Facilitated Discussion Notes
The Education System and Mental Health
May 7, 2014

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: info@plan4children.org.

General Notes

- Location: Value Options, 3rd Floor Hartford Room
- Approximately 17 people in attendance

Question 1: Strengths

- Complementary roles of school social workers and school based mental health clinic staff – the latter can provide more clinical services if in the school systems.
- We have been able to show the positive impact of providing MH services onsite right away without barriers to access.
- Campaign for a Stronger CT- grant that is focused on working with the education community to raise the voice of the education community to raise the awareness of the need for MH services in education. Participant shared those materials.
- EMPS and how widespread it has become. It is an amazing tool. I wish the response time window was less than 45 minutes. But it's an amazing first step.
- School districts are increasing the number of consulting behavioral health professionals in the schools. It's a more recent thing. To create programs to try and assist kids who can't access education in a traditional way—creating opportunities in a regular school setting.
- SRBI (Scientifically Researched Based Interventions) system has potential to have impact –Idea was to shift toward earlier intervention. Provides universal support.
- Positive behavioral supports (PBIS) and interventions that look at a continuum of services and preventative services.
- Inter-agency discussions are helpful
- State grants that provide early MH intervention- One in particular: after responding to a screener, they get services. It has initial screening and outcome data. It is only $500,000/yr across all districts and reaches 1000 kids. Pre-K to grade 3. It focuses on mild-moderate behavioral concerns. It is play-based intervention, helpful for kids that are shy, withdrawn, dealing with family transition. The RFP is sent out annually to district leaders. Apply for grant—approx. 23-26 districts receive the money. Each district gets $25K or so each. They receive in-kind support from providers.
- SAMSHA grants—Safe Schools Healthy Students grants- provides districts with money to provide Positive Behavioral Support interventions, access to resources; focus is that district is working closely with other agencies.
- Having a conversation like this Facilitated Discussion that shows the link between Education and MH. We are beginning to understand each other.
- School-based Health Centers—highly regarded nationally and make a big difference in the schools they are working in.

- Hartford has a model that's working. Private providers housed in school (like a school based health clinic) and families have access to these providers through Medicaid or Husky. They get care in the school- after hours as needed.
- 20 years ago a truant child was ordered to court to attend school and if they didn't, they would go to jail. But now—we can't incarcerate kids who don't go to school. This is good but a problem with that can be that there are not many things a judge can do even in extreme truancy cases.
- A couple of school districts have taken the lead to develop alternative school settings – can range from kids who have anxiety and even more severe illnesses. There are clinicians on site at the school. They hired a non-profit agency to bring their teachers and clinical staff to do the work. From K-age 21. It shows a positive impact. We need more.
- Birth to three years system for early identification.
- Increased focus on trauma for mental health settings and education settings. The huge impact of trauma is important to recognize.
- MH has been a silent issue for so long but now talking openly about it—it's great.
- Emerging initiative - state money for preschool. If we start bringing kids in earlier—we can catch them before it gets severe.
- When it works it works. Birth-to-three special education pre-schools for those who have been identified. It would be good to mainstream them when they go to school if they have their needs addressed in preschool.
- Looking at the older students who are leaving HS, look at post-education goals for them. Where are they headed and what supports do they need. Collaboration with other agencies is good.
- Stigma seems to be reduced.
- More education about conditions like Autism and the subtle difference between Autism and other emotional problems
- The age of doing more with less- There is increased collaboration between schools and local community mental health providers.
- We know (from statewide data) we are making progress serving kids in their own communities versus shipping them to residential treatment centers (in state or out of state).
- CT is leading other states in state-of-the-art treatments based on evidence.
- State's emphasis on early literacy will reach a lot of kids. Dyslexia has an effect MH and addressing it early can reduce later MH problems.

<u>Question 2: Concerns</u>

- We are going from a healthy student and providing things that maintain health and then leap to tier-three where kids are in crisis. We need more early intervention for kids at risk. Need first step early intervention so that we can help them before it gets worse.
- Being housed in a high school, a participant that was a lawyer works with the social worker at schools. He notices that the work the SW has time to do are for PPTs and collecting data-not for providing other MH support services.
- We are servicing much fewer needs than we see. One size doesn't fit all.
- Areas of weakness: Education, Stigma, and Screening. We educate in age appropriate methods to learn about sexual health but why not educate children about mental health. Show them it is like physical health. This will reduce stigma. There is a huge stigma with youth to come forward with problems. Kids present with somatic issues and are not being identified as having MH problems because kids are afraid to come forward.
- Reduce the negative language we use in our daily language—like stupid, psychotic, crazy, idiot. This will reduce stigma and then increase likelihood of getting help.

- We need more pediatric mental health professionals.
- We need more providers that are culturally versed to avoid misdiagnosis or over diagnosis.
- Early intervention – need more.
- School social workers are not allowed to ask about children's psychiatric medication. She can ask them about other physical health meds but not MH problems. She can't recommend therapy because the school may have to pay for it. It's considered an unwritten rule to keep your mouth shut about the needs of kids so that the school doesn't have to pay for it.
- School staff members think about identifying problems and making a referral. What they don't do is think about what the impact is of school (grading, teacher style, etc.) on children.
- There are many missed opportunities where kids are truant, suspended, etc. Schools are not going through the process of identifying MH problems. The schools are reluctant to have to financially support any extra MH efforts.
- There is a lack of knowledge regarding cost—schools think they will have to pay a lot but they may not have to.
- By law you can discuss medication and the facilitation but not recommend the use of the medication.
- Schools are scared because law suits get thrown at them so they have to be so careful.
- We, as school staff, get the direction to be careful on what on what we say. We can't recommend medication or indicate a diagnosis. Can't ask questions or recommend counseling. We can only recommend special education but that may not be the issue.
- The system is at conflict between budget and the needs. They have a limited budget so can't really open their eyes and see what the problem is. There is a disincentive to do something. Can the State help with the financials for schools.
- There are major policy implications for supporting and not supporting kids mental health issues—systems issues.
- Need for confidentiality and need for communication in state of emergency—these two are at odds. You have to be able to override existing confidentiality policies based on emergency needs but it's a tricky situation. Schools need to know what they can do and not do regarding confidentiality.
- One parent indicated she has a child that takes multiple medications every day for physical and mental health problems. She doesn't understand why someone can't ask about her child's use of the medication (did they take the medication?—either physical or mental). This should be allowed.
- One parent indicated that we need the SW to get involved and tell us what referrals we need.
- One parent indicated that the IQ test that the psychologist administered was considered not accurate due to youth's anxiety but can't adjust the IQ test in any way. How do we address the real problem if don't make a connection between the anxiety and the IQ test taking.
- Staffing is an important issue. We have highly trained professionals who can work in MH and work in the school setting. We need to put more staff out there.
- The pressure for the schools to be more rigorous, we need more MH providers. The ratio is 1-1300 (nationally). Should be 1-500 (social workers) or 1-250 (counselors). School psychologist are understaffed in CT. We need more MH staff in schools.
- Access to students is a problem. When do you see the kids and still give them enough time to do the curriculum. How to provide MH services and still progress in education. Increasing staffing will help this.

- Opiate prescriptions for kids under 25 are a problem. They are getting these prescriptions for dental health problems and minor football injuries. They are told by the health professionals that they are getting "the good stuff" for minor injuries and so they are getting addicted.
- Transportation to school based activities is needed. Transportation is a barrier to service. Can we provide buses for kids after school hours? We need to offer MH services in the school and allow them to get counseling after school. If there are later buses, then they can stay in school later.
- Family counseling at the school would be helpful. We notice families know nothing about how to help their kids after they leave the hospital so they don't recidivate.
- School teams need to work together (school social worker, nurse, and psychologist).
- PBS (Positive behavioral Support) is a good program but sometimes it becomes a very strong token economy and the essence of the intervention is lost.
- How prepared are teachers bachelors and masters level students are coming out of higher education? It seems the curriculum is not keeping up with current issues—new teachers are not familiar with state systems, level of acuity they kids are experiencing, and not ready for the work we are doing.

<u>Question 3: Recommendations</u>

- Increasing coordination and collaboration.
- Preparing staff to understand the theory of the interventions they are using.
- NAMI has a wonderful program that the school can use: "Parents and Teachers as Allies". It provides information on understanding of MH illnesses.
- MH First aid should be use more - We need teachers to be aware of what mental illness looks like. Explains things that should be on the top of your mind as teachers. It's an 8 hour lesson. All teachers should be required to take it.
- Allowing confidentiality in emergency circumstance be decreased. We had a situation where a student was taped threatening another student. Police can share info with school but police can't release to MH professional without parent approval.
- State department of education should develop policies around the management of mental health information. We can't keep progress notes because there are no policies around confidentiality and not keeping notes is a safeguard for being asked to share in court.
- Improve access to clinical supervision. Department of Children and Families should provide this supervision to school based mental health center staff, who often work in isolation.
- Get representative/decision makers together to get services for the child seamlessly. Get decision makers to better understand the issues that are going on in the schools.
- Look at the cost benefit of school based mental health. We need to show how it can impact the budget in a positive way to have MH services more active in schools. Recommendation: determine what the costs—economic analysis—to show funding organizations the value.
- Form teams so that everyone is speaking to each other. So people are adequately addressing the needs. Sometimes a child was seeing 4 people in one day (counselor, SW, etc.) while others who need services are not getting any contact at all. If there is a team, we can appropriately allocate the services to the child.
- We need to better utilize the MH professionals we have in the school right now. Those professionals can be a vital resource.
- We have legislation to have student success plans for all students k-12. State Dept. of education-should make sure these are being implemented.

- Understand the social, cultural, and linguist aspects of our students. Understand their background, needs. Understand their identity issues and how they may impact MH and social and emotional functioning. We need training in this area for all school professionals.
- Recommend that school districts maintain the national recommendations around MH staffing levels, including school nurse, SW, psychologist, and counselor. These professionals should be funded by all the state agencies. The money should come from DSS, DPH, and DCF. These should help fund these positions because, ultimately, they will be impacted by good child MH. Eg: in MA, dept. of public health hires all the school nurses. Because kids health is a public health issue. The MA dept. of public health gathers data and then makes data-driven decisions.
- Need State level funding. We need more services at the middle level—kids who are at risk. For high need kids- provide them with a serious level of intervention. Consider re-adjusting the funding so that other agencies can help.
- Kids in shelter need extra educational help. (The McKinney–Vento Homeless Assistance Act of 1987)
- Need to better balance the education with MH issues. Which is more important? For some focusing on MH may be more critical.
- Autism waiver program—there needs to be faster response to families.
- Teachers need good training on what MH and trauma looks like in the classroom—what are the symptoms and behaviors.
- Collaboration between MH agencies and the schools.
- We need to allow schools to tell families what we think is really wrong. When we know there is trauma—we should be allowed to tell the parent that they can benefit from a certain intervention.
- Transportation support for an extended school day based in the schools for after school hours.
- Resource mapping for professionals. Some agency need to be able to link professionals.
- Mindfulness – it has a lot of potential for students and adults. It's easy and effective if delivered in a trained way. Both kids and adults in schools. Adults get drained so they need to also get services to serve students better. Students need to learn to tap into themselves. Mindfulness would help.

General Feedback on the Discussion

- Very effective, well structured.
- I hope there is follow-up that involves the people that were here.
- Use technology to keep the ball going.
- Excited to able to have a voice. Also this was wonderful to see all these professionals out there addressing the same things I am interested in.
- Some people use these types of discussions as a formality but I'm hoping this is not the case and that this conversation will truly inform the process moving forward.