Thanks to:

- Susan Barrett, Lucille Eber, Kathy Georgiades, Sharon Hoover, Nancy Lever, Kathy Short
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
• Child and adolescent mental health is among the most neglected health care needs in the world
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

PBIS | Positive Behavioral Interventions & Supports
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

<table>
<thead>
<tr>
<th>Teaching Matrix</th>
<th>INCORPORATE Coping Strategies for Managing Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Settings</td>
<td></td>
</tr>
<tr>
<td>Halls</td>
<td>Walk, Have a plan, Invite those sitting alone to join in</td>
</tr>
<tr>
<td>Playgrounds</td>
<td></td>
</tr>
<tr>
<td>Lunch</td>
<td>Study, read, compute, Sit in one spot, Watch for your stop</td>
</tr>
<tr>
<td>Library/Computer Lab</td>
<td></td>
</tr>
<tr>
<td>Assembly</td>
<td></td>
</tr>
<tr>
<td>Bus</td>
<td></td>
</tr>
</tbody>
</table>

## Expectations

### Respeful
- Be on task
- Give your best effort
- Be prepared
- Walk
- Have a plan
- Invite those sitting alone to join in
- Study, read, compute
- Sit in one spot
- Watch for your stop

### Achieving & Organized
- Be kind
- Hands/feet to self
- Help/share with others
- Use normal voice volume
- Walk to right
- Share equipment
- Include others
- Choose quiet or social lunch area
- Use cognitive coping skills
- Invite friends to join me
- Whisper
- Return books
- Listen/watch
- Use appropriate applause
- Use a quiet voice
- Stay in your seat

### Responsible
- Recycle
- Clean up after self
- Pick up litter
- Maintain physical space
- Use equipment properly
- Put litter in garbage can
- Use my breathing technique
- Listen to my signals
- Push in chairs
- Treat books carefully
- Pick up
- Treat chairs carefully
- Wipe your feet
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

Zins & Elias, 2004
IDEA

• Connect PBL core behavioral expectations in a school to SEL competencies
### School-Wide Behavior Expectations

#### Arrival & Dismissal
- **Walk** directly to my designated area
- **Stay** in my area
- **Talk** softly
- **Keep** hands, feet, and belongings to myself

#### Hallway & Transitions
- **Walk** directly to my designated area
- **Walk quietly** in a single, straight, and silent line so that others can continue learning and working
- **Walk** to the right side of the hallway

#### Bathroom
- **Keep** hands, feet, and belongings to myself
- **Allow** for the privacy of others
- **Enter and exit** with a pass or my teacher
- **Throw away** my trash and tray
- **Clean** up after myself

#### Cafeteria
- **Conserve** supplies:
  - 2 squirts of soap
  - 2 pushes/tURNS on the paper towel dispenser
  - Dispose of trash in the trash can
- **Move away** from conflict or distractions
- **Ask** for help when needed
- **Be patient**
- **Stay in line**

#### Classroom
- **Listen**
- **Follow** directions the first time given
- **Ask** appropriately for help
- **Clean up** after myself
- **Follow** lab rules and procedures
- **Accept** feedback and discipline from staff by listening, asking questions, and following directions the first time.
- **Be ready** to learn
- **Be present** and focused
- **Encourage** others
- **Attend** class daily and on time
- **Clean up** after myself
- **Be prepared** for instruction with all necessary materials

---

#### Safety First
- **Respect** the space of others

#### Work Together Respectfully
- **Keep** to your own business
- **Remain quiet** in QUIET ZONES
- **Carry** my own belongings
- **Keep** lockers locked
- **Walk** directly to my designated area

#### Accept Responsibility
- **Flush**
- **Wash** my hands
- **Use** appropriate fixtures
- **Go**
- **Maintain** a clean space and conversation
- **Keep** food on my tray or in my mouth

#### Guide Me
- Teachers will supervise groups of students at all times
- Teachers will ensure that they know the location of all students
- Teachers will enforce safety
- Teachers will monitor students by being at their doors and in the hallways
- Teachers will stand by bathrooms to monitor the noise and behavior from the hallway
- Teachers will arrive on time and pick up students on time
- Teachers will walk students directly into the cafeteria
- Teachers will supervise groups of students at all times
- Teachers will be prepared for class
- Lesson plans posted
- Engaged and present
- Observable outcomes
Three Connected Priorities

• Implement effective practices
• Document valued outcomes
• Build capacity
Example Team

**ISF Team**

- Assistant Principal
- School Nurse
- General Educator
- Parent
- Parent
- Parent
- Student
- Collaborating community mental health professional
- School Psychologist
- School Counselor
- Special Educator

Note: *co-leaders*
# 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
- Structured 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**

- Includes perceptions of stakeholders
- Feasibility of implementation changes
- Available resources

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
<table>
<thead>
<tr>
<th>Principle 1: All youth and families are able to access appropriate care regardless of their ability to pay.</th>
<th>not at all in place</th>
<th>fully in place</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCESS TO CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) When indicated, do you provide case management assistance to students and families to assist them in obtaining health insurance or to facilitate enrollment in programs for which they are eligible?</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td><strong>FUNDING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Are you engaged in activities that may bring resources or financial support into the school mental health program?</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td><strong>Principle 2: Programs are implemented to address needs and strengthen assets for students, families, schools, and communities.</strong></td>
<td>not at all in place</td>
<td>fully in place</td>
</tr>
<tr>
<td><strong>NEEDS ASSESSMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Have you conducted assessments on common risk and stress factors faced by students (e.g., exposure to crime, violence, substance abuse)?</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>4) Have you held meetings with students, parents, and teaching staff to ask them about their needs and to ask them for their recommendations for actions by school mental health staff?</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td><strong>ADDRESSING NEEDS AND STRENGTHS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Do you have services in place to help students contend with common risk and stress factors?</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>6) Are you matching your services to the presenting needs and strengths of students/families after initial assessment?</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td><strong>Principle 3: Programs and services focus on reducing barriers to development and learning, are student and family friendly, and are based on evidence of positive impact.</strong></td>
<td>not at all in place</td>
<td>fully in place</td>
</tr>
<tr>
<td><strong>EVIDENCE-BASED PRACTICE: SCREENING, ASSESSMENT, AND INTERVENTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) Do you receive ongoing training and supervision on effective diagnosis, treatment planning and implementation, and subsequent clinical decision-making?</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>8) Do you conduct screening and follow-up assessments to assist in the identification and appropriate diagnosis of mental health problems?</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>9) Do you continually assess whether ongoing services provided to students are appropriate and helping to address presenting problems?</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>10) Is there a clear and effective protocol to assist your clinical decision making and care for more serious situations (e.g., abuse and neglect reports, self-reporting of suicidal/homicidal ideation)?</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>11) Are you actively using the evidence-base practices and programs of what works in child and adolescent mental health to guide your preventive and clinical interventions?</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
</tbody>
</table>
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
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
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
• Aim 2: EQAI intervention on *Youth Psychosocial Outcomes*

EQAI Intervention is related to fewer Youth Psychosocial Problems

More problems among girls and youth receiving free lunch

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

LEADERSHIP TEAM
Planning, Implementation, & Coordination

- Funding
- Visibility & Dissemination
- Political Support
- Policy & Systems Alignment
- Personnel Readiness & Selection

- Training & Professional Development
- Coaching & Technical Assistance
- Evaluation & Performance Feedback
- Local Content Expertise

Local Implementation Demonstrations
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
FY 15 Funding Strategy ESMH

- BHS Baltimore/MHA: $726,000
- BHS Baltimore/ADAA: $345,935
- BCPS: $948,065
- Foundation: $144,000
- Projected Fee-for-Service: $2,166,000
PBIS/SMH in Montana
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, & Colleen Halliday-Boykins (Principal and Co-Investigators)  
Kelly Perales, Elaine Miller, Daniela 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 complementarity 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: 13.23%
- 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
State of the Carolinas: Implementing School Mental Health and Positive Behavioral Interventions and Supports

by Joni W. Splett, Kurt D. Michael, Christina Minard, Robert Stevens, Louise Johnson, Heather Reynolds, Katharina Farber, and Mark D. Weist*

The Carolinas have a rich and diverse history. South Carolina was the first colony to declare independence from British rule during the American Revolution and the first state to declare secession from the Union at the start of the Civil War. The population of South Carolina is nearly 4.8 million. It is the 24th most populous state in the United States and has a diverse citizenry, including 64% Caucasian, 28% African-American, and 5% Hispanic residents (U.S. Census Bureau, 2012). Children and youth under the age of 18 make up 22.8% (1.98 million) of the population.

A large number (25.8%) of North Carolina's children live in poverty (Annie E. Casey Foundation & O'Hare, 2013).

Equally unfortunate, a high percentage of children attending public schools in the Carolinas perform below state standards. For example, in South Carolina, the number of children who perform below state standards in reading (17% in 3rd grade; 32% in 8th) and math (30% in 3rd grade; 30% in 8th) is substantial, and in North Carolina, the situation is considerably worse, with below-standard scores in reading at 65% in fourth grade and 68% in eighth grade.

The Carolina Foundation for Mental Health (SCDMH) has one of the strongest expanded school mental health (SMH) service programs nationally, and the grassroots effort to disseminate and support implementation of Positive Behavioral Interventions and Supports (PBIS) is benefiting from recent interest, renewed energy, and federal momentum.

The Interconnected Systems Framework

The trends in the Carolinas mirror national trends in children's educational and mental health.
PBIS and SBMH

Lexington 05
Dorchester 02
Richland 01
Charleston
Lexington 02
Greenville
South Carolina School Behavioral Health Conference

Please save the date for the first South Carolina School Behavioral Health Conference in Columbia

2nd Annual South Carolina School Behavioral Health Conference

Thursday, April 23 & Friday, April 24, 2015
North Charleston, SC

The 2nd Annual SC School Behavioral Health Conference is an opportunity for professionals from schools, agencies, and families to network, collaborate, and discuss issues with children and families in South Carolina.

Susan Barrett
Project Coordinator
System of Behavioral Supports

Covered Includes:
- Pre-school collaboration
- Best practice considerations for School Mental health services
- Inclusion in behavioral health services
- Strategies for data-driven decision making
- PBIS (Positive Behavior Intervention Support) and other behavioral health services
- Support for at-risk students
- Prevention strategies to promote school safety and prevent dropout

visit:
www.scschoolbehavioralhealth.org

3rd Annual South Carolina School Behavioral Health Conference

Myrtle Beach, South Carolina
Sheraton Myrtle Beach Convention Center Hotel
April 21 and 22, 2016

"Partnering with Students and Families to Promote Leadership in School Behavioral Health"

Keynote Speaker: Nancy A. Lever, Ph.D.
Co-Director, Center for School Mental Health (CSMH), University of Maryland

The Third Annual Conference is an opportunity for representatives from schools and youth-serving agencies in South Carolina to network, collaborate, and learn new strategies to improve school behavioral health outcomes for children and families.

For more information:
www.scschoolbehavioralhealth.org
Email: wendy@pearson.com
Call (803) 777-8940
Fax (803) 777-9958

Registration for the 3rd Annual South Carolina School Behavioral Health Conference is now open and improving! Register today!
www.scschoolbehavioralhealth.org

Partially supported by
Department of Psychology
University of South Carolina
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
From Kathy Short, see School Mental Health International Leadership Exchange (SMHILE.com)

Ontario students are flourishing, with a strong sense of belonging at school, ready skills for managing academic and social/emotional challenges, surrounded by caring adults and communities equipped to identify and intervene early with students struggling with mental health problems.
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 Consortium National Study in SMH (Canada)
https://www.mentalhealthcommission.ca/English/system/files/private/document/ChildYouth_School-Based_Mental_Health_Canada_Final_Report_ENG.pdf
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@SMHASSIST
School Mental Health Survey (SMHS)

Kathy Georgiades and Colleagues
Research-Policy-Practice Meeting
May 25, 2017
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

Yes, 44%

No, 56%

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. 51%
Lack of trust in these people- word would get out. 42%
Worried about what others would think of me. 35%
Teachers’ perceptions of barriers to addressing student mental health in school

- Lack of adequate staff training to address student mental health in the school. 77%
- Low priority given to student mental health versus other initiatives in the school. 54%
- Stigma (negative attitudes or unfair treatment) associated with mental health problems. 51%
- Language and cultural barriers arising from an ethnically and racially diverse student population. 42%
- Lack of contact between the school and parents. 35%
Important Upcoming National Conferences

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

• Advancing School Mental Health Conference
  – October 19-21, 2017; Washington, DC
April 18-20, 2018
Myrtle Beach, SC
Thank you!
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