Best Practices in School-Based Behavioral Health

Presented to: Campus Safety and Security Task Force

ODMHSAS

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Introduction

The creation of this task force is one indicator that Oklahoma intends for its children, youth and families to thrive and succeed in their local communities and schools. Each local school needs to be empowered to become the safe hub where children, youth and families are connected to a supportive community and where healthy social and emotional development and well-being are promoted in a variety of ways.

It is clearly understood that children with healthy social and emotional development are more likely to become productive adults who will contribute positively to their communities (Miles, J., et al., 2010).

Oklahoma has a youth (18 and under) population of 929,666 or 24.7% of the total population. Many of these young residents face a multitude of hardships in their homes, schools and communities.

The Oklahoma Kids Count (2012) states that children's mental health issues in Oklahoma are above the national average of 15%. Eighteen percent of children ages 2-17 in Oklahoma have a mental, emotional, or behavioral (MEB) disorder.

The State Epidemiology Outcomes Workgroup (SEOW) data further illustrate this in that among students grades 9-12, 28.6% reported feeling sad or hopeless, and for females the percentage was even higher at 37.7%. Oklahoma is consistently above the national average in suicide death rates and it has been increasing. Among public high school students in grades 9-12 in Oklahoma, 38.3% of high school students were current drinkers of alcohol. The 2010 National Survey on Drug Use and Health (NSDUH) indicate Oklahoma ranked number one nationally for the nonmedical use of pain relievers in the past year for all age categories. Oklahoma adolescents are also consistently above the national average in tobacco behaviors. Of Oklahomans, 29.0% aged 12 and older were current cigarette smokers, which was above the national average of 22.5%. The Youth Risk Behavior Survey also shows statistically significant differences in tobacco consumption patterns when comparing Oklahoma to the nation, with 50% of students having tried cigarette smoking.

The Effects of Trauma

While it is nationally recognized that one out of every four children attending school has been exposed to a traumatic event that can affect learning and/or behavior, Oklahoma has many factors that greatly influence the exposure to trauma and complex trauma which many of our children face.

Understanding the cumulative effect of these factors is essential in understanding the need in Oklahoma. The Adverse Childhood Experiences study (ACE study) and the 2003 white paper from the National Child Traumatic Stress Network Complex Trauma Task Force on Complex Trauma in Children and Adolescents, documented the significant impact early life events, including early trauma, has on every area of a child's development and ability to learn and interact in a healthy developmentally appropriate manner (Felitti, V.J., et al., 1998; and National Child Traumatic Stress Network Schools Committee, 2008). The science of child development shows the foundation for sound mental health is built early in life, as early experiences, which include children's relationships with parents, caregivers, relatives, teachers and peers, shape the architecture of the developing brain. Disruptions in this developmental process can impair a child's capacities to learn and relate to others, with lifelong implications. Untreated mental health disorders affect multiple domains of development and have detrimental effects on future health and developmental outcomes. Research demonstrates early prevention and treatment are more beneficial and cost effective than attempts to treat emotional difficulties and their effects on learning and health after they become more serious (Cohen, J., Oser, C., and Quigley, K., 2012). Life circumstances associated with family stress, such as persistent poverty, threatening neighborhoods and very poor child care conditions elevate the risk of serious mental health problems (National Scientific Council on the Developing Child, 2008-2012).

One stressor that impacts Oklahoma's children is related to factors unique to military families. Oklahoma is proud of its citizens' military service. With every branch of the military, from coast guard to national guard/reserves, and over 47,000 service men and women plus their families as residents, it is important to understand the impact military culture has on our schools and communities. According to the American Association of School Administrators, the repeated and extended separation and increased hazards of deployment compound stressors in military children's lives. And one-third of school-age military children show psychosocial behaviors such as being anxious, worrying often, and crying more frequently. (AASA, 2009).

Best Practices

The above Oklahoma-specific data verify the state's prevalence is equal and often greater that findings in the general population nationwide. A high prevalence of children experience mental health problems, with estimates as high as at least 40% experiencing criteria for a psychiatric diagnosis at least once before age 18. (Costello, et al, 2003). There is also ample evidence that many of these issues will resolve but others continue, especially for children impacted by multiple risk factors. Children who exhibit comorbid internalizing and externalizing problems will be most likely to develop the highest levels of impairment. (Essex, et al., 2009). These are the youth that have been described as multi-problem. (Biglan, 2001). There is growing evidence that a simple, repetitive procedure can greatly reduce the projected morbidity of multi-problem behavior. One excellent example is The Good Behavior Game. (Embry, 2002). However, for children with comorbid problems at highest risk, there is evidence that targeted interventions provide a more dramatic and effective approach. (Weare, K., and Nind, M., 2011). Oklahoma will plan to utilize both types of interventions. Research also validates that a whole-school approach provides the necessary environment for the promising interventions and procedures to take best effect. Sugai and Horner (2002) determined there is evidence to support exploration of Positive Behavioral Interventions and Supports (PBIS), as a viable model for a school-wide approach. School-wide implementation of PBIS has been shown to improve the perception of school safety as well. (Horner, R., et al, in press).

Early Screening

The case is strong for early mental health screening in schools. Evidence is growing that multiple mental, emotional and behavioral disorders are tightly connected by the same core predictors (IOM, 2009). Studies indicate that early screening can identify the children who are most likely to develop recurring comorbid mental health problems. Multiple studies have made a strong case that the children most at risk for comorbid serious mental health issues can be identified as early as kindergarten (Essex, M., et al., 2009). Many mental, emotional and behavioral disorders are preventable. (IOM, 2009).

Gaps in services are evident on a daily bases in Oklahoma; however, ensuring effective intervention must begin with a strong component for screening children and youth for mental, emotional, and behavioral disorders (MEBs) to effectively identify needs for community-based treatment, and a formalized system for linking them with these services. Since advanced

screening methods have been studied and shown effective to identify the children and youth at greatest risk for serious emotional disturbance, it will be critical to utilize evidence based screening and assessment tools in order to link with effective community-based services early. Linking these children with mental health professionals trained to handle these issues yields better outcomes for the children and allows educators to focus on educational goals (Anderson-Butcher, D., 2006). The ODMHSAS has trained professionals throughout the services system in such effective treatment modalities such as trauma-focused cognitive behavioral therapy, motivational interviewing, strengthening families program, *celebrating families program*, and the wraparound process for children and youth most at risk (Murray, L.K., et al., 2013; Barnett, et al., 2012; Kumpfer, K., et al., 2012; Pires, 2002).

It is essential that the state develop a universal system for mental health promotion and targeted prevention strategies to drastically improve these negative indicators and provide healthy, productive futures for the children. Schools are the greatest resources for doing so. Effective interventions and procedures in school environments can make the difference in children's lives (Gross, J., ed., 2008). In addition, community partnerships with mental health professionals should be built in order to formalize a system of screening, assessment and linkage to community-based services (Anderson-Butcher, D., 2006; Essex, M., et al., 2009). There is much awareness of the need to develop a solid system for actual linkage to services, or else screening in and of itself will do little good (Husky, M., et al., 2011).

School connectedness and the school environment are intricately related. A positive school environment can lead to more connectedness and positive outcomes, while the contrary may also occur. Researchers at Johns Hopkins University recognize the importance of family involvement in promoting school connectedness and offer suggestions for nurturing this relationship, such as making education an important factor in the home and promoting learning, improving communication strategies, increasing parental volunteer involvement at school and in school decision-making, and collaborating with community resources. (Blum, R., 2005).

Educators and their influence on school environments certainly are important in terms of "guiding students toward positive, productive behaviors" (Blum, R., 2009). As stated above, one intervention proven to create positive school environment is the Positive Behavioral Interventions & Supports (PBIS). PBIS provides a continuum of prevention activities for classroom and non-classroom settings.

Cultural Disparities

Cultural disparities exist within school districts and schools themselves. For example, homelessness, chronic hunger, historical trauma, and untreated mental health and substance abuse issues can negatively impact school connectedness, the school environment and the underlying school culture. Many of these issues originate outside the school system. School staff and community providers must be attune and sensitive to these issues. "Positive school climates are inclusive of and responsive to students of all backgrounds, regardless of race, color, national origin, language, disability, religion, or sex." (U.S. Department of Education, 2013). For children in military families, "A positive school environment, built upon caring relationships among all participants—students, teachers, staff, administrators, parents and community members—has been shown to impact not only academic performance but also positively influence emotions and behaviors of students". (AASA, 2009). Dr. William Beardslee of the Judge Baker Children's Center at Harvard Medical School, along with a team from Harvard and UCLA, disseminated FOCUS (Families Over-Coming Under Stress), working with families who have experienced multiple deployments. (Beardslee, W., et al, 2011).

Best Practices for Schools

Schools play a critical role in helping students diagnosed with mental illnesses reach their full academic and functional potential. The academic performance and behavioral functioning of students significantly improves when their mental health needs are effectively addressed. The National Alliance on Mental Illness (NAMI) has generated an excellent list of Ten Best Practices for Schools:

1. Train teachers and staff on the early warning signs of mental illnesses and how to effectively communicate with families about mental health related concerns. To learn more about NAMI's *Parents and Teachers as Allies* publication and in-service education program, visit www.nami.org/caac.
2. Train school professionals in effective and research-based teaching methods and behavioral interventions, including positive behavior interventions and supports (PBIS – as described at www.pbis.org).

3. Educate the entire school community about mental illnesses, including providing age-appropriate information about these conditions in the health curriculum, to help ensure a broader awareness about mental illnesses and to reduce stigma.
4. Develop and implement a plan to reduce the unacceptably high dropout and failure rates of students with mental illnesses. This includes providing a comprehensive functional behavioral assessment for students that need it and implementing effective classroom interventions. Schools cannot do this alone. NAMI stands ready to call on other community leaders to work to reduce school dropout and failure rates for these students.
5. Provide research-based and effective school-based mental health services and develop an effective link to the community mental health system for students with more intensive mental health service needs.
6. Develop effective partnerships with families that recognize the value of their input about how a student's illness impacts their academic work, peer relationships and interaction with others in the school community. These partnerships will recognize the importance of cultural competence.
7. Provide appropriate accommodations for students when they are needed , including a safe place to quiet down, additional time for completing home and school work, the assignment of a mentor, flexibility in the school day schedule and other individualized and appropriate accommodations. When appropriate, refer students for an evaluation for special education services.
8. Provide effective transition services and supports for students returning to school after receiving treatment away from school and for those transitioning between different school levels and/or into life in the community. Provide guidance for teachers and staff on effective supports for students returning to school after time away.
9. Develop effective anti-bullying policies so that students with mental illnesses are not targeted for bullying or singled out as bullies as a result of symptoms of their illness.
10. Develop effective crisis prevention and intervention services to help prevent and address psychiatric crises, youth suicide and related serious public health concerns. (NAMI.org)

http://www.nami.org/Template.cfm?Section=schools_and_education&template=/ContentManagement/ContentDisplay.cfm&ContentID=47652

Trauma-Informed, Community Based Services

As covered earlier, it is known that comorbid externalizing and internalizing problems lead to the greatest impairment and severity of mental health problems, and these can be identified very early in life. The ACE study and the National Child Traumatic Stress Network (NCTSN) Child Trauma Toolkit for Educators identify the relationships between adverse childhood experiences and physical, mental, and negative life outcomes for children and youth (Felitti, V., et al., 1998; National Child Traumatic Stress Network, 2008). These very clearly illustrate factors at work in Oklahoma in terms of problematic outcomes such as behavioral issues, eating disorders, substance use and abuse, risk taking behaviors, suicidal thoughts, impaired learning, and even early death. In Oklahoma high rates of child abuse, interpersonal and domestic violence, traumatic grief, natural disasters, medical trauma, and military trauma are well documented. In addition the state has a history of terrorism with the 1995 bombing.

For youth needing community based services, the ODMHSAS, in conjunction with a current SAMHSA grant working with the National Child Traumatic Stress Network (NCTSN), has been creating a state wide trauma informed System of Care (SOC) that provides trauma specific screening, assessment, and treatment, including Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Seeking Safety (an evidence based group model), through the local CMHCs. In addition, trauma informed training will be available for the communities and partners to support an integrated trauma informed approach.

Culture, language, literacy levels and disabilities should be taken into account when choosing evidence-based and promising practices. The following criteria are recommended for local school districts and communities:

- Tier 1 – Proposed strategy on a national registry of evidence based practices;
- Tier 2 – Proposed strategy in a peer-reviewed publication with positive effects; or
- Tier 3 – Documented effectiveness supported by other sources of information.

School-based early intervention services can include modalities such as brief motivational interviewing; (2) screening for MEBs, and establish referral and linkage to community-based services.

Early Childhood

Promoting Early Childhood Social and Emotional Learning: (1) create awareness of unique needs of infants and young children; (2) build early childhood workforce competency and

capacity (endorsement process); and (3) expand developmentally appropriate EBPs and best practices, such as early childhood MH consultation, Triple P, and child parent psychotherapy (Duran, 2009; Thomas, R, and Zimmer-Gembeck, M., 2007; VanHorn, et al, 2011).

High School

The Centers for Disease Control and Prevention (CDC) Injury Prevention and Control Division lists risk factors associated with youth violence in four categories: individual, family, peer/social, and community. School violence manifests in various forms and behaviors. The abuse can be physical, emotional, verbal, economic, mental, or sexual abuse. Violent behaviors could include intimidation, bullying, hitting or punching, gang violence; any of these acts could be with or without weapons.

Among Oklahoma public high school students in grades 9-12:

- Over one in five females reported being electronically bullied.
- 14.4% of females were physically forced to have sexual intercourse.
- The estimate of females carrying a weapon to school almost doubled from 2003 to 2011 (2.5% and 4.4%, respectively).
- For males, 6.9% had been threatened or injured with a weapon on school property.

In 2010-2011, 21% of students did not graduate on time (KIDS COUNT, 2012). Nearly one out of 10 teenagers 16 to 19 (9%) are not attending school and not working.

State and local partnership infrastructure needs to be built in order to: (1) fully engage schools and local behavioral health agencies as partners and work by their sides to include other local partners that will ensure a stronger bond with families and with the community; (2) provide avenues for youth and their families to participate in positive community efforts; and (3) implement comprehensive prevention and intervention services and provide linkage for youth and their families to a wide variety of community resources, including a full spectrum of mental health and substance use services when necessary.

Conclusion

Each school district in Oklahoma needs a comprehensive plan to: (1) create a positive and safe school environment; (2) partner with the community and state in networks that support children and provide training, technical assistance and support; 3) promote healthy social and emotional development: (4) prevent mental, emotional and behavioral disorders; (5) provide school-based

early intervention services; (6) screen children and youth for mental, emotional and behavioral disorders; and (7) provide linkage to community-based services.

- Promoting Early Childhood Social and Emotional Learning: (1) create awareness of unique needs of infants and young children; (2) build early childhood workforce competency and capacity (endorsement process); and (3) expand developmentally appropriate EBPs and best practices, such as early childhood MH consultation, Triple P, and child parent psychotherapy (Duran, 2009; Thomas, R, and Zimmer-Gembeck, M., 2007; VanHorn, et al, 2011).
- Promoting Mental, Emotional, and Behavioral Health: (1) implement school-based services utilizing evidence based modalities such as brief motivational interviewing; (2) screening for MEBs, and establish referral and linkage to community-based services.
- Connecting Families, Schools and Communities: (1) implement an evidence-based, multi-tiered framework such as PBIS; (2) engage parents, children and youth in the CMT and other community leadership and volunteer activities; (3) utilize programs such as Strengthening Families or Celebrating Families to create school communities.
- Preventing Behavioral Health Problems, including Substance Use: (1) develop a community outreach campaign that emphasizes protective strategies families can take; (2) engage families in prevention programs; and (3) implement district-wide curricula focused on the specific demographics of the school district.
- Creating Safe and Violence-Free Schools: (1) develop coordination plan with OJA and ODMHSAS for students returning from juvenile justice; (2) Review and make recommendations for anti-bullying policies; (3) Make recommendations for bullying prevention programs and public education campaigns.

Oklahoma needs to increase the capacity to implement, sustain, and improve effective promotion and prevention, in state schools. Actions needs include:

(1) Build and sustain community partnerships.
(2) Enhance local understanding of how to identify evidence based services/strategies and adapt services/strategies for specific cultures.
(3) Increase the implementation of creating positive school environments that utilize prevention strategies and standardized screening procedures.
(4) Build and sustain an evaluation system.

Building a system that ensures a positive school environment that routinely screens for behavioral health needs, and systematically links to effective community-based services, will require a close partnership between school systems and local mental health professionals. Our children deserve no less!

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