Reducing Barriers to Learning in Urban Schools through Expanded School Mental Health

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Two Important Goals: Achievement and Wellbeing

1) Achievement promotes wellbeing
2) Wellbeing promotes achievement

School philosophy often acknowledges 1 but fails to acknowledge 2
Schools Increasingly Focus on Reducing Academic Barriers to Learning

Example: Reading First Initiative
- Early intervention on emergent literacy to promote achievement of grade level competency by the third grade
But Schools Often Fail to Focus on Non-Academic Barriers to Learning
And Non-Academic Barriers to Learning Exert a Powerful Negative Influence

Environmental
- Poor nutrition
- Family stress
- Family conflict
- Peer influences
- Exposure to violence
- Abuse, Neglect
- Poor school environment

Personal
- Attentional difficulties
- Behavioral problems
- Depression
- Anxiety
- Social problems
- Trauma reactions
A Paradox

Pressures related to achieving satisfactory Annual Yearly Progress (AYP) have led many schools to increase focus on reducing academic barriers to learning AT THE EXPENSE of programs that focus on non-academic barriers to learning.
School Effectiveness in Promoting Achievement

- Least effective: Limited focus on academic and nonacademic barriers
- More effective: Focus on academic barriers
- Most effective: Integrated Focus on academic and nonacademic barriers
Positive Behavior Interventions and Supports (PBIS)

- A school wide approach to promoting positive and reducing problem school behavior
- Evidence of strong effectiveness in improving school climate, reducing office referrals and suspensions for behavioral concerns, and freeing education and administrative staff to focus on academics
- Schools with PBIS may not focus on more serious emotional/behavioral barriers to learning (see www.pbis.org)
Expanded School Mental Health (ESMH)

- ESMH programs join families, schools, mental health and other community systems
- To develop a full array of effective programs and services that improve the school environment, reduce barriers to learning, and provide prevention, early intervention and treatment
- for youth in general and special education
Outcomes of Effective ESMH

- **Student:**
  - Improved attendance, behavior and academic performance

- **School:**
  - Improved environment, reduced violence, reduced inappropriate special education referrals

- **System:**
  - Enhanced collaboration between child serving agencies, increased and more efficient use of resources
The “Shared Agenda” Initiative

- Collaboration between families, other stakeholders, the National Association of State Directors of Special Education, National Association of State Mental Health Program Directors, and many other organizations
- Broadly disseminated concept paper (see www.nasdse.org/sharedagenda.pdf)
- Seed grants to states
- National and state training programs
**Shared Agenda Impacts**

- Increasing buy-in among education systems of integrated approaches that address academic and non-academic barriers to learning
- Providing support for the growth, improvement and integration of school mental health approaches (e.g., PBIS, ESMH)
- Promoting state-level progress and national to state to local linkages
- Advancing collaborative approaches and the development of communities of practice
University of Maryland
School Mental Health Program (SMHP)

- Established in 1989 in 4 schools
- Currently operating in 21 schools:
  - 9 elementary
  - 2 elementary-middle
  - 6 middle
  - 4 high
- Annual budget of around $1 million ($800,000 contracts; $200,000 fee-for-service)
SMHP Mission Themes

- Committed, energetic, resilient staff from multiple disciplines
- Strong collaborative approach with youth, families and all school staff
- Emphasis on productivity, continuous quality improvement and evidence-based practice
SMHP Statistics 2002-2003

- Total FTE for 21 schools = 19.3
- 2208 Students seen (M per school = 105)
- 11436 Individual sessions (M = 544)
- 14780 Group contacts (2405 sessions) (M = 703)
- 551 Family sessions (M = 26)
- 4490 Contacts with educators (M = 213)
Sample of new cases seen 4 or more times (n = 963):

- 63% had 90% or better attendance rate
- 97% had no school suspensions
- 4% referred for special education assessment
The Baltimore Experience: Key Ingredients

- Strong leadership
- A commitment to children
- Vigorous nonacceptance of *Same Old Same Old*
- History in school health
- Funding experience and perseverance
- Interdisciplinary networks
- Political will and activism
Center for School Mental Health Assistance
Established in 1995 with a grant from the Maternal and Child Health Bureau of the Health Resources and Services Administration (HRSA)

Renewed 5-year funding in 2000 from HRSA, with co-funding from the Substance Abuse and Mental Service Administration
CSMHA Goals

- Increase public support for expanded school mental health
- Improve the quality of mental health promotion and intervention in schools
- Facilitate the integration of youth serving systems in the advancement of ESMH
CSMHA Objectives

- Provide technical assistance and consultation
- Provide national training and education
- Disseminate and develop knowledge
- Promote communication and networking
  - phone: 410-706-0980 (888-706-0980 toll free)
  - email: csmha@psych.umaryland.edu
  - web: http://csmha.umaryland.edu
Dimensions of Progress in ESMH

- Advocacy, coalition building, policy change, resource enhancement
- Stakeholder involvement, needs assessments, resource mapping, strategic development
- Staff training and supervision, evidence-based practice
- Quality improvement and evaluation
Dimensions of Progress (cont.)

- Moving toward a full mental health promotion-intervention continuum
- Coordinating programs and services and contributing to system of care development
- Addressing areas of special need
Three Critical Areas for ESMH to Advance

- Advocacy and Infrastructure Development
- Doing and Coordinating the Work in Schools
- Quality and Accountability
Doing and Coordinating the Work
Continuum of Programs and Services in School Mental Health

- More Intensive Intervention
- Prevention and Early Intervention
- Enhance Environment, Broad Mental Health Promotion
Factors Necessary for the Development of the Continuum

**Desired Outcomes**
- Effective mental health promotion and intervention

**Outstanding Staff and program qualities**
- Ongoing training, technical assistance & support
- School and community buy-in and investment

**Resources**
- Awareness raising, advocacy, policy improvement
Youth Mental Health Services in Most Communities

Primary    Secondary    Tertiary

Education
M. Health
Pub. Health
## The Vision

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### Deciding on Roles in a School

*no stereotyping intended*

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SPEC.ED = X
Two Keys to Prevention

Catalano et al. (2002) reviewed 161 Youth Development Programs.

Two strategies in all effective programs were:

- Skill building
- Environmental, organizational change
Quality and Accountability
Dimensions of Quality

- You are where you should be
- Stakeholders are involved
- Strong collaborative processes
- Access is a priority
- Productive, efficient staff
- Full range of empirically supported approaches
- Developmental/cultural sensitivity
Cultural Competence

- Knowledge dimension (e.g., understanding the culture)
- Skill dimension (e.g., altering interpersonal space)
- Interest in listening/connecting dimension (e.g., ensuring diverse community stakeholders are involved in all aspects of the program).
Importance of Family Involvement

SEARCH Institute study:
– As parental involvement in schools increased, problem behaviors in students (alcohol use, violence, antisocial problems) decreased
– Roehlkepartain & Benson, 1994
Barriers to Family Involvement

- Service availability
- Stigma
- Fear of being blamed
- Feeling unwelcome in the school
- Fear of violated confidentiality
- Perceived lack of mutuality
“In the past, families were seen primarily as contributing to the mental health problems of their children, and their ONLY ROLE was in treatment to alter their structure and/or functioning” (Osher, 2001)
Best Approach

“The model of therapist as expert is replaced by a shared-learner framework in which both parties (family member and clinician) contribute knowledge and insight” (Axelrod et al., 2003)
Dallas Youth and Family Centers

- Family greeter welcomes all new families, helps them with forms, and provides general support
- Flexible hours, centers open at least two nights a week
- Having fun with food!
- Special programs:
  - Adult Basic Education (ABE)
  - Power of Parenting (POP)
  - Family Youth Interaction (FYI)
A Four-Pronged Approach to Evidence-Based Practice in School Mental Health

- Decrease stress/risk factors
- Increase protective factors
- Train in validated skills
- Implement manualized interventions
  – (see Schaeffer, 2002; Weist, 2003)
Examples of Modifiable Stress/Risk Factors

**Individual**
- low commitment to school, early school failure, association with acting out peers

**Family**
- marital discord, poor family management

**Community**
- poor housing, community disorganization
  (Hawkins et al., 1992; Mrazek & Haggerty, 1994)
Examples of Modifiable Protective Factors

**Individual**
- social competence, internal locus of control, reading for pleasure

**Family**
- routines and rituals, parenting skills, parental responsiveness

**Community**
- good schools, positive relationships with other adults (Hawkins et al., 1992; Mrazek & Haggerty, 1994)
Assets

- Receive Support
- Neighbors Encourage
- Feel Safe
- Adult Positive Models
- Feel Valued
- Family has Standards
- Parents feel that the school helps
- Want to do well
- Read for Pleasure
- Stand up for Beliefs
- Accept Responsibility
- Resist Peer Pressure
- Optimistic
- Life has Purpose
Assets – Protective Functions

Source: The Asset Approach: Giving Kids What They Need to Succeed
(Search Institute, 1997)
Critical Parenting Processes

- Consistent, fair discipline
- Careful monitoring and supervision of children’s activities, peer associates, and whereabouts
- Positive family management
- Involvement in the child’s daily life
- Training in problem-solving (Patterson, Reid, & Dishion, 1992)
Validated Skills

- Relaxation training
- Problem solving
- Cognitive restructuring
- Self-control training
- Anger management training
- Social competence and resistance training
  - (see Christophersen & Mortweet, 2001)
EBP should be viewed as a key component of a larger agenda focused on Quality

But:

– The research literature on quality in children’s mental health is very limited (and boring), and
– Quality assessment and improvement efforts in school mental health practice are patchy and highly variable
Enhancing Quality in Expanded School Mental Health

- Randomized controlled study to assess impacts of systematic quality improvement on clinician behavior, satisfaction with services, and student outcomes
- First experimental study of quality improvement in school mental health
- Will provide guidelines for best practice and will help to standardize practice
Example Quality Principle and Indicators

Principle # 3

- *Programs are implemented to address needs and strengthen assets for students, families, schools and communities*

Example Indicators

- *Have you conducted assessments on common risk and stress factors faced by students?*
- *Are you developing programs to help students contend with common risk/stress factors?*
Outcomes Evaluation:
Continuum of Approaches

- Stories, perceptions
- Satisfaction ratings
- Changes in individual students
- Changes in groups of students
- Changes in groups compared to other groups
- Controlled, system-wide, multidimensional
School Mental Health Outcomes Group (SMHOG)

- Interdisciplinary group (psychology, social work, public health; education, mental health, research)
- Tracking and making recommendations to improve ESMH programs in Baltimore
Special Education Placement Rates
Schools that initiated SBMH services in 1992-93 (N=6)

Source: Maryland Department of Education (MSDE)
Advocacy and Infrastructure Development
Barriers to Support of ESMH

Concerns about:
- confidentiality/privacy
- competition for resources
- effectiveness
- appropriateness
Myths about School Mental Health

- “Manipulating children’s minds”
- Teaching “new age” concepts
- Compromising family values
- Providing services without parental approval and parental consent
Stigma is Huge

- Being called “crazy” is about the worst thing you could be called

- Stigma accounts for significant utilization problems

- Knowledge removes stigma
Media Advocacy

Strategic use of media to support a community organization and/or to advance a social or public policy initiative
Boards of Education

- Are often highly political
- Generally are not focused on mental health
The Two-Edged Sword of Systematic Mental Health Screening in Schools

- Need will no doubt overwhelm existing resources.
- But, without screening we are turning our heads away from youth in need, and failing to develop data that will help infuse advocacy efforts with a sense of urgency.
The Need for Advocacy Training

Most people in most child serving systems have little or no training in effective advocacy.
Advocacy Involves:

- Bringing diverse people together around a common theme
- Understanding the lay of the land in terms of the problem and existing efforts to address it
- Developing an idea that works better
- Increasing support for the idea and refining it
- Facilitating the translation of the idea into policy and practice change with necessary resource/system enhancements
Toward Funding for a Full Continuum of Programs and Services

Maximizing all potential sources of revenue:

- allocations from schools and departments of education
- state and local grants and contracts
- federal and foundation grants and contracts
- “line item” support
- innovative prevention funding
- fee-for-service
The Significant Impacts of Federalism

- State of residence determines whether youth use mental health more than race/ethnicity or income.
- Differences in mental health use by children across states are generally not related to differences in levels of need (e.g. AL and TX present higher rates of need but lower rates of use).

  - Sturm, Ringel & Andreyeva, 2003 (www.pediatrics.org)
Ohio Mental Health Network for School Success

- Regional action networks for mental health in schools
- Networks raise awareness, develop resources, offer TA, do training within and across sites
- Annual publication on progress
- Genuine cost sharing across major systems
- Strong partnerships with universities and development of centers of excellence
New Mexico School Behavioral Health Initiative

- Strong regional networks, monitoring that leads to action on where every jurisdiction stands
- Strong training emphasis for MH and primary care providers, train the trainers approach
- Growing legislative advocacy
- “Childhood Revealed” – Youth Mental Health Awareness Initiative
Maryland’s Blueprint for Children’s Mental Health

Three pillars:

- Quality and System Improvement
- Service Delivery Support and Treatment
- Mental Health Promotion: Early Childhood (EC), Expanded School Mental Health (ESMH)
Centers for Mental Health in Schools

Supported by the Office of Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration;

With co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
UCLA Center for Mental Health in Schools

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