

Integrated, Trauma-Informed Mental Health Care to Support Boys & Young Men of Color

Recommendations for School-Based Health Centers



California School-Based Health Alliance

October 2013

www.schoolhealthcenters.org

INTRODUCTION

Trauma-Informed Mental Health

As documented in *Healing the Hurt: Trauma-Informed Approaches to the Health of Boys and Young Men of Color*, “African-American and Latino young men are disproportionately affected by various forms of trauma and adversity including violence, poverty, incarceration, lack of access to health care, marginalization and low social status”(p2). Research demonstrates that there are many long-lasting effects of trauma on individuals, families, and communities. In fact a recent study, *Healthy Communities Matter: Important of Place to the Health of Boys of Color*, reports that African American and Latino boys are 2.5 and 4.1 more likely to have post-traumatic stress disorder than their white peers, due to exposure to trauma (p6). It is becoming increasingly urgent that we take action to address both the underlying causes of trauma and its results.

However, a growing number of organizations are implementing more effective approaches to caring for traumatized clients. As explained by the National Center for Trauma-Informed Care, a trauma-informed program ensures that “every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual seeking services.” (*Healing the Hurt*, p21). One specific approach to trauma-informed care, the Sanctuary Model, developed by Sandra Bloom, M.D., is intended to create “safe environments that promote healing, inclusion, respect for differences, and positive social change”—and it promotes these environments for both staff and clients. The Sanctuary Model has an emerging and very promising evidence base and is, to use a computer analogy, a new “operating system” for an organization.

The California School-Based Health Alliance (formerly the California School Health Centers Association (CSHC)) believes that school-based health centers (SBHCs) are well-positioned to meet the trauma-related mental health needs of boys and young men of color. SBHCs could incorporate trauma-informed models of care, such as the Sanctuary Model, into successful practices already in place, such as:

- 1. Proven Impact:** Some SBHCs are already effectively providing integrated trauma-informed mental health services that meaningfully impact student well-being and school success.
- 2. Smart Location:** SBHCs are a convenient and important health care access point for all students but particularly for boys and young men, who may be less likely to seek care elsewhere.
- 3. Integrated Approach:** The majority of SBHCs already use a model of care that brings together medical, mental health, and youth development services.
- 4. Broad Influence:** SBHC leaders are often important influencers of school-wide policies, systems, and culture, which allows SBHCs to address issues on a population level.
- 5. Interest to Enhance Services:** SBHCs are at varying places in the development of their mental health programs. Some are already doing a great deal, but many are looking for ways to improve their services. Every interviewee expressed a desire to enhance their efforts at implementing integrated, trauma-informed mental health services.

We recently conducted a scan of school-based health centers (SBHCs) to understand what trauma-informed care looks like at the practice level. We interviewed 14 SBHCs that offer mental health programs and could provide useful insights on an integrated, trauma-informed mental health model of care. In addition, we included two non-SBHC providers in the scan because of their experience working with boys and young men of color. This report provides a summary of our findings and highlights best practices that can be replicated across the SBHC field.

MENTAL HEALTH SERVICES AT SBHCS

Our scan of SBHCs found significant variation in the mental health services being offered. Services vary along several dimensions, including:

- **Provider characteristics:** the number of providers, the type of agency that employs them, and their credentials, background and experience.
- **Services provided:** types of counseling provided (i.e., individual, group, and/or family), whether youth development programs complement traditional mental health offerings, and the specific therapeutic approaches and curricula used in counseling sessions and groups.
- **Location of services:** on-campus (e.g., in the SBHC, a classroom, or other space) or off-campus.
- **Service hours:** number of days per week and availability of services before and/or after school and during school holidays.

At most of the schools we interviewed, students have access to mental health services beyond those typically offered by school districts. However, the nature and scope of these services vary greatly, with some SBHCs having significantly more robust programs than others. At the low end of the continuum are the minority of SBHCs that do not provide mental health services on-site, usually as a result of limited resources.

I don't refer to mental health as often as I probably should. The reason is that I have such few resources... When we opened, we had a mental health provider with us. When we had the mental health provider working directly with us, we would refer probably 5 or 10 students a week, because we knew students would go. Now, it's very hard to get them to follow through and get them to go off campus. As a result I find myself referring less and less.

At the middle of the spectrum are SBHCs that have mental health services that are limited to traditional individual therapy and not well-integrated with the medical services, school staff or other programs such as after school youth development programs. At this middle level of capacity, there is not typically a focus on specific services for young men although many do make their way to the SBHC as a result referrals for ADHD-related issues.

At the highest level of capacity, there are SBHCs that have long-standing mental health programs that encompass a variety of services including individual, family, and group therapy, youth development, support groups, and crisis response, as needed. The mental health team is more likely to reflect students' racial/ethnic and gender diversity and has strong relationships with the medical team and school staff.

There is more likely to be a focus on outreach to specific populations and attention to trauma including clinicians own vicarious trauma. At these SBHCs, the mental health program is a core component of the overall model. There is enough service availability, service diversity, and staff capacity to meet the needs of many (although never all) students. And, there is a commitment to collaboration between medical, mental health, educational, and other partners.

SERVING BOYS AND YOUNG MEN AT SBHCs

Already, California's 226 SBHCs are providing high-quality medical, mental health, oral health, and youth development services in diverse communities throughout the state. Because SBHCs are committed to addressing the specific needs of underserved children and youth, and because of their close relationships with schools and other providers, they are well positioned to meet the mental health needs of boys and young men.

Most SBHCs see a relatively even balance of male and female students through their mental health programs. Given that mental health services are typically accessed significantly more frequently by females than males, we believe this is an important indicator of the key role of SBHCs in serving harder-to-reach boys and young men. At the same time, several interviewees noted that males are more likely to be receiving services as a result of a disciplinary referral.

Many interviewees expressed a clear commitment to reaching boys and young men. They use a range of strategies to engage and keep boys and young men participating. Several of these best-practices are outlined below.

➤ **Conducting Active Outreach**

One of the strategies described by several respondents was "hustle outreach":

We do active, what I call hustle, outreach. We "stalk" them, we look for them. If they don't show up, we ask 'Why didn't you come?' We call them. We text them. I feel like that works... We make it clear that if they don't come we miss them. That active outreach is critical. We aren't like a traditional outpatient clinic – we go and pull them out of class. We talk to their teacher, to the principal, to their family.

We're at the table when they come register for classes – get class schedules, enroll in school lunch, and sign up for clinic services. We're part of their world, their daily lives. They see us every day. We attend assemblies so they see our faces. They're familiar with us. It looks quite different than the stigma associated with "therapy" you might expect – and we feel proud of that. Young people say 'Hey, what's up? There's my therapist.' It's a very common thing. Most of the young people are referred to therapy and, if not, their friends are. They all know of us.

➤ **Focusing on Relationship Building**

Many people emphasized the importance of building relationships with young men and becoming an integral part of their environment.

We are enmeshed in their lives and that makes a significant impact. When there's a crisis on campus or near the campus in the community we respond, and they know we know exactly what they're talking about because we were in the room with them during that lockdown.

We're having to do less outreach... Among the students, the network is really tight. Students bring other students in. There is less of a stigma. It's dwindling. [We don't] present ourselves as mental health therapists. It has a lot to do with relationships. Even though we're providing mental health services, our engagement is more relational.

➤ **Employing Gender-Differentiated Strategies in Clinical Work**

Several interviewees talked about the fact that males typically require more active, physical participation in therapy than do females who are often more comfortable with “talk therapy.”

We emphasize clinically that just sitting still in a room, talking about feelings, isn't going to work. They need to be engaged and involved in a different way, and they need to be physically involved. As part of our practicum training we bring in people who train on specific modalities, like art therapy, drama therapy, other embodied practices. We do a lot of stress reduction work and embodied work with boys around identifying how their bodies are feeling, how anxiety or depression is manifesting physically. ... [We help them make] plans to use these strategies throughout the week... One of the issues is that boys who are not involved in sports get stuck inside... We do breathing exercises. They're really open to those techniques, because they work.

Providers also discussed the importance of creating “healing spaces” that proactively build community and trust while also addressing harm, providing opportunities for “rites of passage” interventions, and ensuring that boys and young men have and act as role models.

➤ **Offering Male-Only Groups**

A significant number of interviewees described successful group-based mental health programs targeted to boys and young men. These programs range from traditional group counseling sessions to youth development opportunities to for-credit classes. Youth development programs were particularly common, probably because SBHCs are finding them to be extremely successful at engaging males in therapeutic experiences. Specific examples of male-focused, youth development programs include: an art therapy skateboard group, a gender-specific eighth grade bridge program, and a young men's empowerment and leadership group.

We're really active in the eighth grade bridge program. We do workshops on goal setting, split by gender, and we talk about cultural implications of language, for example calling a girlfriend 'bitch' or 'ho.' That works really well. Young boys together in a group like that is a powerful force.

We have learned they do better in smaller groups rather than large ones. It's important to do intervention, prevention as they're entering into high school, help them think about how they'll identify themselves.

We use [the male-only, for-credit class] to explore lives, political history, analysis, but also just really to set high expectations for their performance... Taking themselves seriously as boys and young men, getting them to focus on other classes. [It was mostly] kids who were on probation or were at risk of getting in trouble, suspensions, fights. But [the facilitator] didn't want only that demographic, wanted a broader range.

➤ **Integrating Mental Health With Other Programs**

Co-locating services was seen as effective in de-stigmatizing the program and taking the focus off mental health by giving youth an opportunity to first engage in “lighter” services. At some schools, students participating in group programs are automatically engaged in individual therapy, while at others the approaches are less tightly connected.

The way we're set up, everything's happening in the same place. It's not that you come here because you're crazy. People might be doing youth development or be in a club.

Any young person who engages in any of the groups becomes our client. They all get seen individually... Maybe not once a week, but to check in, be seen, talk about their progress in the group. It's a comprehensive thing... 'How does this feel for you? You're sitting with a young guy next to you who you hate in class. Now you're sitting together sharing art. How does that impact you? What does that mean for your family?' We're careful to look at implications of this kind of engagement.

➤ **Recruiting Providers Who Can Meet Gender-Specific Needs in the Culturally Diverse Population Served**

Several interviewees described placing a high priority on hiring more male therapists, particularly those who share the racial and ethnic backgrounds of the boys and young men whom they serve. However, SBHCs have had different levels of success at achieving this goal; some have equal numbers of male and female mental health clinicians while other teams are either disproportionately or entirely female. Even if it was not always possible to hire as many male clinicians as desired, interviewees stressed the importance hiring staff members that have experience and a level of comfort with young men of color.

The way that we look at them is very different than other folks who don't want to deal with troubled, angry black boys. We're very committed. We've been here a long time... We've seen them through a lot. We love them. It sounds touchy feely. Some people I interview for positions here are scared of these guys, and some of these guys are scary looking, but they are also sweet, resilient, fragile, insecure, all those normal, human things. We take that approach and know they have high needs, and need to be loved and coached and held accountable for their actions in a supportive, firm teaching way.

➤ **Finding Partner Organizations to Complement the Strengths of the SBHC**

Many interviewees described working closely with individuals and programs with experience reaching and supporting males, including athletes and sports teams. SBHCs often take the initiative to seek out effective partners, such as educators leading academic support efforts for boys and young men or high school graduation efforts and school safety initiatives. Other partners include community-based organizations focused on youth development for African American and/or Latino adolescents or on reducing gang involvement and creating peaceful, non-violent out-of-school-time opportunities for males. Some SBHCs have partnered effectively with School Resource Officers. These partners collaborate closely with SBHC staff and often either facilitate or co-facilitate male-specific groups and classes. This has been particularly important at SBHCs with no or very few male mental health clinicians.

EXPERIENCE WITH TRAUMA AND TRAUMA-INFORMED CARE AT SBHCs

Trauma within the Student Population

Many SBHCs serve a significant number of children and youth who experience chronic adversity and complex trauma including disproportionately high rates of: poverty; unemployment; un-insurance; family, dating, community, and gang violence; incarceration; and immigration-related issues.

We are constantly hearing about gun violence. People who were killed, stabbed, something. Violent death. That impacts our kids a lot... That's a huge, huge problem. Our students come from one of the most violent communities in the country, specifically around gun violence. It really does affect young people. We do get a lot of reports, CPS reports that we have to do, based on violence and neglect and the family. That's an issue that we come across a lot. This year, the last few years, I think it's related to the economy, stresses in people's families ...

Nevertheless, interviewees also described community strengths, including deep resilience in the face of challenges, a commitment to an improved future, and a positive, shared identity.

The community has tremendous potential for resilience. Having worked in various areas, what I've found here is that the student population is very supportive of one another, aware of one another's struggles. It's a very community-feel to it, even though the students may not even be aware of it... It crosses racial, ethnic, and language lines.

Although almost all interviewees serve students who experience similar forms of chronic adversity, there were some differences in how they thought about the concept of trauma. Some thought about it narrowly—for example, as the result of a single horrific event—but most interviewees took a broader perspective. They emphasized the role of ongoing stressors, including both daily, routine struggles and major catastrophes.

It tends to be thought about as an event, outside of people's normal reality. But for these students it's situations that occur regularly and that are an everyday thing. That's unique to the

population that we work with. They go back to trauma, are re-traumatized on a regular basis. It's chronic stress. It's compounded.

... it doesn't necessarily have to be any particular type of violence. Students who haven't eaten in two days. Students who are embarrassed because they don't have enough money to wash their clothes so they are wearing the same for the third day.

We used to get more of the kids who were just getting in trouble, acting out. We've gotten better—all of us, including school personnel—at identifying kids who are sad, quiet, overly anxious. The ones who internalize rather than externalize.

Finally, different interviewees described different rates of formal post-traumatic stress disorder (PTSD) diagnosis. For at least one SBHC, PTSD is the most frequent mental health diagnosis; at others, students are much more commonly diagnosed with other related mental health disorders. At an SBHC using a narrative therapy approach, clinicians do not diagnose students' mental health conditions, avoiding all such labels and thereby seeking to avoid stigmatization.

Trauma-Informed Care – Promising Practices at SBHCs

Implementing an integrated, trauma-informed approach to mental health care is a long-term process that evolves over time. SBHCs are at different places on this continuum, with some having spent years explicitly focused on these issues; other programs, while not yet fully developed, have already adopted some essential practices. Our assessment revealed a number of promising practices in place at many SBHCs.

➤ Focusing on Staff Recruitment and Support

Respondents emphasized that individual staff do make a difference and that not everyone is suited to working with boys and young men who are experiencing trauma. They also noted the importance of supporting staff and addressing the vicarious trauma that many experience.

I really carefully choose who's going to be here. These are people who are experts in what they do. I know that you as a teen will engage with this person because that's what they're good at, they're sincerely invested in what they do.

We're multi-stressed, resource-poor. Working here means that you'll be working more than you thought you would and it's going to be exceptionally rewarding, and it'll mean we'll be burnt out and fried sometimes, and there's going to be vicarious trauma for staff sometimes. I'll try to scrounge up some funding to do things that'll help feed our souls as well. It can be intense sitting hour after hour, listening, witnessing someone's heartbreak.

It's really important that we talk, support each other, and process things. It takes a toll. The interns don't take the more complex assignments: they go to the school psychologist or myself. We have to watch ourselves closely. I was telling a colleague that I feel like I may have secondary PTSD. Too many horrific crises, one right after the other. I know the signs. I needed to take a break...

➤ **Integrating Mental Health With Medical Services**

Many interviewees described how they screen medical patients for mental health needs, and vice versa, to make sure youth's needs are assessed comprehensively.

100% of our mental health clients are screened for medical issues. When's the last time you saw a medical provider? Are you in any pain? It's a whole screening process. 100% are asked, 'Do you need a medical appointment?' If they haven't had one in a certain amount of time or need one, we get them hooked up. The medical folks have a medical social worker who goes into rooms with them after appointments... They do the screening that way, and, if they need mental health, they are referred to us. It's part of every visit. In both ways, we're touching 100%.

We really see [our front desk outreach person] as the heart... He does initial triage, so everyone sees him. He also does stuff like Band Aids and Tylenol and things like that, ice—but often those things lead to other things. 'Why do you have a headache?' 'How are you feeling?' 'Why do you have an injury?' This is a doorway into other support that the counselors do.

We're housed in the same place, literally. There are the exam rooms, the nurse's office, and three doors down the social worker's office. So, when kids come in the door and sign in, they could be going to any of the three places – dental, medical, or mental health. It's very easy for us to collaborate. The mental health providers consult with the nurses, because they want to rule out physical conditions, and vice versa: if a student comes in with chronic headaches, they might end up referring them to the social worker for psychosocial issues.

➤ **Integrating the SBHC Into the School**

When SBHCs are successful in forging a close working relationship with the school, the providers are united in their belief this relationship is critical to being able address the needs of youth who are experiencing trauma in a comprehensive manner.

Several of the people who work at the clinic are school district employees, and even the people who aren't really become part of the school environment. We're faculty advisors to clubs, the dance team... We're really part of the school community. That also increases the number of kids that get referred. People don't see us as separate. They know who we are and where to find us.

The more people that you can get involved in a case like this, the more points of access you have. If he's having a difficult time, he can talk to a teacher, or us, or someone at the district. He's now much more comfortable asking for things.

We're very integrated into the [school] culture. With the school year ending, next year coming, we participate very closely with principal in planning for the school year. I've been here longer than any principal and I hold institutional knowledge that they don't, so the SBHC kind of gets grandfathered in every year. Our health clinic is a major partner in what the school offers. We meet twice a month to discuss the whole referral process. We meet with principals and teachers, and talk about what we're doing, who we're seeing. We have a very open dialogue about who's being seen, not being seen, needs to be seen. It's a very tight relationship.

➤ **Taking a Broad Social Perspective That Does Not Pathologize the Individual**

Interviewees discussed the importance of creating spaces that allow deep engagement with cultural, historical, and gendered issues including male identity, fatherhood, racism, and agency.

Something that is often said but not practiced as much, is coming from a strengths-based perspective which means not telling students what not to do, what they're doing wrong, and how to change. We reverse it: 'Look at the system and how it's not working. Let's examine that because there's nothing wrong with you. Perhaps it's what they're asking you to do that is wrong.' Completely changing the paradigm..

We began to teach them the effects of trauma on community, on family, within a particular race, that may not have been brought to their attention or explored or even thought about, and how it's impacting them. Many are members of the football or basketball teams, and we explored the lack of trust amongst each other, even though they have grown up together. The impact of trauma, self-preservation – 'let me get mine first' – was being exhibited in courts and on the field, resulting in poor records. When we began to explore that lack of trust, where it stemmed from, to build trust, explore why they're doing it, whether it's real or imagined, what the alternatives are, and how to build trust, they began to trust each other and improve on the court and on the field. The impact of trauma is so embedded in the community that it has become normalized. We begin to pull the layers off... And at the same time to allow them to explain why they do what they do and we challenge them to look at it. We afford them the opportunity to change their behaviors and attitudes. It works.

We encourage them to think critically about various types of topics and issues, so for example we talk about the crime in the community, difference between [our community] and [nearby affluent communities], about sexism and stereotypes. We had a great recent discussion about Trayvon Martin. We talk about education, what education is like here, what that means. We talk about racism quite a bit, about internalized racism. We look at self-perception and how internalized racism has begun to manifest as a result of generational trauma, specifically among African Americans...

➤ **Using Non-Traditional Therapeutic Approaches**

Respondents described different practices and ideas for approaches to clinical work that recognize the social and environmental origins of trauma.

I see [narrative therapy] as a very respectful way of approaching therapeutic work, in that one of the key concepts is that we see the student or the person as the expert in their own life. They're the one who really knows how problems are affecting their life. That's part of the respect. I'm not the expert who will fix the problems. I'll ask about how things are affecting your life. You know strategies that you've already used, what's already working. Building on you own skills and knowledge from living with the problems. Externalizing the problem is a key part of it – non-pathologizing, we don't use DSM, don't diagnose. We rarely call it counseling. We destigmatize, we use non-pathologizing language, which I do think really helps in this school environment.

I would like to create a whole new program that would focus on drama therapy, with therapists trained in very active techniques to help kids quickly identify and express in an embodied way what's going on inside of them, the trauma they're feeling. It's not just psychological, it's in our bodies as well. Even though narrative therapy does externalize the story, so it's not so much held as 'there's something wrong with me,' even that doesn't go far enough in really giving embodied, active expression, which can help transform the trauma into something manageable.

SUMMARY

California's 226 SBHCs are committed to addressing the specific needs of underserved children and youth. Because many already provide high quality mental health and youth development services and have close relationships with schools and other providers, they are well positioned to meet the mental health needs of boys and young men through integrated, trauma-informed care. Here is a summary of our findings and best-practices to move SBHCs to a trauma-informed model of care:

- **SBHCs committed to better serving boys and young men have implemented explicit strategies to engage this population. These SBHCs:**
 - Build strong relationships and use "hustle outreach" to keep clients engaged.
 - Use gender-differentiated strategies in individual counseling sessions.
 - Offer male-only groups, youth development programs, and for-credit classes.
 - Recruit and hire therapists who represent the cultures of the diverse population served and can meet gender-specific needs.
 - Work with individuals and programs that have experience reaching males.
- **Many SBHCs that have integrated trauma-informed approaches to mental health. These SBHCs:**
 - Focus on staff recruitment, selection, training, and support (including addressing vicarious trauma among staff and ensuring positive staff experiences).
 - Screen medical patients for mental health needs, and vice versa, and maximize opportunities for collaboration between medical providers, mental health providers, educators, other school- or community-based partners and families.
 - Foster safe spaces that allow deep engagement with cultural, historical, and gendered issues (including male identity, fatherhood, racism, and agency).
 - Use narrative therapy and other non-traditional therapeutic approaches.