School-Based Mental Health Services and Service Coordination

Project Summary and Phase III Report for Jackson County Community Mental Health Fund

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Project Overview

In September 2018, the Jackson County Community Mental Health Fund (CMHF) Board proposed a study of school-based mental health services and service coordination, to be completed in three phases. Resource Development Institute was contracted, for each phase, by the CMHF to complete the work.

In Phase I, data were gathered from relevant reports and existing data sources to clarify factors contributing to youth need for mental health services in the county and county school districts. The environmental scan clearly identified that Jackson County youth are disproportionately represented by social determinants of mental health (social inequalities that increase risk factors), environmental, and peer surroundings. County youth encounter a higher burden of social determinants than youth in the state as a whole and carry a significant burden of trauma.

Data plainly document Jackson County youth need for mental health services. This is notable in terms of the number of youth who die by suicide, but also by a high percent of youth self-reporting indicators such as disruption in sleep/schoolwork and having depressive thoughts/behaviors. By 6th grade, 2018 Missouri Student Survey indicators evidence need for services.

Recommendations from Phase I included face-to-face data collection to identify specific services being provided to the students in need. A cross-section of districts for inclusion in interviews was proposed based on multiple district-specific factors: incidence of suicide, poverty and crime rates, homelessness, student mobility, free/reduced lunch, and whether the districts were urban, rural, or in Eastern Jackson County. Five large districts and two charter districts participated in interviews (1-2 people each from Fort Osage, Genesis School, Guadalupe, Hickman Mills, Independence, Kansas City Public Schools, and Lee's Summit). Consultations with local funders, policy makers, CMHF Board Members, Children's Mercy Hospital providers, and a retired district superintendent generated questions for district interviews.

Phase II interviews evidenced differences between districts in both philosophy and methods used to address student mental health services. These included the foundational difference in whether districts *should* provide direct mental health services. However, all districts recognized that underlying student mental health needs impact educational outcomes.

Phase three generated a combined model of mental health service provision in the districts based on districts' perception of their roles providing direct, individualized, mental health treatment for individuals. In the District Model, the districts assume primary responsibility for those services while in the Partner-Based Model, the district's role is education and mental health services are provided by trained community providers. In the Shared Model, both district and community providers meet student need due to chronic or severe mental illness. Additionally, recommendations to inform funding decisions were identified in the areas of readiness, buy-in, measurability, and feasibility.

Phase I

Social Determinants of Mental Health and Mental Health Indicators speak to the need for intervention.

- 60% Free/Reduced Lunch
- 42 % Single Parent Homes
- 5% Homeless
- 7% Uninsured
- 28% African American/Black; 15% Hispanic
- 25%+ of homes in many Zip codes survive below poverty levels (Grandview, Hickman Mills, Independence, Kansas City, Raytown).
- 20%+ of homes in many Zip codes are in the top 50% for violent crime counts (Blue Springs, Center, Hickman Mills, Independence, Kansas City, Lee's Summit, Raytown).
- Five public and three charter districts underperform state high school graduation rates.

County youth are significantly impacted by *Social Determinants of Mental Health*.

Social inequities set the stage for youth mental health difficulties.

County youth have documented mental health needs.

47 County Youth Deaths by Suicide 2013-2017

- Two Zip codes each had five deaths (Blue Springs & Independence).
- A large increase was found from prior 5 years for African American/Black students.

Elevated Mental Indicators (MO Student Survey, 6-12th grade, 2018)

- 12% considered suicide; 10% made a plan.
- 30% reported disruption in sleep and schoolwork.
- By 6th grade Mental Health indicators show need for services.
- LGBTQ students have increased burden.

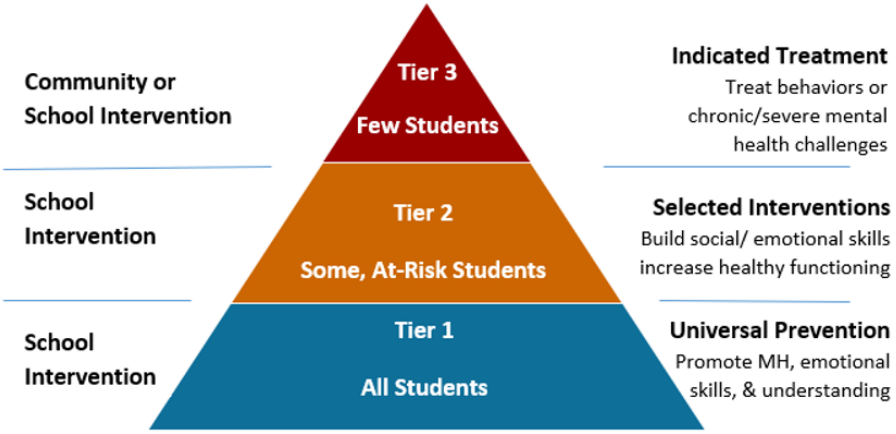
Phase II

Interview data highlight fundamental, between-district service differences.

Districts responses to the following questions vary widely.

- **Should** districts provide direct MH services?
- Should community providers provide services during the school day?
- What types of support, if any, should be given directly to families?
- What training/credentials should be required of providers?
- What level of engagement with the MO Model for Trauma-Informed Approaches is sufficient? How is that level determined?

Districts provide services in three tiers.

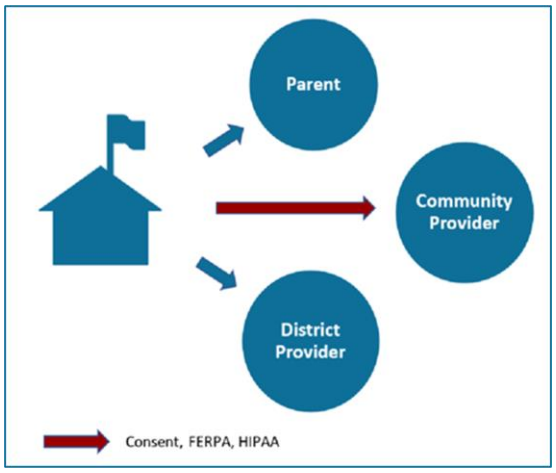


Many services districts discuss as Tier 1 mental health services do not directly address mental health needs. Examples are often school-wide or district-wide behavior/classroom management programs. Additionally, while school-wide trauma-informed initiatives are important to set the stage for school environments, they, themselves, are not mental health services. An example of a Tier 1 mental health approach is Signs of Suicide, a prevention program with a screening tool employed with all students in pertinent grade levels. Tier 2 mental health services can include small groups focusing on social/ emotional skills, or individual/family case management for access to services or basic needs for students with demonstrated social determinants. Tier 3 services are individualized and provided as treatment for chronic/severe mental health challenges by licensed providers.

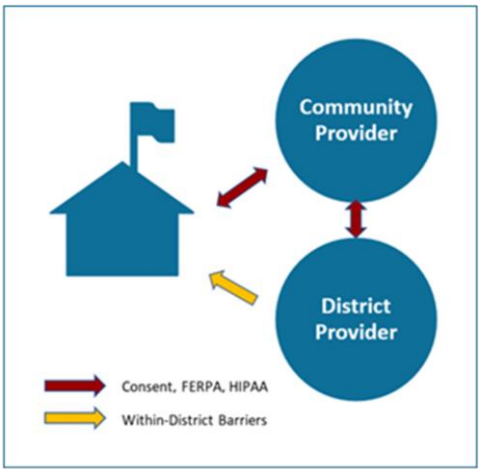
Schools often report functional/academic data to document mental health need/outcomes; mental health indicators are not globally used.

Functional/academic data include attendance, behavior, and grades. Clinical outcomes used by districts include ACES, depression scales, and suicide screens. Data transfer barriers related to consent, FERPA, and HIPAA exist using both data types. Barriers to sharing data when obtaining, coordinating, or providing mental health services are illustrated by the red and yellow arrows in the following figures.

Functional/Academic Outcomes



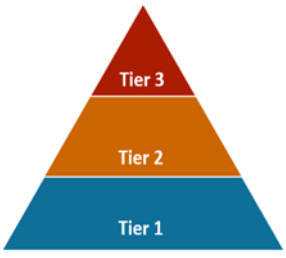
Clinical Outcomes



Phase III

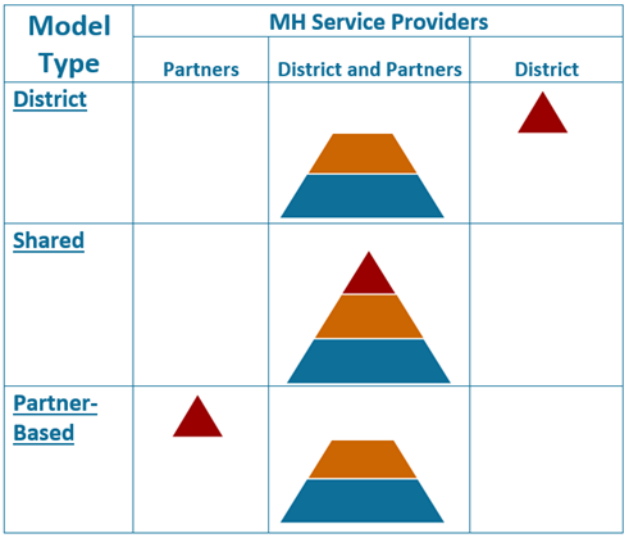
Three distinct models of mental health services to Jackson County school students exist.

The discriminating factor between the three models of mental health services in Jackson County schools is the determination of *who* provides Tier 3, direct, individualized, mental health services.



Models

- **District**
  - The district has primary responsibility for providing Tier 3 services (direct, individual, services to treat chronic/severe mental illness.
  - Tiers 1 and 2 are provided by either the district or community partners.
- **Shared**
  - Services in all three tiers can be provided by the district or by community partners.
- **Partner-Based**
  - The district, whose specialty is education, does NOT provide any Tier 3 (direct, mental health) services. Tier 3 services are provided by community partners whose specialty is mental health. Tiers 1 and 2 are provided by either the district or community partners, with significant engagement by the district in case management and family support.



Service coordination is emphasized in both the District and Partner-Based models with significant, centralized decision-making about community partner involvement in service provision.

Recommendations in readiness, buy-in, measurability, and feasibility can increase proposal quality.

Tier 2 interviews identified four categories of recommendations which can be used to increase the quality of applications to the CMHF.

Readiness

Of the five readiness items presented, most districts discussed the bottom four listed. However, few discussed how specific mental health services fit into an overall district plan of supporting student mental health. Often, programs were discussed as stand-alone entities.

Readiness

- Proposal place in overall service plan
- Evidence-based model
- Fit of model to population served
- Stage of MO Model of Trauma-Informed Schools attained
- Required training/credentialing for providing staff

Buy-In

Interviews with districts employing strong, centralized decision-making regarding collaboration with community providers highlighted the importance of detailed, written, transparent project buy-in. This lays the groundwork for accountability for all partners as well as highlights data needs and processes necessary to report outcomes.

Buy-In

- Project partner collaboration details documented at application
- Project partner data-sharing collaboration documented at application
- Leadership signatures on collaboration documents by all project partners prior to application

Measurability

Of note is the lack of fit between functional/ academic data often used by districts to document need and the CMHF's mandate to address mental health. High quality proposals include measurable clinical outcomes using standardized assessment tools, progress toward Tier 2 or 3 goals, or distal outcomes contributing to the CMHF's community impact. Given consent barriers, detailed data collection and reporting plans are critical.

Measurability

- Standardized assessment tool, distal outcomes, or progress toward Tier 2/3 goals
- Detailed pre/post data collection plan with data responsibilities for all partners
- Date data first available to CMHF

Feasibility

Feasibility is key to successful applications. Five elements of successful projects require careful attention to feasibility and should be presented with detailed, transparent plans including staff responsible for project accountability (coordination/tracking), data sharing between partners, reporting tasks, parent engagement, and parent consent for the school and provider.

Feasibility

- Coordination/project tracking
- Data-shairing plan between partners
- Plan to report data to CMHF
- Ongoing parent engagment (Tiers 2 &3)
- Parent consent (school and provider)

Appendix A: Project Overview Data Sources

1. U.S. Census Bureau Factfinder: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_DP03&src=pt
2. U.S. Census Bureau, *2013-2017 American Community Survey 5-Year Estimates: Poverty Status in the past 12 Months:* https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?fpt=table
3. Jackson County COMBAT accessed May 14, 2019: http://jacksoncomo.maps.arcgis.com/apps/webappviewer/index.html?id=edb9e5151b63459a94dfcb65c716dc32
4. Missouri Department of Elementary and Secondary Education: Missouri Department of Elementary and Secondary Education, *Missouri Comprehensive Data System: Missouri Public School Accountability Report Card*: https://apps.dese.mo.gov/MCDS/Reports/SSRS_Print.aspx
5. Missouri Department of Health and Senior Services, *Missouri Public Health Information Management System Death Profile*: https://healthapps.dhss.mo.gov/MoPhims/MICAHome
6. Missouri Department of Mental Health Missouri Student Survey 2016-2018 Website Excel File: Provided by Susan Depue, Missouri Institute of Mental Health
7. Missouri Behavioral Health Epidemiology Workgroup, *Missouri State Epidemiological Profile July 2018*: https://dmh.mo.gov/ada/mobhew/documents/missouristateepiprofile2018.pdf

Appendix B: Phase III Bibliography

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The Missouri Model for Trauma-Informed Schools https://dese.mo.gov/sites/default/files/cnsl_Missouri_Model%20school_guidance_doc.pdf

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