Commission on Innovation and Excellence in Education
Behavioral Health Related Recommendations for
Working Group 4: More Resources for At-Risk Students
June 28, 2018

Add Element:
Integrate school behavioral health services and supports into education systems to enable districts, schools and communities to partner to promote student wellness and social-emotional competence, and to identify and address behavioral health problems with at-risk students.

Integration of behavioral (mental health and substance use) health services and resources into schools for those students who need additional supports can help address gaps in behavioral health care, and is a key factor in promoting academic success, improved social-emotional functioning and safe and supportive learning environments. Providing behavioral health services and supports in schools offers a host of benefits including: improved access to care, ability to engage key socialization agents (e.g., family, peers, school staff), opportunities for behavioral health screening and early identification of behavioral health concerns, and the ability to provide a full continuum of behavioral health supports. Schools are not expected to take on the function of being a health care system, but rather are helping to improve the access to and coordination of care to youth by providing services in a primary and natural setting-- schools. School behavioral health services delivered by community providers are financed by commercial and public insurance (e.g., Medicaid) and can be supplemented with other funds to support non-billable services (e.g., prevention, teacher consultation, participation in school team meetings, and training of school staff on behavioral health identification, referral, and basic strategies that can be used in the classroom to better support students with behavioral health concerns). Providing behavioral health services in schools improves access to and coordination of care, leading to improved student success and a reduced need for higher end, more expensive services such as emergency room, inpatient and residential care and other non-public school placements.

1. DEDICATED STATE AND LOCAL SCHOOL SYSTEM STAFFING

A. **The Maryland State Department of Education should have an office and at least one full-time staff member dedicated to comprehensive school behavioral health** (Some states such as New Hampshire, Wisconsin, and Montana have established these offices/positions under different titles – e.g., "school wellness" or "school climate and social emotional health.").

This position would require an individual with at least a Masters Degree, behavioral health training and experience in schools and would require close collaboration with other youth-serving agencies to establish shared goals, processes to collect and share data, and consider ways to leverage and braid/blend funding to support school behavioral health. This person would be responsible for supporting local education authorities (LEAs) in their efforts to establish and sustain comprehensive school behavioral health systems by providing **TA/resources and supporting accountability of LEAs** through systematic data collection and reporting based on national performance metrics. Cost ~$150,000

B. Similar to the state, **every LEA in Maryland should have an office and at least one full-time staff member dedicated to school behavioral health**.

This position would require an individual with at least a Masters Degree, behavioral health training and experience in schools and would require close collaboration with other local youth-serving agencies to establish shared goals, processes to collect and share data, and consider ways to leverage and braid/blend funding to support school behavioral health. This person would be

responsible for supporting school building comprehensive school behavioral health systems implementation, including supporting a **district model for establishing and monitoring school-community behavioral health partnerships** (e.g., issuing a district request for proposals for community behavioral health providers to work in schools, providing a standard memorandum of understanding, establishing required outcomes metrics). Cost ~$125,000 per LEA

C. Provide **appropriate funding** (often supported by IDEA and other educational funds) for adequate staffing of **school-employed staff** (e.g., school psychologists, school social workers, school counselors, occupational therapists) to support student behavioral health using recommended ratios from national guild groups.

D. Join together with **Community Partnered School Behavioral Health programs and provide adequate funding to support non-billable activitie**s such as prevention, behavioral health promotion, teacher consultation, attendance at team meetings, and professional development training of school staff.

Community Partners should maximize funding through fee-for-service funds from public/private health insurance with supplemental funds specifically for wellness and prevention activities associated with Tier1 and Tier 2 noted below To promote student behavioral health, schools, community partners and families must be committed to working together to address the interconnected academic, social, emotional, and behavioral needs of all students. This integration requires that school partners are open to having community partners (e.g., community behavioral health providers, youth-serving agency workers, advocates, health care providers) and families engage in all aspects of the comprehensive school behavioral health systems, including team meetings. It also requires that community partners have the necessary funding to be able to support clinician time in non-billable meetings without jeopardizing fiscal sustainability. Prior to provision of services, a Memorandum of Understanding among the school, school system and the community partner should be developed outlining roles and responsibilities of both the school (e.g. identifying schools with readiness to include community partner, providing confidential space in school with access to file cabinet, computer, phone, and internet, facilitate inclusion in team meetings, create data-based decision models and referral processes that promote early identification and intervention) and the community partner (e.g., providing specific screening, assessment, and evidence-based therapeutic services, participating in school teams, collecting and reporting on data, complying with all outpatient regulations stipulated at federal, state, and local levels).

E. **Youth guided, family driven and family-school-community partnerships** must be a priority

Parents/ guardians and other family members are the experts on their own children and their active participation is needed. Parent engagement offers an opportunity to reduce stigma related to behavioral health, increase access to needed services, enhance parenting skills and psychoeducation related to behavioral health, improve communication between the school and home, and improve social, emotional and educational outcomes for students. (CP-SBH Report 3.5.15).

F. **Community School Coordinators should partner and communicate with existing behavioral health programs and systems within and connected to the school or district to identify gaps and needs related to behavioral health.**

Community School Coordinators play an integral role in bringing services and programs into the school building. Decisions on when, who, and how to integrate new providers should offer opportunities for existing behavioral health staff and leadership of community-partnered programs

to inform decisions and to develop an array of services and a referral process that is sensitive to clinical needs of youth and families and expertise of behavioral health partners. Community School Coordinators should work in collaboration with the State and Local Education Agency School Behavioral Health leads related to the selection of providers and service delivery considerations. This is especially important to ensure appropriate MOU processes are followed to best serve and also to protect youth and families as well as ensuring that any providers obtaining funding through the public behavioral health system are able to appropriately provide services within their scope of practice.

2. SCALING OF SCHOOL BEHAVIORAL HEALTH SERVICE AVAILABILITY IN ALL JURISDICTIONS

A. **Provide funding for a FULL continuum of behavioral health supports** in schools that reflects a Multi-tiered Systems of Supports (MTSS) approach:

The MTSS approach ensures that all students are included in the service array, including students in both general and special education, and that all students will have at least some exposure and access to behavioral health programming and/or services. The number of tiers in a MTSS can vary, though many districts employ a 3-tiered model:

Universal services and supports (Tier 1) are behavioral health-related activities, including promotion of positive social, emotional, and behavioral skills and wellness designed to meet the needs of all students regardless of whether they are at risk for behavioral health problems. These activities can be implemented school-wide, at the grade level, and/or at the classroom level and may include broader classroom management systems and strategies aimed at promoting positive behaviors. An example of a Tier 1 support is teaching and reinforcing for all students in a grade, basic social emotional learning skills such as understanding and managing emotions and feeling and showing empathy for others. Tier 1 services are typically funded through education dollars, private foundation, and grants.

Selective services and supports (Tier 2) to address behavioral health concerns are provided for groups of students identified through needs assessments and school teaming processes as being at risk for a given concern or problem. When problems are identified early and supports put in place, positive youth development is promoted and problems can be eliminated or reduced. Sometimes these are referred to as "prevention" or "secondary prevention" services. An example of a Tier 2 support is providing a prevention group for students who have been exposed to trauma to help them learn skills to address depression and anxiety. Tier 2 services are funded through a blend of funding mechanisms including the public behavioral health system and private insurance, education dollars, private foundation, and grants.

Indicated services and supports (Tier 3) to address behavioral health concerns are individualized to meet the unique needs of each student who is already displaying a particular concern or problem and displaying significant functional impairment. Sometimes these are referred to as behavioral health "intervention" or "tertiary" or intensive services. An example of a Tier 3 support is providing individual sessions to a student already displaying significant anxiety to help build coping skills and strategies to reduce symptoms and improve functioning for the youth. Tier 3 services are typically funded through the public behavioral health system and private insurance.

Comprehensive school behavioral health systems provide an opportunity for strategic collaboration between school systems and community programs that offer a full array of evidence-based tiered services (universal behavioral health promotion, selective prevention, and

indicated early intervention). This integration may enhance wellness and reduce the prevalence and severity of mental illness and substance use disorders in children, particularly in the most vulnerable communities. Despite significant advances in integrating behavioral health into education, there remain challenges with respect to developing state and local school behavioral health infrastructure, professional development, and strategic financing to support the full continuum of behavioral health supports in schools. Behavioral health resources and supports are essential to safe and supportive schools. Promoting positive school culture and climate reduces isolation, verbal and physical bullying, sexual harassment/assault, cyberbullying, negative relationships between students and between students and teachers and decreased student/ teacher reports of weapons use, being threatened by a weapon, and seeing or knowing about a weapon on school grounds. (USC Suzanne Dworak-Peck School of Social Work)

B. **Have systems in place to address both mental health AND substance use**

The co-occurrence of mental health and substance use disorders among adolescents is fairly common according to published reports (Riggs, 2003). Findings from research studies estimated that up to 90% of adolescents who received treatment for substance use had at least one co-occurring disorder (Hawkins, 2009; Alumbaugh, 2008). Nationally, 43% of youth receiving mental health services were also diagnosed with co-occurring substance use disorders (Center for Mental Health Services, 2001). Integrating comprehensive behavioral health treatment services into school settings provides an opportunity for teachers and other school staff to refer students who they are concerned about to appropriate staff in the natural environment of the school, increasing access to care.

C. **Promote increased integration of telehealth into service provision** to better meet needs of all students

Telehealth, particularly in rural communities can offer an effective approach to providing behavioral health services, including medication management where otherwise the services may not be available within a reasonable geographic distance. In particular, child psychiatrists are in short supply and being able to provide medication management as part of a team approach via telehealth is a way to maximize the availability of these health care providers. Telehealth can be used to provide behavioral health services in schools located in rural, suburban and urban areas to increase access and capacity of providers who otherwise would need to be commuting to the schools to see students. Telehealth not only increases availability of health care providers, it can also be cost-effective, as these providers can serve multiple schools on the same day, with travel eliminated reducing costs and maximize time available for service provision. (Stephan, Lever, Bernstein, Edwards and Pruitt, 2016)

3. SYSTEMATIC SCREENING AND IDENTIFICATION OF STUDENT NEEDS

A. Develop **screening strategies for identifying students at-risk for behavioral health concerns**.

Integrating behavioral health into schools offers the opportunity to identify and address behavioral health problems early on. A first step in this process is understanding and identifying the behavioral health needs of the population through systematic, evidence-based measurement. Screening in schools, or the voluntary assessment of behavioral health needs and strengths across the student population, (Dowdy, E., Furlong, M. et. al, 2015) of the full school, grade level, students referred for counseling, students seen in health suite, or other strategy allows schools and community partners to better identify behavioral health needs in their student population, identify students who may most benefit from prevention and intervention efforts, and monitor changes in these needs over time. It is important to note that while screening can be based on student-level

surveys, teacher and/or peer nominations can also be utilized. Teachers play an important role in screening, as they view a large sample of same-aged children and are well-positioned to nominate students who are atypical in their development and behavior. Screenings can vary widely in how often they are administered. For example, suicide prevention/awareness screenings can be given annually or biannually or can be a one-time screening for a specific grade or group, or could be linked to specific events, such as following suspensions or re-entry after prolonged school absence. For more information about best practices in school-based screening please see the Center for School Mental Health's Playbook titled School Mental Health Screening: http://csmh.umaryland.edu/media/SOM/Microsites/CSMH/docs/Reports/School-Mental-Health-Screening-Playbook.pdf.

Screening Example: One suburban community started very small with ad hoc screening with individual students and with input and lessons learned from students, parents, educators, and health providers, they scaled up to the macro level and were able to develop a district screening process that allowed for broad scale implementation including procedures for follow-up for students identified at risk. Steps used for their successful screening implementation within the district are highlighted below:

- Use needs assessment data to identify most pressing behavioral health concerns in school district (anxiety and depression were identified)
- Pilot screeners at micro level (individual students) to get informal input on what screeners to use and best process for administration and follow-up
- Select specific screeners to match population's most pressing needs General Anxiety Disorder-7 and Patient Health Questionnaire-9 were selected).
- Use Google Forms to develop an electronic screening process or use paper and pencil process
- Develop parent consent and/or opt-out process (notification and opt-out process established in advance of the screenings to secure passive consent)
- Identify time period and time for administering screening (administered screening during the school's advisory block)
- Administer screening (two large scale screenings were conducted at district high schools)
- Review of screenings and identification of students at severe and moderate risk
- Follow-up with students identified at high risk and make referrals as needed for additional services and supports

4. STATEWIDE SYSTEM OF ACCOUNTABILITY AND OUTCOME MEASUREMENT

A. Decisions related to school behavioral health should be **data informed** to address unique behavioral health needs of schools and districts.

Data should be collected across comprehensive school behavioral health system staff including school employed staff and community partners to demonstrate student and school level outcomes (e.g., academic, behavioral, social emotional) as well as cost benefits of services. Creating

standardized data collection expectations and systems such as the evidence-based process of feedback-informed treatment (SAMHSA, 2013) to collect, analyze and share findings can help demonstrate the value and impact of school-based behavioral health services and can inform practice.

Data collected from universal screenings and voluntary assessments can inform resource utilization and programming prioritization (Dowdy, e., Ritchey, K. et. al., 2010). Promoting positive behavioral health for all young people is foundational to the work of school behavioral health. Prevention approaches can help prevent behavioral health problems and reduce the risk factors that may lead to or aggravate mental illness and substance use disorders. Identifying behavioral health problems early leads to better long-term outcomes, with the length of time a child's behavioral health problems go unidentified being correlated with maladaptive trajectories. Given that youth mental illness costs the U.S. billions of dollars annually, efforts to reduce the incidence of mental illness and substance use disorders through screening and early intervention could serve to not only improve quality of life, but can significantly reduce fiscal burden. (Mrazek, P.J., & Haggerty, R.J. 1994; O'Connell, M.E., Boat, T., et. al., 2009). In fact it is estimated that for every dollar spend on child behavioral health services, approximately $2-$10 is saved in later more intensive services such as Juvenile Justice, Social Services, Education, Health, and lost productivity (SAMHSA, 2011, Retrieved June 4, 2018, https://store.samhsa.gov/shin/content/SMA11-4666/SMA11-4666.pdf).

Develop a single, comprehensive system comprehensive school behavioral health data collection and program evaluation across jurisdictions to streamline and inform decision-making and encourage and appropriately reimburse/incentivize providers to utilize empirically-supported treatments and best practices tailored to suit the needs of youth, families, schools, communities, and jurisdictions. (CP-SBH report, 2015). Incorporating academic data (e.g., grades, attendance, test scores, grade promotion) from the schools enables providers to assess functional improvements in students they work with, which would also help better align treatment and academic goals.

5. BEHAVIORAL HEALTH TRAINING FOR SCHOOL PERSONNEL

A. Identify existing and/or develop **behavioral health training** for all school staff on identification and referral of students who may be at risk for or how are already displaying signs and symptoms of behavioral health concerns.

This is included in Element Detail 4b. As written it does not explicitly mention substance use, only mental health issues. Train all school staff to recognize symptoms of psychological distress and substance use using evidence-based training programs such as Youth Mental Health First Aid and Kognito. School staff and teachers in particular are most likely to notice that a student needs to be referred for more intensive assessment. Their key role is not to provide treatment but to identify that a student is at-risk and in need of referral to appropriate school and/or community behavioral health staff so that they can be further assessed and provided additional services and supports if needed in the school and/or community. Training needs to be readily accessible and provided at no cost/low cost. As recommended in the 2015 Maryland CP-SBH report, training should address mental health, substance use, and co-occurring disorders across a multi-tiered system of support.

.