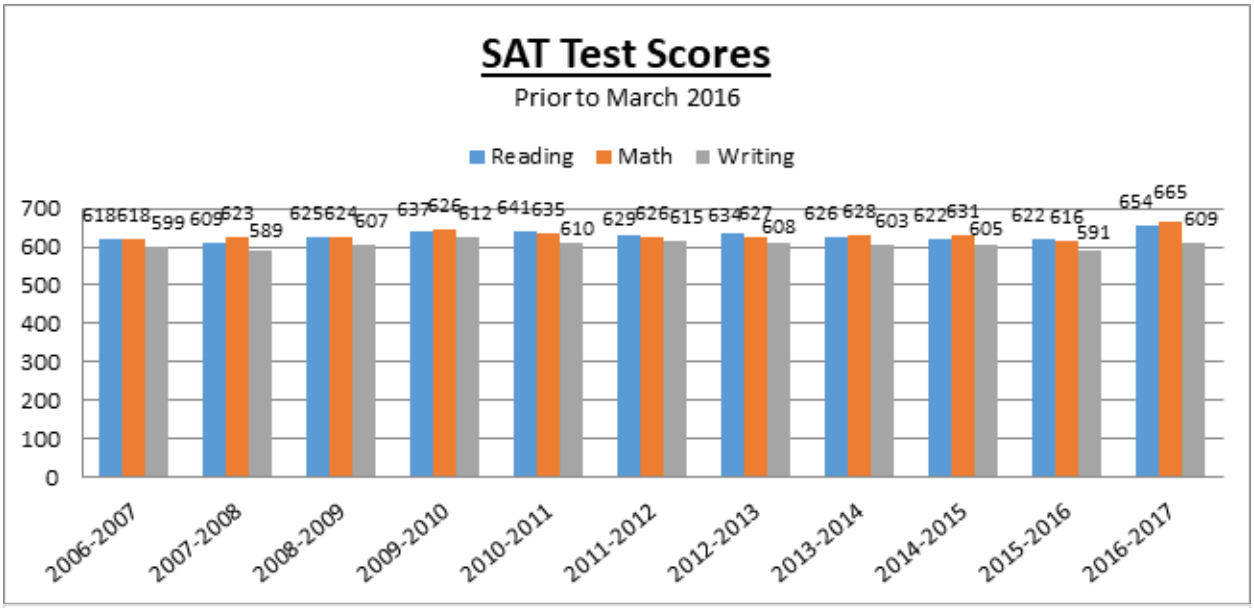
Minnetonka ACT Test and Composite Results from 2001-02 to 2018-19
(Updated with highest ACT subtest and composite score calculation from 2004-05 through 2018-19)

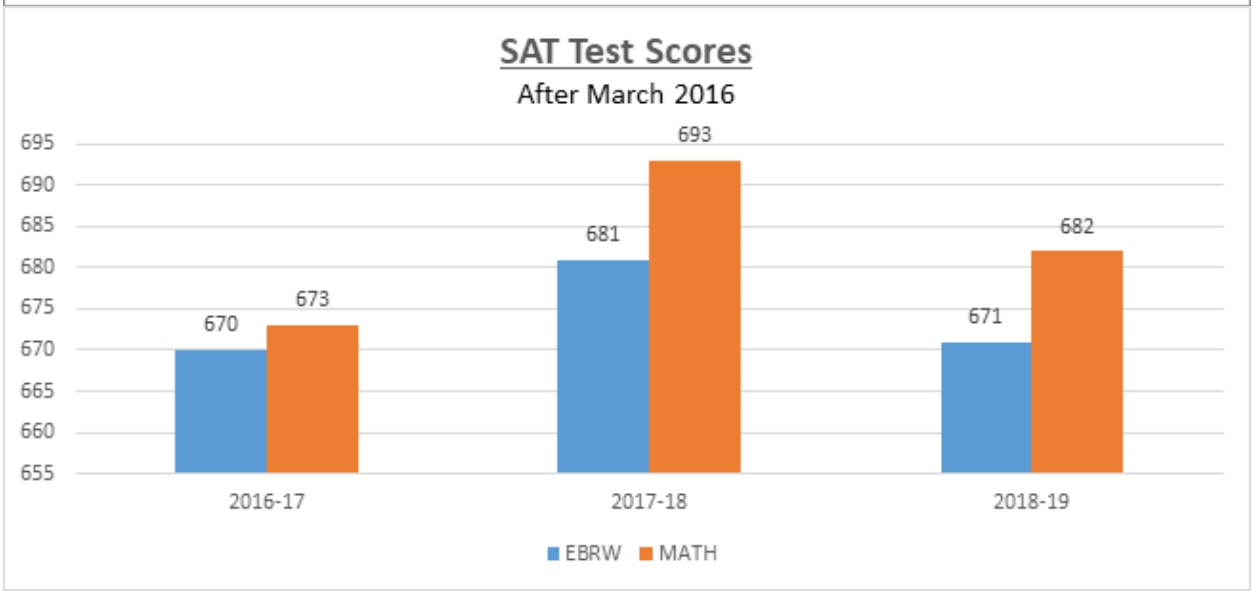
Year	English	Math	Reading	Science	Composite	PLAN High Comp Est.
2001-02	22.4	23.0	23.6	23.0	23.1	NA
2002-03	23.6	23.8	24.4	23.6	24.0	NA
2003-04	23.7	24.5	24.6	23.8	24.3	NA
2004-05	23.2	23.0	23.2	23.0	23.1	NA
2005-06	23.9	24.5	25.0	24.1	24.4	NA

2006-07	24.7	25.2	25.8	24.8	25.1	NA
2007-08	25.0	25.0	25.6	24.6	25.1	*24.8*
2008-09	26.0	25.4	26.7	25.7	26.0	*25.8*
2009-10	26.5	25.5	26.7	25.7	26.1	25.6
2010-11	26.0	25.4	26.3	26.1	26.0	25.3
2011-12	25.6	25.4	26.2	25.7	25.7	*25.8*
2012-13	26.6	25.8	27.2	26.7	26.6	25.7
2013-14	26.5	25.7	26.9	26.7	26.5	25.9
2014-15	26.8	26.2	27.5	27.0	26.9	25.8
2015-16	26.7	26.3	27.1	26.8	26.7	25.8
2016-17	27.6	26.7	28.3	27.5	27.5	26.5*
2017-18	27.3	26.9	28.4	27.5	27.7	26.3*
2018-19	**27.6**	**26.7**	**28.6**	**27.6**	**27.7**	**26.6***

*** Pre-ACT instead of PLAN**

SAT Test Scores for Reading, Math, and Writing





NWEA Results

For years Minnetonka K-8 students have performed beyond national targets on the NWEA battery of tests measuring Reading and Math performance. By 2015, the average Minnetonka Fifth Grader was achieving beyond the Eleventh Grade level consistently in Reading and Math. These results are predictors of future performance on the both the MCA and ACT Tests according

to historical NWEA linking studies. The evidence is clear that as students reach higher levels on the NWEA Tests, they too, reaching higher levels on the ACT Tests as proven in the previous section highlighting the consistent positive trend of the ACT Composite score.

In addition, regardless of program, whether students are in the Chinese or Spanish Immersion programs, or the English program, Minnetonka students perform similarly on the NWEA Tests. Beginning at Third Grade, performances on the NWEA Reading Test among the English, Spanish, and Chinese Immersion programs is consistent. The greatest difference in scoring between these two programs in the past few years was **0.6 RIT points**. At this time, the greatest difference lies within Grades 6 and 7 where there is a 3-4 point average RIT score difference between English, Chinese and Spanish. Performance for all three programs at Grades 3-5 has been consistently strong with very little difference in student performance by the end of Fifth Grade.

NWEA Spring Mean Performance Four-Year Trend Data

GR	SUB	Spring 2019	Spring 2018	Spring 2017	Spring 2016
K	R	Early 1st Grade	Early 1st Grade	Early 1st Grade	Early 1st Grade
K	M	Early 1st Grade	Early 1st Grade	Early 1st Grade	Early 1st Grade
1	R	Mid 2nd Grade	Mid 2nd Grade	Mid 2nd Grade	End of 2nd Grade
1	M	Mid 3rd Grade	Mid 3rd Grade	Mid 3rd Grade	Early 3rd Grade
2	R	*Mid 3rd Grade*	Early 4th Grade	Early 4th Grade	Early 4th Grade
2	M	Early 4th Grade	Early 4th Grade	End of 3rd Grade	Early 4th Grade
3	R	Mid 5th	Mid 5th	Mid 5th	End of 5th

		Grade	**Grade**	**Grade**	**Grade**
3	**M**	**Early 6th Grade**	**Early 6th Grade**	**Early 6th Grade**	**Mid 5th Grade**
4	**R**	**Early 8th Grade**	**Early 8th Grade**	**Early 8th Grade**	**Mid 8th Grade**
4	**M**	***Early 8th Grade***	**Mid 8th Grade**	**Mid 8th Grade**	**Early 8th Grade**
5	**R**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**
5	**M**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**
6	**R**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**
6	**M**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**
7	**M**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**
8	**M**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**

NWEA Spring Mean Performance Four-Year Trend Data

GR	SUB	Spring 2015	Spring 2014	Spring 2013	Spring 2012
K	Rdg	Early 1st Grade	Early 1st Grade	Early 1st Grade	Early 1st Grade
K	Math	Mid 1st Grade	Mid 1st Grade	Early 1st Grade	Early 1st Grade
1	Rdg	End 2nd Grade	Mid 2nd Grade	Mid 2nd Grade	Mid 2nd Grade
1	Math	Mid 3rd Grade	Early 3rd Grade	Early 3rd Grade	End 2nd Grade
2	Rdg	*End of 3rd Grade*	Early 4th Grade	End of 3rd Grade	End of 3rd Grade
2	Math	Early 4th Grade	Early 4th Grade	Early 4th Grade	End of 3rd Grade
3	Rdg	End of 5th Grade	Mid 5th Grade	Mid 5th Grade	Mid 5th Grade
3	Math	End 5th Grade	Mid 5th Grade	Mid 5th Grade	Mid 5th Grade
4	Rdg	Early 8th	Mid 7th	Early 7th	Mid 7th

		Grade	**Grade**	**Grade**	**Grade**
4	**Math**	***Early 8th Grade***	**Mid 7th Grade**	**Early 7th Grade**	**Early 7th Grade**
5	**Rdg**	**Beyond 11th Grade**	**Early 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**
5	**Math**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Mid 10th Grade**
6	**Rdg**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**
6	**Math**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**
7	**Math**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**
8	**Math**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**	**Beyond 11th Grade**

Spanish and Chinese Student Performance on NWEA
Three-Year Trend

	Math				Reading			
	N	Spring 2017 Mean RIT	Spring 2018 Mean RIT	Spring 2019 Mean RIT	N	Spring 2017 Mean RIT	Spring 2018 Mean RIT	Spring 2019 Mean RIT
Grade K			**Math Primary Grades**				**Rdg Primary Grades**	
English	416	166.5	166.1	166.5	410	163.5	162.4	163.9
Ch. Immersion	125	172.7	173.2	176.8	125	161.9	164.9	167.5
Sp. Immersion	393	168.8	167.4	*165.4*	*	*	*	*
Grade 1			**Math Primary Grades**				**Rdg Primary Grades**	
English	335	195.1	194.9	*193.1*	335	188.0	187.8	*185.8*

Ch. Immersion	**107**	**196.4**	**201.6**	***198.4***	**107**	**177.7**	**178.9**	**180.2**
Sp. Immersion	**306**	**197.3**	**196.1**	***195.4***	*	*	*	*
Grade 2			**2-5 MN 2007**				**2-5 Common Core**	
English	**405**	**204.6**	**202.7**	***201.3***	**404**	**200.1**	**199.1**	***197.3***
Ch. Immersion	**104**	**204.8**	**207.3**	**209.3**	**104**	**189.8**	**190.0**	**190.1**
Sp. Immersion	**309**	**202.9**	**202.9**	***201.2***	*	*	*	*
Grade 3			**2-5 MN 2007**				**2-5 Common Core**	
English	**433**	**216.1**	**214.8**	***213.3***	**433**	**210.0**	**209.4**	***207.3***
Ch. Immersion	**119**	**223.5**	**222.8**	***222.1***	**119**	**208.2**	**208.4**	***207.3***
Sp. Immersion	**302**	**217.7**	**217.9**	***214.6***	**302**	**210.9**	**210.9**	***208.5***

Grade 4			2-5 MN 2007				2-5 Common Core	
English	449	226.7	228.3	*225.4*	451	215.9	217.1	*215.6*
Ch. Immersion	95	234.1	234.8	*233.2*	95	217.1	217.7	*216.6*
Sp. Immersion	267	228.0	229.8	*228.4*	267	219.2	217.6	218.2
Grade 5			**2-5 MN 2007**				**2-5 Common Core**	
English	486	238.8	238.7	*235.0*	485	224.5	223.6	*221.9*
Ch. Immersion	82	245.1	245.8	*243.3*	82	225.9	225.6	*222.4*
Sp. Immersion	250	240.2	240.2	*237.1*	249	225.3	225.4	*221.7*
Grade 6			**6 + Math**				**6 + Reading CCSS**	
English	526	242.8	242.6	*239.4*	527	227.9	228.0	*225.6*

Ch. Immersion	**94**	**249.2**	**249.7**	***246.6***	**94**	**230.8**	**230.8**	***229.7***
Sp. Immersion	**243**	**247.3**	**247.6**	***243.6***	**243**	**231.5**	**231.1**	***229.9***
Grade 7			**6 + Math**				**6 + Reading CCSS**	
English	**542**	**248.1**	**249.7**	***248.2***	**404**	**225.9**	**228.0**	***227.3***
Ch. Immersion	**81**	**256.3**	**257.6**	**258.3**	**56**	**230.1**	**230.6**	**231.6**
Sp. Immersion	**220**	**256.6**	**255.9**	***251.4***	**170**	**230.3**	**231.2**	***230.4***

MCA Results

Over the years, Minnetonka students have performed solidly on the MCA Tests. The bulk of the tables in this section display results since 2013, because prior to 2013, students were administered the MCA II Tests.

Overall, combined grade level results indicate a steep decline in Math performance across all elementary sites with the exception of Minnewashta. Minnewashta students saw a significant increase in their proficiency percentage improving by **4.5 percent**. However, there were also significant decreases in proficiency at Clear Springs, Deephaven, and Excelsior Elementary schools that warrant further analysis. Clear Springs and Scenic Heights Elementary Schools have experience two-year declines, although the most recent decrease in proficiency at Scenic Heights was minimal at **0.4 percent**. In addition, Scenic Heights Elementary students had the highest rate of proficiency among the elementary sites. Typically, it is important to view summative

assessment data such as the MCAs or NWEAs over time. With consistent assessment experiences from year to year, one would conclude that there should be consistent results. For example, 2017 was a rebound year for the Deephaven and Excelsior Elementary Schools and more typical of what they have historically expected. In addition to the improved performance by the two sites, 2017 marked the first year where all six elementary sites surpassed 80 percent proficiency. Like 2016, 2018 once again saw a decrease in performance. In addition, Clear Springs, Deephaven, and Excelsior experienced their lowest proficiency levels in the past four years, warranting further study of the results. MMW has shown steady improvement, increasing by a significant **5.0 percent** since 2015.

The High School continues to have students take higher level Math courses through the AP and IB programs. More students who have never taken an honors level course in the past are taking honors level courses such as AP Statistics. Overall, the elementary school sites had disparate proficiency results, which, if continued for multiple years would be cause for concern. Staff should consider measuring MCA Math performance against NWEA Math performance. The new Math assessments being implemented at the elementary level should yield improved performance over time as they are closely aligned with the state standards and District Essential Learnings. In addition, consistent implementation of the Everyday Math materials along with the supplemental Singapore Math materials should pay dividends for years to come. In the meantime, it is recommended that all elementary staff focus on analyzing their individual student performance and spend time during the Fall data retreats analyzing the most recent NWEA Math results.

Spring 2013-2018 MCA III Math Proficiency by Level (All Students)

Group	2013 % Proficient	2014 % Proficient	2015 % Proficient	2016 % Proficient	2017 % Proficient	2018 % Proficient
Elementary	83.4	83.8	83.2	83.1	82.8	81.2
Middle	81.3	82.8	80.7	82.1	82.1	84.6
High School	72.9 (MCA II)	73.7	70.9	69.5	69.1	70.0

Spring 2013-2018 MCA III Math Proficiency by School

School	2013 Math % Proficient MCA III	2014 Math % Proficient MCA III	2015 Math % Proficient MCA III	2016 Math % Proficient MCA III	2017 Math % Proficient MCA III	2018 Math % Proficient MCA III
Clear Springs	75.5	83.1	82.6	84.4	82.7	76.9
Deephaven	92.8	87.7	84.4	79.2	82.4	76.2
Excelsior	86.5	87.0	82.0	78.7	82.1	78.1
Groveland	80.7	79.7	81.8	83.0	84.4	83.3
Minnewashta	77.1	78.9	79.1	82.2	80.3	84.8
Scenic Heights	88.6	87.2	89.5	90.3	85.8	85.4
MME	82.2	79.8	80.7	84.5	81.2	83.5
MMW	80.3	80.6	80.9	79.3	83.0	85.9
MHS	72.9 (MCA II)	73.7	70.9	69.5	69.1	70.0

Overall, results for the ethnic student groups listed in in the table below show improved performance for three of the five student groups. The American Indian population out-paced their state counterparts by a significant margin of **35.4 percent**, the same as last year. The African American population scored **18.6 percentage points** higher than African American students statewide compared to **27.0 percentage points** higher a year ago. Hispanic students out-performed their counterparts by **35.9 percent** compared to a **28.5 percent** difference from 2016 to 2017. Despite the smaller population, school staff have access to the pertinent data to make instructional decisions based on the students' individual needs.

Spring 2013-2018 MCA III Math Proficiency by Ethnicity

	American Indian	Asian	African-American	Hispanic	Caucasian
2018	64.7	88.9	47.2	70.2	82.4
2017	72.2	88.6	57.8	64.1	81.9
2016	73.3	87.8	43.4	58.6	82.9
2015	61.9	89.2	45.5	60.8	82.1
2014	53.3	88.0	55.6	67.0	91.8
2013	59.3	86.7	54.6	70.0	83.5

The table below should be used to see the history of successful Reading performance across all levels in previous years. The data from 2010-2012 is not displayed as those data were from the MCA II Test and should not be compared to MCA III performance. There was a significant increase in student Reading performance at MMW (**7.9 percent**). However, there were decreases five of

six elementary sites, with the exception of Scenic Heights. The drops in Reading performance, although not statistically significant from 2017, do show a need for further analysis. For example, Reading performance saw a two year decline at Clear Springs and Groveland, and a three year decline at Deephaven and Excelsior. The declines in proficiency when comparing the lower levels to the highest levels over the past four years is significant.

At **78.5 percent** proficient, Grade 10 students performed second to Orono, and students showed a **0.5 percent** decrease in proficiency compared to their same grade level counterparts from a year ago. Middle School results showed a significant increase at MMW with both schools performing beyond the **80 percent** proficiency level for the third time in the past four years.

Minnetonka students have performed well on the MCA III Reading in past years as displayed in the table below. The academic program is designed in a way for students to receive differentiated instruction through guided reading lessons at the elementary level. The lessons learned in elementary school allow students to make a smooth transition into their reading and language arts classes at the middle school. By the time students reach high school, they are typically performing well above their peers across the state and out-performing most students across metro area districts. Various instructional strategies to help students improve their critical thinking skills in Reading and strategies to help students build stamina to read independently, not only has aided with increasing test results, but it has also helped to create a passion for reading in students. Students are expected to read every night at a young age, and schools implement Reading initiatives that recognize students for their hard work in this area. It is evident that schools are helping to create life-long readers and critical thinkers at all grade levels.

Middle school student performance yielded fairly similar results and much improved compared to 2016. The two sites have performed similarly in the past with the exception of 2016. It is suggested that MMW staff view the results along with MME to compare how students performed on the subtests that make up the MCA Reading. As part of the Language Arts curriculum review, the Language Arts department chairs will begin the work of analyzing the data. Department chairs will be working with all Language Arts teachers to discuss longitudinal data as well as receive professional development in the area of on-going data analysis in order to use data in a formative manner.

Spring 2013-2018 MCA Reading Proficiency by Level (All Students)

Group	2013 % Proficient MCA III	2014 % Proficient MCA III	2015 % Proficient MCA III	2016 % Proficient MCA III	2017 % Proficient MCA III	2018 % Proficient MCA III

Elementary	79.1	78.9	82.0	81.1	79.6	78.2
Middle	79.1	79.8	81.7	75.7	82.7	86.9
High School	86.7	83.2	80.8	78.1	79.0	78.5

Spring 2013-2018 MCA Reading Proficiency by School

School	2013 MCA III Reading % Proficient	2014 MCA III Reading % Proficient	2015 MCA III Reading % Proficient	2016 MCA III Reading % Proficient	2017 MCA III Reading % Proficient	2018 MCA III Reading % Proficient
Clear Springs	74.3	80.4	79.9	84.3	80.4	78.8
Deephaven	81.3	82.0	83.7	79.7	78.5	76.8
Excelsior	81.6	79.3	84.3	74.5	73.5	72.0
Groveland	79.6	76.8	77.6	82.7	81.7	79.4
Minnewashta	76.5	76.7	84.0	81.6	84.9	82.0
Scenic Heights	81.6	78.7	82.0	83.7	78.6	80.3

MME	81.1	79.3	81.9	77.4	83.5	85.9
MMW	77.0	80.5	81.4	73.8	80.3	88.2
MHS	86.7	83.2	80.8	78.1	79.0	78.5

Although Minnetonka does not have a large population in some student groups compared to other districts across the state, there has been a rise in the African American population. Although there was an increase in student count among African American students, they have performed at their second highest levels in four years. Minnetonka Asian, Hispanic and American Indian students significantly out-performed their counterparts across the state on the MCA III Reading. In addition, Hispanic students showed a strong increase in performance over the past four years, marking two straight years of improvement. Hispanic students are out-performing their counterparts across the state by **33.3 percent**. Although there has been a fluctuation in performance over the past three years for this particular student group, most likely due to low numbers of students, it will be important for schools to monitor their individual student achievement data.

Spring 2014-2018 MCA Reading Proficiency by Ethnicity

	American Indian	**Asian**	**African-American**	**Hispanic**	**Caucasian**
2018	50.0	84.7	51.7	72.1	83.5
2017	83.3	85.8	56.2	70.6	82.7
2016	66.7	85.9	48.4	61.5	79.8

2015	68.2	84.9	46.4	63.4	83.6
2014	55.6	81.2	55.8	66.5	81.2
2013	58.6	84.3	49.6	66.5	81.4

Immersion Assessment Results

STAMP Test Results for Chinese Immersion

In 2019, there were a total of **213** students who took the Chinese STAMP 4S assessment (down from 320) and **574** students who took the Spanish assessment (down from 906). The decreases are due to the discontinuation of students in Grades 7 and 9 taking the STAMP this year. Results indicate that Grades Six, Eighth, and Tenth Grade Spanish students mainly performed within the Intermediate-Mid to Intermediate High ranges for the four skill areas. Grade 10 students reached the Advanced-Low range for Reading and Listening. In Reading and Listening, students who reach the Advanced proficiency levels can understand and use language for straightforward informational purposes and understand the content of most factual, non-specialized materials intended for a general audience.

Chinese Immersion student results increased significantly compared to last year which ranged from Novice-Mid to Intermediate-Low ranges on the Reading Test. This year the proficiency levels on the Reading Test ranged from the Intermediate-Low to Intermediate-High ranges. In 2019, Grade Six Chinese Immersion students out-performed Grade Six Chinese Immersion students in three of the four sub-tests, with the exception of Listening, in which they underperformed by **0.4 points** compared to last year. Chinese Immersion students grew a range of **1.7 points** to **2.6 points** in Reading, which is considered the most challenging of the subtests for Chinese language learners. Spanish Immersion students exhibited more modest average score growth, yet Grade 6 students improving on three of four subtests and Grade 8 students improving on all four subtests. Tenth Graders saw similar results compared to last year with Listening showing the largest decrease of **0.4 points**. Strong growth for a cohort would be approximately **0.5 points**. It is clear that students in the Chinese Immersion program have been steadily improving their language performance on the STAMP Test with some grade levels performing at all-time high levels on the sub-tests within the Chinese Immersion program.

As students reach the upper Intermediate levels, it is expected that they will be able to pass the AP Language and Culture Exams with at least a score of 3. Students reaching the Advanced-Low to Mid levels could be expected to earn a score of at least a 4 out of 5 on the exams. Students

reaching the Advanced-Low levels on the AP or STAMP Exams within four years of graduation may earn the highest-level Platinum Bilingual Seal from the state of Minnesota. Students reaching the Intermediate-High proficiency level can earn the Gold Seal.

Based on language acquisition research, language production is a skill that is acquired later in the language learning process, and it is not uncommon for students to perform lower in this skill area compared to the other three areas. For Chinese Immersion students, Reading is an area that needs to be targeted based on the predicted proficiency level of Intermediate-High at Sixth Grade and Advance Low and Mid for Seventh through Ninth Grades compared to their Novice-Mid and High performances.

Below are some of the highlights of student performances within the Chinese and Spanish Immersion programs. In some cases, students are reaching all-time high levels.

Chinese Immersion:

· Reading results for both MME and MMW yielded an improved performance for Sixth and Eighth Graders reaching their highest all-time levels.

· In Reading, cohort performance improved by an average of **1.9 to 2.6 points** as students moved from the Seventh to Eighth Grade level. This well-surpassed the national annual growth expectations for language Immersion programs of **0.5 points**.

· The cohort transitioning from Ninth to Tenth Grade showed improvement as more students are moving into the Intermediate-High levels improving from **6.1 percent** as Ninth Graders to **45.2 percent** as Tenth Graders.

· In Speaking, both Seventh to Eighth Grade cohorts at MME and MMW tied for their second highest all-time levels improving by at least **0.5 points** from last year.

· In Writing, Eighth Grade students at MME and MMW reached their second highest all-time levels surpassing the national proficiency target of Intermediate-Low and moving into the Intermediate-High level.

Spanish Immersion:

· Spanish Immersion Eighth Grade students reached their highest all-time levels on all four sub-tests (Reading, Writing, Listening, Speaking).

· For Listening, the Grade 7 to Grade 8 cohort improved by **0.8 points**, surpassing national expectations of **0.5 points** annual growth.

· In Reading, Grade 6 students reached their second all-time highest performance with Eighth Graders tying or eclipsing their all-time highest average scores.

· On the Speaking test, Grade 6 and 8 Spanish Immersion students at MME and MMW met or surpassed their all-time high scores.

· In Writing, MME Sixth Graders reached their highest all-time levels along with Eighth Graders at both MME and MMW.

2020 Grades 6, 8, and 10 Mean Score and Proficiency Level
Sub-Test Results for Chinese Immersion

	Grade 6 **Total Chinese Immersion** **(N=76)**		**Grade 8** **Total Chinese Immersion** **(N=79)**		**Grade 10** **Total Chinese Immersion** **(N=44)**	
	Mean Score	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**
Rdg	4.6	Int Mid	5.6	Int High	6.0	Int High
Write	4.9	Int Mid	5.4	Int Mid	5.0	Int Mid
List	5.9	Int High	6.6	Adv Low	6.5	Adv Low
Spkg	4.7	Int Mid	5.0	Int Mid	5.0	Int Mid

2019 Grades 6, 8, and 10 Mean Score and Proficiency Level
Sub-Test Results for Chinese Immersion

	Grade 6 Total Chinese Immersion (N=93)		Grade 8 Total Chinese Immersion (N=78)		Grade 10 Total Chinese Immersion (N=42)	
	Mean Score	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**
Rdg	4.4	Int Low	5.6	Int High	6.3	Int High
Write	4.7	Int Mid	5.1	Int Mid	5.4	Int Mid
List	4.2	Int Low	5.2	Int Mid	5.6	Int High
Spkg	4.2	Int Low	4.9	Int Mid	5.3	Int Mid

2018 Grades 6-10 Mean Score and Proficiency Level
Sub-Test Results for Chinese Immersion

	Grade 6 Total Chinese Immersion (N=85)		Grade 7 Total Chinese Immersion (N=85)		Grade 8 Total Chinese Immersion (N=55)		Grade 9 Total Chinese Immersion (N=49)		Grade 10 Total Chinese Immersion (N=44)	
	Mean Score	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**

Rdg	2.7	Nov High	3.2	Nov High	3.3	Nov High	3.6	Int Low	3.7	Int Low
Write	4.4	Int Low	4.6	Int Mid	5.2	Int Mid	5.0	Int Mid	4.8	Int Mid
List	4.6	Int Mid	4.9	Int Mid	4.9	Int Mid	5.3	Int Mid	5.3	Int Mid
Spkg	4.1	Int Low	4.4	Int Low	4.4	Int Low	4.8	Int Mid	4.7	Int Mid

2017 Grades 6-10 Mean Score and Proficiency Level
Sub-Test Results for Chinese Immersion

	Grade 6 Total Chinese Immersion (N=88)		**Grade 7 Total Chinese Immersion (N=58)**		**Grade 8 Total Chinese Immersion (N=49)**		**Grade 9 Total Chinese Immersion (N=48)**		**Grade 10 Total Chinese Immersion (N=28)**	
	Mean Score	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**
Rdg	2.4	Nov Mid	2.7	Nov High	3.5	Int Low	3.5	Int Low	3.7	Int Low
Write	4.2	Int Low	4.5	Int Mid	5.1	Int Mid	4.7	Int Mid	4.9	Int Mid
List	4.5	Int Mid	4.6	Int Mid	5.2	Int Mid	5.2	Int Mid	5.5	Int High
Spkg	4.3	Int Low	4.2	Int Low	4.7	Int Mid	4.5	Int Mid	4.7	Int Mid

2016 Grades 6-9 Mean Score and Proficiency Level
Sub-Test Results for Chinese Immersion

	Grade 6 Total Chinese Immersion (N=64)		Grade 7 Total Chinese Immersion (N=50)		Grade 8 Total Chinese Immersion (N=48)		Grade 9 Total Chinese Immersion (N=34)	
	Mean Score	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**
Rdg	2.4	Nov Mid	3.0	Nov High	2.9	Nov High	3.2	Nov High
Write	3.9	Int Low	4.8	Int Mid	4.7	Int Mid	4.8	Int Mid
List	3.8	Int Low	4.9	Int Mid	4.9	Int Mid	5.1	Int Mid
Spkg	4.1	Int Low	4.4	Int Low	4.6	Int Mid	4.8	Int Mid

2020 Grades 6, 8 and 10 Mean Score and Proficiency Level
Sub-Test Results for Spanish Immersion

	Grade 6 Total Spanish Immersion (N=231)		Grade 8 Total Spanish Immersion (N=219)		Grade 10 Total Spanish Immersion (N=160)	
	Mean Score	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**

Rdg	6.6	Adv Low	7.5	Adv Mid	8.0	Adv Mid
Write	5.1	Int Mid	5.7	Int High	6.0	Int High
List	6.7	Adv Low	7.7	Adv Mid	8.0	Adv Mid
Spkg	5.6	Int High	5.9	Int High	5.9	Int High

2019 Grades 6, 8 and 10 Mean Score and Proficiency Level
Sub-Test Results for Spanish Immersion

	Grade 6 **Total Spanish Immersion** **(N=243)**		**Grade 8** **Total Spanish Immersion** **(N=208)**		**Grade 10** **Total Spanish Immersion** **(N=123)**	
	Mean Score	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**
Rdg	4.9	Int Mid	6.4	Int High	6.9	Adv Low
Write	4.8	Int Mid	5.7	Int High	5.9	Int High
List	4.5	Int Mid	6.3	Int High	6.5	Adv Low
Spkg	4.9	Int Mid	5.6	Int High	5.6	Int High

2018 Grade 6-10 Mean Score and Proficiency Level
Sub-Test Results for Spanish Immersion

	Grade 6 Total Spanish Immersion (N=224)		Grade 7 Total Spanish Immersion (N=205)		Grade 8 Total Spanish Immersion (N=179)		Grade 9 Total Spanish Immersion (N=147)		Grade 10 Total Spanish Immersion (N=123)	
	Mean Score	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**
Rdg	4.8	Int Mid	5.7	Int High	6.2	Int High	6.5	Adv Low	7.0	Adv Low
Write	4.7	Int Mid	5.1	Int Mid	5.5	Int High	5.9	Int High	5.9	Int High
List	4.6	Int Mid	5.5	Int High	5.9	Int High	6.2	Int High	6.9	Adv Low
Spkg	4.8	Int Mid	5.1	Int Mid	5.2	Int Mid	5.5	Int High	5.8	Int High

2017 Grade 6-10 Mean Score and Proficiency Level
Sub-Test Results for Spanish Immersion

	Grade 6 Total Spanish Immersion (N=219)		Grade 7 Total Spanish Immersion (N=183)		Grade 8 Total Spanish Immersion (N=147)		Grade 9 Total Spanish Immersion (N=121)		Grade 10 Total Spanish Immersion (N=87)	
	Mean Score	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**

Rdg	5.0	Int Mid	5.6	Int High	6.0	Int High	6.7	Adv Low	6.6	Adv Low
Write	4.6	Int Mid	4.9	Int Mid	5.5	Int High	5.6	Int High	5.6	Int High
List	5.1	Int Mid	5.3	Int Mid	5.6	Int High	6.5	Adv Low	6.4	Int High
Spkg	4.9	Int Mid	5.0	Int Mid	5.1	Int Mid	5.5	Int High	5.4	Int Mid

2016 Grade 6-9 Mean Score and Proficiency Level
Sub-Test Results for Spanish Immersion

	Grade 6 **Total Spanish Immersion** **(N=186)**		**Grade 7** **Total Spanish Immersion** **(N=149)**		**Grade 8** **Total Spanish Immersion** **(N=128)**		**Grade 9** **Total Spanish Immersion** **(N=105)**	
	Mean Score	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**	**Mean Score**	**Prof Level**
Rdg	4.9	Int Mid	5.3	Int Mid	6.1	Int High	6.4	Int High
Write	4.7	Int Mid	5.1	Int Mid	5.2	Int Mid	5.2	Int Mid
List	4.4	Int Low	5.2	Int Mid	5.8	Int High	6.0	Int High
Spkg	4.6	Int Mid	4.9	Int Mid	5.1	Int Mid	4.9	Int Mid

AAPPL Results

Due to technical issues during the 2018-19 AAPPL Test, results from the 2017-18 test and prior are discussed in this section. Overall, students have performed within the Intermediate-Low to Mid ranges on this language proficiency test. With students reaching the Intermediate-Mid level on average by Fifth Grade, this is an indication that students are out-performing their language immersion peers nationwide. By the end of Fifth Grade, the average immersion student is expected to perform at the Intermediate-Low level, and in Minnetonka, many students are reaching the Intermediate-Mid range, while the majority of students are performing at or beyond national expectations.

HIGHLIGHTS

- Chinese Immersion students increased the percentage of students reaching the Intermediate High range on the Listening Test from **34.4 percent** to **53.6 percent**.
- The Chinese Immersion Third to Fourth Grade cohort saw a drop in AAPPL rating from I1 (Intermediate Low) to N4 (Intermediate Low) from 2017 to 2018 in Reading.
- On the Listening Test, the Chinese Immersion Fifth Grade cohort saw a strong increase the last three years from Third Grade to Fifth Grade increasing from I1 (Intermediate Low) in 2016, to I3 (Intermediate Mid) in 2017, to I4 (Intermediate High) in 2018.
- In Listening, Spanish Immersion students saw an increased percentage of students reaching the Intermediate Low level (**9.2 percent** to **31.2 percent**), a result of a drop from Intermediate Mid previously reached in 2016 and 2017.
- More Spanish Immersion students are reaching the Intermediate-High levels with respect to Speaking compared to 2016 and 2017, increasing from **27.9 percent** in 2016 to **32.6 percent** in 2018.
- On average, Chinese Immersion students are reaching the goal Intermediate Mid target in Reading by the middle of Fifth Grade which is an indicator of solid classroom reading performance, and Spanish Immersion students are reaching the goal target of Intermediate High in Reading.

Spring 2016-2018 Grades 3, 4, 5 AAPPL Rating and Proficiency Levels for Chinese and Spanish Interpretive Reading

		Chinese Immersion					
		2016		2017		2018	
Grade	N	AAPPL Mean Rating	Prof. Level	AAPPL Mean Rating	Prof. Level	AAPPL Mean Rating	Prof. Level

3	95	N4	Int. Low	I1	Int. Low	N3	Nov. High
4	86	I1	Int. Low	I1	Int. Low	N4	Int. Low
5	99	I2	Int. Mid	I2	Int. Mid	I1	Int. Low

		Spanish Immersion					
		2016		**2017**		**2018**	
Grade	**N**	**AAPPL Mean Rating**	**Prof. Level**	**AAPPL Mean Rating**	**Prof. Level**	**AAPPL Mean Rating**	**Prof. Level**
3	270	I1	Int. Low	I1	Int. Low	I1	Int. Low
4	249	I2	Int. Mid	I2	Int. Mid	I1	Int. Low
5	259	I3	Int. Mid	I3	Int. Mid	I2	Int. Mid

Spring 2014 and 2015 Grades 3, 4, 5 AAPPL Rating and Proficiency Levels for Chinese and Spanish Interpretive Reading

		Chinese Immersion		Chinese Immersion			Spanish Immersion		Spanish Immersion	
		2014		2015			2014		2015	
Grade	N	AAPPL Mean Rating	Prof. Level	AAPPL Mean Rating	Prof. Level	N	AAPPL Mean Rating	Prof. Level	AAPPL Mean Rating	Prof. Level
3	88	N4	Int. Low	N4	Int. Low	247	I1	Int. Low	I1	Int. Low
4	97	N4	Int. Low	I1	Int. Low	231	I2	Int. Mid	I2	Int. Mid
5	66	I2	Int. Mid	I1	Int. Low	198	I3	Int. Mid	I3	Int. Mid

Appendix 7: Associations Between Grades and Mood

Reported Grades this Year Versus Feeling Down, Depressed or Hopeless Nearly Every Day

8th Males	Y	N	Total	%
A	3	127	130	**2%**
B	4	105	109	**4%**
C	0	22	22	**0%**
D	0	5	5	**0%**
F	0	0	0	**#DIV/0!**
Total	7	259	266	**3%**

8th Females	Y	N	Total	%
A	8	193	201	**4%**
B	13	74	87	**15%**
C	5	19	24	**21%**
D	1	3	4	**25%**
F	1	0	1	**100%**
Total	28	289	317	**9%**

8th Total	Y	N	Total	%
A	11	320	331	**3%**
B	17	179	196	**9%**
C	5	41	46	**11%**
D	1	8	9	**11%**
F	1	0	1	**100%**
Total	35	548	583	**6%**

9th Males	Y	N	Total	%
A	0	155	155	**0%**
B	14	110	124	**11%**
C	0	32	32	**0%**
D	1	3	4	**25%**
F	0	1	1	**0%**
Total	15	301	316	**5%**

9th Females	Y	N	Total	%
A	15	226	241	**6%**
B	14	80	94	**15%**
C	6	19	25	**24%**
D	1	0	1	**100%**
F	2	2	4	**50%**
Total	38	327	365	**10%**

9th Total	Y	N	Total	%
A	15	381	396	**4%**
B	28	190	218	**13%**
C	6	51	57	**11%**
D	2	3	5	**40%**
F	2	3	5	**40%**
Total	53	628	681	**8%**

11th Males	Y	N	Total	%
A	8	105	113	**7%**
B	5	86	91	**5%**
C	2	37	39	**5%**
D	2	2	4	**50%**
F	1	0	1	**100%**
Total	18	230	248	**7%**

11th Females	Y	N	Total	%
A	12	152	164	**7%**
B	10	83	93	**11%**
C	2	20	22	**9%**
D	1	4	5	**20%**
F	0	0	0	**#DIV/0!**
Total	25	259	284	**9%**

11th Total	Y	N	Total	%
A	20	257	277	**7%**
B	15	169	184	**8%**
C	4	57	61	**7%**
D	3	6	9	**33%**
F	1	0	1	**100%**
Total	43	489	532	**8%**

Reported Grades this Year Versus Considering Suicide in the Last Year

8th Males	Y	N	Total	%
A	5	122	127	**4%**
B	8	101	109	**7%**
C	0	22	22	**0%**
D	1	4	5	**20%**
F	0	0	0	**#DIV/0!**
Total	14	249	263	**5%**

8th Females	Y	N	Total	%
A	10	189	199	**5%**
B	15	72	87	**17%**
C	5	18	23	**22%**
D	1	3	4	**25%**
F	1	0	1	**100%**
Total	32	282	314	**10%**

8th Total	Y	N	Total	%
A	15	311	326	**5%**
B	23	173	196	**12%**
C	5	40	45	**11%**
D	2	7	9	**22%**
F	1	0	1	**100%**
Total	46	531	577	**8%**

9th Males	Y	N	Total	%
A	9	153	162	**6%**
B	18	107	125	**14%**
C	3	30	33	**9%**
D	1	3	4	**25%**
F	0	1	1	**0%**
Total	31	294	325	**10%**

9th Females	Y	N	Total	%
A	17	223	240	**7%**
B	17	77	94	**18%**
C	11	14	25	**44%**
D	1	0	1	**100%**
F	2	2	4	**50%**
Total	48	316	364	**13%**

9th Total	Y	N	Total	%
A	26	376	402	**6%**
B	35	184	219	**16%**
C	14	44	58	**24%**
D	2	3	5	**40%**
F	2	3	5	**40%**
Total	79	610	689	**11%**

11th Males	Y	N	Total	%
A	11	100	111	**10%**
B	15	76	91	**16%**
C	3	33	36	**8%**
D	1	3	4	**25%**
F	1	0	1	**100%**
Total	31	212	243	**13%**

11th Females	Y	N	Total	%
A	22	141	163	**13%**
B	16	75	91	**18%**
C	8	14	22	**36%**
D	1	4	5	**20%**
F	0	0	0	**#DIV/0!**
Total	47	234	281	**17%**

11th Total	Y	N	Total	%
A	33	241	274	**12%**
B	31	151	182	**17%**
C	11	47	58	**19%**
D	2	7	9	**22%**
F	1	0	1	**100%**
Total	78	446	524	**15%**

Appendix 8: Minnetonka Special Education Database

Form filled out by (name and job title): _____
Date of documentation_____
Student's Name _____
Male___ Female___
Date of Birth_____
Grade___
Age___
Current School Site____
Children's Global Assessment Scale rating___
System involvement- Services being provided at this time by:

- Special Education
- Child Protection
- Juvenile Probation
- Mental Health Case Manager
- Truancy Officer
- Developmental Disabilities
- Adoption Worker
- Mental Health Professional
- Chemical Health Professional_
- Medical Professional

Educational History:
Please check categories of Special Education services student is receiving now (N) or in the past (P):

Autism Spectrum Disorders
Blind-Visually Impaired
Deaf-Blind
Deaf and Hard of Hearing
Developmental Cognitive Disabilities
Developmental Delay
Emotional or Behavioral Disorders
Other Health Disabilities
Physically Impaired
Specific Learning Disabilities
Speech or Language Impairments
Traumatic Brain Injury

Does the student have significant academic difficulties?

No___
Yes __
If yes, did the difficulties begin within the last school year?

Types of academic difficulties that the student has experienced:

- Listening
- Comprehension
- General Comprehension
- Oral Expression
- Reading
- Written Expression
- Math
- Speech Difficulties
- Discrimination
- Memory
- Visual Motor Coordination
- Gross Motor Coordination
- Other

Date of last achievement testing
Date of I.Q testing
Verbal I.Q_____ Performance I.Q._____ Full Scale I.Q._____
% Rank:
Written Language____ Reading ____Math____
If student is receiving Speech and Language services, is this for:
Expressive speech___ Receptive speech___ Articulation___
If student is receiving L.D. services, is this for:
Reading___ Writing___ Mathematics____

For students who have an identified mental health disorder, what functions of behavior are hypothesized in the functional behavioral assessment?

Concerns about student (check all that apply)
Behavior problems at school___
Behavior problems at home ___
Behavior problems in the community___
Learning problems at school___
Truancy___
Suspected drug and/or alcohol use___
Confirmed drug and/or alcohol use___

Conduct Problems
Is there a history of:

- Aggressive Behavior
- Stealing
- Lying
- Running Away Overnight
- Fire setting

- Use of Drugs/Alcohol
- Sexually Assaulting Others
- Destruction of Other's Property
- Truancy
- Oppositionality/Defiance
- Use of a weapon or of objects as weapons
- Cruelty to animals
- Cruelty to people

Health History
Chronic Medical Conditions: Yes__ No__ If Yes: _____
On Medication(s) for medical (not mental health) disorders? Yes__ No__
If Yes, Type(s) and Dosages_____
Mental Health History
Does the child/adolescent have a diagnosis of, or evidence of:

	Diagnosed	Evidence
ADHD	___	___
Autism Spectrum Disorder	___	___
Depression	___	___
Drug or Alcohol Abuse or Dependency	___	___
Bipolar Disorder	___	___
Mood Disorder NOS	___	___
Panic Disorder	___	___
Obsessive Compulsive Disorder	___	___
Post-Traumatic Stress Disorder	___	___
Schizophrenia	___	___
Conduct Disorder	___	___
Oppositional Defiant Disorder	___	___
Other_____	___	___

Is the Child/Adolescent taking psychiatric medication? Yes___ No___
If yes, is it a (check all that apply):

Stimulant (e.g. Ritalin, Adderall, Dexedrine)___
Antidepressant (e.g. Prozac, Zoloft, Paxil) ___
Mood Stabilizing medication (e.g. lithium, Depakote)___
Antipsychotic (e.g. Risperdal, Zyprexa, Abilify)___
Other___

Is there a release of information for the school staff to communicate with the medical provider? Yes__ No__

If there is a release of information, is there documentation of communication? Yes__ No__

Are there concerns that:

The medication is not working? ___

The student is not taking medication consistently? ___

Is the Child/Adolescent receiving mental health psychotherapy?

Yes__ No__

If a student has been diagnosed with a mental health condition (e.g. ADHD), are the symptoms of that condition (e.g. impulsivity, distractibility, hyperactivity, etc.) the reasons for the special education evaluation referral? If so, and if the student is on medication, is there a protocol by which a release of information is obtained in order to communicate to the prescribing physician the nature and extent of ongoing symptoms? Yes__ No__

What were the results of mental health screening (e.g. the BASC)? For students who do not have documented mental health disorders, what disorders are suggested in the screening? _

Was screening done in order to rule out substance use as the primary cause of the student's behavior? Yes__ No__

Is there documentation of a Tennessen warning being given to the parents when private information such as mental health information is requested? Yes__ No__

In cases where a student has been diagnosed with a mental health disorder, is there documentation that indicates the severity of symptoms and the student's level of functioning? Yes__ No__

If there is a change in medication or other therapies, is there documentation that clarifies the nature and degree of changes in symptoms? Yes__ No__

Does the student have an IEP that includes mental health treatment as a related service? Yes__ No__

Appendix 9: Special Education File Review

Student	Gender	Grade	Services Provided *	Disability Current**	Disability Past	Academic Difficulty	Area of Academic Difficulty	Achieve-ment Testing	Date of IQ testing
1	M	1	Sp Ed, MH Prof.	EBD		NO	Reading, Written Expression, Math	FEB 2020	JAN 2020
2	M	5	Sp Ed, MH Prof.	EBD	EBD SPL	NO		MAR 2017	FEB 2017
3	M	8	Sp Ed, MH Prof, Med Prof.	EBD OHD		NO		FEB 2020	FEB 2020
4	F	7	Sp Ed, MH Prof, Med Prof.	EBD OHD		YES	Reading, Written Expression, Math	MAR 2020	FEB 2011
5	M	5	SP ED, MED PROF	EBD		NO		DEC 2019	NOV 2019
6	M	3	Sp Ed, MH Prof, Med Prof.	EBD SLD	DD SPL	YES	Reading, Written Expression, Math	NOV 2019	NOV 2019
7	F	6	Sp Ed, MH Prof, Med Prof.	EBD		YES	Math	NOV 2019	NOV 2019
8	M	6	Sp Ed, MH Prof, Med Prof	EBD		NO		NOV 2019	FEB 2017
9	F	1-Ch.	Sp Ed	EBD		NO		FEB 2020	MAR 2020
10	M	3	Sp Ed, MH Prof, Med Prof.	EBD SPL		YES	Reading, Written Expression, Math, Speech	MAY 2019	MAY 2019
11	F	10	Sp Ed	EBD		NO	other	JAN 2017	FEB 2017
12	F	11	Sp Ed, MH Prof.	EBD		NO		NOV 2019	NOV 2019
13	M	K	Sp Ed, MH Prof.	EBD		NO		MAR 2020	MAR 2020
14	M	3	SP ED, MH	EBD		NO	Reading	MAR 2018	MAR 2018

			PROF, MED PROF, CP						
15	F	9	Sp Ed, MH Prof, Med Prof.	EBD		NO		JAN 20120	MAR 2015
16	M	10	Sp Ed, MH Prof, Med Prof.	EBD		NO		OCT 2019	OCT 2019
17	M	4	Sp Ed, MH Prof, Med Prof.	EBD OHD	OHD	NO	Reading, Written Expression, Visual Motor Coordination	MAR 2020	MAR 2017

*Sp Ed: Special Education; MH Prof: Mental Health Professional; Med Prof: Medical Professional; CP: Child Protection Services

**Disability: EBD: Emotional and Behavior Disability, OHD: Other Health Disability, SPL: Speech/Language, SLD: Specific Learning Disability

Student	Full Scale IQ	Behavior on FBA	Behavior Problems at:	Conduct Problems:	Medical/Mental Health History
1	96	He does not have a mental health diagnosis	School, Home, Community, Learning problems	Aggression, Destruction of property, O/D	
2	123	Escape task demands, social situations and sensory input	School, Home,	Aggression, O/D	Anxiety Disorder
3	111	Attention from peers/adults and avoidance of non-preferred tasks	School, Home	Aggression, Lying O/D	ADHD, Depression, Anxiety, Allergies
4	92	Avoidance of non-preferred social interactions, avoidance of non-preferred activities or classes, gaining or maintaining control, positive peer reinforcement	School, Home, Learning Problems	O/D	ADHD, Anxiety, Depression, Celiac Disease
5	130	Anxiety release; delay of work tasks; attain control of situation in order to do things on his own terms	School, Home	Aggression, O/D	ADHD, Depression
6	81	Avoid challenging work/situations; attain adult attention; communicating/releasing negative emotions	School, Home, Community, Learning problems	Aggression, O/D	ADHD, this child has history or abuse/neglect/trauma
7	98	Lack of participation in class/school activities	School	O/D	Diabetes, Anxiety
8	117		School, Home		Headaches

Student	Full Scale IQ	Behavior on FBA	Behavior Problems at:	Conduct Problems:	Medical/Mental Health History
9	149	Dysregulated and Unexpected Behaviors (ex. yelling, throwing objects, rolling on floor, talking out of turn, arguing)	School, Home	Aggression, Destruction of property	
10	85	Attention, self-regulation, social interactions, need for movement	School, Home, Community	Aggression, O/D	ADHD, ODD
11	110	disengagement and inattention	School	O/D	ADHD
12	107	Anxiety and depression. Emotional regulation, over reacts emotionally; Difficulty with unstructured or unpredictable situations, workload and peer relationships. Coping skills and social communication	School, Home, Community		Anxiety, Depression, OCD
13	104	Attention seeking from peers and staff. Avoid non-preferred tasks. Seeks power and control.	School, Home	Aggression	ADHD, Anxiety
14	87	Escape/avoidance; coping skills for stress, limited self-awareness.	School, Home, Learning Problems		
15	95	Gaining control and seeking attention	School, Home	Aggression, O/D	ADHD, ODD, Anxiety
16	116	Avoidance/Escape	School, Home	Aggression, Lying	ADHD, Mood Disorder NOS
17	116	Escape/avoidance,control,anxiety/ executive function skills	School, Home, Community		ADHD, Anxiety, social anxiety, Sensory Processing Disorder, Skin Condition

Student	Psychiatric medication	Concerns	Mental health psycho-therapy?	Is ROI with Dr. for symptoms of MH meds?	What were the results of mental health screening (e.g. BASC)? For student who do not have document mental health disorders, what disorder are suggested in the screening?
1					Clinically significant aggressive behaviors, hyperactivity, anxiety and depression.
2	no		no		Clinically significant scores for aggressive behaviors, anxiety and depression
3	no	meds not working	yes	yes	Clinically significant or at-risk ratings at home and school in the areas of: hyperactivity, aggression, conduct problems, adaptability, social skills, leadership, study skills
4	yes	meds not working	yes	yes	Clinically significant/at risk scores for both parent and teachers: anxiety, somatization, attention problems, leaning problems, atypicality, withdrawal, adaptability, social skills, leadership, functional communication
5	yes		no		Findings of mixed symptoms of anxiety and depression were consistent with his prior diagnosis of Unspecified Depressive Disorder; Symptoms of ADHD appear to be well managed with medication.
6	yes		yes	no	Significant hyperactivity, inattention, mixed symptoms of anxiety/depression, weaknesses with functional communication
7	yes		yes	yes	Conduct problems, depression, atypicality, withdrawal
8	no		yes		Depression, internalizing behaviors (shutting down, difficulty expressing emotions appropriately, avoidance) and externalizing behaviors (impulsivity, meltdowns, eloping, defiance, unkind words towards self and others)
9	no		no		All core areas of BASC clinically significant. Difficulty regulating emotions and impulsive behavior in school and home setting. Easily upset and overreacts to small problems.

Student	Psychiatric medication	Concerns	Mental health psycho-therapy?	Is ROI with Dr. for symptoms of MH meds?	What were the results of mental health screening (e.g. BASC)? For student who do not have document mental health disorders, what disorder are suggested in the screening?
10	yes		yes	no	Clinically significant scores in all subareas of externalizing behaviors. At risk for mental health difficulties, should be monitored closely.
11	no		no	no	Diagnosed ADHD not currently on medication. No other formal medical or mental health diagnoses. IEP has SEL and Behavior needs since 2014. Has significant needs related to aggression/conduct, depression, and inattention and exec. functioning and withdrawal.
12	yes	not taking meds	yes	yes	Anxiety and Depression. Rating scales reflect behaviors related to significant thoughts, behaviors and feelings related to anxiety and depression, and are impacting relationships. Functioning should be closely monitored and supported
13	no		yes		Diagnosis: (ADHD), and anxiety disorder; several areas of social, emotional, and behavioral functioning concerns. BASC-III rating scale were elevated: Hyperactive or impulsive behaviors; Aggressive behaviors; anxiety; symptoms of depression; Atypical or unusual behaviors for his age; difficulty being adaptable or flexible with change; and difficulty displaying age-appropriate social skills. Student should continue to be monitored closely, with frequent communication between home and school. Strategies to address and support his emotional and behavioral regulation skills, self-monitoring and behavioral inhibition skills, social skills, flexible thinking skills, and coping strategies to handle stress, frustration, and anxiety more effectively

14	no		yes	yes	anxiety, mood regulation,
15	yes		no	no	consistent with clinical diagnoses
16	yes		yes	no	consistent with clinical diagnoses
17	yes	meds not working	yes	yes	anxiety, depression, social anxiety, impulsivity, OCD

Student	Screening to rule out substance use cause of behavior?	Tennessen warning	Documentation indicates severity and level of functioning?	If meds/therapies change, does documentation clarifies changes in symptoms?	IEP has mental health treatment as a related service?
1	No	No			Yes
2	No	No	Yes		Yes
3	No	No	Yes	No	No
4	No	No	Yes	No	Yes
5	No	No	No	No	Yes
6	No	No	No	No	Yes
7	No	No	Yes	Yes	No
8	No	No			No
9	No	No	No		Yes
10	No	No	Yes	No	Yes
11	No	No	No	No	No
12	No	No		Yes	No
13	No	No	No		No
14	No	Yes	Yes	No	No
15	No	No	No	No	No
16	No	No	No	No	No
17	No	Yes	Yes	No	No

Appendix 10: Total Special Ed Student Counts by Disability Category

District Wide	2020	2019	2018	2017	2016	2015
ASD	244	241	226	217	212	220
D-B	1	1	0	0	0	0
DCD-M	27	23	20	26	29	29
DCD-S	15	20	21	22	21	21
DD	70	81	85	67	59	56
EBD	164	150	140	105	92	83
DHH	28	23	22	21	20	17
OHD	210	215	206	178	177	178
PI	32	30	23	17	22	24
SLD	226	212	201	180	170	178
SMI	14	13	15	15	13	12
SPL	335	314	327	265	279	288
TBI	0	0	1	3	3	3
VI	7	7	7	5	5	5
Total	1378	1330	1294	1121	1102	1114

CLEAR SPRINGS	2020	2019	2018	2017	2016	2015
ASD	15	17	8	9	13	15
D-B			0	0	0	0
DCD-M	3	1	1	2	3	3
DCD-S	2	3	2	1	2	3
DD	5	6	7	6	3	2
EBD	11	12	8	8	8	8
DHH	3	3	2	1	1	0
OHD	8	10	4	9	9	11
PI	7	5	4	1	2	2
SLD	13	15	10	12	10	12
SMI	1	1	0	0	0	0
SPL	48	50	52	39	39	37
TBI	0	0	0	0	0	0
VI	1	2	0	0	0	
Total	117	125	98	88	90	93

DEEPHAVEN	2020	2019	2018	2017	2016	2015
ASD	12	13	18	19	14	12
D-B	0	0	0	0	0	0
DCD-M	0	0	0	0	0	0
DCD-S	0	0	0	0	0	0
DD	0	1	3	0	2	4
EBD	2	4	8	5	7	5
DHH	2	2	2	2	1	1
OHD	3	3	4	2	3	3
PI	3	3	0	0	0	0
SLD	7	10	9	11	5	7
SMI	0	0	0	0	0	0
SPL	41	41	37	35	25	28
TBI	0	0	0	0	0	0
VI	1	0	1	0	0	1
Total	71	77	82	74	57	61

EXCELSIOR	2020	2019	2018	2017	2016	2015
ASD	21	18	23	23	21	23
D-B	0	0	0	0	0	0
DCD-M	5	4	1	1	2	2
DCD-S	2	3	3	4	3	4
DD	6	1	4	6	6	2
EBD	10	8	9	4	2	2
DHH	4	6	6	6	6	5
OHD	6	7	13	7	6	5
PI	4	4	2	1	1	3
SLD	10	14	14	9	9	16
SMI	0	1	1	2	2	2
SPL	46	42	48	47	40	48
TBI	0	0	0	0	0	0
VI	1	1	1	1	1	1
Total	115	109	125	111	99	113

GROVELAND	2020	2019	2018	2017	2016	2015
ASD	7	7	11	9	22	26
D-B	1	1		0	0	0
DCD-M	0	0		0	1	1
DCD-S	0	0	1	1	0	0
DD	6	4	2	2	3	0
EBD	17	14	13	6	7	9
DHH	2	2	3	2	3	3
OHD	16	15	12	11	12	13
PI	1	2	3	3	3	3
SLD	9	9	10	5	5	6
SMI	0	0	1	1	1	2

SPL	57	47	47	38	41	34
TBI	0	0	0	0	0	0
VI	0	0	0	0	0	0
Total	116	101	103	78	98	97

MINNEWASHTA	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
ASD	23	15	15	12	13	15
D-B	0	0	0	0	0	0
DCD-M	0	0	0	0	0	0
DCD-S	0	0	0	0	0	0
DD	8	13	9	1	3	2
EBD	11	10	9	7	5	3
DHH	0	0	1	2	1	1
OHD	14	13	10	7	12	8
PI	2	1	1	1	3	2
SLD	19	18	20	12	16	12
SMI	0	0	0	0	0	0
SPL	35	36	33	32	28	33
TBI	0	0	0	0	0	0
VI	0	0	0	0	0	0
Total	112	106	98	74	81	76

SCENIC HEIGHTS	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
ASD	21	18	15	13	7	5
D-B	0	0	0	0	0	0
DCD-M	0	1	0	0	0	0
DCD-S	0	0	0	0	0	0
DD	1	2	6	2	2	2
EBD	20	17	15	7	7	4
DHH	2	1	1	0	0	0
OHD	15	11	11	3	6	2
PI	2	2	2	1	1	1
SLD	5	6	5	5	6	4
SMI	0	0	0	0	0	0
SPL	32	36	35	33	42	49
TBI	0	0	0	0	0	0
VI	2	2	1	0	0	0
Total	100	96	91	64	71	67

MME	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**

ASD	27	29	23	21	21	28
D-B	0	0	0	0	0	0
DCD-M	0	1	1	3	1	2
DCD-S	1	1	2	2	3	3
DD	0	0	0	0	0	0
EBD	21	16	20	22	16	14
DHH	3	3	1	2	0	0
OHD	29	25	28	24	29	32
PI	2	0	1	1	1	1
SLD	39	34	30	25	24	24
SMI	1	2	2	3	3	1
SPL	20	18	15	12	13	13
TBI	0	0	0	0	0	0
VI	0	0	0	0	0	0
Total	143	129	123	115	111	118

MMW	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
ASD	34	41	40	40	29	28
D-B		0	0	0	0	0
DCD-M	3	2	1	3	2	2
DCD-S	3	5	6	4	2	2
DD		0	0	0		0
EBD	26	24	22	13	8	4
DHH	6	3	2	3	3	3
OHD	37	36	36	32	17	23
PI	1	3	3	3	2	3
SLD	37	32	33	38	36	31
SMI	2	1	1	1	0	2
SPL	9	10	13	6	7	5
TBI	0	0	0	0	0	0
VI	1	1	0	1	1	1
Total	159	158	157	144	107	104

MHS	**2020**	**2019**	**2018**	**2017**	**2016**	**2015***
ASD	63	54	50	57	62	58

D-B	0	0	0	0	0	0
DCD-M	9	9	8	16	19	18
DCD-S	5	6	3	10	11	9
DD	0	0	0	0	0	0
EBD	40	38	27	29	29	32
DHH	3	2	3	2	2	1
OHD	74	83	75	77	81	78
PI	6	4	2	6	9	9
SLD	82	69	66	58	57	65
SMI	6	7	7	7	6	4
SPL	4	2	0	0	0	2
TBI	0	0	1	3	3	3
VI	1	1	1	0	0	0
Total	293	275	243	265	279	279

* inlcudes T plus

MCEC	2020	2019	2018	2017	2016	2015
ASD	9	17	12	5	8	6
D-B	0	0	0	0	0	0
DCD-M	0	0	0	0	0	0
DCD-S	0	0	0	0	0	0
DD	43	49	48	48	38	41
EBD	0	0	0	0	0	1
DHH	3	1	1	1	2	2
OHD	1	2	0	0	0	0
PI	1	2	1	0	0	0
SLD	0	0	0	0	0	0
SMI	0	0	0	0	1	1
SPL	39	26	41	39	39	37
TBI	0	0	0	0	0	0
VI	0	0	3	2	2	2
Total	96	97	106	95	90	90

Appendix 11: The Children's Global Assessment Scale (CGAS)

I would recommend the use of the Children's Global Assessment Scale (CGAS) at the time of a special education evaluation as well as periodically following the evaluation. This is the scale:

100–91 Superior functioning in all areas (at home, at school, and with peers); involved in a wide range of activities and has many interests (e.g., has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc.); likeable, confident; ‘everyday’ worries never get out of hand; doing well in school; no symptoms.

90–81 Good functioning in all areas; secure in family, school, and with peers; there may be transient difficulties and ‘everyday’ worries that occasionally get out of hand (e.g., mild anxiety associated with an important exam, occasional ‘blowups’ with siblings, parents or peers).

80–71 No more than slight impairments in functioning at home, at school, or with peers; some disturbance of behavior or emotional distress may be present in response to life stresses (e.g., parental separations, deaths, birth of a sibling), but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.

70–61 Some difficulty in a single area but generally functioning well (e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky or petty theft; consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behavior; self-doubts); has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.

60–51 Variable functioning with sporadic difficulties or symptoms in several but not all social areas; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.

50–41 Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor to inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.

40–31 Major impairment of functioning in several areas and unable to function in one of these areas i.e., disturbed at home, at school, with peers, or in society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behavior

due to either mood or thought disturbance, suicidal attempts with clear lethal intent; such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).

30–21 Unable to function in almost all areas e.g., stays at home, in ward, or in bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (e.g., sometimes incoherent or inappropriate).

20–11 Needs considerable supervision to prevent hurting others or self (e.g., frequently violent, repeated suicide attempts) or to maintain personal hygiene or gross impairment in all forms of communication, e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.

10–1 Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing, communication, cognition, affect or personal hygiene.

I believe that the use of the CGAF scale would add to special education evaluations and follow-up by providing objective evidence of students' level of functioning. It could help guide decisions regarding level of services, and would also be useful in communicating with treatment providers.

Appendix 12: District Mental Health Supports

STUDENT RESOURCES AND PROGRAMS

STUDENT SUPPORT ACTIVITY	WHO (Students/Grades)	WHEN (How Often)	WHEN (did this start pre or post Goal 1)	NOTES/OUTCOME DATA
ADHD coaching/Lab	All elementary and Middle Schools	Weekly	Pre	All students who attended lab regularly (36 students) were able to discuss how they practice self-advocacy in their school day. During 1st quarter, most students needed some encouragement to ask teachers for additional help or were unaware of what resources they have available, particularly current 6th grade students. Speaking directly to teachers, as well as practicing how to communicate electronically, will give them opportunities for self-reliance and independence that they will need as they move towards high school.
Adoption Group				
Anti-bullying curriculum	Elementary	Monthly	Pre	
Anxiety Group	Elementary/Middle	Weekly	Pre	
Chemical health specialist	MHS	As needed		Students are typically referred by administration, counselors, social workers, parents and self. Students with campus violations follow building regulations and receive support and education or refer for agency intervention and family support. Individual and support group options are available to students. The desired outcome is for no

				subsequent violations and an increase in healthy decision-making.
Emotional Regulation Group	All elementary	1x/wk. for 8 weeks	Started Pre; expanded to all buildings post	Student referred based on teacher observation, universal screening, and progress monitoring data
Empower U	High School, 14-18 yrs., 22 seats	Semester course	Same Time	See attached
Exercise Intervention	MWA	30 2x/wk.	Pre	Data reflect increased student engagement and decreased disruptive behavior following group
Family Change Group	Elementary/Middle	Weekly	Pre	
Growing through Grief	All levels	Weekly	Pre	
IM4 education	Students referred to SST K-5	Pilot	Post	This platform was piloted with a handful of students at GRV this year. It seems to have promising utility for matching student needs to SRB Interventions, but was challenging to implement more broadly with other big initiatives being implemented concurrently.
Make it Okay	For adults training	Offered in school and community 2 times	Same Time	Post Survey data encouraged offering this for community partners, and we did
Men and Women of Color Groups	MHS	Weekly		
Mental Health Resource Fair	District wide	Annually	Pre	
New Student Group	Elementary	As needed	Pre	

Primary Project	SHE, CS, kinder-2nd grade students	Weekly for 12 weeks	Pre	Primary Project evaluations from 2018-2019 indicate that 92% of the teachers thought their student benefitted from the program. 80% thought self-confidence improved for the students involved in the program, 74% thought there was improvement in school adjustment, and 97% said their student's social skills improved. 100% of the teachers said they wanted Primary Project to continue as a pre-referral intervention for their students. Additionally, 100% of parents reported that their child enjoys Primary Project. The students often know which day of the week is "their day" for this pull out.
Relaxation Group	MWA, EXC	30 min/wk.	Post	Data reflect positive outcomes
Resource Map	E - 12 grade programs/resources	Yearly	Same Time	Utilization evidence that many visit this website (have actual data) and use for resources/who to call
Responsive Classroom	All elementary	Embedded in schedule	Pre	School wide SEL curriculum
SEL small skills groups (SAEBRS)				
Self-Regulation Group	All elementary	1x/wk. for 6 weeks	Started pre-expanded to all buildings post	Student referred based on teacher observation, universal screening, and progress monitoring data
Social Skills Group	All elementary	1x/wk. for 8 weeks	Started Pre; expanded to all buildings post	Student referred based on teacher observation, universal screening, and progress monitoring data
Suicide awareness				

and prevention				
Well -being Guide			Post	
Well-being website				
Who are your people?				
Winning Team/Goal Getters	SHE, other elementary	Daily	Pre	
Youth Mental Health First Aid	Multi-disciplinary staff, nurses 8-hours			Surveys indicate positive feedback and expansion of knowledge

Bullying Curriculum:

Minnetonka students, staff and teachers work hard to promote positive social and academic environments in each of our schools. Routine monitoring has consistently shown that Minnetonka schools provide the culture of caring and respect that is essential to student success. In order to help maintain that environment, Minnetonka elementary schools adopted the Olweus Bullying Prevention Program® in 2010. Used worldwide, the Olweus (pronounced ol-va-us) program addresses bullying school-wide and gives children and adults a common language designed to improve peer relations and make schools safer, more positive places for students to learn and develop.

The Olweus Bullying Prevention Program is designed to improve peer relations and make schools safer, more positive places for students to learn and develop. Goals of the program include:

- reducing existing bullying problems among students
- preventing the development of new bullying problems
- achieving better peer relations at school

IM4 Intervention Matching Tool:

provides a much-needed solution to improve intervention programming for students who exhibit social, emotional, and behavioral challenges that serve as barriers to learning. IM4 simplifies intervention programming by coordinating the process from beginning to end: Match, Map, Monitor, and Meet.

The IM4 system has many ready-to-go interventions based on whether the student's main problems of concern are due to a performance-deficit (won't do or lack of will) and acquisition-deficit (can't do or lack of skill). Each intervention is coupled with an automated implementation-facilitation function, such as a step-by-step outline of the active ingredients, customizability progress monitoring tool that can be tailored case-by-case, and fidelity checklist to track the degree to which the intervention is delivered as planned. Also, there is a function to add Ad Hoc interventions and simply use the IM4 as

an automated implementation aid to do planning, PM, graphing, fidelity check and decision making.

EmpowerU

The EmpowerU program provides an online learning experience with embedded daily coaching to help students build resilience and improve their mental health. It is an adjunct to the students' education program at school, and students gain credit for their work with the program.

Students who have evidence of anxiety, depression and/or negative self-esteem are candidates for the program.

EmpowerU is a Tier 2 mental health intervention. It does not provide mental health treatment, but students who are in their program may also be receiving treatment with mental health professionals.

Students sign onto the EmpowerU portal for 20- 30 minutes each school day and complete one lesson. Each lesson builds upon prior content to create momentum. Students apply learning to their own goals and become active participants in building their resilience, while earning needed credit.

EmpowerU instructors build a personal relationship with each student, providing daily online feedback, customized to each student's individual goals. At the end of each of the six units, instructors help the student with deeper reflection and goal setting. They send weekly updates to school on student progress.

EmpowerU teaches the core competencies of social emotional learning.

Programming is divided into units:

Unit 1: My Unique Self - Strengths, Values and Learning Where I Want to Make Change
Unit 2: Learning How to Make Effective Personal Change
Unit 3: The Power of Thoughts - Cultivating our Inner coach.
Unit 4: Coping with Stress & Anxiety in a Healthy Way
Unit 5: Creating Connections and Meaningful Friendships
Unit 6: Developing Life Balance and Wellness
and achieving well-being.

18 Minnetonka students completed the program and the 2018/19 year, and 26 students are expected to complete the 2019/20 school year. Completion rates for activated students are over 90% for intervention start to finish – and expected to stay close to that level. 100% of students made personal growth on their specific goals in each unit.

Make It OK is a resource campaign and toolkit to support our District and Community with presentations and materials – all school teams have had access to these materials.

- This toolkit and the material contained in it are made available to you free of charge by HealthPartners, Inc. Make It OK campaign.
- Materials on this website are for educational and non-commercial use to promote the message of this campaign.
- Materials may be formatted to fit your organization's campaign, but must not be changed in any way that diminishes or negatively alters existing Make It Ok messaging.

- If modifications are made to co-brand Make It OK materials the following statement must be included in your modification: ***The Make It OK campaign is made possible by HealthPartners, Inc.***

This Well-Being website:
This was created for our parents and school community as a tool to provide information and connections in the area of student academic, social, emotional and behavioral well-being. The following resources give an overview of student well-being and outline our school processes for accessing supports within the district and from the wide variety of community agencies out there which can provide additional supports.

Resource Map for Student Support and Well-Being:
This was a coordination and inventory of resources around responsive education and student well-being supports within and outside the community. We put together a "resource map" of program and people resources and assets within the school, district and community that can be mobilized to facilitate student success. Resource mapping is a strategic process with maps continually updated as new resources are identified, acquired or developed.

Youth Mental Health First Aid:
This 8-hour course is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. Youth Mental Health First Aid is primarily designed for adults who regularly interact with young people. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders.

Responsive Classroom:
This is an evidence-based approach to teaching and discipline that focuses on engaging academics, positive community, effective management, and developmental awareness. Our professional development, books and resources help elementary and middle school educators to create safe, joyful, and engaging classrooms and school communities where students develop strong social and academic skills and every student can thrive. All Minnetonka teachers receive this training.

Growing through Grief:

The grief support programming is available to all students in the Minnetonka School District. The students and families are made aware of the program through school support staff and opportunities such as mental health fairs or open house events. 100 percent of GTG students would be willing to refer a friend or family member to the program which another way students become aware of the opportunity. It is also one of our best measures of quality programming when students are willing to refer a friend or family member. Having services embedded right into the school environment promotes a barrier free program addressing concerns with cost (free to students and families), access and stigma.

Project Play is a data driven program designed to promote school adjustment in students' grades kindergarten through second grade. Increased open enrollment in each of our buildings has created an increase in the number of students with school adjustment issues: separation anxiety, emotional dysregulation, difficulty attending to academic tasks, and inadequate social skills. Any of these factors are barriers to school success. Students and their families are entering a new setting without the support of the neighborhood community. Students meet 30 minutes per week with a trained child associate over 12 weeks. Post-data collected from teacher ratings and parent feedback support that this intervention increases student's confidence and school adjustment, time on task and improved social skills. Site supervisors and child associates for Project Play are available to conference with parents at the termination of the intervention. This is an opportunity for support staff to initiate an on-going relationship with families.

The ADHD Mentorship Program is a school based early intervention seeking to enhance learning and strategy skills for 5th grade students with an ADHD diagnosis. This program addresses the well-being of children and their families by partnering with classroom teachers, parents and students to increase student success. Fifth grade students that participate in this program often do not qualify for more intense school programs but have identified at-risk factors for school success.

The Minnetonka Middle Schools ADHD Learning Lab offers support for all students and families within our program. We have an open communication with families, counselors, social workers and administration. Staff also participate in Staff Development programs focusing on the efforts of ACEs and how to best connect with students with High ACEs. Middle Schools also offer parent talks to help ease some of the everyday questions and struggles with ACEs and educational challenges. With being able to offer these services at an earlier age, we can support and education students with ACEs with strategies and programs and mental wellbeing opportunities. Minnetonka Middle Schools support students in grades 6-8, who have a medical diagnosis of ADHD by offering the ADHD Learning Lab program 2 days a week. Students are also provided ADHD education, executive functioning strategies, and academic support to learners with attention-deficit/hyperactivity disorder.

The Child Family Support Program (CFSP) program provides early prevention and intervention services for children experiencing social-emotional and behavioral challenges within the context of the child's family, early childhood settings and community. By providing individual support, parent education, timely referrals to mental & physical health services, service coordination and staff training the CFSP program effectively improves the mental health of young children and strengthens the capacity of families to support their child's healthy development and school success.

Families with young children birth to kindergarten living within the geographic boundaries of the Minnetonka Public School District can access an array of CFSP supportive services that best suits the needs of their child and family. This program provides services to children and their families ages birth to kindergarten who present social-emotional and/or behavioral challenges within their home or early childhood setting. Families can access individualized parent education, support and referral services as well as child specific classroom intervention, strategies and support.

Relate mental and chemical health programs will meet the needs of Minnetonka children and youth by providing:

· Licensed chemical health staff at Minnetonka High School which covers a total of 760 hours for the school year (20 hours per week/.5 FTE)

· Onsite early childhood services which cover a total of 532 hours for the school year (4 hours per week/.35 FTE)

· Onsite, licensed mental health clinicians at Minnetonka schools including 1.3 FTE at the elementary level, .4 FTE at the middle school level, and 1.0 FTE at the high school level. This equates to over 4,000 hours of mental health care for Minnetonka Schools during the school year.

Relate clinicians will also provide ongoing resources to school teachers, staff, and parents. Members of Relate's Minnetonka Mental Health team provide information to all program staff in the district. Community-wide collaboration is also conducted between Relate, MHS staff, community members/organizations, and the Tonka Cares coalition. Further visibility is provided through the use of monitors at the Minnetonka Community Education Center that highlight information regarding mental health and also display contact information for mental health professionals.

Appendix 13: Minnetonka High School Support Staff Ratios

Minnetonka High School
Student Support Services

In order to support the whole student, at MHS we utilize the following resources:

1) **9 full-time counselors** divided alphabetically. This breakdown brings our ratio to 1:376 students. For the 2020-2021 school year (or sooner), we will move to 10 counselors. [We currently have one counselor on leave and his return date is unknown. We hired his replacement for the entire year. When he returns, we will have 10 counselors and this will bring our ratio to 1:340.]
2) **1 full-time college counselor**. We have one full-time college counselor, Phil Trout, who works with all students in their post-secondary planning.
3) **1 full-time 504 counselor** and academic support coach. We have a full-time 504 coordinator and academic support coach, Shelly Hughes. She is a licensed school counselor with nearly 20 years of experience.
    a. In neighboring schools, 504 work is done by regular counselors and the "504 counselor position" does not exist. By structuring the position in the way we do, we ensure consistency in our 504 practices, and this additional work is not on the counselors' portfolios of assignments.
4) **2 full-time social workers**: We have two social workers, one of which works with students who receive special education services.
5) **Laura Herbst,** a licensed school counselor, works with our advanced learners and provides academic counseling.
6) 1 full-time school psychologist. Jonna Hirsch
7) **1 full-time support staff** for the Compass program. Licensed teacher Renee Morabito, our support staff for Compass, is dedicated to supporting the students in the Compass program. This program is for our highest at-risk students and provides significant support to the students while they take general level academic courses. **The role is at a 1:50 ratio for support.**
8) **Chemical Health Counselor.** Judy Hanson, our chemical health counselor, works with students facing chemical health issues and is at MHS 2 days per week
9) **Co-located Relate Counseling**. We have a .6 person, Emily Neighbors, from Relate here at .6 position.
10) All counselors lead support groups, and MHS has outside resources.

High School Comparison Data

High School	# of counselors	Ratio for student population	# of College Counselors (not included in the ratios in column 2)	# of 504 counselor	# of Social Workers	# Psychologists
Hopkins	7	1:235	0	0	2	1
Eden Prairie	8	1:375	1 (half time/non-licensed)	0	2	1
Edina	8	1:340	1	0	?	?
Wayzata	12	1:308 (they are staffed for 4200 students: 1: 350)	0	0	4 (staffed for 4200)	1 (Sped evals only)
Buffalo HS	4	1: 473	0	0	2	1
St Michael Albertville	4	1:550	0	0	2	1
Orono	3	1:316	0	0	.5	.5
Mound West Tonka	3	1:341	0	0	0	0
Chanhassen HS	4	1: 408	0	0		
Minnetonka High School	9	1:376 --------- **1: 340** *including 504 counselor)***	1	1	2	1

A few additional notes about MHS counseling ratios:

1. If we compare apples to apples to all other districts, our counselor ratio is 1:340 including the 504 counselor in the calculation. This person is a licensed counseling position. If we include the college counselor, the ratio is 1:309.
2. We are adding a 10th counselor this year, or, at the latest, in the fall of 2020. In doing so, our ratio will go to 1:340 or, if including the 504 counselor, 1:309. (This does not include the college counselor). If we include the college counselor, the ratio goes to 1: 283.
3. Neither the Advanced Learning Coordinator (a licensed counselor) or the Compass coordinator, who both serve students, are in the calculation.
4.

Appendix 14: Student Support Services Staffing- Historical Data: 2015-2020

CLEAR SPRINGS	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
TOTAL ENROLLMENT	**881**	**876**	**863**	**842**	**812**	**794**
Special Education enrollment	117	125	100	88	87	93
SOC. WORKERS (SPEC ED)	0.6	0.6	0.6	0.6	0.6	0.6
SOC. WORKERS (GEN ED)	0.4	0.4	0.4	0.4	0.4	0.4
PSYCHOLOGIST	0.45	0.45	0.45	0.4	0.4	0.4
SCHOOL COUNSELOR	0	0	0	0	0	0
NURSES	0.85	0.85	0.85	0.85	0.85	0.85
# BEHAVIOR STRATEGIST	0	0.11	0.11	0.13	0	0
***ASD CONSULTANT	0	0	0	0	0.2	0.2
TOTAL FTE	**2.3**	**2.41**	**2.41**	**2.38**	**2.45**	**2.45**
STUDENTS PER STAFF RATIO	*383.0*	*363.5*	*358.1*	*353.8*	*331.4*	*324.1*

DEEPHAVEN	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
TOTAL ENROLLMENT	**648**	**662**	**668**	**668**	**651**	**667**
Special Education Enrollment	71	77	83	74	57	61
SOC. WORKERS (SPEC ED)	0.5	0.5	0.5	0.5	1	1
SOC. WORKERS (GEN ED)	0	0	0	0	0	0
PSYCHOLOGIST	.2/.1 CEIS	0.2	0.3	0.3	0.3	0.33
SCHOOL COUNSELOR	0.5	0.5	0.5	0.25	0	0
NURSES	0.7	0.5	0.5	0.5	0.5	0.5
# BEHAVIOR STRATEGIST	0	0.11	0.11	0.13	0	0
***ASD CONSULTANT	0	0	0	0	0.2	0.2
TOTAL FTE	**2**	**1.81**	**1.91**	**1.68**	**2**	**2.03**
STUDENTS PER STAFF RATIO	*324*	*365.7*	*349.7*	*397.6*	*325.5*	*328.6*

EXCELSIOR	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
TOTAL ENROLLMENT	**814**	**806**	**809**	**801**	**757**	**746**
Special Education Enrollment	115	109	125	111	99	113
SOC. WORKERS (SPEC ED)	0.5	0.5	0.5	0.5	0.5	1
SOC. WORKERS (GEN ED)	0	0	0	0	0	0
PSYCHOLOGIST	0.4	0.4	0.5	0.4	0.4	0.34

SCHOOL COUNSELOR	1	1	0.5	0.25	0	0
NURSES	0.85	0.85	0.85	0.85	0.85	0.85
# BEHAVIOR STRATEGIST	0	0.11	0.11	0.13	0	0
***ASD CONSULTANT	0	0	0	0	0.2	0.2
TOTAL FTE	**2.75**	**2.86**	**2.46**	**2.13**	**1.95**	**2.39**
STUDENTS PER STAFF RATIO	*296*	*281.8*	*328.9*	*376.1*	*388.2*	*312.1*
GROVELAND	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
TOTAL ENROLLMENT	**897**	**865**	**850**	**844**	**822**	**784**
Special Education Enrollment	115	101	103	78	98	97
SOC. WORKERS (SPEC ED)	0.5	0.5	0.5	0.5	1	1
SOC. WORKERS (GEN ED)	0.5	0.5	0.5	0	0	0
PSYCHOLOGIST	.5/.2 CEIS	.3/.2 CEIS	.3/.1 CEIS	.3/.2 CEIS	0.3	0.33
SCHOOL COUNSELOR	0	0	0	0.25	0	0
NURSES	0.75	0.75	0.75	0.75	0.75	0.75
# BEHAVIOR STRATEGIST	0	0.11	0.11	0.13	0	0
***ASD CONSULTANT	0	0	0	0	0.25	0.25
TOTAL FTE	**2.45**	**2.36**	**2.26**	**2.03**	**2.3**	**2.33**
STUDENTS PER STAFF RATIO	*366.1*	*366.5*	*376.1*	*415.8*	*357.4*	*336.5*
MINNEWASHTA	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
TOTAL ENROLLMENT	**946**	**929**	**896**	**886**	**857**	**839**
Special Education Enrollment	112	106	98	74	81	76
SOC. WORKERS (SPEC ED)	0.5	0.5	0.5	0.5	0.5	0.5
SOC. WORKERS (GEN ED)	0	0	0	0	0	0
PSYCHOLOGIST	0.4	0.4	0.7	0.4	0.4	0.33
SCHOOL COUNSELOR	1.1	0.6	0.5	0.5	0.5	0.5
NURSES	0.75	0.75	0.75	0.75	0.75	0.75
# BEHAVIOR STRATEGIST	0	0.11	0.11	0.13	0	0
***ASD CONSULTANT	0	0	0	0	0.2	0.2
TOTAL FTE	**2.75**	**2.36**	**2.56**	**2.28**	**2.35**	**2.28**
STUDENTS PER STAFF RATIO	344.0	393.6	350.0	388.6	364.7	368.0
SCENIC HEIGHTS	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
TOTAL ENROLLMENT	**905**	**878**	**879**	**864**	**840**	**800**
Special Education Enrollment	100	96	91	64	71	67

SOC. WORKERS (SPEC ED)	0.8	0.8	0.9	0.5	1	1
SOC. WORKERS (GEN ED)	0.2	0.2	0.1			
PSYCHOLOGIST	0.3	0.3	0.3	0.3	0.3	0.33
SCHOOL COUNSELOR	1	1	1	0.25	0	0
NURSES	0.75	0.75	0.75	0.55	0.55	0.55
# BEHAVIOR STRATEGIST	0	0.11	0.11	0.13	0	0
***ASD CONSULTANT	0	0	0	0	0.075	0.075
TOTAL FTE	**3.05**	**3.16**	**3.16**	**1.73**	**1.925**	**1.955**
STUDENTS PER STAFF RATIO	*296.7*	*277.8*	*278.2*	*499.4*	*436.4*	*409.2*
MME	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
TOTAL ENROLLMENT	**1322**	**1306**	**1275**	**1259**	**1231**	**1200**
Special Education Enrollment	143	129	123	115	111	118
SOC. WORKERS (SPEC ED)	0.8	0.8	0.7	0.6	0.75	0.5
SOC. WORKERS (GEN ED)	0	0	0	0	0	0
PSYCHOLOGIST	0.6	0.6		0.5	0.5	0.34
SCHOOL COUNSELOR	3.4	3.4	3.4	3.4	3	3
NURSES	0.8	0.8	0.8	0.8	0.8	0.8
# BEHAVIOR STRATEGIST	0	0.11	0.11	0.3	0	0
***ASD CONSULTANT	0	0	0	0	0.225	0.225
TOTAL FTE	**5.6**	**5.71**	**5.01**	**5.6**	**5.275**	**4.865**
STUDENTS PER STAFF RATIO	236.1	228.7	254.5	224.8	233.4	246.7
MMW	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
TOTAL ENROLLMENT	**1250**	**1266**	**1227**	**1167**	**1075**	**1040**
Special Education Enrollment	159	158	157	144	107	104
SOC. WORKERS (SPEC ED)	1	1	0.6	0.5	0.75	0.5
SOC. WORKERS (GEN ED)	0	0	0	0	0	0
PSYCHOLOGIST	0.55	0.7	0.5	0.5	0.5	0.6
SCHOOL COUNSELOR	3.5	3	3	3	3	3
NURSES	0.9	0.9	0.9	0.9	0.9	0.9
# BEHAVIOR STRATEGIST	0	0.11	0.11	0.3	0	0
***ASD CONSULTANT	0	0	0	0	0.3	0.3
TOTAL FTE	**5.95**	**5.71**	**5.11**	**5.2**	**5.45**	**5.3**
STUDENTS PER STAFF RATIO	210.1	221.7	240.1	224.4	197.2	196.2

MHS	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
TOTAL ENROLLMENT	**3394**	**3297**	**3276**	**3120**	**3068**	**2987**
Special Education Enrollment	293	275	243	265	279	279
SOC. WORKERS (SPEC ED)	1	1	1	1	1	1
SOC. WORKERS (GEN ED)	1	1	1	1	1	1
PSYCHOLOGIST	0.95	0.9	0.9	0.85	0.85	0.65
SCHOOL COUNSELOR	10	9	10	9	8	8
NURSES	1.1	1.1	1.1	1.1	1.1	1.1
# BEHAVIOR STRATEGIST	0	0.11	0.11	0.3	0	0
***ASD CONSULTANT	0	0	0	0	0.55	0.55
TOTAL FTE	**14.05**	**13.11**	**14.11**	**13.25**	**12.5**	**12.3**
STUDENTS PER STAFF RATIO	*241.6*	*251.5*	*232.2*	*235.5*	*245.4*	*242.8*
DISTRICT WIDE**	**2020**	**2019**	**2018**	**2017**	**2016**	**2015**
TOTAL ENROLLMENT	**11,057**	**10,885**	**10,743**	**10,451**	**10,113**	**9857**
Special Education Enrollment	1376	1303	1255	1080	1083	1102
SOC. WORKERS (SPEC ED)	6.2	6.2	5.8	5.2	7.1	7.5
SOC. WORKERS (GEN ED)	2.1	2.1	2	1.4	0	0
PSYCHOLOGIST	6.5 (1.15 VACANT)	5.1	4.7	4.1	4.1	3.7
SCHOOL COUNSELOR	21.2	18.7	19.2	17.2	14.8	14.8
NURSES (inludes T Plus)	8.45*	8.7	8.7	8.5	8.5	7.9
# BEHAVIOR STRATEGIST	1.0 (VACANT)	1.8	1	1.8	0	0
***ASD CONSULTANT	0	0	0	0	2.2	2.2
TOTAL FTE	**44.35 (filled FTE)**	**42.6**	**41.4**	**38.2**	**36.7**	**36.1**
STUDENTS PER STAFF RATIO	*249.3*	*255.5*	*259.5*	*273.6*	*275.6*	*273.0*
if fully staffed and .8 nursing added	233.8					

* DIST NURSE PULLED OUT OF FTE .8

** INCLUDES MCEC AND T PLUS

*** BEHAVIOR STRATEGIST WAS CALLED ASD CONSULTANT 2014-2016

#BEHAVIOR STRATEGIST BECAME DISTRICT WIDE POSITION,

NOT ALLOCATED FTE PER BUILDING (AVERAGE WAS ADDED TO EACH BUILIDNGS TOTALS)

Appendix 15: Co-Located Mental Health Services: Other Districts

School District	Total Enroll-ment	Agencies providing Co-located Services	FTE of Clinicians	Distribution of Clinicians	Funding Sources	Total Cost per FTE
Buffalo-Hanover-Montrose	5,496	Central MN Mental Health Center	2		Private Insurance, DHS SLMH	$54,000
Edina	8,500	Fraser Relate	6.5	.6 FTE per Elem .5 FTE per Middle 1. FTE HS .4 FTE Chem. Health-HS	Private Insurance, LCTS, LEA funds	
Elk River	14,000	Bridging Hope Rogers Therapy Central MN Mental Health Center Greater MN Family Services Parasol Wellness, Lutheran Social Services	14	1.0 FTE per building	LCTS, DHS SLMH, LEA	$7,000
Mounds View	12,000	North East Youth Services Natalis Counseling CLUES Family Innovations			LEA, LCTS, DHS SLMH,	
Orono	2,850	Relate	1.8			
Osseo	20,369	Peoples Inc. St. David's Lee Carlson	17	.4-1.4 FTE per Elem .5-1.0 FTE per Middle 1.0 FTE per HS	DHS SLMH, Private Insurance, LEA	$35,000- $40,000
Wayzata	12,000	Relate Washburn	7	flex, based on need	DHS SLMH, LCTS, Private Insurance	$20,000

Appendix 16: Creating a School District Mental Health Plan that Meets the Needs of Students who have Psychiatric Disorders

School districts often have medical plans- E.g., protocols for addressing chronic medical illnesses such as diabetes, asthma or infectious disease. They tend to not have mental health plans for working with students who have mood disorders, anxiety disorders, ADHD, etc. Given the nature and extent of mental health disorders experienced by students, and the effect that these have on their education, a mental health plan makes sense.

Because of the huge variability of school district resources, staff skill sets, community resources, student populations, etc., mental health plans need to be tailored to each district, sometimes to each school.

Essential Components of a School District Mental Health Plan

Roles and Responsibilities

The first component is the need to clarify the roles and responsibilities of staff who work with students who have mental health disorders.

Who works, directly or indirectly with students who has a mental health disorder? Teacher, school psychologist, school counselor, school social worker, school nurse, principal, dean, and, if the student is in special education: special education teacher/case manager and special education director.

Clarifying roles and responsibilities helps to address the problem of overlap in some areas and gaps in others.

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?

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

Examples of mental health activities provided by school employees
-Participating in the educational assessment process
-Performing and interpreting mental health screening as part of educational evaluations
-Psychometric testing
-Conducting functional behavioral assessments
-Identifying evidence of chemical health problems

-Clarifying appropriate interventions based on information obtained during mental health screening
-Participating in teams (teacher assistance teams, IEP teams, etc.)
-Assisting in the development of Individual Educational Programs for students with disabilities
-Identifying appropriate accommodations and modifications, based on students' emotional and behavioral difficulties
-Communicating with the students' parents on a regular basis about both problems and successes in schools
-Providing individual and group counseling
-Providing skills training
-Providing crisis intervention, or working with County crisis teams when they provide crisis intervention services
-Providing in-service presentations to school staff about mental health issues
-Serving as a resource to building staff regarding identifying and reporting child abuse and neglect
-Facilitating due process procedures
-Administering medication
-Collecting, analyzing and interpreting data to support school-based decisions
-Teaching, monitoring and planning interventions for increased achievement of all students
-Teaching student lessons that are designed to improve knowledge and skills in career, academic, personal and social development
-Individual student planning- goals, careers, transition to post-secondary options, etc.
-Assisting school staff in problem solving re: cultural competence, PBIS, due process, etc.
-Working with medical and mental health, correctional and social service professionals in the community
-Gathering mental health information, with parent permission, from treating professionals in the community
-Reviewing the information obtained, and translating it into educational terms for educational staff
-Assisting educational staff in monitoring target symptoms of students' mental health disorders
-Documenting the nature, frequency and severity of the target behaviors
-Communicating with community professionals about students' symptoms at the time of their mental health evaluations, and subsequently, during treatment
-Coordinating activities with County and community agencies
-Case management (coordinating services with community mental health professionals, assisting families in obtaining services, etc.)
-Consultation with educational staff
-Making referrals to community resources for students and families
-Coordinating on-site, co-located mental health services provided by community mental health staff

By identifying activities that need to be done, and identifying the specific skill sets of school professionals, it is possible to maximize the impact of these professionals. For example, only nursing staff can distribute medication and only school psychologists and do psychometric testing. On the other hand, many types of school professionals (school social workers, counselors, psychologists, teachers, etc.) can provide skills training. Understanding staff skill sets and prioritizing activities that need to be done will result in more effective and efficient mental health related activities.

Supervision
The supervisor may have no background in the work that the supervisee does (e.g., a special education director supervising a school social worker). This can result in minimal or no supervision of mental health related activities.

Supervision is essential and needs to address the following:
What are staff doing?
How many hours/week for each activity?
How are they prioritizing their activities?
How are students identified to receive services?
What determines the duration of services?
What is documented in contacts with students?
What is the outcome of activities?

Pre-referral Interventions
E.g., is the student taking medication for a disorder that has the symptoms that are resulting in consideration of a special education evaluation?
Has a release of information been obtained to allow communication with the student's physician?

Educational planning
-Best practices for conducting team meetings regarding students who have mental health problems
-Methods of providing educational evaluations of students who have mental health disorders
-Has mental health or substance use screening been done as part of the educational assessment?
-Has a functional behavioral assessment been done? Does it acknowledge that intrinsic factors may be driving the student's behavior?

Clarification of behavioral vs. clinical contributors to the student's school difficulties

Use of the Clinical-Behavioral Spectrum concept (See Dikel and Ostrom, http://www.williamdikel.com/the-behavioralclinical-spectrum.html)

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

Designing accommodations and modifications based on the symptoms of a student's mental health disability

Crisis Intervention
How are crises (e.g., a student making a suicide threat) to be assessed?
How does the district clarify staff roles and responsibilities regarding crisis intervention?
-School district social worker
-County crisis team
-Law enforcement
-Co-located mental health professional

Mental Health Data Practices
Clarification of how mental health data should be handled
-Desk drawer rule
-Information from medical and mental health providers
-Notes from school employees who are counseling students
-Treatment notes from school employees, if the district adopts a model of school-hired therapists (bad idea)
-Assurance that district data practices are following requirements of HIPAA, FERPA and State data practices

Gathering and Analysis of Individual and Group Mental Health Data
Gathering information that documents the nature of a student's mental health diagnosis, changes in symptoms in response to treatment, outcome data, etc.

Documentation of activities
It is often the case that activities go undocumented, or have inadequate documentation. This is very problematic in some situations- e.g. a potentially suicidal student who regularly sees a school social worker for counseling.

Documentation of counselors', psychologists' and social workers' records, of progress/change of behaviors, assuring appropriate data management/privacy, requesting, reviewing, interpreting and documenting mental health information

Protocols and checklists
It is helpful to create specific protocols and checklists that assure that services have been provided and to assure staff accountability.

Symptom monitoring and communication of behavioral observations to parents and medical/mental health providers
School files tend to not reflect clinically useful information. Even when a student has OHI special education services for ADHD, the educational record may not reflect the nature and severity of symptoms over time, how they change in response to medication changes, etc.
Data regarding students' performance at school it's very useful to treating professionals in making diagnoses pending monitoring treatment. Ideally, this information should be

provided directly from school staff with a release of information signed by the student's parent.

Provision of Direct Services to Students
Direct service: E.g.: crisis intervention, individual and group counseling, skills training

Treatment: A clinical service that is focused on reducing or eliminating the symptoms of a disorder. In mental health, this may include psychotherapy and/or medication treatment

Counseling: The provision of information, assistance and guidance

Skills Training: Teaching skills to help an individual who has skills deficits (e.g., social skills, organizational skills, etc.)

How are students prioritized for direct services? Who is seen? For how long?
Individual vs. group sessions? Skills training? Therapy? When are these services no longer required? How is outcome determined?

Adopting evidence-based teaching methods for students who have emotional/behavioral problems
Proactive Classroom Management techniques (PCM), Clear Rules/Expectations (CRE), Crisis Intervention Planning (CIP), Academic supports and curricular/instructional modifications (CIM), Systemic approach to cooperative learning (CL), Specialized instruction to promote learning and study skills, Peer-Assisted Learning Strategies (PALS), Peer-mediated intervention to promote positive behavioral skills (PMI), A conflict resolution program (CRP), Social skills instruction taught as part of regular classroom instruction (SSI), Anger management program (AMP), A behavior support/management plan (BSM), Pre-correction instructional strategies (PCIS), Group-oriented contingency management (GOCM), Choice-making opportunities for students, Instruction in self-monitoring of student performance (SMSP), A system of positive behavioral intervention and support, The use of peer reinforcement to promote appropriate student behavior (PR), Instruction in self-monitoring of non-academic behaviors (SMAB), Behavior contracts (BC), A formal procedure for developing function-based interventions (FBA)

Creating partnerships with community providers, including the establishment of co-located mental health services

Maximizing reimbursement to assure program sustainability
Assuring that services do not rely on time limited grants, identifying sources of income, consideration of Medicaid billing etc.

Coordinating with County resources
Working with County professionals: crisis, truancy, children's mental health, child protection, juvenile probation, public health, developmental disabilities

Mental health training

For educational staff, administrators, mental health staff, nurses, student health curriculum

Use of mental health consultation
Psychiatric consultation regarding medical and medication issues, diagnostic issues, etc.
Behavior analyst for clarification of behavioral intervention plan

Outcome assessment
Have interventions been successful? What does the behavioral data indicate? The academic data? If outcomes are negative, what interventions will be altered?

Summary:
A well-constructed school district mental health plan results in improved services for students and in improved academic performance, reduced behavioral incidents and cost savings for the district.

Appendix 17: Staff Interviewed for this Report

Dennis Peterson, Superintendent
Michelle Ferris, Executive Director of Student Support Services

Paula Hoff, Principal-Middle School West
Pete Dymit, Principal-Middle School East
Cari Lindberg, Minnetonka Family Collaborative

Special Ed Directors:
Christine Breen, MHS, Scenic Heights, Excelsior
Kristin Laughlin, Minnewashta, Clear Springs, Groveland, TPLUS
Mandy Kasowicz (via phone), MME, MMW, Deephaven

David Senior, Director of Relate Counseling
Robin Riggs, Relate Counseling staff

School Social Workers:
Aubrie Roley, MHS
Kathleen Leisman, MHS
Amy Horning, CS
Elizabeth Warden, SH
Donna Dahl, GRV
Katie Klemme, MME
Jessica Thull, DH and EX

School Psychologists:
Jonna Hirsch, MHS
Sarah Dittberner MME, EXC
Talia Lehmann, MMW, CS
Natalie Hanson, DH, SH, MCEC
Mandy Mattke, MWA

Teaching & Learning Department:
Steve Urbanski-Director of Curriculum
Sara White: Director of Staff Development and Q Comp;
Diane Rundquist: Director of Advanced Learning

ASD teachers:
Anne Schulenberg, MHS
Reilly Woodruff, MMW

Minnetonka High School Administrators:
Jeff Erickson, Principal

Ann Hanstad, Assistant Principal
Freya Schirmacher, Assistant Principal
Nate Gibbs, Assistant Principal
Josh Stephan, Dean of Students

MHS Counselors:
Brad Burnham
Jennifer Stout
Theresa Exenberger
Conor Maher
Stephanie McClendon
Christina Taylor
Amanda Warvin
Kendra Olson
Dave Bierly

Shelly Hughes, 504 Coordinator

Health Educators:
Maggie Dow, MHS Health Educator
Jen Syverson, Middle School Health Educator

Nurses:
Sue Rockers LSN, Scenic Heights
Annie Lumbar Bendson, Coordinator Health Services
Rachel Snyder-LSN, MMW

K-8 Counselors:
Howe Siegel, Deephaven and Scenic Heights
Lindsay Stashek, MME
Dawn Brueshoff, MME
Paula Erbisch, MMW
Courtney Davis, Scenic Heights
Laura Rosati, MMW

Elementary Principals:
Stacy Decorsey, Excelsior
Curt Carpenter, Clear Springs
Joe Walker, Scenic Heights
Cindy Andress, Minnewashta
Bryan McGinely, Deephaven
Andrew Gilbertson-Groveland

EBD Teachers:
Keely Pullman, Scenic Height
Jani Pankoff, MHS

Dave Olmstead, MHS

Matt Rega, Director of Assessment
Matt Breen, Vantage and Math Teacher
Judy Hanson, Relate Chemical Health Counselor, and Tonka Cares Coordinator

Early Childhood:
Sally Blad, Early childhood Education Coordinator
Angela Kleinedler, Early Childhood Special Ed Coordinator

Special Ed Facilitators;
Erin Osgood, MMW and DH
Kris Pakkala, MHS
Laurie Harkness, MME and GRV
Diane Sleeman, CS, EXC