Positioning Schools as Hubs of Community Systems of Care to Address Students’ Mental Health Needs

Frank Rider, Eric Bruns, Anne Katona-Linn, Joe Barnhart, and Joyce Sebian
Welcome

Who is participating in today’s institute?
Widescale Adoption Is Ultimate Destination for Expansion of Systems of Care
Basic SOC Expansion Approaches

...to Serve More Children, Youth and Families

- Geographic – sequentially add counties, regions
- Age band – early childhood, young adults
- Funding eligibility – Medicaid, CHIP, then private insurance
- Service sector – child welfare, juvenile justice, special health care needs, intellectual disabilities
- Or…

Expanding Systems of Care in “3-D”

…by level of MH need within the child/youth population

Beginning with highest-need children (e.g. out-of-home, and at risk for out-of-home placement)?

What if we used a public health approach to develop a complete (i.e. “comprehensive”) system of care?

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Positioning Schools as Hubs of Community Systems of Care to Address Students’ Mental Health Needs

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Center for Mental Health Services
Mental Health Promotion Branch
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Washington DC
July 27, 2018
8:30 AM until Noon.
The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).
SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.
A Call for Action

Make a real change in the way we approach children’s mental, emotional and behavioral health
“The grass is greener where you water it.”
A Paradigm Shift

- Beyond the “One child at a time” approach
- Population approach
- Informed by the growing body of prevention science

Mental health intervention spectrum. SOURCE: Adapted from Institute of Medicine (1994, p. 23).
Five Guiding Principles: Public Health Approach

• Population focus
• Emphasis on creating supportive environments and building skills
• Balanced focus between children’s mental health problems and positive mental health
• Cross-system and cross-sector collaboration
• Local Adaptation

http://gucchdтаcenter.georgetown.edu/public_health.html
Mental health intervention spectrum. SOURCE: Adapted from Institute of Medicine (1994, p. 23).
Medical vs Public Health Approach

**Individual Focus:**
- Medicine-MH Clinicians are concerned with individual patients,
- Medicine focuses on healing patients who are ill.

**Community/Population Focus:**
- Public health regards the community as its patient, trying to improve the health of that population.
- Public health focuses on preventing illness and addressing population needs/disparities.
In public health, 'upstream' approaches seek the root causes of disease and preventable disability in order to address prevent problems where possible- rather than just waiting for illness and more costly interventions.
Core Concepts of Prevention

1. Prevention requires a paradigm shift
2. Behavioral health and physical health are inseparable
3. Successful prevention is inherently interdisciplinary
4. MEB disorders are developmental
5. Coordinated community level systems are needed to support young people
6. Developmental perspective is key.
Focus on Prevention and Wellness

- Estimated $247 billion in annual costs
- Costs and savings to multiple sectors: education, justice, health care, social welfare
- Costs to the individual and family
- IOM report documented that an increasing number of MEB problems in young people are preventable.
- Called on states, communities, schools, primary care medical systems, child welfare, criminal justice systems, and others to take action to prevent MEB problems, including substance abuse.

www.national-academies.org
www.nap.edu
Focus on Prevention and Wellness

• Well-designed prevention interventions work

• Prevention and wellness interventions can have multiple benefits that extend beyond a single disorder.

• Key is to identify factors that may increase a child’s risk of Mental, Emotional and Behavioral Health (MEB) disorders, including substance abuse.

www.national-academies.org
www.nap.edu
• 365 LEA grants awarded

• 7 state grants awarded at $2.2 million per year for four years
3 CORE Functions
And
10 Essential Elements

http://www.health.gov/phfunctions/public.htm
A Conceptual Framework for a Public Health Approach to Children’s Mental Health

http://gucchdtacenter.georgetown.edu/public_health.html
Eight Dimensions of Wellness

Tools for Positive Mental Health

- Foster Optimism
- Practice Gratitude
- Avoid Negative Thinking

https://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness

http://www.mentalhealthamerica.net/live-your-life-well
National Prevention Strategy

Increase the number of Americans who are healthy at every stage of life.

[Diagram showing various components such as Tobacco Free Living, Preventing Drug Abuse and Excessive Alcohol Use, Healthy Eating, Active Living, Empowered People, Elimination of Health Disparities, Mental and Emotional Well-being, Injury and Violence Free Living, Healthy & Safe Community Environments, Reproductive and Sexual Health, and Clinical & Community Preventive Services.]
Mental and Emotional Well-being

- Promote positive early childhood development, including positive parenting and violence-free homes.
- Facilitate social connectedness and community engagement across the lifespan.
- Provide individuals and families with the support necessary to maintain positive mental well-being.
- Promote early identification of mental health needs and access to quality services.
Resilience:
Stack the Scale - Hope

(Adapted from https://developingchild.harvard.edu/science/deep-dives/lifelong-health/)

Baltimore City
Positive influences can effectively “stack the scale” with positive weight and optimize resilience across multiple contexts. These counterbalancing factors include:

• facilitating supportive adult-child relationships;
• building a sense of self-efficacy and perceived control;
• providing opportunities to strengthen adaptive skills and self-regulatory capacities; and
• mobilizing sources of faith, hope, and cultural traditions.

(Adapted from https://developingchild.harvard.edu/science/deep-dives/lifelong-health/)
“BOTH/AND” - Medical Model *and* Public Health Model

**Public Health – Successful Examples:**
- Vaccinations
- Water quality
- Seat Belts
- Obesity Efforts
- No Smoking
- Child Car Seats

**Mental Health Public Health Initiatives at SAMHSA**
- Suicide Prevention,
- Bullying Prevention,
- National Child Traumatic Stress Network etc.

*School Mental Health - *It’s Time!*
Between 1993 and 2006 SAMHSA Funded Systems of Care Initiatives in 126 Communities across the United States...

Funded Communities

Date Number
1993–1994 22
1997–1998 23
1999–2000 22
2002–2004 29
2005–2006 30
Only 1 in 4 featured any school-based programs or components.

Funded Communities

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<thead>
<tr>
<th>Date</th>
<th>Number</th>
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<tr>
<td>1993–1994</td>
<td>5</td>
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<td>1997–1998</td>
<td>11</td>
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<td>1999–2000</td>
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Schools in Community Systems of Care

Only 32 (25.3%) of those first 126 sites had any kind of school-based programs or components:

- PBIS (7)
- School-based wraparound/care coordination (16)
- School-based counseling/therapy (7)

were the most common programs/components.

Sandy (Keenan) Williamson, American Institutes for Research (2007)
Stroul, Pires et al., 2014: Return on Investment in Systems of Care:

- Fewer school dropouts among students with SED in SOCs (8.6%) than for similar students in national population (20%) = potential $380 million saved when applied to all children in funded SOCs (based on monetizing average annual earnings, lifetime earnings)

Example of link between students’ mental health and school success: Methuen MA school district

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Positive Education Outcomes from 400+ school districts:

- Decreased behavioral and emotional problems, suicide rates, substance use, and juvenile justice involvement
- Increased strengths, school attendance, grades, stability of living situation.
- For families, reduced caregiver strain and improved family functioning.

Findings from 36 primary research, review, and meta-analysis articles published between 2000-2017:

Benefits of school behavioral health clinical interventions and targeted interventions on a range of academic outcomes for adolescents.

Per our federal cross-system action blueprint ("ISMICC"):

- 15% of children age 2-8 have parent-reported MEBD diagnosis
- 3.1-million adolescents with major depressive episodes (2017)
- Adverse childhood experiences increase likelihood for SED -> SMI
- SAMHSA estimates prevalence of SED between 6.8 – 11.5%.
- Suicide rate increase quickly among young Black children 5-11 y.o.
Children are not receiving MH services they need:

- Only 20% of children, adolescents with MH disorders were identified and receiving MH services -- U S Surgeon General, 1999

- Fewer than 2% of school-age population identified with emotional/behavioral disorders that qualify for special education under IDEA


- 66.6% of young adults with any mental illness had received no MH services in past 12 months -- SAMHSA, 2014
Schools as Primary Access Points for Mental Health Services

Commonwealth Fund, 2018 Scorecard:

1/3 of children needing MH treatment in 2016 did not receive it.

Challenges to accessing mental health services include:

- high costs,
- family stressors,
- inadequate transportation,
- school absenteeism (child),
- lost wages (parent)...

...are greatly mitigated when MH services are provided in K-12 schools.

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Schools as Primary Access Points for Mental Health Services

**Location, location, location!**

- “Neighborhood schools” guarantee easy access to all children
- Situated in center of communities, campuses can maximize reach of service providers to everyone in the community.
- School buildings often underutilized (7 hour school day/180 day calendar), “can offer prime real estate” for service providers. *(Runge, Knoster, Moerer, Breinich & Palmiero, 2017)*
- Clinical efficiency, productivity = lower costs of service delivery
Schools as Primary Access Points for Mental Health Services

Advantages to school-based delivery of MH services:
- Reduce disparities along cultural, socio-economic dimensions
- Lowers attitudinal barriers (stigma) to seeking MH treatment
- Less threatening than typical clinical environment:
  - clinician as part of school team, and
  - students in their own social context
  - outreach to students with internalizing problems

Increased likelihood of treatment completion
(Hoover et al., 2018: 90.3% of 350 students completed 70 CBITS groups)
Schools as Primary Access Points for Mental Health Services

Advantages to school-based delivery of MH services:

- Generalization of interventions and outcomes more likely when MH treatment can be directly applied in context of naturally occurring school milieu (Mazza & Reynolds, 2008; Merrell, Gueldner & Tran, 2008)
- Teachers, staff can reinforce student skills from treatment
- On-site MH services can provide:
  - crisis intervention support to students;
  - wellness support to highly stressed faculty and school staff
Wellness Support for School Staff?

Used with permission of Sharon Hoover PhD, Center for School Mental Health
Per non-federal ISMICC member recommendations (December 2017):

2.6 Prioritize early identification, intervention for children/youth/young adults.

3.2 Make screening and early intervention among children, youth, transition-age youth and young adults a national expectation.

“Education is the only common denominator for virtually all our kids.”
Conni Wells, ISMICC, 6/8/18

“School-based services in affiliation with the Dept. of Education play a central role in the lives of children and youth with SED.”

The Way Forward
Schools in Community Systems of Care

Schools now eager for mental health support for their students: 622 school districts surveyed by School Superintendents’ Assn [AASA] (EdWeek 6/17/18):

- 63% want to spend ESSA Title IV-A grants on making students safer
- 51% want to spend Title IV-A funds on PBIS
- 43% want to spend ESSA grant funds on school counseling

Federal School Safety Commission/Secretary DeVos -> SEL, SMH.

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School MH, Safety, Improvement Reforms Embrace SOC Core Values and Principles

**Systems of Care:**
- Community-based
- Family Driven
- Youth Guided
- Culturally Competent
- Evidence-Based
- Least Restrictive
- Data-Driven CQI
- Collaborative across Systems

**Comprehensive School Mental Health Systems:**
- Community-based
- Family Driven
- Youth Guided
- Culturally Competent
- Evidence-Based
- Least Restrictive
- Data-Driven CQI
- Collaborative across Systems
School MH, Safety, Improvement Reforms Embrace SOC Expansion Strategies

**Systems of Care:**
- Policy and Partnership Changes
- Expand Services and Supports
- Improve Financing Strategies
- Workforce Development (Training and Coaching)
- Generating Support through Strategic Communications

**Comprehensive School Mental Health Systems:**
- Policy and Partnership Changes
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Discussion Question

What examples of aligning/integrating SOCs with school mental health services [SMH] where you live?

- What opportunities can you see for aligning/integrating school mental health services [SMH] with your system of care?

- What barriers/challenges to such alignment and integration do you perceive/have you encountered?
Systems of Care *featuring* Comprehensive School Mental Health Systems

- Collaborative Structures and Practices across Systems
- *Evidence-based, Community-based Services, Supports*
- Student/Youth and Family-Driven Approaches
- Strategic Communications to Generate Support
- Financing Strategies for Sustainability
Building Multi-Tiered Systems of Evidence-Based School Support (MTSS)

• What is the *Multi-Tiered System of School Supports*?
• How does School Mental Health interact with MTSS?
• What do you have to do across these “tiers”?
• How to make sure MTSS programming is effective?
• What is the role of systems of care in MTSS?
http://education.washington.edu/smart
SMART Center Mission

• To promote quality improvement of school-based mental/ behavioral health services by facilitating the transfer of evidence-based practices to educational settings.

• Overarching SMART Center Goals:
  1. Prevent, address MH problems that interfere with academic success.
  2. Promote the well-being of youth across school, home, and community contexts.
  3. Make effective use of evidence-based intervention programs across all three tiers of support.

http://education.washington.edu/smart
Organizing school-based supports

In an ideal world:
A continuum of evidence-based supports, tiers of MH intervention parallel tiers of educational intervention

Targeted/Intensive (FEW High-risk students) Individual Interventions (3-5%)

Selected (SOME At-risk Students)
Small Group & Individual Strategies (10-25% of students)

Universal (All Students)
School/class wide, Culturally Relevant Systems of Support (75-90% of students)
Multi-Tiered Systems of Support

• Serving **ALL** students through continuum of care
• **Proactively** identifying students who are at-risk (i.e. universal screening)
• **Matching** evidence-based interventions to student need
• Frequently **monitoring student progress** to make decisions with regard to an intervention or goals
• Monitoring and examining treatment integrity to make legally sound and valid educational decisions
Interconnected Systems Framework (ISF): Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide Positive Behavior Support

https://www.pbis.org/school/school-mental-health/interconnected-systems
MTSS and School MH: What is needed?

• District and Building Level Teams to manage MTSS
• Clear, identified strategies across the 3 tiers
• Positive Behavior Supports at Building Level
• Risk Assessment and referral
  • School-wide screeners, review of disciplinary referrals, referrals from relevant school staff
• Data systems to ID students, monitor implementation, track outcomes
Multi-Tier System of Supports (MTSS)
A continuum of evidence-based supports for social-emotional needs

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Tier 3 Menu of Individual Supports for a FEW:
• FBA-based Behavior Intervention Plan & Replacement Behavior Training
• Cognitive Behavior Therapy
• “Tier 3 Wraparound” teaming

Tier 2 Menu of Default Supports for SOME:
• Behavioral contracting
• Self monitoring
• School-home note / “Class pass”
• Mentor-based programs
• Targeted individual MH treatment
• Group social-emotional skills training

Tier 1 Menu of Supports for ALL:
• Schoolwide PBIS
• Positive relations with all students
• Social-emotional learning (SEL)
• Evidence based prevention E.g., Good Behavior Game
• Proactive classroom management
Interconnected Systems Framework

Tier I: Universal/Prevention for All

*Coordinated Systems, Data, Practices for Promoting Healthy Social and Emotional Development for ALL Students*

- **School Improvement team** gives priority to social and emotional health
- Mental Health skill development for students, staff/, families and communities
- Social Emotional Learning curricula for all
- Safe & caring learning environments
- Partnerships: school, home & community
- Decision making framework guides use of and best practices that consider unique strengths and challenges of each school community
Tier 2: Early Intervention for Some
Coordinated Systems for Early Detection, Identification, and Response to Mental Health Concerns

- **Systems Planning Team** coordinates referral process, decision rules and progress monitors
  - Array of services available
  - Communication system: staff, families and community
  - Early identification of students at risk for mental health concerns due to specific risk factors
  - Skill-building at the individual and groups level as well as support groups
- Staff and Family training to support skill development across settings
An Expanded Tier Three

- Mental health professional(s) part of tertiary systems team
- FBA/BIP and/or Person-Centered Wraparound plans completed together with school staff and mental health provider for one concise plan, rather than each completing paperwork to be filed
- Quicker access to community-based supports for students and families
Expanded School MH

Traditional → Preferred

- Each school works out their own plan with Mental Health (MH) agency;
- District has a plan for integrating MH at all buildings (based on community data as well as school data);
Expanded School MH

Traditional ➔ Preferred

• A MH counselor is housed in a school building 1 day a week to “see” students;

• MH person participates in teams at all 3 tiers;
Expanded School MH

Traditional  ➔  Preferred

• No data to decide on or monitor interventions;

• MH person leads group or individual interventions based on data;
How Would you Evaluate the “Interconnectedness” of your School MH initiative?

• The Expanded School MH Collaboration Tool*
  • Community mental health professionals use this instrument for evaluating current collaborations and associated strategies for strengthening collaborative relationships.
  • Mental health administrators can identify key considerations in planning new ESMH collaborations.
  • Policymakers, evaluators, and researchers may also find this tool useful for examining process and impact of SMH.

Access ≠ Effectiveness

Access & Utilization of Services

Enhancing Service Quality

Mind the Gap
Developing a Contextually Appropriate Intervention for SMH: The Brief Intervention for School Clinicians (BRISC)

Funded by the Institute of Education Sciences (R305A120128 – Bruns & McCauley & Bruns, Co-PIs)
Summary: BRISC Design

• **Satisfaction / Reputation**
  • Options for “Tier 2” SMH programming widely sought

• **Efficiency**
  • 3-4 brief sessions

• **Learnability**
  • Small number of evidence-based modules/skills

• **Find a Good fit for Schools**
  • Fit within the structures and priorities of the school setting
  • Problem solving framework to enhance engagement with adolescents
### BRISC: Finding a “Good Fit” for Schools

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<td>Students feel like therapy is just “a lot of talking”</td>
<td>Active engagement of the student by focusing on their needs as they describe them</td>
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Session 1: Engagement & Problem Identification
Session 2: Stress Psychoeducation & Problem Solving
Session 3: Skill/Module Implementation
  • Practical difficulties (problem solving)
  • Getting along with other people (communication skills)
  • Just don’t feel like it (motivation enhancement)
  • Handling hard feelings (mood/stress management)
  • Dealing with a hard situation I can’t change (cognitive restructuring)
Session 4: Review Skill Implementation & Plan for Next Steps
Core BRISC Process

- Engage, Assess
- ID Top Problems
- Collaborative Problem Solving
- Did student successfully implement step?

If NO: What was the BIGGEST BARRIER to moving forward?
- Wrong Problem/Solution
- Can’t Manage Stress/Mood
- Unable to Express Needs
- Stuck in Negative Thinking

THEN: Individualized, skill-based response
- Revisit Problem List/PS Steps
- Stress and Mood Management Guide
- Communication Guide
- Realistic Thinking Guide

Yes

No

MORE TO WORK ON

DONE WITH COUNSELING

CHOOSE A NEW PROBLEM
Can we improve SMH Usual Care?

Examining shift in practices measured via the TPOCS*

**Trying to move from:**

- Psychodynamic Focus
- Psychodynamic: Transference
- Psychodynamic: Explores Past
- Psychodynamic: Interpretation
- Family Focus
- Targets Others
- Recruits Others
- Parenting Style
- Operant strategies - parent
- Parenting Skills
- Multiparticipant
- Play/Art Therapy
- Self Disclosure
- Advice
- Questioning

**To:**

- Cognitive Education
- Cognitive Distortion
- Cognitive Coping Skills
- Behavior Focus
- Relaxation
- Skill Building
- Behavioral Activation
- Monitoring
- Psychodynamic: Resistance
- Validate Client
- Client Perspective
- Homework
- Session Goals
- Treatment Goals
- Previous Themes
- Coaching
- Assessment
- Psychoeducation

*Therapy Process Observation Coding System (McLeod, Weisz, et al., 2010)
Success! (?): BRISC Clinicians’ use of BRISC-consistent practices was higher than for SAU

Use of Practice Elements Consistent with BRISC (more “evidence-based”)

Use of Practice Elements Antithetical to BRISC (less “evidence-based”)

SMH SAU (38 tapes)  BRISC (46 tapes)

SMH SAU (38 tapes)  BRISC (46 tapes)
BRISC was efficient as well as effective

1. Therapy finished: Come back if you need it (54%)
2. Let's keep an eye on you: Supportive monitoring (18%)
3. More work to do: Continue BRISC or other school MH service (18%)
4. We need more: Intensive services (2%)
BRISC Reducing the percent of students in the clinical range – in four sessions and eight weeks.
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<th>SCHOOL-WIDE</th>
<th>CLASSROOM</th>
<th>FAMILY ENGAGEMENT</th>
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<td>1. Leadership team</td>
<td>1. All school-wide</td>
<td>1. Continuum of positive behavior support for all families</td>
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<td>3. Set of positive expectations &amp; behaviors</td>
<td>3. Positively stated expectations posted, taught, reviewed, prompted, &amp; supervised.</td>
<td>3. Formal &amp; active participation &amp; involvement as equal partner</td>
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<tr>
<td>5. Continuum of procedures for encouraging expected behavior</td>
<td>5. Continuum of strategies to acknowledge displays of appropriate behavior.</td>
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<tr>
<td>7. Procedures for on-going data-based monitoring &amp; evaluation</td>
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<th>EVIDENCE-BASED STRATEGIES and PRACTICES</th>
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<td>1. Positive expectations &amp; routines taught &amp; encouraged</td>
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<tr>
<td>2. Active supervision by all staff (Scan, move, interact)</td>
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<td>3. Precorrections &amp; reminders</td>
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<td>4. Positive reinforcement</td>
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<td>1. Behavioral competence at school &amp; district levels</td>
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<td>2. Function-based behavior support planning</td>
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<td>3. Team- &amp; data-based decision making</td>
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<td>4. Comprehensive person-centered planning &amp; wraparound processes</td>
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<td>5. Targeted social skills &amp; self-management instruction</td>
</tr>
<tr>
<td>6. Individualized instructional &amp; curricular accommodations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NON-CLASSROOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Positive expectations &amp; routines taught &amp; encouraged</td>
</tr>
<tr>
<td>2. Active supervision by all staff (Scan, move, interact)</td>
</tr>
<tr>
<td>3. Precorrections &amp; reminders</td>
</tr>
<tr>
<td>4. Positive reinforcement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FAMILY ENGAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Continuum of positive behavior support for all families</td>
</tr>
<tr>
<td>2. Frequent, regular positive contacts, communications, &amp; acknowledgements</td>
</tr>
<tr>
<td>3. Formal &amp; active participation &amp; involvement as equal partner</td>
</tr>
<tr>
<td>4. Access to system of integrated school &amp; community resources</td>
</tr>
</tbody>
</table>
Getting to “Tier 3”: Intensive services

“Here comes the really hard part!”
What is Tier 3 intensive?

• For students with serious and challenging behaviors that require individualized interventions

• Collection of data to determine function of behavior (FBA) and positive behavior plan to address function (BSP)

• For youth who require it – Coordination of home, school, community interventions
  • Potentially using the wraparound process
Tier 2/3 Process Builds Across Tiers

Tier 2
- Teams
- Goals
- Assessment
- Intervention
- Evaluation

Tier 3
- Teams
- Goals
- Assessment
- Intervention
- Evaluation

Tier 3 Wraparound
- Teams
- Goals
- Assessment
- Intervention
- Evaluation
# Comparison Tiers 2, 3, and Wraparound

<table>
<thead>
<tr>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 3 Wraparound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small emotional/behavioral planning team</td>
<td>Student-specific team members (student, parent, peer, administrator,</td>
<td>Student and family identify team members which may include peers and professionals</td>
</tr>
<tr>
<td>reviewing students who need more than Tier 1</td>
<td>teacher, behavioral staff member, etc.)</td>
<td>outside of school</td>
</tr>
<tr>
<td>interventions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Comparison Tiers 2, 3, & Wraparound

<table>
<thead>
<tr>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 2</strong></td>
</tr>
<tr>
<td>Similar goals for all students: in class, on task, responding successfully to Tier 1 supports</td>
</tr>
</tbody>
</table>
## Comparison Tiers 2, 3, & Wrap

<table>
<thead>
<tr>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 2</td>
</tr>
<tr>
<td>Tier 3</td>
</tr>
<tr>
<td>Tier 3 Wraparound</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 3 Wraparound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical Functional Behavior Assessment (FBA) of problem behavior</td>
<td>FBA including observations and interviews</td>
<td>More comprehensive measures assessing strengths &amp; needs in home, school and community</td>
</tr>
</tbody>
</table>
## Comparison Tiers 2, 3, & Wraparound

<table>
<thead>
<tr>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 3 Wraparound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiers 1 and 2 interventions with individualized components to Tier 2 interventions if needed</td>
<td>Tiers 1 and 2 interventions and Behavior Support Plan (BSP) including Safety Plan</td>
<td>Same as Tiers 1, 2 and 3; Crisis/safety plan; Community services, as needed</td>
</tr>
</tbody>
</table>
## Comparison Tiers 2, 3, & Wraparound

<table>
<thead>
<tr>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 2</strong></td>
</tr>
<tr>
<td>Office discipline referrals, Check-in/Check out data, attendance, nurse visits, other</td>
</tr>
</tbody>
</table>
Tier 2/3 Process Builds Across Tiers

Tier 2
- Teams
- Goals
- Assessment
- Intervention
- Evaluation

Tier 3
- Teams
- Goals
- Assessment
- Intervention
- Evaluation

Tier 3 Wraparound
- Teams
- Goals
- Assessment
- Intervention
- Evaluation

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“Tier 3” Wraparound: Main Messages

• School-wide PBS (with all three tiers) is proving to be both practical and effective at building the positive social cultures that support educational gains.

• Addressing the behavior support needs of those students with the most intensive needs is part of school-wide PBS.
  • Commonly referred to as “Tier 3” or intensive individualized supports

• School-based wraparound can be key “Tier 3” strategy within PBS; emphasizes collaborative, team based approach to solving behavior problems
  • However, system collaboration and workforce support is critical to success

• Wraparound is about to “go to scale” in Washington State
Effective School Mental Health: A Summary of main points

☑ Comprehensive: Teams & Strategies across All Tiers

☑ Interconnected: Building, district, community on same page and working together

☑ All Strategies are Evidence Based

☑ Data Used to refer, monitor, and evaluate success
Roles for Community-Based Systems of Care in Promoting Effective MTSS + School-Based Mental Health

Systems change
• Convening stakeholders, prioritizing needs, strategic planning
• Promoting adoption of MTSS framework across the “Tiers”
• Participating in activities of school teams

Consultation on Tier 1 implementation
• Including selection of specific strategies

Consultation on Tier 2-3 strategies
• Selection, resourcing, and oversight of specific strategies
• Case management for individual students

Data-based decision making
• Screening and referral based on screening
• Progress monitoring for specific students
Roles for Community-Based Systems of Care in Promoting Effective MTSS + School-Based Mental Health

• Behavior management trainings
  • For teachers – classroom management
    ▫ For parents – e.g., quarterly parenting classes
  ▫ Individual or group therapy with students in need
    ▫ Cognitive Behavior Therapy and other EBPs
    ▫ Effective group interventions (Coping Cat, Coping Power, social skills)

• Conduct FBA and develop individualized BIPs
• Facilitating effective “Tier 3” wraparound
• Ensuring access to parent and youth peer support
Facilitating a School Mental Health (SMH) Planning Process

A core role of Systems of Care
The Partnerships for Success (PfS) Model

Partnerships for Success is “a comprehensive approach to building community capacity to prevent and respond effectively to child and adolescent social emotional needs while promoting positive youth development”

The PfS model revolves around a core of data-informed decisions and is encompassed by a continuous need for community mobilization.
Community Mobilization

Success of the model depends on ongoing and sustained mobilization of the community.

- Executive Team
- Core Team
- Community Stakeholder Team
- Broader community involvement
Planning Process

Planning is composed of three basic activities:

- Needs Assessment
  - Identify areas of need
- Resource Assessment
  - Realistic view of current programs, services, and available resources
- Identify Strategic Actions
  - Address gap between needs & services

*Followed by Implementation and Evaluation Planning*
Implementation is the process of turning a recommendation into a series of “action steps” that are subsequently executed and evaluated against PfS guiding principles.

**Implementation options**
- Implement a new program
- Enhance an existing program
- Change or enhance local infrastructure to support youth programming
Ongoing evaluation informs the progress of the model and provides outcomes for accountability.

Evaluation activities might include:

- Administrative data
- Surveys (community, agencies, therapists, youth, parents)
- Focus groups
Q&A – Break Time

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