



Mental/Behavioral Health Care in School Based Health Centers (SBHC)

A Snapshot

ANALYSIS OF ANNUAL REPORTS

2014-2015

INTRODUCTION

Child and adolescent mental/behavioral health has been front and center for over twenty years. Several key national and state reviews including the Surgeon General's Action Agenda for Children's Mental Health (U.S. Public Health Service, 2000): *Achieving the Promise: Transforming Mental Health Care in America* (President's New Freedom Commission on Mental Health, 2003) served to highlight the youth mental health crisis. The federal government continues to recognize mental health and mental disorders as an area in need of improvement as evidenced by the specific goals and objectives identified in Healthy People 2020, a national health promotion and disease prevention initiative.

The Centers for Disease Control (CDC) report on Mental Health Surveillance among Children — United States, 2005–2011, states that 13% to 20% of children now living in the United States experience a mental illness in a given year, and surveillance over the past two decades has shown an increase in the prevalence of these conditions. According to the Connecticut Children's Behavioral Health Plan Overview, approximately 783,000 children under age 18 are currently in Connecticut. This represents about 23% of the state's population. Epidemiological studies using large representative samples suggest that as many as 20% of that population, or approximately 156,000 of Connecticut's children, may have behavioral health symptoms that would benefit from treatment. The fact that many children and adolescents in need of mental care don't receive services is well documented.

Child and adolescent mental/behavioral health is important to overall health. Research conducted by Kessler, Berglund, Demler, Jin, Merikangas, & Walters, (2005), determined that one-half of all lifetime diagnosable mental health conditions begin by the age of 14.

Mental disorders are chronic health conditions that can continue through the lifespan. Without early diagnosis and treatment, children with mental disorders can have problems at home, in school, and in forming friendships. This can also interfere with their healthy development, and these problems can continue into adulthood. In addition to the human cost, undiagnosed disorders/problems carry a heavy financial toll. The 2015 Child Mind Institute Children's Mental Health Report states that the cost of lost productivity and crime spending related to mental illness in those under 24 at 202 billion dollars.

Although the statistics can be distressing, a silver lining exists. Childhood Mental, Emotional Behavioral (MEB) disorders/problems can be treated and managed. A 2007 Journal of Emotional and Behavior Disorders article entitled, "Empirically Based School Interventions Targeted at Academic and Mental Health Functioning" reported that *a growing body of empirical literature that includes the results of controlled clinical trials and within-group studies has documented the impact of mental health treatments and other interventions on child and adolescent outcomes. These studies demonstrate that specific treatments are efficacious for most of the common clinical conditions in children* (Burns & Hoagwood, 2002, 2004; Burns, Hoagwood, & Mrazek, 1999; Hoagwood & Burns, 2005; Jensen et al., 1999; Kazdin, 2005; Loeber & Farrington, 1998; U.S. Public Health Service, 1999, 2000, 2001a, 2001b; Weisz, 2004; Weisz & Jensen, 1999; Weisz, Weiss, Han, Granger, & Morton, 1995).

that said, access to comprehensive, coordinated, culturally sensitive, developmentally appropriate mental health services that are delivered by licensed mental health clinicians with expertise in addressing the Mental, Emotional, Behavioral (MEB) needs of children is often problematic.

DPH supports ninety-six School Health Service Programs serving students in pre-school through high school in twenty-eight communities statewide. Eighty-eight percent of the programs are School Based Health Centers that also provide primary care and, in some cases, dental services. All the School Health Service Programs provide mental health services including: crisis intervention individual/group/family counseling care coordination, case management and mental health promotion/education activities to eliminate/reduce barriers to learning and maximize student's potential to reach his/her potential.

According to DPH SBHC data for contract year 2013-2014, the latest year available, an estimated 21,279 students made at least one SBHC medical visit. The total number of medical visits was about 59,761. During the same time period, 3,895 students made at least one mental health visits for a total of 48,482 visits. This data illustrates the difference in service utilization between students seen for medical care versus students seen for mental/behavioral health services.

All DPH supported SBHC programs are contractually required to submit an annual year-end activity report. Twenty-four out of twenty-four (100%) year-end activity reports for the period July 1, 2014-June 30, 2015 were reviewed and analyzed by the DPH social work consultant during the last quarter of 2015.

This document provides an anecdotal analysis of the mental health trends, challenges, interventions, and successes that showcase those components that make this venue of service delivery unique and effective.

Decisions for inclusion in this report are based on frequency of reporting. The examples are excerpts from reports that were submitted that included a certain level of detail. Although numerous examples were provided, space constraints limit the number of stories featured here.

For the purpose of this report, the term School Based Health Centers includes all DPH supported School Health Services Programs. MEB Disorders are defined as a "diagnosable mental or substance use disorder" and MEB Problems are described as "difficulties that may be early signs or symptoms of disorders but are not frequent or severe enough to meet the criteria for diagnosis". Children will be used to refer to the population served and Parent will also encompass individuals that are identified as primary caregivers (i.e. biological parent, family members and non-familial guardians).

TRENDS

It is important to note when discussing trends that the ones identified here are not mutually exclusive. The submitted reports repeatedly mentioned anxiety, depression and difficulties with emotional regulation which seems to mirror what has been observed on the national level.

Twenty-two of the twenty-four reports reviewed (91%) noted a continued swell in the number of students presenting to the SBHC with anxiety, a phenomenon that transcended all age groups served. More than a few contractors mentioned increased visits to the nurse as the result of anxiety related symptoms. Although anxiety and depression are different conditions, they commonly occur together which was also reflected in the information provided. Several contractors cited an increase in the number of students experiencing panic attacks and another noted, an increase in the number of students requiring homebound tutoring because of anxiety, depression, and school phobia.

An increase in the number of students diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD) was another frequently cited trend. Reports frequently mentioned students exhibiting poor impulse control, aggressive/disruptive behavior, self-injury and other manifestations of emotional dysregulation resulting in negative consequences.

Also on the rise, is the number of students dealing with issues of grief and loss stemming from a number of factors, most notably, parental/guardian/caregiver absence due to death, divorce, incarceration, mental illness, substance abuse, etc. As one contractor put it *“There was a strong presence of grief and loss work required in nearly 80% of students around the death of or the inconsistent involvement of one parent”*.

Another concern is the impact of technology, particularly social media, and its effect on student functioning (i.e. sleep, concentration, bullying, self-esteem and academic performance). Numerous contractors identified increases in cyber-bullying and sexting. In the words of one contractor, *“Trends in use of technology and social media have had a negative impact on SBHC mental health. Among this population, risks have included cyber-bullying, ‘sexting’, relationship abuse, sexual solicitation and predation privacy concerns/policies and a ‘digital divide’*.

Other mental/behavioral health trends included: increases in bullying, trauma and relationship conflicts (familial, peer, significant other) and substance abuse. Truancy and absenteeism were also reported.

CHALLENGES

The most frequently cited challenges related to mental health services were: booking appointments that meshed with the student’s academic schedule; parental participation; the availability of affordable, appropriate and accessible outpatient mental health and psychiatric treatment services and substance abuse programs, waiting lists for outpatient services, and insufficient mental health hours available to meet student need. Other less frequently identified barriers included: student motivation, stigma, parental resistance to referrals, medication evaluations; school staff’s understanding of the role of the mental health clinician and the type of students to refer; financial hardship, transportation and language.

INTERVENTIONS

The SBHC mental health clinicians utilized a variety of interventions/strategies to address student mental/behavioral health issues. Crisis intervention, individual treatment, skill building/support groups, classroom lessons and school wide events were the most frequently identified venues. Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), play therapy and art therapy were the most frequently cited treatment approaches.

According to the reports, individual therapy/counseling was provided at all DPH supported SBHCs during the reporting period. Although services can only be provided to one student at a time, this form of treatment is extremely beneficial to students. The SBHC mental health clinician (MHC) has the opportunity to establish a trusting relationship with the student that allows him/her to feel comfortable sharing feelings and concerns. Individual therapy also provides confidentiality in what is said between the student and the MHC, a key factor for students receiving mental health care. The MHC is also able to obtain a more complete understanding of the student's strengths, difficulties and capacities to better address his/her specific issues and needs.

The question is often asked regarding the success of individual sessions. As part of another contract deliverable, 31 SBHCs serving students in grades, Pre-K-12, statewide, chose to submit data to determine if students who received individual treatment were better off. In 2013-2014, a total of 1,645 students had at least one mental health visit. Of those, 920 (84.4%) students were assessed using a DPH approved tool/method to determine a baseline level of symptom severity/level of psycho-social functioning. Those students then received at least 3 months of consistent therapy. Of those students that received at least 3 months of consistent treatment, 740 (80.4%) students showed improvement in problem severity/level of psychosocial functioning when reassessed using the same tool/method after the 3 month period.

A report from a contractor operating a SBHC serving elementary students stated:

“The children have learned and practiced ways to correctly identify and express their feelings to themselves and others; visits to the nurse have significantly been reduced per nurses report; all clients being seen currently state they wish to continue therapy sessions over the summer and during the following school year; their parents have started to attend family sessions and request more support around psychoeducation and how to manage family dynamics that affect the wellbeing of the child and family as a whole; children have started expressing and identifying difficult emotions and are practicing their skills at home; rapport has been built and is strong between clinical staff and the school staff as well as parents engaged in services; children are starting to use techniques that allow them to stop and think before reacting out of impulsivity or anxiety; Children are starting to build relationships in their new school through ego strengthening and appropriate social skill development which is decreasing the intensity of depression, anxiety and adjustment issues overall. Significant work is being conducted with families and children around absentee parents, children are learning to ask for what they need emotionally and have needs met within the supports available to them through work reinforcing that they are not the cause of the parent's absence”.

Below is an excerpt from another report from a contractor operating a SBHC that serves older adolescents:

“JZ was referred to the health center because she has been caught stealing her peers electronics several times this school year. She is a good student, had never been in trouble before for any kind of misconduct or oppositional behavior in class. Everyone that she steals from always forgives her because she has a nice personality and is always trying to help people. Through individual sessions, the therapist learned about her family’s culture. JZ lives with her father and 2 older half-sisters. The entire family was born in another country and came to the United States when JZ was 9. JZ’s mother stayed behind in the homeland and this is something that JZ continues to struggle with on a daily basis. She misses her mother every day and feels the emptiness that her absence leaves. JZ’s father has a low wage job and works very hard to support his family that he would not be able to get his daughter to counseling appointments outside of the school because of his work schedule and the family’s limited financial resources. When talking about the stealing, JZ explained it as an impulse that she gets when she sees that all of her friends have things that she doesn’t and it makes her upset. Her family attended a session to talk about ways to work together to help JZ control these impulses. Her father explained to the therapist that he is very embarrassed by his daughter’s actions and the only way he knows how to handle it is to ignore her and distance him from her. JZ expressed that this upsets her greatly and that her father is her best friend and all she wants is another chance for him to love her again. The therapist explained the importance of emotional support and how “shutting JZ out” is more damaging to her than any grounding or punishment. The father was able to understand the impact that his actions were having on his daughter JZ has been coming to therapy on a consistent basis and has been working to understand the connection between her thoughts and her actions. She has been working towards being aware of and reframing the negative thoughts that make her want to steal things from her friends and express those thoughts to her therapist in the moment when they are happening. This was able to take place because the health center is easily accessible to her within the school during school hours and is always open to her to come in and talk about what she is feeling. If the therapist was with another student, JZ was allowed to come to the health center and write down her feelings on a piece of paper, draw them in a picture or just wait until therapist was done and could process these feelings with her. JZ is now able to process these thoughts on her own and use the coping skills learned without accessing the health center on a daily basis. She has not had any incidents of stealing since starting therapy JZ was a great success story this year because this case highlighted the importance of the health center being located within the school and providing mental health counseling to kids that might not have the opportunity otherwise”.

A third and final story that highlights individual counseling comes from a report of a contractor operating a SBHC in a middle/high school:

“Several students had sad moods and oppositional behavior due to their father’s incarcerations. These students were able to attend individual therapy sessions focusing on improving their own lives and as a result improved their moods. One student had significant anger issues at school. In individual therapy sessions, this student was able to identify underlying family issues causing him to act out with anger especially toward school staff. By identifying these underlying issues

the student was able to decrease his angry outbursts. One student diagnosed with anxiety had a difficult time coming to school, going to sleep at night and participating in the classroom. The student participated in individual therapy sessions and decreased his anxiety within tolerable levels so he could go to school daily, go to sleep in his own bed and participate in the classroom”.

Classroom lessons were another frequently reported mode of service delivery for all age groups. This venue works well as students are already familiar with the classroom setting and program staff has the ability to serve more students in what is often a limited timeframe.

Below is an excerpt from a report highlighting the use of classroom lessons by a SBHC serving elementary school students:

SkillStreaming in Early Childhood, <http://www.skillstreaming.com>, a research-based skills training curriculum originally developed by Goldstein and McGinnis, was provided to students in kindergarten and first grade. “The MHC presented one social skills lesson a week in two classes. A few examples of lessons included: Listening, Self-Control, Asking for help, using nice talk, using brave talk, Asking a question, etc. Students practiced each skill for the week and shared their results the following week during skill review time before beginning a new lesson. Special lessons were created by MHC for specific classroom challenges following weekly teacher consults. In addition to classroom presentation, the MHC met with small groups of students who needed additional practice/education with certain skills”. Letters were sent to the student’s parents/guardian explaining the program and how they can help their child practice their new skills at home.

Another report from a contractor serving students K-4 also employed age appropriate classroom lessons. Some were based on books/DVDs (i.e. Edward the Emu, Spookley the Square Pumpkin, Don’t Feed the Monsters on Tuesdays). Stories focused on: diversity/differences, kindness, cooperation, teambuilding and strategies for coping with anxiety.

Another report, this one from a contractor serving middle school students, conducted classroom lessons on digital citizenship (<http://digitalcitizenship.net>) and implemented Second Step (<http://www.secondstep.org>), a research based bullying prevention program that utilizes the classroom lessons format.

Group therapy/support groups were also a popular mode of service delivery. Groups are beneficial to students in that they provide a unique opportunity for participants to receive multiple perspectives, support, encouragement and feedback from other individuals in a safe and confidential environment. These interpersonal interactions can provide group members an opportunity to deepen their level of self-awareness and to learn how they relate to others. Like classroom lessons, groups enable MHC’s to expand their reach as multiple students are served simultaneously.

From what could be ascertained, nearly all contractors serving the elementary school population provide at least one but often multiple groups-focused social skills/self-control/anger management. One contractor also provided groups for students with ADHD.

Groups targeting middle and high schools concentrated on: stress reduction, healthy relationships, self-esteem, violence prevention, substance abuse prevention, coping strategies, grief and bereavement, puberty, transition, and problem solving. Additional subjects addressed at the high school level included: suicide prevention, depression awareness, and smoking cessation.

Many examples of successful groups/activities targeting high school students were shared. One responder described the Girls Wellness Group that was conducted. According to the report,

“The group met once a week throughout the school year and was comprised of five girls who attended on a regular basis. A variety of topics were discussed including: relationships, teen pregnancy, STD’s, etc. Initially, the group was divided into pairs, meaning that there were two sets of friend groups. They wouldn’t talk to one another, and one student would say that she was frightened of the other group members. Throughout the year, though, the girls learned to depend on one another for support and feedback. They would look for one another in the hallways or class”.

Another report included an evaluation of a stress management/anxiety group, an excerpt from the report is as follows: *All six consistent group members reported benefiting from the group in regards to helping them with stress, anxiety, anger, depression. Some comments from the evaluation include: “Group makes me feel good about myself”, “I like that I can be myself”, “I like the communication within the groups and it helped me control my anger and think before I react”, “I loved the group, it helped me a lot and it felt like a sisterhood”.*

A third report included a detailed description of a writers group conducted with adolescent females. An excerpt from the report reads as follows:

“Ten girls participated in a group that was started in response to an Op Ed in the New York Times about students with mental illness and the struggles they faced in school. Our original goal was to use the discussion time to help the girls write articles for the school newspaper on their own mental health challenges; I met with the editor of the newspaper and got his enthusiastic endorsement. However, the timing was not right; the girls seemed to need support and empathy first and foremost; although they wrote poetry, letters and journal entries, their vulnerability was still high and it was clear they weren’t ready for publication! Numerous times, the girls spoke about how the group had “saved their lives” this year”.

Another method for reaching students that was identified in multiple reports involved SBHC hosting/participating in school-wide events. According to, *School Connectedness: Strategies for Increasing Protective Factors among Youth* (Division of Adolescent and School Health, CDC, (2009), *“Students feel more connected to their school when they believe that the adults and other students at school not only care about how well they are learning, but also care about them as individuals. Young people who feel connected to school are more likely to succeed academically and make healthy choices”.*

One contractor shared an example of an activity targeting middle school students which also highlights the collaborative efforts between SBHC staff and school personnel:

“The MHC collaborated with the school social skills counselor in facilitating a weekly Leadership Club. This new endeavor culminated in a week long “Broadview United: A Week of Kindness and Inclusion”. Highlights included daily themes (Mindful Monday, Tolerant Tuesday, etc.), a presentation on breaking down stereotypes by staff from the local Women’s Center, and raffle prizes given to students “caught being kind”.

Another contractor reported that the SBHC serving middle school students hosted Red Robin Week to promote a healthy drug-free lifestyle. According to the report,

“Each day during the week, two students were chosen to read Red Ribbon Week facts over the morning announcements. The health center, located in a middle school, also created an activity for the teachers to complete during homeroom which included watching a video and a question and answer session. Finally to wrap up the week, an information booth outside of the cafeteria during lunch was set up to hand out educational materials and the students signed a red hand cutout which represented their pledge to be drug free”.

Other schoolwide events included a Drug Prevention Teen Idol Talent Show, anti-bullying rallies/assemblies and health fairs.

COLLABORATION

Research shows that parent engagement in schools is closely linked to better student behavior, higher academic achievement, and enhanced social skills. Parent engagement also makes it more likely that children and adolescents will avoid unhealthy behaviors, such as sexual risk behaviors and tobacco, alcohol, and other drug use. According to the year-end reports, school based health programs make every effort to engage parents/guardians. Many contractors mentioned that successful parent engagement is an ongoing challenge, however; some successes were shared.

One report stated that one of their elementary school SBHC MHCs, established the *Circle of Caregivers*, a monthly support and educational group for parents and caregivers of elementary school students. A monthly topic was presented and parents had the opportunity to share their parenting and family successes and challenges, explore monthly topics and connect with the other caregivers in the school community.

One school based health program serving students in grades K-4, included a parent component. A parent counselor worked in tandem with program staff to provide parents/guardians with support/ parenting education to promote healthy parent/child relationships and to encourage parents to promote the positive behaviors learned in school at home. According to the program report, twenty-five of the twenty eight (89%) parents referred to the parent counselor followed through with their appointment(s).

Collaborative relationships within and outside of school are a major hallmark of SBHCs. Such efforts were repeatedly noted in the documents reviewed. The majority of reports stated that the MHCs meet with school support staff regularly. A number of contractors mentioned MHC

attendance at Planning and Placement Team (PPTs) and 504 educational meetings. The following story from a report for a SBHC serving elementary/middle school students illustrates how working together can help students at risk:

“A kindergartener who was very physical and verbal with his behavior toward the adults in the school; he was unsafe many times throughout the day and was very hard to control with his lashing out at staff. The team working with the student came up with a Behavior plan to be consistent with rules and consequences. After a few months his behavior started to improve and he started to be safer in the school building. By mid-school year, he was able to transition and follow school rules with his behavior improving by 80% from the start of school. The consistency of all staff members working together was the key to his successful school year as a kindergartner”.

Students with complex mental health needs often have more than one service provider involved in his/her care. The following is an excerpt from a report from a contractor operating a SBHC serving high school students highlighting the importance of establishing positive working relationships with other service providers:

“Student A returned to the school in late October after his second hospitalization for a psychotic break. Student A was hysterical most days, unable to remain in a classroom for the entire period without removing himself to cry in the bathroom; he felt hopeless and extremely anxious most of the time. This student often experienced suicide ideation, was combative with his mother, and disruptive in class. The school and city were evaluating his tenure at the school as well, due to his erratic behaviors and inability to show any emotional control or regulation, in addition to poor grades and other educational challenges. A higher level of care was being evaluated, and seemed to be the next step that would be needed. Student A was referred to the Health Center in the interim, where he has been meeting with a clinician twice a week. He was also seeing an outside psychiatrist intermittently due to his hospitalization. He was being medicated and his mother wanted to maintain seeing his current psychiatrist, instead of the Health Center psychiatrist, in the event he was transferred during treatment to another school facility. Through the course of his treatment, student A has come to rely on having a stable environment to turn to during his school day when he needs to re-group. He has been able to learn skills to calm himself during times of hysteria or panic. He has been able to work to identify his feelings, acknowledge his strengths and has been able to set forth personal goals related to individual qualities he would like to enhance. This student went from crying through entire sessions, barely able to speak, to eagerly coming to session to share his new video game interest with the clinician. His productivity in school has significantly increased and he will be graduating the 8th grade this year, something that was quite questionable just three months ago. During the course of treatment, the client’s family lost their healthcare insurance due to father being laid off and in between jobs. In the interim, the Health Center was able to provide continued psychiatric care for him as well. Through the ongoing care, the psychiatrist was able to identify negative side effects that his medication was providing that were otherwise undetected. Slowly, she began to amend his dosage and paired it with another medication to help combat the side effects. The negative side-effects almost immediately began to lessen.

Student A is now stable, engaged in school, and responding more positively at home. He is able to acknowledge his behavioral responses, both positive and negative. With continued encouragement and treatment, he is working to shape his identity as a young adolescent and integrate into his peer community”.

CONCLUSION

This report provides a more intimate look at the scope of the mental/behavioral health services provided by the SBHCs and the benefits to those that receive them. The mental/behavioral health services provided at the SBHCs are comprehensive; coordinated; culturally sensitive, developmentally appropriate and don't pose a financial burden on the families of students served. The care is delivered by experienced mental health professionals in a safe, supportive, confidential environment that is located where children spend much of their time... in school. Given the increasing numbers of students with MEB disorders/problems, the importance of early identification and intervention, and the impact of unmet mental/behavioral needs on children, their families, communities and society as a whole, the value of SBHC mental/behavioral health services is immeasurable.