

Webinar
NRCMHPYVP Online Learning Event
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Mary:

Our website for the National Resource Center is healthysafechildren.org and we believe that with the right resources and support, all communities regardless of their zip code can promote positive outcomes for children, youth and families and as I mentioned just a few minutes ago, we're funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and we're coordinated by the American Institutes for Research and we're joined by more than 10 partner organizations who help us carry out our mission.

In order to carry out the mission, we provide information and materials to support the efforts for those who serve children and youth and it's really the entire age spectrum from birth through each high school including in areas especially hit hard by youth violence and we serve two grantee programs: Safe Schools/Healthy Students (SS/HS) grantees and Project LAUNCH grantees and then the field at large and this webinar that we're doing today is an example of the types of services that we provide for the field at large. I just want to tell you a couple of things about Safe Schools/Healthy Students, the grant program kicks a comprehensive approach drawing on the best practices in education, justice, social services and mental health to help communities take action to prevent youth violence and promote mental health and well-being and we recognized the violence among young people is caused by a multitude of factors and really therefore needs a comprehensive approach to address that no single action can be counted on to prevent youth violence. An evaluation of Safe Schools shows that the model worked when more than 90% of school staff reduced violence on school grounds. Nearly 80% reported that Safe Schools/Healthy Students had reduced violence in their communities and there is a 263% increase in the number of students who receives school-based mental health services and a 519% increase in those receiving community-based services and nearly 90% of school staff stated that they were better able to detect mental health problems in their students and so that you'll hear more about how that was accomplished through our online learning event today.

Project LAUNCH is linking actions unmet in children's health and that grant initiative promotes the wellness of young children ages birth to eight, by addressing the physical, social, emotional cognitive and behavioral aspects of their

development and it's granted in a public health approach and seeks to really improve coordination across child serving systems, build infrastructure and increase access to high quality prevention and as I mentioned earlier, you can use the question and answer box on the right hand side of your screen to chat with the presenters at any point during today's event.

So let me tell you a little bit about the presenters that we're joined by today. We have Beth Freeman who's a resource specialist at the National Center for Mental Health Promotion and Youth Violence Prevention. Beth is a licensed clinical social worker with over 25 years of experience in building this collaboration among community groups using evidence-based practices and implementing systems level of change to improve and expand mental health services in schools for children and families.

Frank Rider is a financing specialist also at the National Resource Center. He has extensive experience working with states and communities in system financing, program sustainability and implementation of the affordable care act to develop, strengthen and expand effective systems of care for children, youth and families and both Beth and Frank provide training and technical assistance to the SAMHSA funded Safe Schools/Healthy Students grantees. I'm going to turn it over now to Frank Rider. Welcome Frank and thank you for joining us for today's online learning event.

Frank Rider: Thank you, Mary. Welcome everybody. We appreciate your time and attention today. We interpret your interest as curiosity about the nature and extent of mental health challenges our children and young people face today. We hope to arm you with credible and compelling evidence about how mental health needs can impact student's success in school, in family and in community. We want you to appreciate that mental health is essential to overall health and well-being to feel confident that mental health challenges in children and youth can be effectively addressed, prevented, mitigated, treated and supported and also to appreciate the important place for schools in helping to accomplish these things.

Beth and I will expose you to some general models for comprehensive school mental health services and we'll identify some key components as well as early steps that you can take to build from where you are today toward a more complete and effective response to students' needs.

Finally, we will point you to some resources, both informational and consultative that can support your efforts to enhance the school mental health services available to young people where you live, work and play. Every human being has both physical health and mental health. Just as we try to vaccinate against, detect early warning signs of, and actively intervene to treat physical illnesses, injuries and disabilities in children so must we also support their positive mental health.

Left unaddressed, mental health challenges can become chronic disorders that can persist to the whole lifespan. We understand that half of all adult mental health problems began before age 14 and half of the remainder by age 24. Further, we've become much smarter about the many connections between physical health and mental health in recent years and we can look forward to an exciting future in which we will realize the promise of President Obama's current brain initiative to further expand our understanding of and ability to promote and maintain positive mental health.

Already, we know that children's mental health disorders affect boys and girls of all ages, ethnicities and location. The US Surgeon General's office in 1999, the National Research Council and Institute of Medicine report in 2009 and the Centers for Disease Control and Prevention in 2013, have all concluded that between 13 and 20% of all children living in the United States, that's up to one in every five, experience a mental disorder in any given year. According to the US census data, that prevalence rate yields an estimate of more than 17 million American children and youth who have or have had a diagnosable psychiatric disorder in 2015. The graph that we're looking at from the Centers for Disease Control shows the prevalence of the most frequently occurring mental health problems among students ages eight to 15.

We know that major mental health problems occur in children as young as seven years old. A recent national comorbidity survey focusing on adolescents shows that if children become teenagers, anxiety disorders and mood disorders become more prevalent as disruptive behavior disorders like ADHD becomes less so.

Although there remains much to learn about supporting optimal mental health, we already know that mental health problems derive from a variety of causes, some are organic, some environmental, some are behavioral and even sociological.

Schools and pre-schools serve a broad age span from infants and toddlers through childhood and adolescents to young adulthood. The frequency of different types of mental health problems will wax and wane with predictability even while we caution ourselves not to overly generalize about either the nature of mental health support needs among our young nor about the challenges that impede children's access to appropriate mental health services.

Federal Substance Abuse and Mental Health Services Administration (SAMHSA) teaches about a wide array of factors that influence our mental health including genetics and biology, stress levels, income, access to health resources, social isolation versus social inclusion and even faith. We know about unique mental health issues that tend to be prevalent in each age group. Some problems that are concentrated within specific cultural, racial and even nationality subgroups. Some that varied by gender and some that will be found more commonly within particular helping systems like child welfare, juvenile justice and intellectual and developmental disability programs.

Childhood mental health disorders are issues that must be taken seriously. About half of all young people with diagnosable mental health needs suffer limitations and functioning that characterize them as severely, emotionally disabled. In far too many cases, behavioral health challenges including mood disorders, substance abuse and acute traumatic stress become literally matters of life and death. For young people ages 10 to 24, suicide has become the third leading cause of death taking approximately 4,600 lives each year. CDC's nationwide survey of youth in high school, found 16% of students reported seriously considering suicide, 13% reported creating a plan and 8% reported trying to take their own lives in the 12 months preceding the survey.

We should think about the continuum of mental healthcare just as we think about the continuum of primary or physical healthcare. There are many evidence-based treatment options that are well-known, widely taught and fully recognized by mental health systems. Indeed, the past 20 years have seen a transformation of our national healthcare policy in the United States to have now finally, firmly established that mental health services must, by law, be provided at equal parity with primary healthcare services in both private and commercial insurance plans and through publically funded healthcare programs like Medicare, Medicaid, the Indian Health Service and CHIP.

This slide lists the very basic foundational components of an appropriate continuum of services in either context, physical or mental health. You should keep this list close at hand as you act on your efforts to develop or enhance mental health service systems for children and youth in your states and communities and nations. While we have come to understand so much more about the nature and importance of mental health and how to promote and support it in our young people, we unfortunately recognize some grim realities as well. A variety of credible national reports have told us a consistent story for far too many years now, namely that a huge majority of child mental health needs continue to grow unaddressed.

So what's the big deal? This is particularly frustrating in light of the already impressive and rapidly growing body of evidence that we've already amassed about how to address children's mental health issues with appropriate and effective care. We can look for example to about 400 school districts across the United States that have implemented Safe Schools/Healthy Students initiatives with support from SAMHSA since 1999. We can also examine 18 years of extensive national evaluation of more than 170 SAMHSA funded collaborative systems of care initiatives in all 50 states that have demonstrated significant improvements and outcomes for students, their families and helping systems that support them.

Outcomes for children and youth have included decreased behavioral and emotional problems, suicide rates, substance use and juvenile justice involvement as well as increased strength, school attendance and grades and stability of living situation. For families, findings include reduced caregiver strain and improved family functioning. For communities, Mary shared several specific findings from the national evaluation of Safe Schools/Healthy Students and SAMHSA's system of care initiatives have also demonstrated improvements in service delivery systems such as an expanded array of home and community-based services and supports, individualization of services, increased family and youth involvement in services, increased coordination of care across systems and increased use of evidence-based practices.

Let's look at a simple but typical example. Earlier this year, a school district in Massachusetts instituted a new mental health screening initiative. Very few students and families opted out so some 900 freshmen have been screened this year. Those grade 9 students who scored in the severe range for depression had an

average grade point average of 2.18 while all other grade 9 students in the same high school had an average GPA of 3.11. Those students who screened into the severe anxiety or severe depression range were absent 65% more often than those who scored lower on the screeners, even though students who scored in the moderate range for depression or anxiety were also reported to have increased absenteeism and decreased grade point averages compared to the average.

In addition to outcome data, there's also a growing body of evidence indicating that the system of care approach is cost effective and provides an excellent return on investment. [Beth] and her colleagues have quantified a return on investment in terms of cost savings derived from reduced use of inpatient, psychiatric, hospitalization, emergency rooms, residential treatment that have been far more than offset the cost of increased investments in home and community-based services and care coordination. Significant cost savings have also been derived from decreased involvement in the juvenile justice system, from fewer school failures and from improved family stability.

Now, building comprehensive school mental health services will certainly require some significant investments so it should be reassuring to know how well documented and compelling are the data that can document the benefits of doing so and how effective programming will save dollars through decreases in high end, high cost services and otherwise poor outcomes.

Now, Beth and I think that our nation schools more than any other institution hold the key to our ability to turn around some of the grim statistics that measure and describe how far or short of a sufficient mental health services system. We provide to our nation 17 million young people with diagnosable mental health problems and the many times more young people whose positive mental health we are all committed to promote and protect. After all, most of those many millions can be typically found within 100,000 public schools and 130,000 schools in all across the country.

Besides holding almost the captive audience, let's think about why else it makes sense that schools might serve as the best hub for mental healthcare for children and youth in our communities. Schools are in every community. Schools provide ways for students to get to and from. Schools tend to be trusted by families and they are seen as non-stigmatizing venues for healthcare and mental health service

delivery. Schools are accessible to everybody and we can rely on schools to help to mitigate and reduce disparities that otherwise persist in access to mental health services across populations.

Renewed emphasis in the past 20 years in the health and social services arena on increasing linkages between schools and community service agencies to enhance the wellbeing of young people and their families has added impetus to advocacy for mental health services in school.

Those 400 Safe Schools/Healthy Students initiative since 1999 have harnessed the power of schools, local agencies and community partners to bring about some of the positive results I shared a few minutes ago. In my home state of North Carolina, Barbara Burns and her colleagues with a great Smoky Mountain study in North Carolina recognize schools as “the major player” in the de facto system of care more than $\frac{3}{4}$ of children receiving mental health services were seen in the education sector and for many this was the sole source of care.

So we’re zeroed in on this vision of providing a complete mental healthcare system. That sounds like a pretty tall order, right? Maybe too big to try to take on right now but wait a minute, when we talk about school mental health, maybe we’re in a little better starting place than we first thought. Maybe we don’t have to actually start from scratch. One method that this slide conveys is that there are often already existing, some important building blocks that you can build on. Many school districts already have at least a few such pieces in place.

Ultimately, a high quality, fairly comprehensive mental health service system is likely to include many potentially congruent frameworks and programs such as: positive behavior interventions and supports, social and emotional learning, response to intervention, student assistance teams, IDEA and special education, suicide prevention initiatives and so on. Maybe your school building or district is already participating in a grant program or in a mandate that promotes school mental health such as Safe Schools/Healthy Students, Systems of Care, The Mental Health Services Act, Project Aware, Suicide Prevention grants and so on.

For many of you it will make sense to assess and strengthen and sustain what you already have in place and then to start building out in directions and ways that we will soon begin to share with you. We’ll go ahead and suggest the definition to you.

We agree with the Center for School Mental Health and its partner, the Health Resources and Services Administration in the federal government a long time catalyst for school mental health services. That comprehensive school mental health systems are defined as school, district, community partnerships that provide a continuum of mental health services to support students, their families and the school community.

Let's take a moment to emphasize some key tenets of comprehensive school mental health services. They should involve partnerships between schools and community organizations. They should be guided by the voices and needs of our young people and their families. They should build on existing school programs. They should focus on all students, both the general education population as well as the special education population and they should ultimately involve a full array of programs, services and strategies including mental health promotion through intensive intervention.

We've already talked about the high incidence of roughly 13-20% of students likely to have a treatable mental health need on any given day that for many such children, the need is severe enough that it is causing substantial limitations in the child's functioning perhaps academically in terms of self-direction, self-care, socially or in other ways. Now think about our increasing understanding of factors that might contribute to or mitigate mental health problems in young people. We know for example about many different risk factors that can either trigger, contribute to or exacerbate mental health problems or that can be managed in ways that can mitigate those same risk factors and think about our awakening in recent decades to the reality that all of us have mental health just as we do physical health and that the two are intertwined and that illness and injury is as likely to affect our minds as it is the rest of our bodies. Fetching appreciation then allows us to conceptualize a framework that conserve as the skeleton for a comprehensive mental health services system, a pyramid if you will, whose tiers represent on the bottom about 80% of us on any given day and that is where we provide universal health promotion and mental health promotion supports and services. In the middle tier, we can identify groups of students who may share risk factors in common and so we can target supportive interventions and services to help to us set or mitigate those risk factors. At the top of the pyramid, we have students whose needs are very intensive and for whom particular interventions are

indicated and so we can really focus our treatment and intervention on those students with the most acute and intensive need.

Beth and I are sharing with you today a couple of graphic representations or models of a full continuum of mental health services for children and youth. This model was presented by the late Dr. Joseph Zins, formerly a professor in the College of Education at the University of Cincinnati. Dr. Zins was known for his work in social and emotional learning and bullying prevention. In the outside circle you see prevention and promotion services. These are for all students in both general education and special education. This may include school wide intervention such as bullying prevention or classroom presentation on signs and symptoms of mental illness. The middle circle shows early intervention services. These are services that help to identify or intervene with students at risk such as screening an assessment to determine the level of need for students. These services are for the student who presents with a problem or symptom which could be a student having a bad day because of her breakup with a best friend or a conflict with a parent, or perhaps it could be something more serious and finally in the smallest circle we have treatment which encompasses those interventions for students who have diagnosable problems, maybe a student who shows symptoms of depression or anxiety for example.

The reason for concentric circles is to show that the services in each level are not mutually exclusive. For instance, a student getting treated for an anxiety disorder in the small circle can also benefit from those interventions targeted for all students and finally at the bottom you see the foundation for this work which are the partnerships between students and their families and the school and the community that the school anchors and serves.

Now that we have some fairly basic, generic but complete models or frameworks that can guide us, let me just emphasize a few more key elements that experience and science have taught us should characterize comprehensive school mental health services for young people. Effective prevention should not be put off until there's a crisis but instead should become our high priority. The best prevention strategies prevent not only human pain and suffering but unnecessary treatment and related expense as well. Done well, effective prevention begins with a foundation in universal health promotion on which well integrated service structures should be erected across healthcare, education, behavioral health,

public health, law enforcement, protective services, judicial and other related systems, in order to provide the right support at the right time in schools and communities. Environments in our schools and communities must provide, one, evidence-based universal prevention that fosters inclusive nurturing climates and promotes wellness. Two, targeted prevention and intervention programs and services that support mental, emotional and behavioral wellbeing of our young people. Three, specific and appropriate mental and behavioral health services and supports that address the difficulties that children, youth and young adult face and finally, four, training for school and community staff to respond appropriately to young people to support their wellness, to identify and respond to early warning signs, have threat assessment teams in schools and communities and in addition, we must develop awareness among community members who can recognize when a young person is troubled and may require help, adults who have been taught how to help them to seek, find and access that assistance.

So at this point, I am going to turn over to my colleague, Beth Freeman, who will help you to examine some of the workforce implications and dimensions of comprehensive school mental health services before helping you to organize some initial steps so that you can begin to advance a vision of comprehensive school mental health services in your community. Beth?

Beth Freeman: Thank you Frank for laying the foundation for us. When you're starting to make decisions in your school and your community about what some of the aspects that you already have as Frank has put together and also aspects of what you have in your community that would be partners for you. You want to start looking at who actually provides the mental health services in your school and that can entail the school employed mental health providers like your school psychologist, your guidance counselors, your social workers and your nurses and then you also have community employed school mental health providers that are both public and private providers. They will serve children, youth and families in mental health clinics and you will have clinical counselors and therapists, psychologists, social workers, nurses, psychiatrists and medical professionals very similar to what you have [found] of those same professionals in schools but they may have different credentials and so we have a great workforce that is in our communities that could provide and work together these services for students and their families and schools. Some people have not actually thought about this but you have many century art providers such as music and art therapy and dance therapies that can

have after school programming that would be able to provide and enhance the social, emotional and learning and behavioral difficulties that children have to really improve upon those difficulties to be more healthy and functioning adults and students. Then you also have substance abuse counselors and therapies in your communities that can come to the schools and provide services there. Those community agencies and organizations are very important to building your program but they are also you want to think about your faith-based organizations that have many youth counselors or youth providers of services that could enhance your program. There are many after-school program organizations and prevention and early intervention activities from many organizations. You want to do a really good mapping process to find out who are the people in our community that can do this.

I want you to remember too in 2015, the Child Mind Institute talked about the workforce development issues in our nation and specialists in training as we've mentioned here are in short supply. We have around 8,300 practicing child and adolescent psychiatrist but they are often housed in large cities, So we are looking at Telemedicine as a way to provide those services to those rural and frontier communities in our nation. We have an estimated 12,600 number needed by 2020. You see, we have a large gap in the number of child and adolescent psychiatrist that we need and we have anticipated 9,000 would be in supply by 2020. So we still have a big gap to go. There are over 28,500 practicing school psychologist in the US. That's a 9,000 number estimated shortage of practicing school psychologist and we know that it's a one to 1,482 ratio of school psychologist to students in our nation, and there are over 5,000 clinical child psychologists in our communities. So as you see, you will really need to build on what you have in your community so that we can address the needs as Frank was laying out in our multi-tiered framework of student supports.

Now the role of community mental health, behavioral health professionals, we need to discuss what that is among yourselves and your communities. So you want to look at your broad spectrum of the continuous services so that you can supplement your school employed staff services such as your teachers and your social workers, nurses and school guidance counselors and not every school in our nation has all of those professionals working outside of school. So the mental health of our students cannot fall on only schools alone along with our school support staff including the psychologists and social workers and people's personnel workers, those school counselors and school health providers such as our nurses,

our occupational therapists. You will want to have your school staff all working together. We believe that our community mental health partners must be a part of education because as we said, that is where the children are. So you add these mental health partners to your student support team. This will include their ability to provide a broad spectrum of services from prevention to intervention to supplement your school employed staff services and community mental health partners in schools also reduced the unnecessary and expensive psychiatric services such as your ER visits crisis, et cetera. They will facilitate connections. They'll have referral pathways to community providers for more intensive and specialized services. They'll provide preventative care such as screening, identification and brief interventions and these will reduce the unnecessary expensive intensive care. We know that providing the services outside of schools saves a lot of dollars in your community. So you can realign those dollars to transition back from the high cost care to the school in order to provide the services there. You will reduce those unnecessary expensive services, you'll facilitate connection, you'll provide preventative care and you will assist with transition back to school for more restrictive psychiatric, far more restrictive psychiatric placements all cost saving dollars.

You also want to think about what makes a successful school mental health clinician. We have learned over our research and our work over the last years that not everyone who works in a clinic setting is the best person to work in a school setting. Often we will have people who are clinical staff working in the schools with our school guidance counselors and our school staff side by side, their roles are blurred. They're not just a clinical staff, they are school employed staff now even though they are housed from and employed by a community mental health facility. So what makes them successful? They have to be highly flexible and highly creative. They have to think about how visible are you in the school so that others know you're a part of the school system and there's not a stigma for anyone in the school system to come and see the mental health professional. They are accountable. They provide accountability to the work that they do and make sure that it is evidence-based. They are culturally sensitive to the needs of the students and families that they serve and they have high energy. As you know if you work in a school system, you don't get a break. You don't take a lunch break and you're always on the go. You must be a team player. You become part of the team with the school staff and all of you have valued experience to share and each one of you has a role to play in providing a wraparound type approach of services for students

and their families and you have to be respectful of the individuals in schools and what their roles are and the knowledge and experience they have but on top of all that, you must have good clinical skills in order to be eclectic, be able to meet the needs of the various needs that are presented before you as a clinician.

How do you get started in developing this program? A lot of people think about, "Okay, we have a professional. Let's move that person into the school and just let them do their job." Oftentimes we have found that that does not work. One of the reasons we have found that it doesn't work is that we need preplanning in order to make sure that your program is smooth, works well and there are not any kinks in the beginning. So the steps to getting started would be to begin holding a meeting with the school principal and the community partner to discuss what would your mental health program look like, what are the needs in the school and what are the needs from the community's perspective? That includes resource mapping what your needs are. So you have this conversation but you also look at data that you have in your community about what the needs are. As Frank talked about nationwide data earlier, you then drill it down to what is your community data and your district data sources so that you can actually see how many suicides did we have as attempts from our data, what is it telling us? Did we have 8% of our students or 5% of our students in our whole district that say they actually attempted suicide last year? That causes great alarm in your community. How many of those students actually received services in a hospital setting or a community clinic setting? Could we reduce that by providing services in the school and we know from research the answer is yes, you can move it down from 8% to probably 2% or less if you build the program and build it right.

What you want to do in that needs assessment is to really create and define what your school-wide mental health program will look like but also who is that school-wide mental health team? Who needs to be on this team? It would be school employed staff that work directly with student support, community level staff that work with students and families but also your families and your family partners, your community organizations, faith-based organizations who has a particular interest in working with students and families. You want a well-rounded team then you start defining what the services look like and also how will you manage referrals within the school system and with the outside of the school system and then you want to get the message out about what school mental health will look like and start building those relationship.

When you start meeting with the school principal, here are some ideas of what your goals would be at the end of that meeting. You want to ensure there is buy-in from the school principal as we all know if the principal does not agree to having the service or an intervention [Unintelligible] school site, it will not work so you go where the partnership has buy-in not only from the principal but from the community. Everyone needs to be on the same page. You need to look at delineating the basic services. That is the first step. You want to have consent for services and your released policies in place before you begin your program. You want to agree on the basic roles and expectations of your school support staff and your community support staff. We do not want to duplicate services. We want to enhance services that each person brings with their own expertise and their own experience. We want to agree on referral and appointment process. We don't want chaos when we start having a family come in and say, "This is what I need," and then nobody knows exactly what the steps are so we educate everyone who is in the school about what those roles, what their policies, what the referral process is and what the appointment process is. You want to ensure that there is development of a confidential office space in the school so that children, youth and families will feel non-stigmatized and safe when they start presenting their problems and what their needs are so that they know they will receive the services and the safety and providing - pouring their heart out to tell you what their needs are. So you want to ensure that there is a space in the school to provide those services. What we have found is that it works best to have that space near the guidance counselor's office so that when someone walks into the office at the school, most people do not know why they're going in there and they have no stigma attached to what they're walking into the school for. You do not want to put that office by the gym or in the back of the building or somewhere where it's just offsite because it's not user-friendly for the families and for the students.

Another idea to discuss with your principal is that you need to look at the school district schedule and optimal appointment time. We know that elementary schools, middle schools, junior high, high schools, adult education for our students, they often will have different working agendas, different times to start their school day, different times to end, some classes may be 90 minutes, some may be 45 minutes so you want to know what classes a student could come out of in order to receive the services so you have to really look at the school schedule and what are the times of the day that a student could access a mental health service.

You want to look at the specific related mental health needs. You want to look at the range of services provided in your school, what type of prevention activities and promotion activities are you going to provide or are you going to train teachers and school staff on what is prevention, what is promotion, what is awareness and how to identify students in need, what type of interventions you're going to provide for the various multi-tiered service levels? What do you need? Do you need a psychiatrist? What type of consultation will you need? So you start talking about all of those various types of details before you actually begin your program and then how will a crisis be managed and who would be the first person that would address the crisis? So you have to start talking with the community provider how are they going to be accessible to the school, the hours that they would be accessible? What we have found is that the community providers usually become part of the school and on the school's schedule. If the school opens at 7:30, the provider is there at 7:30. If it closes at three, the provider is through with the students at three but they may seek families at the school after three o'clock because the school may be open until five or later in the evening. So you really work out all those fine details as you build your program.

A minute ago I mentioned resource mapping and needs assessment. These are some of the things that you would want to look at when you're looking for resource mapping and what your needs might be in a school. You want to know how many support staff you may have, what programs and services are already being provided in the school, are they universal programs or multi-tiered programs, what is actually available on site at school and then what is available onsite in the community and what services and programs fit with each - within each of the three tiers. So what we often do is look at those three tiers and lists the type of programs that are available and then we look at where are the gaps? What are the unique needs of our students and what are we missing?

Now, as you start looking at your team, we mentioned earlier about creating and funding your school-wide mental health team but these are some questions that are important in your first step to plan your school-wide team and your referral process, who else is providing mental health services in the schools? Your guidance counselor, your social worker, what is their process? What has their process been for providing those services and how can the services be differentiated? In other words what services does a guidance counselor provide? What services will a social

worker provide and what services will the mental health community worker provide? So you start delineating the roles of your school-wide team. Who is going to be in charge of overseeing this team and making sure that everyone is following through on what the treatment or the intervention plan will be and what students are we outreaching to? Do all students have access to our team?

We want to make sure there's a full continuum of care for our students in our schools and that takes planning. So as I mentioned, you will look at the gaps in care, you'll look at trying to make sure you do avoid overlap of services where we do not duplicate services. You want to make sure that you're collaborating together and meeting together on a weekly basis to talk about how the program is working, how we're collaborating together, who would be best served to provide the services for the student and where and how are we going to communicate with each other more than just once a week? How are we going to communicate on a daily basis that is our confidentiality protected and what will we share with each other and what will we be allowed to share with each other based on confidentiality guidelines? So that leads in to defining your services.

Now, I know you are thinking, we have to do all of these before we start our program. Well, yes, we have learned that it really is good practice to define your services so that you know what you're doing when you start the program and so that you can advertise what type of services you will be providing in the school. So you want to know what services you're going to offer and you want to plan this by three-year process. You want to start your first year with what is actually most needed. In your second year, you build upon the services you've developed in the first year and you add services where the gaps may be and in the third year you really refine your program to meet the needs of what has come to your awareness for the first two years. For instance, you may have found that you had more children in your middle level, tier II which would be selective or indicated problems because there were more children unidentified for mental health needs and so you'll provide more services in the second tier, maybe your second year and then by the third year you have really honed down those who need the very indicated services to a smaller number than you did before in the middle level will then go in to the first level for universal prevention because you've actually worked with those students. So you really want to define what you're going to do in year one, who you're going to offer the services to, when and where they'll be available, who will be providing them and how are families and school staff and others

involved? I cannot express enough how often you need to include families on a daily basis and weekly basis in your school team to talk about how is the program really moving forward, what are we doing right, are we providing services or are we going to provide services that will be beneficial to you?

Oftentimes families have very cost effective means of being able to share what they need that will be more cost effective to your program than you could think about before. As you're defining your services, think about the referral process and those consent and release procedures that we talked about, how are appointments made, what do you have to do in the school for a student to walk from the class to the office, do they need school passes, do you need to schedule them, is there a particular timing for students that is right, how often and for what length of time can a student be seen? Oftentimes in elementary school they may need less time than they need in high school. You need to make those critical decisions.

How is the intake process and the treatment decisions made? The intake process needs to be easily accessible. How are you going to complete all of that paperwork in a timely manner without burdening the client and also burdening the staff in your school? Make it user-friendly.

Then after you have made all of these great decisions about how you're going to define your services and how you're going to implement your program in your school, you want to get the message out about what you actually will be doing in this school with school mental health. You want to integrate your community mental health provider within the school. You want to invite them to partner and plan to attend all of your meetings at school whether they'd be teacher, staff meetings and professional meetings, development meetings where you are having some type of development for your school staff, you want your mental health providers from the community to understand what the staff are learning and vice versa, you want to invite the school staff to any clinical professional development programs such as your social workers and your community workers are obtaining you want your school staff to attend those meetings as well. You want the staff coming from the community to attend PTO meetings and be available for parents to ask questions and to talk with them about the services.

The mental health provider would need to visit the classroom to present about mental health services in a non-stigmatizing way. You want to be able to meet all

the staff and families at a personal level so that they know that this new person at the school is someone who is part of the school staff as usual. You want to intentionally spend times in the busy areas of the school so that your face will be seen and known and so that students will not feel uncomfortable coming to see that person. They will see them as just another school counselor on school campus. The partner agency should always be aware of school procedures and follow those procedures and the partner agency should have a process for accessing students. You want to develop an introduction letter to explain school mental health services to everyone. You want to educate the staff about the program so that they can educate others that they talked to about the program. You want your community mental health partner office to place a non-stigma passing sign on their door to denote the place for school mental health services and that will be part of your school mental health team, your school team to decide what the set sign look like and what will be non-stigmatizing in your community. You want to place materials in a folder on the door that others can pick up. You want to have an envelope with the introduction letter, the referral form, the basic mental health information and brochures and the Notice of Privacy Practices are just a few ideas of items that could be placed in that folder.

We've given you today many ideas of what comprehensive programs could look like and how to access those services but I wanted to make sure that you knew that we have these resources for you on the National Center's website. Comprehensive Programs, School Mental Health Programs, we have a self-paced online module and the series as you see, you note here, it's a module series of interactive, self-paced learning modules. You can take it from anywhere you are with a computer or you can access these modules and you can learn more about Comprehensive School Mental Health Programs and Services and the links are provided for you there, for the National Resource Center and the safe school - safe children - Healthy Safe Children Learning Portal.

This is what our learning portal looks like when you access it. You will see we have also access on Healthy Safe Children and Twitter. So as you start looking at this, you will see that our website is healthysafechildren.org. We're on Facebook and Twitter. Be sure to follow us with the latest news and updates from the National Resources on Young Children and Young Mental Health Promotion and Violence Prevention and if you would like more information about the content of this online learning event or about help the National Resource Center for Mental Health

Promotion and Youth Violence Prevention can help you with the work you do, please contact us at this phone number, 1-866-577-5787 or via email at healthysafechildren@air.org.

We also are going to be offering you some more learning events. So please join us on Wednesday, July the 28th from 3:00 PM - 4:30 PM Eastern Standard Time as the presenters Dr. Ken Martinez from our National Resource Center and Dr. Lark Wang, Director of the Office of Behavioral Health Equity, SAMHSA. They will discuss how SAMHSA grantees and communities around the country are using disaggregated demographic data to actively reduce and eliminate disabilities in new and creative ways, disabilities and disparities in new and creative ways.

Thank you for joining us today. We would love for you to click on the link in the chat pod to complete our feedback form about today's online learning event. We often learn from what you tell us to do. As you see the pod, the chat pod, the link is there. Please click that on and tell us what you thought. We'd love to hear from you. Thank you.

- End of Recording -