Mental Health Needs in Schools

1 in 5 children in California between the ages of 6 and 17 is identified as having a mental health disorder.

75% of mental health disorders onset prior to age 24.

Only 1/3 of all children with mental health needs receive treatment.

Sources: Kessler, et al., 2005; Howell, 2004; California Health Interview Survey, 2005
Mental Health Needs are Compounded by Poverty

83% of urban youth living in poverty report experiencing at least one traumatic event

1.5x Youth living in poverty are 1.5 times more likely to be diagnosed with Emotional/Behavioral Disorders

ONLY 10% of youth living in poverty with mental health needs receive treatment

Sources: Collins, et al., 2010; California Department of Education Dataquest, 2013; California Health Interview Survey, 2005
The Overlay Between Learning and Emotional Well-Being

Imagine, for a moment...
Poverty, Trauma, and Student Achievement

Increased difficulty...
- Processing information
- Distinguishing between threatening and non-threatening situations
- Forming relationships
- Modulating emotions

Negative impact on student achievement

Increased referral rates to Special Ed

Youth who experience complex trauma are 3x more likely to drop out of school

Increased rates of arrest, unemployment and substance abuse

Sources: Cole et al., 2005; National Child Traumatic Stress Network, 2014
Impact on Education

3x  Children in preschool and elementary school with mental health needs are three times more likely to be suspended or expelled.

44%  of youth in high school with mental health problems drop out.

1 in 10  youth who drop out of school will end up incarcerated.

Sources: National Child Traumatic Stress Network, 2014; Wagner, 2005; Sickmund & Puzzanchera, 2014
Importance of Schools in Addressing Mental Health Needs

- Schools are the de facto mental health system for children
- Schools are an effective intervention site for screening and intervention
- Providing services in schools can:
  - Reduce barriers to access
  - Reduce stigma and affordability
  - Catch problems before they become severe
  - Provide maximum opportunity for universal prevention and early intervention programs

Sources: Kutash, et al. 2006, Gulliver, et al. 2010
High Poverty Schools in Double Jeopardy

HIGHEST CONCENTRATION OF STUDENT NEED

LEAST PREPARED TO MEET STUDENT NEED

Source: Editorial Projects in Education, 2004
Schools Need Integrated Services

Great work is being done, but more integration is needed
Existing Models of School-Based Mental Health Service Provision

- Clinics providing services without integration to the rest of campus
- “60 minutes per week” model
- Providers working isolation = service gaps
- No connection to process of learning
- Resources spent almost exclusively addressing the pressing needs of the most struggling students
Impact/Consequences of Non-Integrated Approaches

- Students with mental health needs feel excluded from the school system.
- Secondary cycle of school failure: academic challenges → behavioral/emotional challenges → segregation from mainstream classroom.
- Only 34% of teachers feel equipped to address mental health needs.

Sources: Reinke et al., 2011
The Positive Inter-Relationship of Education and Mental Health
Alternative Vision for What is Possible

• Schools help to break the cycle of challenges associated with trauma and poverty, increase student achievement and social-emotional well-being, helping youth learn and become well-adjusted.
Key Characteristics of this Alternative Vision

- Trauma-informed
- Integrated mental health services
- Multi-tiered system of supports (universal, targeted, and intensive academic, behavioral, and social-emotional supports)
- Data-driven practice
- Coordination of services
- Multi-disciplinary decision-making
Multi-Tiered System of Supports

- MTSS is an integrated, comprehensive framework that aligns the entire system of services and supports to promote the achievement and success of all students.
- Services and supports quickly identify and are adjusted to serve all students according to individualized need.
- Integrates instructional and intervention support to ensure sustainable systemic changes.
- Implements continuous improvement processes at all levels of the system.
**TIER 3**
- The most intensive of the three tiers often requires one-to-one support or addresses a considerable skill gap for students at the lowest levels of academic or social emotional achievement.

**TIER 2**
- Students receiving targeted interventions have demonstrated the need for support to supplement what is offered in the classroom.

**TIER 1**
- As part of high quality instruction, in a climate of positive classroom culture, students receive interventions at many points throughout the day.

**ACADEMIC INTERVENTIONS**
**BEHAVIORAL INTERVENTIONS**
**SOCIAL-EMOTIONAL INTERVENTIONS**
Blended Funding Sources

- Prevention and early intervention activities have historically been underfunded. MHSA PEI funds represent an important opportunity.
- Cost savings associated with enhanced universal and targeted supports can be leveraged to create sustainability.
Initial Outcomes of UE Model

ACADEMIC YEAR 14-15 OUTCOMES FROM SRI INTERNATIONAL

3,264 students served (17% at tier two and 14% at tier three)

+.11 Increase in school connectedness

3.80 to 3.91 on SCAI items
Initial Outcomes of UE Model

ACADEMIC YEAR 14-15 OUTCOMES FROM SRI INTERNATIONAL

Compared to similar students in schools that did not participate in UE, did students (in grades 4-8 and 9-12) who attended schools that participated in the UE program demonstrate:

- higher scores in English Language Arts
- higher scores in Mathematics
- better attendance
- lower suspension/expulsion rates
Initial Outcomes of UE Model

Positive academic effects during first year of implementation

- All Students
- African American Students
- Latino Students
- English Language Learners

Statistically Significant
Initial Outcomes of UE Model

Students With Disabilities showed improvement on 9 of 13 outcomes:

- Word Segmentation*
- Rapid Letter Naming
- Passage Comprehension*
- Oral Reading Fluency (x2)*
- Applied Problems
- Motivation
- Social Self-Concept
- Overall Self-Concept

* Statistically Significant
Partnership Models for Implementation

SELPA AS MENTAL HEALTH PROVIDER: THE DESERT MOUNTAIN SELPA MODEL

• Awarded Medi-Cal EPSDT contract in 2003. Created the Desert Mountain Children’s Center (DMCC) to coordinate and provide all services within an interconnected MTSS framework to students with IEPs, Medi-Cal eligible students, and general education students.

• Strong partnership between DM SELPA, San Bernardino County Department of Behavioral Health, DMCC, and the CAHELP-JPA.
Partnership Models for Implementation

2. Districts Contract with Provider Agency: The School Partnership Model

- Districts and LEAs partner with community-based organizations (CBOs) in the provision of mental health and special education services

- CBOs bring access to additional funding sources, and promote the blending of funding sources (e.g. EPSDT, MHSA, special education, general education funds, private insurance).
Barriers in Implementing Integrated School-Based Mental Health Services

• Building bridges between traditionally fragmented systems
• Funding innovation
What’s next?

• Identifying, scaling and disseminating models
• Maximizing and creating funding sources for integrated and multi-tiered school-based services
• Using MHSA to leverage additional funding
• Capacity-building for teachers and administrators in the provision of trauma-informed care
• Encouraging a mandate from the state to incentivize implementation
References


References


