

Extending School-Based Mental Health: A Collaborative Public Health Model

Katherine Halley, Ph.D.

Psychologist

Madison Metropolitan School District

Scott Strong

Executive Director

Community Partnerships

LA Unified School District and Mental Health

- http://notebook.lausd.net/portal/page?_page_id=33,922882&_dad=ptl&_schema=PTL_EP

LA Unified School District and Mental Health

- Video
- http://notebook.lausd.net/portal/page?_page_id=33,922882&_dad=ptl&_schema=PTL_EP_-

Why in the Schools?

- All youth attend school. Ease of access.
- Mental health needs are often first identified in schools, where students spend much of their time.^{4,5}
- Accessing mental health services at school improves access, reduces stigma, and allows coordination of care.
- Accessing services at school can pull in families.
- Providing school-based services reduces healthcare disparities.

Mental Health Affects School Success

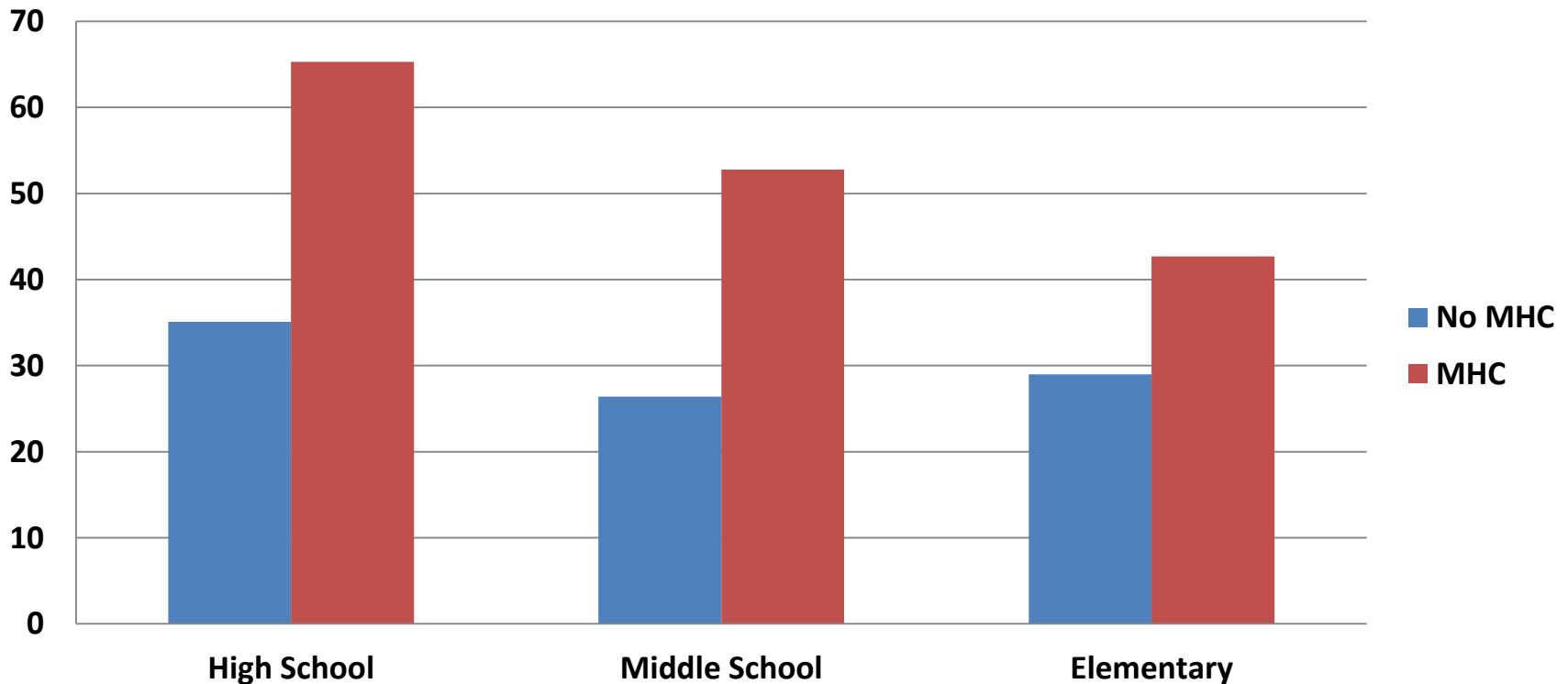
- Mental health conditions create barriers to learning, for the student, and for classmates.
 - Racing and intrusive thoughts
 - Sleep problems and fatigue
 - Memory and attention problems
 - Fearful states
 - Low motivation & energy
 - Anger and difficulty controlling emotions
 - Self-doubt, self-criticism and negative thoughts
 - Painful feelings, withdrawal, isolation
- There is a **STRONG** research link between mental health and academic achievement.⁷

MMSD students identified with MHC are at greater risk for a multitude of school and community concerns.

- Attendance problems
- Habitual Truancy
- Academic failures and under-achievement
- Lower graduation rates
- Need special education and alternative programs
- Higher rate of suspensions
- Increased juvenile justice involvement
(explanation of MMSD Mental Health Data 2010, 2013)

ATTENDANCE: Students with an identified MHC are absent from school more often.

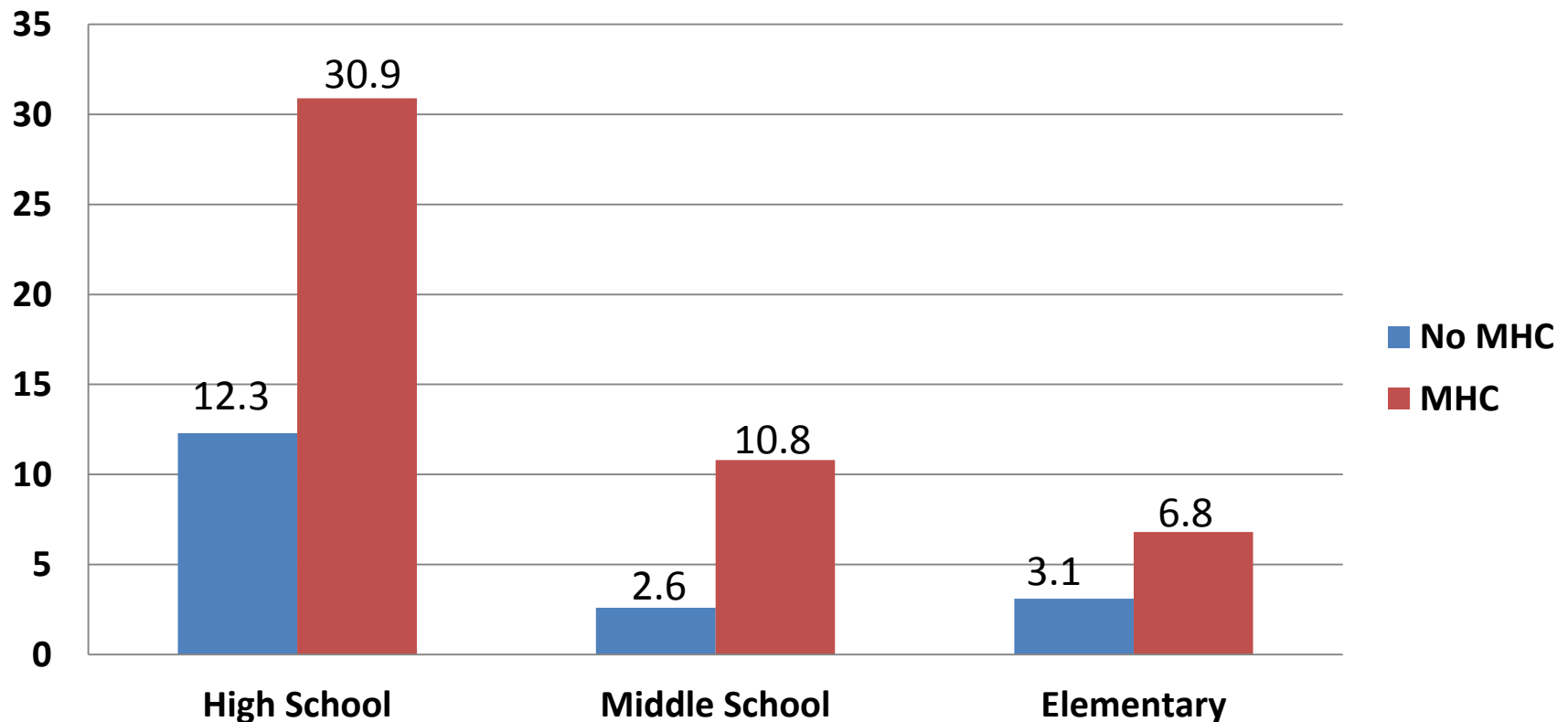
**Percent with Attendance Below 94%
9-1-09 through 3-30-10**



Students with an identified MHC are 2 to 4 times more likely to be **Habitually Truant**

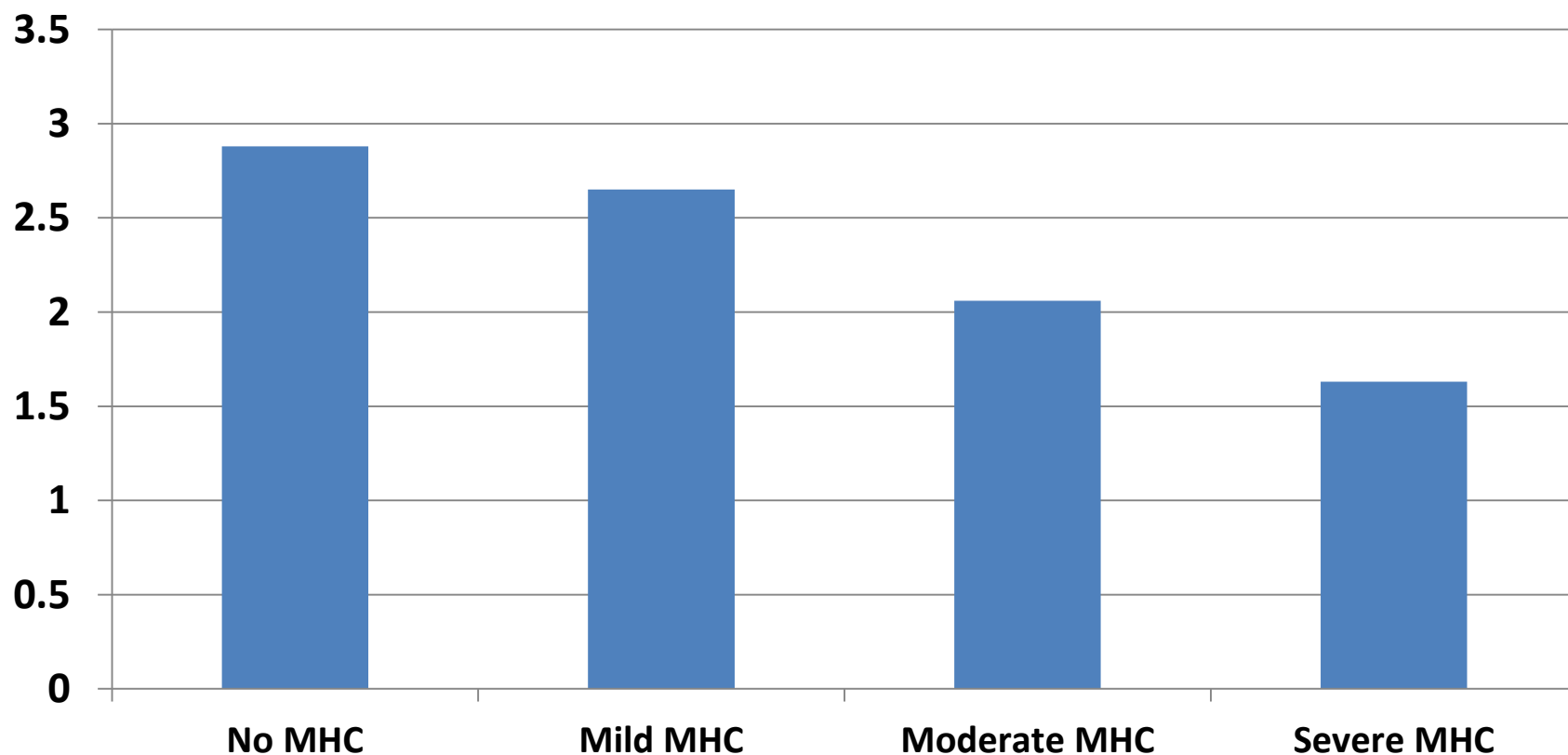
Percent Habitually Truant

Semester 1 09-10



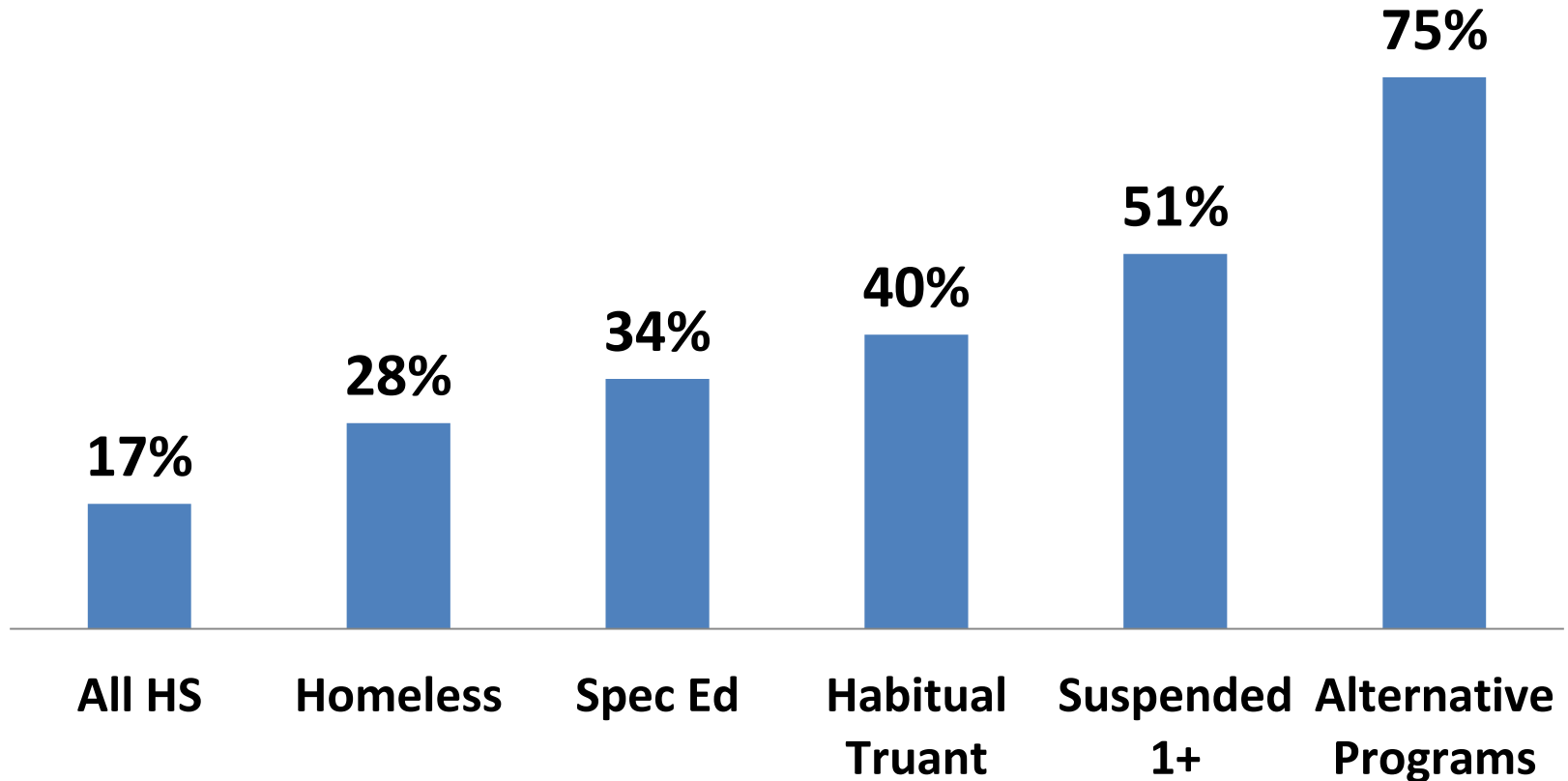
Academic Achievement—High School

GPA Average and Mental Health Condition

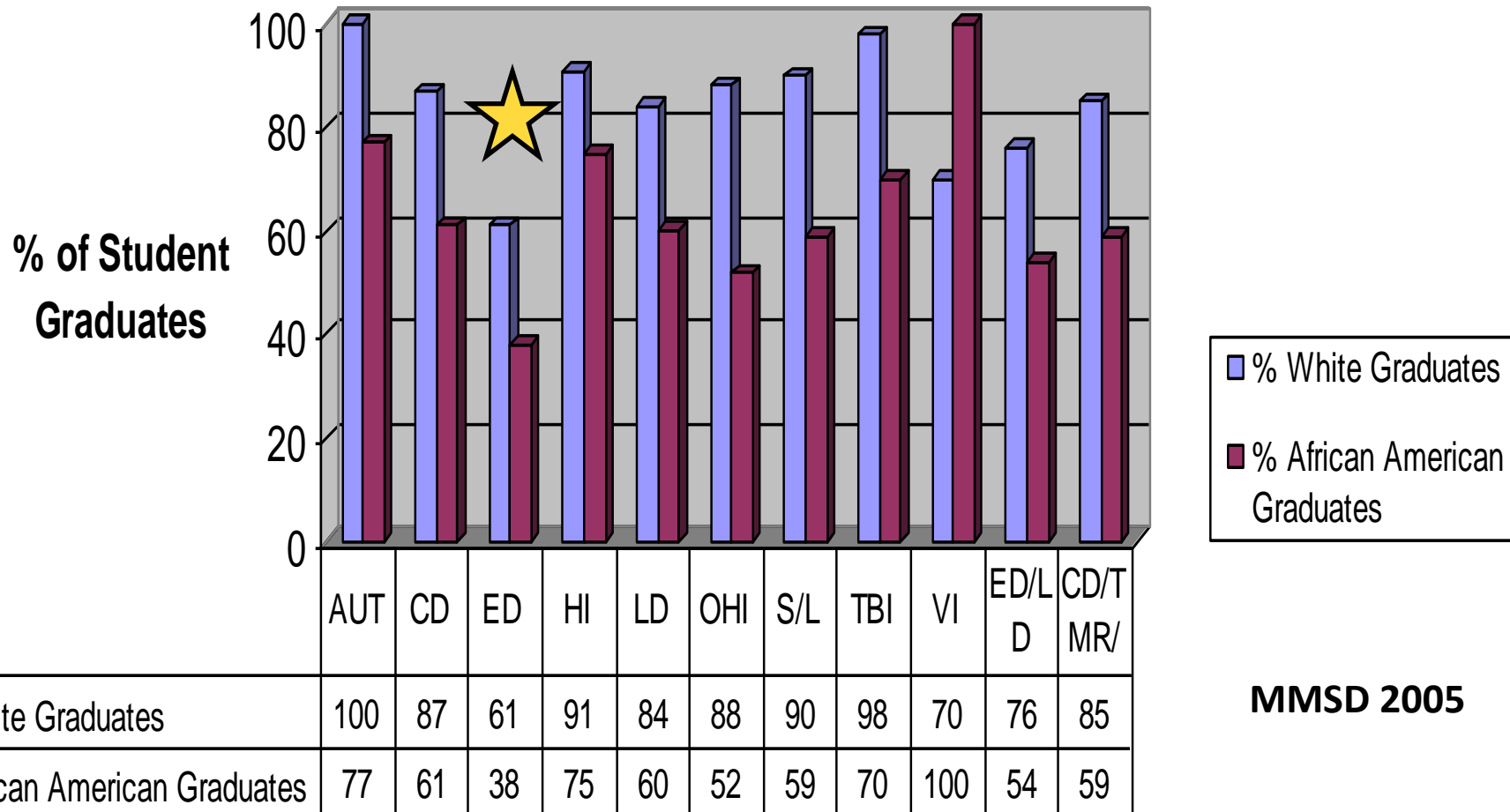


Special Populations Demonstrate Greater Needs in Mental Health

Percent Identified with MHC

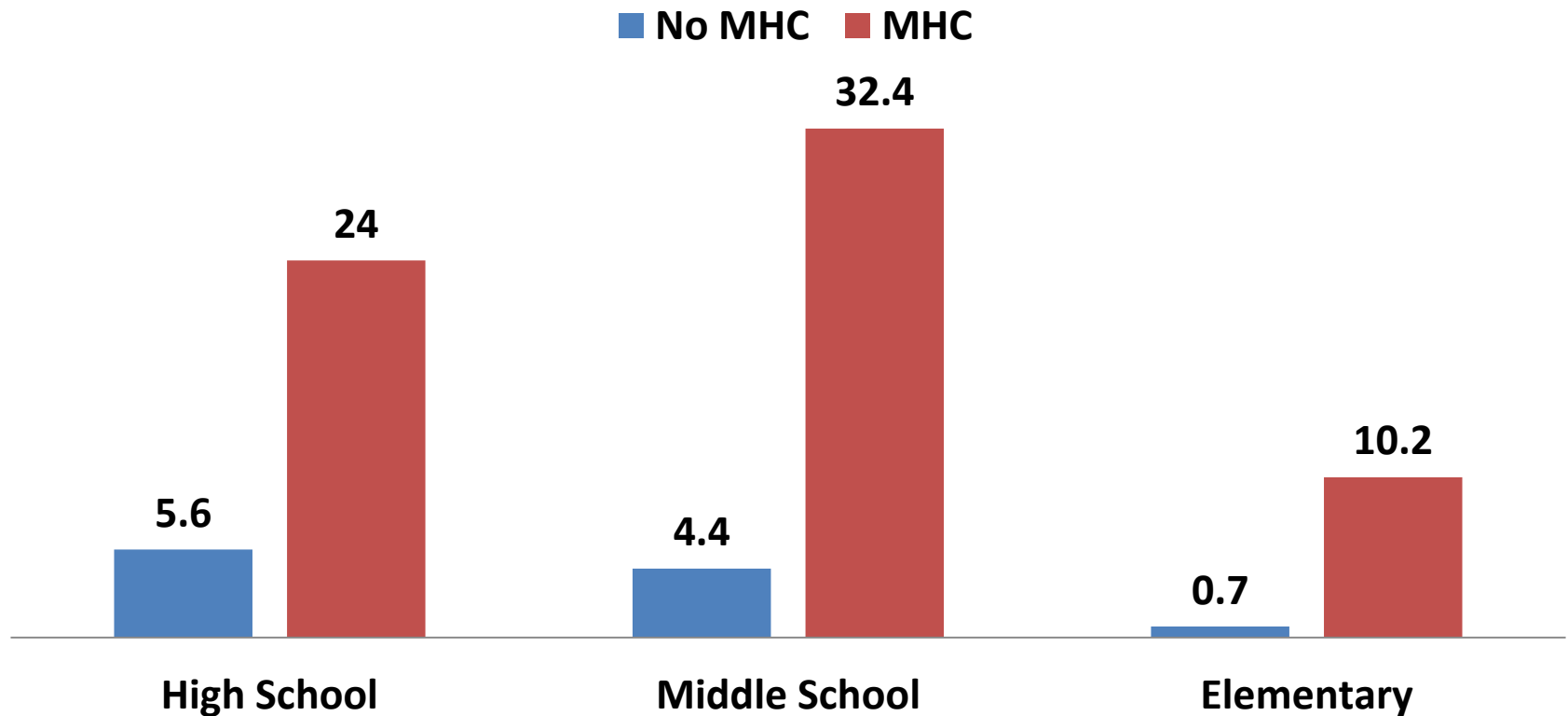


Special Education Students with Emotional Disabilities have the poorest graduation rates.



Students with an identified MHC are at greater risk for suspension.

Percent of Students Suspended 1 or more times
(Sept 1-Mar30, 2010)



Youth in the Juvenile Justice System

- Across Dane County, 74% of corrections commitments had mental health and/or alcohol or other drug abuse diagnoses.⁸
- The more severe the MHC the more risk of Juvenile Justice Involvement.³

Mild MHC	Moderate MHC	Significant/Severe MHC
4%	13.4%	29.4%

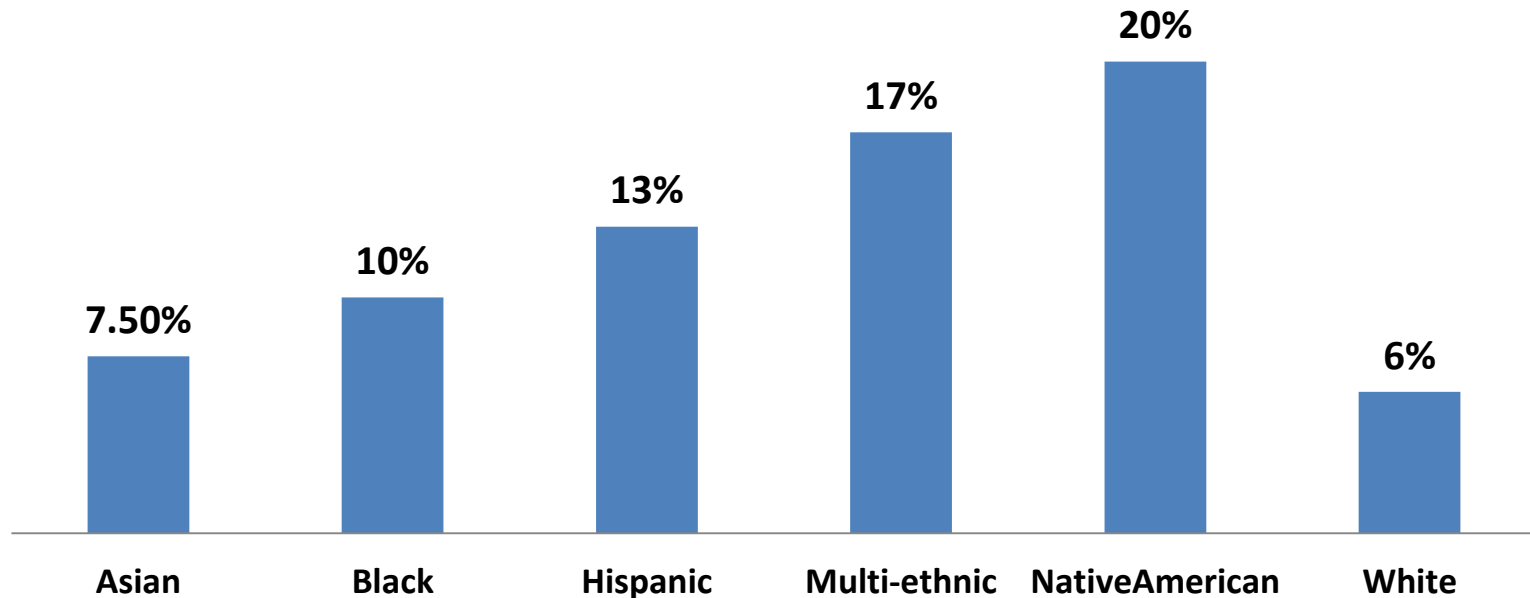
The Youth Voice—Depression⁹

During the past 12 months, did you ever feel so sad or hopeless almost every day for **two weeks or more in a row** that you stopped doing some usual activities?

YES %	33.3	46.7	19.8	22.0	33.3	21.7	29.4
Group	Hispanic	Native American	Asian	African American	Pacific Islander	White	Multi-Ethnic


The Youth Voice—Suicide⁹

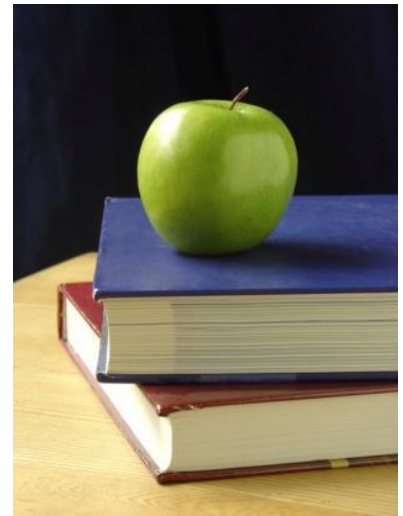
**In past 12 months attempted Suicide
1 or more times—self-report**



27% of Self-identified Gay/Lesbian/Bisexual HS students reported 1+ suicide attempt

What does the research say about school-based mental health outcomes?

- Improvements in social competency, behavioral and emotional functioning
- Improvements in academics (GPA, test scores, attendance, teacher retention)
- Cost savings!
- Increased access to care  Decreased health disparities



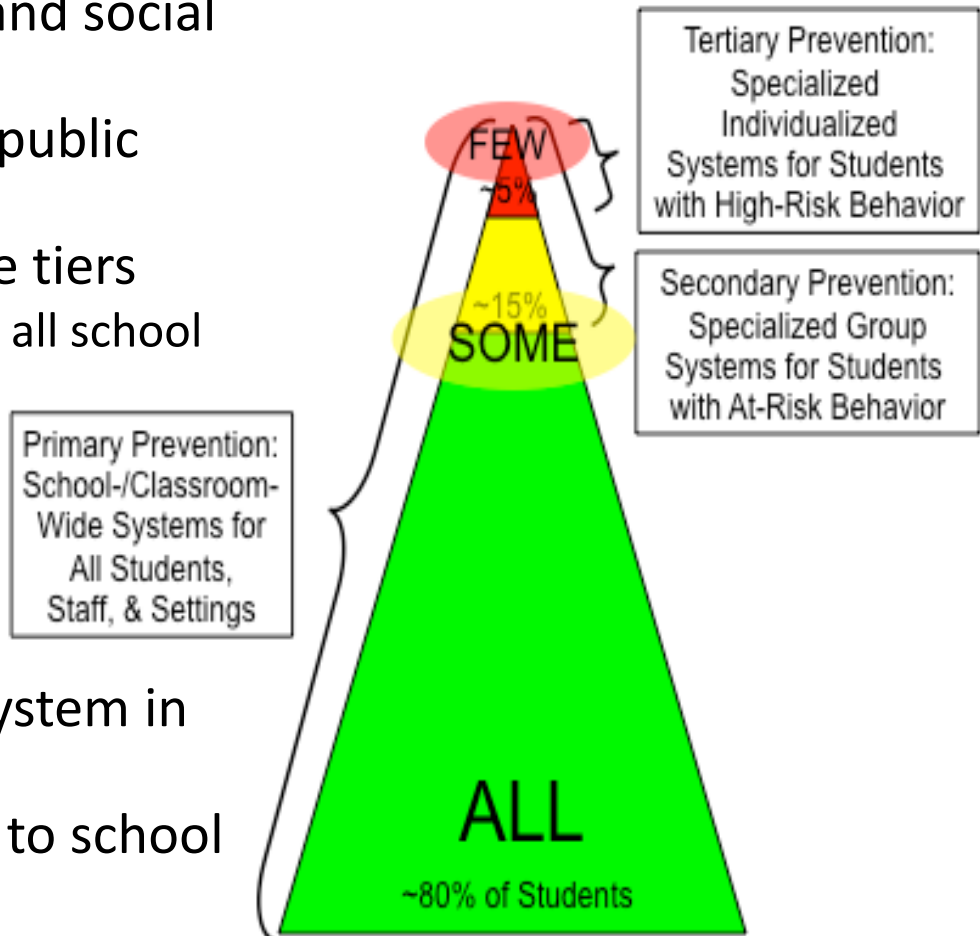
Greenberg et al., 2005; Greenberg et al., 2003; Welsh et al., 2001; Zins et al., 2004; Bruns et al., 2004; Lehr et al., 2004; Jennings, Pearson, & Harris, 2000; see Hoagwood, Olin, Kerker, Kratochwill, Crowe, & Saka, 2007 and Wilson & Lipsey, 2007)

What are we doing currently?

- Student services (psychologist, social worker, nurse and/or counselor) in every school.
- Three-tiered model of services around behavior, attendance, mental health called Positive Behavior Support.
- School-community collaboration at T2-T3.
- **The capacity is insufficient to address the needs.**

Positive Behavior Intervention & Support (PBIS or PBS)

- A framework of supports and practices to improve student behavior and social functioning.
- Population-based model (like public health)
- Provides supports across three tiers
 - Universal: Primary prevention, all school education about expectations
 - Secondary, Targeted groups
 - Tertiary, Intensive, individual
- Robust research
- Strong evidence base
- Recommended as preferred system in IDEA '97
- Statewide training is available to school districts



Mental Health: Universal Level

All students, preventive, educational

- Social emotional learning standards
 - 4K – 12th grade
 - Modeled from Alaska and Illinois state standards
 - 1. Emotional development
 - 2. Self concept
 - 3. Social competence
- Strong evidence base for Universal SEL programs
- Meta-analysis by Durlak, etal. (2011)
 - 213 universal programs
 - 270,000+ students
- Average 11-percentile point increase in academic achievement
- Improved socials and emotional skills
- Decreased behavior problems

Extensive developmental research indicates effective mastery of social-emotional competence is associated with greater well-being and better school performance .

(Eisenberg, 2006; Guerra & Bradshaw, 2008; Masten & Coatsworth, 1998; Weissberg & Greenberg, 1998).

Mental Health: Universal Level

All students, preventive, educational

- **Second Step** is MMSD SEL universal curriculum
 - 4K – 8th grade instruction in every classroom 2013-14
 - 13-22 lessons per year
 - Listed in SAMHSA's registry of evidence-based programs.
<http://www.nrepp.samhsa.gov>
 - Empathy,
 - Emotion Management
 - Problem-Solving.
- **Trauma-Informed Educational Practices**
 - 9 video modules for all school staff
 - Planned parent access
 - Understanding trauma
 - Focus on universal school and classroom practices
 - Creating Safety
 - Building Relationships
 - Empowering Students
 - Supporting /Teaching Emotional Regulation
 - Staff Self-Care

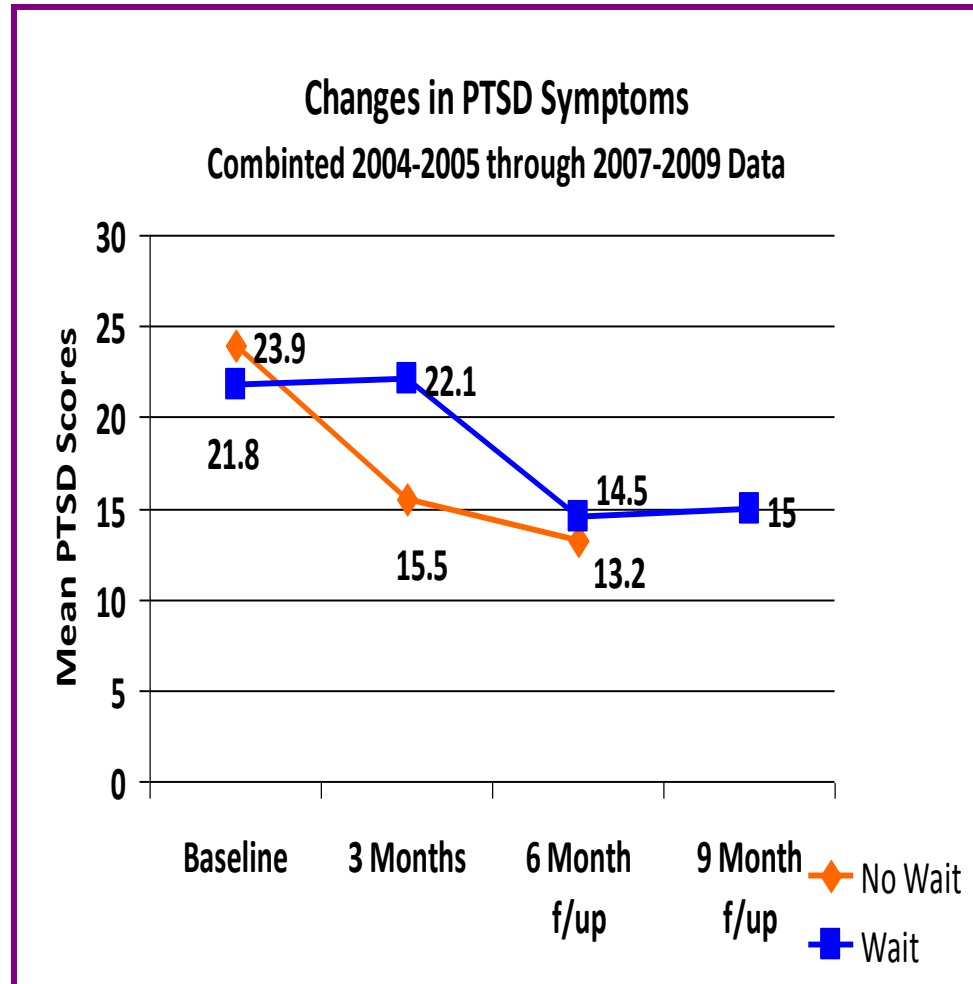
Second Tier

- Systematic interventions for identified students who need more behavioral or emotional support.
- Social-emotional groups
 - Evidence-based curricula
 - Student services staff facilitated
 - Second Step Boosters
- FACE-Kids Groups—K-12
 - Collaboration between schools and non-profit mental health agencies.
 - Funded by United Way
 - Anxiety, grief/loss, anger management, stress coping, social skills
 - 612 students in 2012
 - 60% uninsured
 - 94% meet most or all goals



Cognitive Behavior Intervention for Trauma in Schools

- CBITS – Developed in LA Unified Schools.
- Strong evidence-based
- Includes teacher, parent and facilitator training.
- Includes evaluation
- Students identified by self-report screener for all 6th graders and an interview.
- 12 sessions



Third Tier

- Intensive, individualized interventions
- Complex issues
- Typically require on-going collaboration
- Early identification of high risk youth
- Wrap-Around
- Violence Risk Assessment
- Suicide Risk Assessment
- Individual Counseling
- Motivational Interviewing
- Case Management
- Functional Behavior Assessment & Behavior Intervention Plan
- FACE-Kids Connections



Need Expanded School-Based Services

- School Board hears about urgent needs:
 - Parents
 - Teachers
 - Principals
- Data: Significant need in the district.
- Mental health affecting attendance, behavior, academic success and graduation rates.
- Youth needing mental health services are not accessing community sites for care
- 50% of visibly ethnic/minority clients do not return after 1st session. (Sara?)
- Untreated mental health issues are a significant barrier to learning and educational success
- Disparities exist between rates of access based upon income and race.

School Board directs Superintendent Nerad to convene a Mental Health Task Force of school and community stakeholders to address student mental health needs.

Advocacy for bringing schools, families and the community together.

- federal support for *Systems of Care*¹⁰
- fundamental aspect of the 2011 Safe Schools / Healthy Students Program¹¹
- central focus in recommendations for newly established *Office of Adolescent Health* in the U.S. Department of Health and Human Services¹²

Mental Health in Schools Act of 2011 (H.R. 751)¹³

- emphasis on facilitating “community partnerships among families, students, law enforcement agencies, education systems, mental health and substance use disorder service systems, family-based mental health service systems, welfare agencies, health care service systems, and other community-based systems.”



Mental Health Task Force

- Vision: We will . . .
 - Empower parents/caregivers to fully participate
 - Identify and implement culturally competent, trauma-informed, evidence based practices
 - Take collective responsibility to develop and sustain a coordinated system of care
 - Include evaluation to improve the program
- So that: all students will have access to the mental health services they need to support the full achievement of their full potential as healthy and contributing community members.

Mental Health Task Force

- Mission: Create a comprehensive, integrated, culturally-competent and trauma informed school-linked system of mental health practices and supports for MMSD students and their families.



Strategic Goal Areas

- Organization/Policy
 - Blended funding model
 - Shared ownership and responsibility
 - Coordinated systems, policies, strategies, resources
- Education/Outreach (Universal)
 - Education around supporting mental health
- Direct Service/Access (Tier 2)
 - Responsive, efficient system of referral & services
- Individualized Care (Tier3)
 - Timely & appropriate access to coordinated and quality individualized care

Membership of the Task Force

- Parent representatives, Cultural groups
- Medical community: UW Health, Dean, GHC, Meriter, Access Community Health
- Non-profit mental health agencies
- Advocacy agencies—NAMI, Disability Rights-WI
- City of Madison government
- Dane County Human Services
- Law enforcement, juvenile justice
- Madison Schools
- Funding agencies

Work of the Task Force

- Monthly for 13 months, 2 hours per month.
- Understand current community and school mental health services, delivery and access
- Look at the research and data— MMSD, Dane County Youth Assessment, Youth Risk Behavior Survey
- Look at Exemplar Models for school-community collaboration from across US— Seattle, Baltimore, Boston, Los Angeles, Minneapolis
- Determine and prioritize actionable recommendations.
- Implementation Planning Team continues to refine—3 months

What does the research tell us about mental health and SBHCs?

- Adolescents are 10-21 times more likely to come to a SBHC for mental health services than a community health center or HMO.¹⁴
- Dallas SBHCs found that mental health services helped decrease discipline referrals by 85%.¹⁵
- Harder-to-reach populations, especially minorities and males, are more likely to receive mental health care and risk screens.¹⁶
- 75% of student say that they are receiving services that they otherwise would not get.¹⁷

Seattle Data on School-Based Health Clinics

- Adolescents use of SBHCs is positively related to
 - Increased GPA
 - Increased attendance
 - Higher graduation rates
- Students at higher risk for dropout (free/reduced lunch, GPA <2.5, attendance <90%) experienced greater benefits related to SBHCs.¹²

Exemplar Models: School-Based Mental Health

- Most states, including recently Wisconsin, have a state-wide Positive Behavior Support model.
- Many states have school-based mental health services
 - Pennsylvania, South Carolina, Montana, Ohio, Minnesota, Illinois, Oregon, Washington, Massachusetts, Connecticut .
- Minnesota
 - 200 districts, 550 schools, have school-based MH centers
 - State grants to mental health clinics funding start-up costs and non Medicaid covered costs—\$4.9 million for 2014.
- 75% of the nearly 2000 School Based Health Centers in US schools integrate MH services: Los Angeles, Seattle, Boston, Beloit WI

Dodge County Wisconsin

- Waupun, Beaver Dam and Lomira
- LSS and school collaboration for 3 years
- Increases in GPA and standardized achievement test scores
- Increase CANS score of 19% for users of mental health services
- Doubling of students seeking services between year 1 and year 2.

Top Prioritized Action Steps

- Develop a county-side system that enables collaboration, communication and information sharing that furthers effective care.
- Empower and Support Parents
 - Advocacy, education, partnering, parent leadership
- Pilot a comprehensive, collaborative School-Based Health Center as part of a 3 Tiered model that will provide mental health prevention, early intervention and treatment.

*“Inclinations to intensify security in schools should be reconsidered. We cannot and should not turn our schools into fortresses... **We need resources such as mental health supports in every school and community so that people can seek assistance when they recognize that someone is troubled and requires help...** If we can recognize and ameliorate these kinds of situations, then **we will be more able to prevent violence.**”*

-
December 2012 Connecticut School Shooting Position Statement Interdisciplinary Group on Preventing School and Community Violence December 19, 2012

What can the legislature do?

- Encourage DPI to develop state SEL Standards to support social-emotional development and school and career success for all students.
- Increase funding of state Positive Behavior Support program
- Increase Medicaid funding, broaden criteria, and broaden mental health services to maximize access for children.
- **Provide competitive start-up financial support for school-based extended, collaborative mental health service delivery.**

References

1. Committee on Adolescent Health Care Services and Models of Care for Treatment Prevention and Healthy Development, National Research Council, & Institute of Medicine. (2009). *Adolescent health services: Missing opportunities*. Washington, DC: National Academies Press. Retrieved November 9, 2012, from: http://www.nap.edu/catalog.php?record_id=12063
2. Knopf, D. K., Park, J., & Mulye, T. P. (2008). *The mental health of adolescents: A national profile, 2008*. Retrieved November 9, 2012, from <http://nahic.ucsf.edu/downloads/MentalHealthBrief.pdf>
3. Katherine Halley, PhD. Madison Metropolitan School District Mental Health data collection, March 2013.
4. Substance Abuse & Mental Health Services Administration Office of Applied Studies. *National survey on drug use and health, 2007 and 2008, Tables 6.31B and 6.34B*. Retrieved November 12, 2012, from <http://www.oas.samhsa.gov/NSDUH/2K8NSDUH/tabs/Sect6peTabs31to33.pdf>
5. Foy, J. M., & Perrin, J. (2010). Enhancing pediatric mental health care: Strategies for preparing a community. *Pediatrics*, 125(Supplement 3), S75-S86.
6. Substance Abuse and Mental Health Services Administration Office of Applied Studies. (2007). *Detailed tables of 2006 National Survey on Drug Use and Health, table 6.20A*. Retrieved April 28, 2011, from <http://oas.samhsa.gov/NSDUH/2k6NSDUH/tabs/Sect6peTabs1to41.htm#Tab6.20A>
7. Jeffrey L Charvat, PhD. (2012). *Research on the Relationship Between Mental Health and Academic Achievement*, National Association of School Psychologists,. Retrieved April 27, 2013 from: <http://www.nasponline.org/advocacy/Academic-MentalHealthLinks.pdf>
8. Rhonda Voigt. Dane County Human Services Department, Delinquency and Liaison to Corrections, 2002-2005.
9. Youth Risk Behavior Survey, Centers for Disease Control Data 2013. Retrieved from <http://yrbs.learningpt.org/adminlogin.aspx>
10. Retrieved from U.S. Dept. of HHS, <http://www.samhsa.gov/Grants/2010/TI-10-007.aspx>)
11. Retrieved from <http://www2.ed.gov/legislation/FedRegister/proprule/2011-1/021811b.pdf>)
12. National Alliance to Advance Adolescent Health, 2011.
13. Retrieved from: <http://www.govtrack.us/congress/bills/112/hr751/text>
14. Juszczak L, Lelinkovich P, Kaplan D. *Journal of Adolescent Health* 2003; 32S: 108-118
15. Dallas Youth and Family Centers Program: Hall, LS (2001) Final Report
16. Kaplan D, et al. *Archives of Pediatric and Adolescent Medicine*. 1998; Jan; 152(1): 25-33.
17. Walker SC, Kerns, SEU, Lyon AR, Bruns EJ, Cosgrove TJ. *Journal of Adolescent Health* 2010; (46) 251-257
18. Dilley J. Research Review: School-based Health Interventions&Academic Achievement, September 2009, Washington Dept of Health.