Advancing High Impact School Behavioral Health in Virginia

Mark D. Weist, Ph.D., Professor, Clinical-Community and School Psychology, Department of Psychology
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Thanks to:

- Susan Barrett, Lucille Eber, Kathy Georgiades, Sharon Hoover, Nancy Lever, Kathy Short

University of South Carolina
School Mental Health Team
Outline

• School Mental Health (SMH) – Needs, Strengths, Limitations
• Positive Behavioral Intervention and Support (PBIS) – Strengths and Limitations
• Interconnected Systems Framework (ISF) for SMH/PBIS
• Key Themes: Teams, Readiness, Quality, Evidence-Based Practices, Using Data
• Advancing the Work at Building, District and State levels
• Challenges and Overcoming Them
• Community of Practice Approach
• Resources

Reality 1

• Child and adolescent mental health is among the most neglected health care needs in the world

Reality 2

• Children, youth and families are not getting to places where mental health services are traditionally delivered
Reality 3

- Schools are under-resourced to address mental health issues, and may view this as beyond their mission

“Expanded” School Mental Health

- Full continuum of effective mental health promotion and intervention for students in general and special education
- Reflecting a “shared agenda” involving school-family-community system partnerships
- Collaborating community professionals (not outsiders) augment the work of school-employed staff

School Mental Health (SMH) MH vs Clinics

- Catron, Harris & Weiss (1998)
- 96% offered SMH received
- 13% for clinics
SMH vs Clinics 2

- Atkins et al. (2006)
- 80% enrolled in SMH vs 54% in clinics
- At 3-month follow-up, 100% retained in schools, 0% in clinics

Failed Interventions are Not Neutral

- They can lead to:
  - Harm
  - Avoidance of MH for the rest of someone’s life
  - The perpetuation of negative stereotypes
  - Lost policy opportunities

Maternal and Child Health Bureau/Health Resources and Services Administration

- Mental Health in Schools Initiative, 1995
- Two National Centers
  - University of Maryland School of Medicine
  - University of California, Los Angeles
- Five States
  - Kentucky, Maine, Minnesota, New Mexico, South Carolina
- Initial leadership by project officers Juanita Cunningham Evans, and Dr. Michael Fishman
Advantages

- Improved access
- Improved early identification/intervention
- Reduced barriers to learning, and achievement of valued outcomes
- WHEN DONE WELL

But

- SMH programs and services continue to develop in an ad hoc manner, and
- LACK AN IMPLEMENTATION STRUCTURE

SMH Handbook, 2014
Discussion

• What are some major strengths and weaknesses of the child and adolescent mental health system in Virginia?

Positive Behavior Intervention and Support (www.pbis.org)

• In 23,000 plus schools
• Decision making framework to guide selection and implementation of best practices for improving academic and behavioral functioning
  – Data based decision making
  – Measurable outcomes
  – Evidence-based practices
  – Systems to support effective implementation

Advantages

• Promotes effective decision making
• Reduces punitive approaches
• Improves student behavior
• Improves student academic performance
• WHEN DONE WELL
But
• Many schools implementing PBIS lack resources and struggle to implement effective interventions at Tiers 2 and 3
• View student issues through lens of “behavior”

Discussion
• What are strengths and weakness of PBIS in Virginia?

Key Rationale
• PBIS and SMH systems are operating separately
• Results in ad hoc, disorganized delivery of SMH and contributes to lack of depth in programs at Tiers 2 and 3 for PBIS
• By joining together synergies are unleashed and the likelihood of achieving depth and quality in programs at all three tiers is greatly enhanced
Logic

Youth with challenging emotional/behavioral problems are generally treated very poorly by schools and other community agencies, and the “usual” approaches do not work.

Logic CONT.

• Effective academic performance promotes student mental health and effective mental health promotes student academic performance. The same integration is required in our systems.

The Status Quo

• Increasing placement restrictiveness/JJ involvement
• Poor data use, pro-forma team functioning, non-empirical approaches
• Rare/ad hoc MH system involvement
• Limited school employees and constrained roles
• Disconnected youth-serving systems/silos
Development of the Interconnected Systems Framework (ISF)

- 2002-2007 – Exploration of ideas in sites with PBIS Expansion (informal and independent)
- 2005 - Community of Practice focus on integration of PBIS and SMH
- 2008 - First ISF White Paper
- 2009 - 2013 Monthly calls with implementation sites, national presentations (from sessions to strands)
- 2009 - Grant Submissions
- 2013 - ISF e-book published
- 2015 - ISF Learning Community started with a Webinar Series
- 2016 – Large RCT grant awarded, webinars continuing

POSITIVE BEHAVIOR INTERVENTIONS AND SUPPORTS AND SCHOOL MENTAL HEALTH

Not two, but one
Dynamic Duo

ISF Defined

- Structure and process for education and mental health systems to interact in most effective and efficient way

- Guided by key stakeholders in education and mental health/community systems, including youth and families

- Who have the authority to reallocate resources, change roles and functions of staff, and change policy
ISF Defined 2

- Tiered prevention logic
- Cross system problem solving teams
- Use of data to decide which evidence based practices to implement
- Progress monitoring for both fidelity and impact

ISF Defined 3

- A strong, committed and functional team guides the work, using data at three tiers of intervention
- Sub-teams having “conversations” and conducting planning at each tier
- Evidence-based practices and programs are integrated at each tier, with implementation support and coaching
- SYMMETRY IN PROCESSES AT STATE, DISTRICT AND BUILDING LEVELS

ISF Conceptual Framework

- Improved behavioral/academic outcomes for all
- Greater depth and quality in services
- Improved data use, team functioning
- Systematic MOAs
- Strong district/building leadership
- A SHARED AGENDA
Layered Mental Health Interventions within the MTSS

Social and Emotional Learning

• “SEL involves the processes through which children and adults acquire and effectively apply the knowledge, skills, and attitudes necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions”
  – Bradshaw et al., 2014

Benefits of SEL

• Improved social/emotional skills
• Improved emotional/behavioral functioning
• Increased prosocial behavior
• Increased academic performance
• Increased positive attitudes toward self and others

Durlak et al., 2011; Child Development
Collaborative for Academic, Social, and Emotional Learning (CASEL)

• Founded in 1994
• Goal of advancing SEL from preschool to high school
• Interdisciplinary
  — Education, mental health, developmental psychology
• Focus of work in research, practice, and policy
• Free guide of evidence-based SEL programs
  — Rated according to evidence strength
  — See casel.org

Core Competencies of SEL

• Self awareness
  — Self-efficacy
  — Emotion regulation
• Social awareness
  — Empathy
  — Perspective taking
• Responsible decision making
  — Problem solving
  — Personal responsibility
• Self management
  — Stress management
  — Goal setting
• Relationship skills
  — Cooperation
  — Negotiation
  — Help seeking

IDEA

• Connect PBL core behavioral expectations in a school to SEL competencies
Three Connected Priorities

• Implement effective practices
• Document valued outcomes
• Build capacity

Example Team
Effective Teams

- Clear memoranda of agreement/understandings between school systems and community mental health agencies
- Strong leadership
- Team members on the team at the school and community level with decision making authority and ability to allocate resources
- Effective meeting agendas, frequent and consistent meetings, high levels of attendance
- Opportunities for all to participate
- Note taking and archiving/reviewing notes
- Clear action planning
- Systematic follow up on action planning

How do schools know if they are ready to implement the ISF?

**Readiness Assessment**

Schools are ready to implement if:
- High status leadership and team with active administrator participation
- School priority is to improve social/emotional/behavioral health for all students
- Committed to SMH-PBIS integration
- Invested in prevention
- Stable staffing and resource allocation
- Active data-based decision making
- Strong family and community support

Principles for High Quality SMH – Early 2000s

- 1) Emphasize ACCESS
- 2) Address needs, and strengthen assets
- 3) Evidence-based
- 4) Diverse stakeholders involved
- 5) Active quality assessment and improvement
Principles CONT

- 6) Full continuum of promotion/prevention, early intervention and intervention
- 7) Hiring, training and supporting the right staff
- 8) Assuring developmental and cultural competence
- 9) Promoting interdisciplinary collaboration
- 10) Improving cross-system coordination

School Mental Health Quality Assessment Questionnaire - 2004
The Challenge of Evidence-Based Practice (from Sharon Hoover)

**Intervention/Indicated:**
- Cognitive Behavioral Intervention for Trauma in Schools, Coping Cat, Trauma Focused CBT, Interpersonal Therapy for Adolescents (IPT-A)

**Prevention/Selected:**
- Coping Power, FRIENDS for Youth/Teens, The Incredible Years, Second Step, SEFEL and DECA Strategies and Tools, Strengthening Families Coping Resources Workshops

**Promotion/Universal:**
- Good Behavior Game, PATHS to PAX, Positive Behavior Interventions and Support, Social and Emotional Foundations of Early Learning (SEFEL), Olweus Bullying Prevention, Toward No Tobacco Use

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Typical Work for Clinician for Evidence-Based Prevention Group

- Screen students
- Analyze results of screen
- Obtain consent/assent
- Obtain teacher buy-in
- Coordinate student schedules
- Get them to and from groups
- Rotate meeting times
- Implement effectively
- Promote group cohesion
- Address disruptive behaviors
- Conduct session by session evaluation
- Deal with students who miss groups

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Strengthening School Mental Health Services

- NIMH, R01MH081941-01A2, 2010-14 (building from a prior R01)
- 46 school mental health clinicians, 34 schools
- Randomly assigned to either:
  - Personal/ Staff Wellness (PSW)
  - Clinical Services Support (CSS)
CSS: Four Key Domains

- Quality Assessment and Improvement
- Family Engagement and Empowerment
- “Modular” Evidence Based Practice
- Implementation Support

Structure for Implementation

- Twice monthly two-hour training
- Monthly or more coaching visits at school
- Coaching involving observing family sessions and collegially providing ideas and support

Results

- Aim 2: EQAI intervention on Youth Psychosocial Outcomes

Model fit indices: $\chi^2(8) = 8.13, p > .05; CFI = .99; RMSEA = .01$
Other Conclusions

• Need the right clinicians
• For true EBP demands are intense at multiple levels
• TRAINING/IMPLEMENTATION SUPPORT + INCENTIVES + ACCOUNTABILITY

Advancing Evidence-Based Assessment

• Expanding range of intervention targets
• Improve measure selection and move to those in public domain
• Assess and improve organizational readiness
• Provide implementation support
• Promote efficient data collection and use

What data are analyzed to assess implementation across tiers?

School Data
• Academic
• Discipline
• Attendance
• Climate/Perception
• Visits to Nurse, Social Worker, Counselor, etc.
• Screening from one view

Community Data
• Community Demographics
• Food Pantry Visits
• Protective and Risk Factors
• Calls to crisis centers, hospital visits
• Screening at multiple views
District Community Leadership Team

- Systems leaders (e.g., School Superintendent, MH Agency Leader)
- Those involved in ISF coaching (from EDU and MH)
- Educators (including principals) and clinicians
- Family members and older youth
- Representatives from other diverse youth-serving systems (e.g., child welfare, juvenile justice, disabilities, primary healthcare)
- Government officials
- University staff and researchers

Role/Function of the DCLT

Importance of Memoranda of Agreement (MOAs)

- Enables common expectations and move toward standardization in evidence-based assessment and practice
- Providing “one door” for community mental health and other systems to come through
- Creates opportunities for system collaboration, braided funding, and growth in funding to enable other system involvement in Tiers 1, 2 and 3
Challenges cont.

- Negative, pejorative labeling of children and cumulating negative labels (and in some cases medications)
- Status quo to focus on experts who tell people what to do to treat their “psychopathology” or “severe emotional disturbance”
- Intractable silos of youth serving systems
- Increasing but not decreasing restrictiveness in placements
- Poor handling of youth transitions between systems
Roles of School-Employed MH Staff (in some instances)

- Course scheduling
- Attendance monitoring
- Examination monitoring
- Career guidance
- Logistics assistance
  - See Steve Evans, Ohio University

A Common Pattern

- Crisis of the Week (COW) therapy
- Putting out fires
- Failing to achieve valued outcomes
  - Thanks to Sharon Stephan

Students in Alternative Schools
from Jason Bird and Bobby Markle

Negative School Climate -
- Stigmatized by teachers and students
- Negative peer interactions at both schools
- Little positive support from teachers and school staff upon returning from alternative school

Inconsistent School Structure and Procedures -
- Larger, more difficult classes upon return to regular school
- Less perceived expectations/accountability at the alternative school placements
- Unclear transitional procedures between schools
Factors Associated with Educator Burnout

- Student misbehavior and disengagement
- Low sense of self-efficacy
- Inadequate salary and perceived lower status of the profession
- Time pressure
- Lack of autonomy

Need to Address Tokenism
INTERCONNECTING PBIS AND SCHOOL MENTAL HEALTH TO IMPROVE SCHOOL SAFETY

Mark D. Weist, Joni Splett, & Callen Halliday-Boykins (Principal and Co-Investigators)
Kelly Reden, Claire Miller, Daniele Wojtalewicz & Joshua Bradley (Assisting Implementation and Measurement)

Study Design

24 Participating Elementary Schools
- Charleston County, SC (12)
- Marion County, FL (12)
- Prior to study all were implementing PBIS; none were implementing SMH
Each school is randomized to one of three conditions:
- PBIS Only
- PBIS + SMH (business as usual)
- Interconnected Systems Framework
Intervention in place for 2 academic years, starting August, 2016
All students in the building are participants unless they opt of study

Jacksonville Beach, 6.27.17
PASS: Key lessons learned, 1.5 years in

1. Hiring the right people is essential (and there are school, and mental health system politics to navigate)
2. How assure complementarit in roles for school - as compared to community-employed staff?
3. High level leaders in all systems need to be engaged and involved
4. Teams are all over the map and usually need to be re-organized
5. There is strong resistance to genuine family engagement

PASS lessons learned, cont.

6. At times there is a need to be prescriptive, how move to that from a more organic approach?
7. System for coaching of coaches is critical
8. Drift back into prior practices is an overwhelming force; how can the strength of implementation support be raised to counter this?
9. Need fluid assessment, fluid intervention, and fluid adjustment of services, but categorical approach is everywhere and poses a large challenge

PASS, lessons learned 3

10. There is a lot of ambiguity in Tier 2, and as work here progresses there can be a clear tension between Tiers 2 and 3 (see next slide)
11. There is a critical need for child welfare and juvenile justice systems to be involved but in general they are not involved
12. What are the best decisions rules for re-screening youth?
13. Tremendous potential for creating integrated education, health, mental health on-line academic-health records for students
14. Research studies can be strategically used for promoting sustainability and building capacity but researchers are often not focused on this and this work is hard
Student Baseline Data (from Spring, 2016)

1,775 Student Assessment Batteries Completed
- Male: 49.26%
- White: 45.03%
- Black/African American: 34.26%
- Hispanic: 16.57%
- Other: 4.14%
- SDQ Borderline: 18%
- SDQ Abnormal: 10.25%
- Reported 1 or more exposure to violence in past 6 months: 70.35%

763 Teacher Ratings on Selected Students
- SDQ Borderline: 15.53%
- SDQ Abnormal: 20.47%

Importance of Relationships in Change

There will never be enough laws, policies, processes, documents, etc. to force change.

Change is best realized through the relationships we build with those people and groups that have a common interest toward solving a persistent problem or seizing an opportunity.

Bill East, Joanne Cashman, Natl Assoc of State Directors of Special Education

Systematic Agenda

Relationships
Communities of Practice

“Communities of practice are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis” (p.4)


Leading by Convening

Creating conditions for groups with common interests to be actively engaged and move from discussion to dialogue to collaboration to policy improvement and enhanced resources

Joanne Cashman & Bill East, National Association of State Directors of Special Education (2014)

Key Role of Universities and Colleges

- As “neutral” convener
- With knowledge of state-of-the-art developments in research and practice
- Representing diverse disciplines involved in the work
- Enabling a win-win for trainees and practice sites
Multiscale Learning

• People with common interests interacting at multiple levels, within and across
  • Teams
  • Communities
  • States
  • Regions
  • Countries
PCORI

Patient-Centered Outcomes Research Institute

PCORI believes that combining patients and other stakeholders’ individual experiences and passion for improving healthcare quality with the expertise of researchers will result in research that better meets the needs of the entire healthcare community.

Stakeholders (Leaders and Staff)

• Youth and Families
• Government
• Education
• Child and Adolescent Mental Health
• Juvenile Justice
• Child Welfare
• Disabilities
• Primary Healthcare
• Allied Health Services
• Vocational Rehabilitation
• Universities and Colleges
• Faith
• Business
School Mental Health International Leadership Exchange (SMHILE)

- Emphasis on building collective knowledge on leadership and implementation foundations for effective prevention and mental health promotion in schools
- Established in 2014
- International Core Development Team (with leaders from Australia, Canada, England, Germany, Ireland, Norway, and the U.S.)
- See www.smhile.com

SMHILE: Five Critical Themes

- 1) Cross-sector collaboration in building systems of care
- 2) Meaningful youth and family engagement
- 3) Workforce development and mental health literacy
- 4) Implementation of evidence-based practices
- 5) Ongoing monitoring and quality assurance

School Mental Health Promotion and Intervention: Experiences from Four Nations

- Review of SMHILE’s five critical themes as they are playing out in four nations – Canada, USA, Norway and Liberia
- Authors: Mark D. Weist, Eric Bruns, Kelly Whitaker, Yifeng Wei, Stanley Kutcher, Torill Larsen, Ingrid Holsen, Janice Cooper, Anne Geroski, and Kathryn H. Short
- In press, School Psychology International
Ontario students are flourishing, with a strong sense of belonging at school, ready skills for managing academic and social/emotional challenges, and surrounded by caring adults and communities equipped to identify and intervene early with students struggling with mental health problems.

Our Vision

From Kathy Short, see School Mental Health International Leadership Exchange (SMHILE.com)

Taking Mental Health To School:

A policy-oriented paper on school-based mental health for Ontario

- Synthesis of literature
- Scan of the practice landscape
- Consultation with policy officials across 5 ministries before and after report development
- Culminating in a set of recommendations for policy related to school mental health in Ontario

Taking Mental Health To School (Ontario)


Taking Mental Health to School Scan Findings and Gap Analysis

- Different models of mental health service delivery across boards
  - Variable leadership structures, variable levels and types of professional support, variable relationship with community, variable range of services provided
- Educators are very concerned about student mental health, but feel ill-prepared
- Inconsistent use of evidence-based practices
- Acknowledgement of promising supports (e.g., Student Support Leadership Initiative)
- Need for leadership, coordination, access to evidence-based approaches, implementation support, evaluation
Similar Findings
Nationally and Internationally

- Provincial, national, international recognition of the problems associated with mental illness, and the critical role of schools in prevention
- Interest amongst policy makers, funding bodies, researchers, media
- Philanthropy and campaigns (e.g., Bell Let's Talk, Jack Ride)
- But a lack of coherence and sustainability in most jurisdictions

School-based Mental Health and Substance Abuse: A National Study in SMH (Canada)
https://www.mentalhealthcommission.ca/English/system/files/private/document/ChildYouth_School_Based_Mental_Health_Canada_Final_Report_ENG.pdf

Kathy Short
Director
School Mental Health ASSIST
kshort@hwdsb.on.ca
kshort@smh-assist.ca

Visit us online:
http://smh-assist.ca/
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@SMHASSIST

School Mental Health Survey (SMHS)
Kathy Georgiades and Colleagues
Research-Policy-Practice Meeting
May 25, 2017

CONTACT US:
Overview of SMHS – Data Collection & Survey Response Rates

Anonymous Surveys

1. Students: all grade 6-8 students; random selection of SS students [response = 62%; n=31,124]
2. Teachers: all elementary teachers; select teachers from participating SS classrooms [response = 71%; n=3,373]
3. Principals: all principals [response = 83%; n=206]

Students’ perceptions of barriers

Students’ Mental Health Concerns
If you felt you needed help for concerns regarding your mental health, would you speak to a school social worker, child or youth worker, counsellor, psychologist … at school about these concerns?

Student Reported Barriers

- Prefer to handle the problem myself: 77%
- Don’t think these people would be able to help. 54%
- Wouldn’t know who to approach. 46%
- Lack of trust in these people would get out. 34%
- Worried about what others would think of me. 29%

Teachers’ perceptions of barriers to addressing student mental health in school

- Lack of adequate staff training to address student mental health in the school. 27%
- Low priority given to student mental health versus other initiatives in the school. 36%
- Stigma (negative attitudes or unfair treatment) associated with mental health problems. 32%
- Language and cultural barriers arising from an ethnically and racially diverse student population. 24%
- Lack of contact between the school and parents. 18%
Important Upcoming National Conferences

• PBIS Implementers Forum
  – September 28 and 29, 2017; Chicago

• Advancing School Mental Health Conference
  – October 19-21, 2017; Washington, DC

Thank you!
weist@mailbox.sc.edu