

DC Family Policy Seminar

Do School-Based Mental Health Services Make Sense?

Seminar Highlights

**Moderator: Donna Morrison,
Assistant Professor of Public Policy and Demography,
Georgetown University**

Introduction

The fact that many mentally ill children and adolescents in the United States fail to receive needed treatment is becoming more widely recognized. Children in poverty are at a particularly high risk for developing mental health problems, and are less likely than other children to obtain treatment. Because one or more of the risk factors associated with poor mental health are present in a relatively high percentage of District of Columbia (DC) children, for DC, the issue is a particularly urgent one. School-based mental health services are now being given serious consideration as a viable method by which to provide children and adolescents with the mental health services they need. The DC Family Policy Seminar on school-based mental health services was organized for the purpose of discussing the advantages and challenges associated with establishing school-based mental health services in DC.

After welcoming attendees to the seminar, moderator Donna Morrison raised some key points. She stated that in this country today, approximately one in five children suffer from mental health problems, and the consequences of these problems present challenges and even dangers to the children, their families, and their communities. It is estimated that only 20 to 30 percent of children who need treatment for a mental health problem ever receive it. In light of this alarming statistic, many communities have integrated mental health programs into schools, where services are more easily delivered and problems can more easily be identified.

Morrison went on to explain that the panel of experts assembled would discuss in detail the advantages and challenges associated with school-based mental health centers (SBMHCs), and would talk about several specific intervention strategies that have been successful.

**Shalini Madan-Benson, Associate Director of Prevention,
National Mental Health Association, Alexandria, VA**

Madan-Benson opened her presentation with an anecdote. This morning, she began, a school bus parked in front of a middle school in DC. Children got off the bus and, perhaps, began their day with laughter, last-minute studying for a big exam, and some yawns. Eight of these approximately 40 children also brought with them mental health problems requiring treatment; four have mental disturbances so severe that they impair the child's daily functioning in class, with friends, and at home.

Prevalence of Mental Health Disorders in Children

Madan-Benson discussed the prevalence of mental health disorders in children. She emphasized that the statistics on mental health disorders in children are not inflated, and that the national estimates of children's mental health needs are really as high as statistics suggest. According to the federal Center for Mental Health Services, at any given time, 1 in 5 children and adolescents has a mental health problem that requires treatment, and 1 in 10 has a serious emotional disturbance that may severely disrupt daily functioning. As stated earlier, the numbers of children who do not receive needed treatment is also alarming. The Center for Mental Health Services estimates that 2 out of 3 children with mental health problems are not receiving the help they need. This means that of those 8 children who need mental health services, only 2 or 3 will get help.

Out of 100 children, as many as
6 have major depression,
1 has bipolar disorder,
5 have attention deficit/hyperactivity disorder,
5 have a learning disorder, and
4 to 10 have a conduct disorder.

Out of 100 adolescents, as many as
12 have clinical depression,
3 have schizophrenia,
1 to 3 have bulimia nervosa
or other eating disorder.

Consequences of Untreated Mental Health Problems

Madan-Benson went on to talk about the consequences of untreated mental health problems in children and adolescents. She pointed out that children and adolescents have mental health problems that are just as severe as adults', and that their treatment needs are equally pressing. But they need additional help dealing with their illnesses and disorders. Mental health problems often limit young people's current and future productivity. Young people with untreated mental health problems are at greater risk for school failure, family conflicts, substance abuse, low self-esteem, violence, and even suicide. High truancy and dropout rates are prevalent among children with mental health treatment needs.

As the potential outcomes indicate, youth with mental illness are more likely than their counterparts to have contact with the juvenile justice system. According to the Department of Justice, 60 percent of the 100,000 teenagers in juvenile detention have behavioral, mental, or emotional problems.

Youth with mental health problems are more prone to committing or attempting to commit suicide. U.S. Surgeon General David Satcher calls the youth suicide rate in this country a “public health crisis.” Suicide, the third leading cause of death for 15- to 24-year-olds, kills approximately 5,000 young people per year. Suicide is the sixth leading cause of death for 5- to 15-year-olds.

In addition to providing treatment, it is also essential that we work to prevent the onset of mental illness in children. Mentoring, peer counseling, and interventions designed to reduce risk factors for children at risk for developing a mental or emotional disorder all exist.

Advantages of School-Based Services

On a more positive note, Madan-Benson suggested that schools are the ideal setting for the delivery of preventive and mental health services. They are ideal for the following reasons:

- They are easily accessible to students and their families
- They are comfortable and familiar
- They can encourage a reduction of the stigma associated with mental health problems

Most important, according to Madan-Benson, providing appropriate mental health services to children can improve all aspects of their lives—from self-esteem and peer relationships to school attendance and academic performance.

**Olga Acosta, Associate Director,
Center for School Mental Health Assistance, Baltimore, MD**

Overview of Mental Health Issues

Acosta opened her presentation by providing an overview of children’s mental health issues. Children’s mental health is the most widely neglected health issue in our nation, she began. Adolescent needs are the most pressing and the least likely to be addressed. In her book, *Full Service Schools*, Joy Dryfoos astounded readers with her report that 10 million children ages 10 to 17 would benefit from mental health services and that one in four children are at risk for pathology. Stated another way, this means that 20 percent of all youth under age 20 exhibit psychosocial problems that are severe enough to warrant intervention, yet, less than one in three will actually receive mental health services.

Acosta went on to state that adolescents from inner cities are at particular risk for developing mental illnesses, because of high stress related to poverty, exposure to

violence and crime, a higher than average incidence of abuse and neglect, and family problems. In fact, a 1992 survey of inner-city children revealed that while 38 percent were at risk for developing psychiatric problems, only 11 percent received treatment in traditional mental health settings. Clearly, the current mental health system is unable to handle the demand for mental health services for children and adolescents.

This unmet need for mental health services is of particular concern when it is coupled with the accessibility of guns and other weapons. It is estimated that one-third of all male students and 8 percent of all female students have carried a weapon of some sort in the last 30 days. Nationwide, 7.6 percent of students surveyed in the **National Health Interview Survey** reported carrying a gun during the last 30 days. As we know, the increased prevalence of weapons is a problem in cities as well as in rural and suburban areas.

Challenges of Addressing Adolescent Mental Health Needs

Acosta continued her presentation with a discussion of the challenges of addressing adolescent mental health needs. Adolescents use health care services less than any other age group does and are least likely to seek health or mental health care through traditional office-based settings. These low utilization rates are related to barriers that exist both within families and within systems.

Family barriers include

- (1) stigmas about obtaining mental health services,
- (2) transportation problems,
- (3) limited knowledge about services,
- (4) concerns regarding confidentiality, and
- (5) financial obstacles.

System barriers include

- (1) inaccessibility,
- (2) long waiting lists, and
- (3) complicated forms.

In addition, young adults and adolescents are more likely than any other group to be uninsured. The end result is that the traditional community mental health center model has been generally ineffective at providing services to adolescents.

The traditional community mental health center also introduces biases toward treatment of children and adolescents with externalizing disorders, because youth that act out are more likely to be identified for mental health services. Youth with internalizing disorders are less likely to be referred for traditional services. This bias is of particular concern during adolescence, when the likelihood of experiencing internalizing problems, such as depression, anxiety, and post-traumatic stress disorder increases significantly.

School-Based Mental Health

Acosta introduced a ray of hope into an otherwise rather grim picture. There is some good news, she said, about both mental and physical health—service delivery for adolescents. According to the 1993 State Adolescent Health Coordinators Conference Proceedings, school-based or school-linked centers are successful and noteworthy models of service delivery, and it has been noted that they are more effective than hospital-based clinics and inpatient adolescent units. Making the Grade reports that there are 1,154 SBHCs around the country; a growing number of those centers are home to mental health programs. In fact, referrals for children with mental health issues greatly outnumber those for children with **solely** physical complaints. Mental health services are the most heavily used service in many school-based health clinics.

Many of these school-based programs follow the Expanded School Mental Health (ESMH) program model. This model involves the collaboration of schools and communities and incorporates a full range of services for youth in both special and regular education programs. These services include crisis intervention; focused evaluation; individual, family and group therapy; consultation; case management; and preventive services. The services cover three levels of intervention:

- Primary prevention— **providing programs to an entire population** before problems are identified
- Secondary prevention—providing services to youth who are under stress and who exhibit incipient problems
- Tertiary care—providing services to youth with serious and/or chronic problems

ESMH programs in schools offer numerous advantages over the traditional method of providing services in clinics and hospitals. Because they are located in schools, ESMH programs are able to address traditional barriers to service that include poor accessibility, low use on the part of youth, and economic barriers to care. They also offer the following advantages:

- They are able to provide a full range of preventive services.
- They allow mental health professionals to see students in multiple settings and over longer periods of time.
- They reduce the stigma related to seeking and receiving mental health services.
- They provide opportunities for improving the overall school environment through collaborative efforts.
- They offer improved outreach to youth with internalizing problems.
- Their presence reduces the number of **inappropriate** referrals of students to special education programs.

There are also several challenges involved with establishing ESMH programs. The challenges include

- Funding shortages and lack of other, nonfinancial resources
- **Vaguely** defined staff member roles (e.g., social workers' vis-à-vis psychologists' roles)

- Difficulty penetrating barriers that exist between systems and that can thwart collaboration
- “Turf wars” and space issues

Two additional challenges warrant special consideration. The first is the challenge associated with confidentiality issues and with legal and ethical concerns about parental consent. Introduction of nonschool personnel into schools creates mental health record–ownership and confidentiality issues. The second is the challenge of bridging the gap between practitioners and researchers. The continued growth and improvement of ESMH programs is dependent upon improved communication between researchers and practitioners.

Are ESMH Programs Working?

Continuing in this hopeful vein, Acosta went on to discuss the growing body of evidence suggesting that these programs are leading to enhanced positive outcomes in youth, as measured by fewer absences, improved grades, fewer disciplinary actions, fewer inappropriate referrals to special education, and fewer psychiatric hospitalizations.

Researchers conducting a 1996 study in a high school serviced by a SBMHC found that students who received mental health services showed statistically significant declines in depression and statistically significant improvements in their self-esteem following individual and group therapy sessions. The treatment group showed declines in anxiety and anger following therapy, but these declines were not statistically significant. Additional preliminary studies have shown that students have high satisfaction levels with the mental health services provided in their schools.

Center for School Mental Health Assistance

Acosta concluded her presentation by acknowledging the work of the Center for School Mental Health Assistance (CSMHA). The center, established in 1995, is funded by the Maternal and Child Health Bureau of the Health Resources and Services Administration. The center’s mission is to assist in the advancement of comprehensive SBMHCs by

- (1) providing technical assistance and consultation,
- (2) conducting national training and education,
- (3) collecting, developing, and disseminating relevant materials,
- (4) analyzing, discussing, and addressing critical issues,
- (5) facilitating networking activities between practitioners and researchers.

Deborah Hobbs, Chief of Community Programs, Child and Youth Services Administration, Washington, DC

Hobbs introduced her presentation by pointing out that many children are traumatized even before their school day begins, because of the inherent dangers involved with the trip to school, which may require that they navigate dangerous, crime-ridden neighborhoods.

In order for teachers to be able to teach, children must be mentally available to learn. One of the goals at the Child and Youth Services Administration (CYSA) is to help children be available to receive instruction.

Current Status of Mental Health Care

Hobbs spoke about the current status of mental health care for children and adolescents in DC. There are SBMHCs in 23 DC schools, she said. These programs work in conjunction with satellite clinics, such as the Northwest Youth and Family Center, to provide services to children and their families. CYSA is working with the DC Public Schools (DCPS), other mental health providers, and the Metropolitan Police Department to improve the services provided to children and to improve DC neighborhoods and communities. This collaborative effort between CYSA and MPD is necessary and is currently gaining momentum in DC.

Challenges

Hobbs went on to discuss the challenges faced by the CYSA staff, and to explain the strategies the agency employs to deal with these difficulties. The staff is working to address several challenges in order to provide mental health services on more school campuses in DC, she said. As discussed earlier, the development of working partnerships is essential to the success of SBMHCs. The agency is working to eliminate established agency barriers that have formed as a result of each agency's own mandates. This collaboration is particularly crucial in DC because of the shortage of available physical space in the schools. Space will only be allocated for mental health services if they are prioritized by both health care and education officials.

The CYSA staff is currently working with community agencies, including the DC Metropolitan Police Department, to address the needs of children in the context of their neighborhoods and families.

Shifting the Focus Toward Prevention

Hobbs concluded her presentation with a discussion of CYSA's efforts to shift the focus of mental health services for children toward the provision of expanded preventive mental health services, while still continuing to providing treatment for children with established mental health needs. This is a challenge because so many children are in immediate crisis, which makes it difficult to focus resources and energy on providing better preventive mental health services for those who are not yet at a crisis stage. In addition, many insurance companies do not reimburse for the preventive care currently being provided, thereby making the shift even more difficult to engineer.

**William Granatir, MD, Project Chair,
The Pilot Project of Enhanced Mental Health Assistance at
Miner Elementary School, Washington, DC**

Granatir began his presentation by discussing statistics about the prevalence of mental illness in inner-city children. According to Juan Lovelace, former CYSA director, 5,820 DC children have been diagnosed as having emotional or mental health problems.^{1*} As reported in a *Washington Post* article on October 28, 1999, DC Child and Family Services caseloads include 3,334 children, and 2,700 DC children are in the juvenile justice System. In DC, these agencies are under receivership and are not responsible to the mayor; therefore, they do not often communicate with one another. However, department heads of agencies that work with children are now making an effort to meet with one another regularly.

Traumatized Inner-City Youth

Granatir continued his presentation with a discussion of inner-city youth and their particular problems. Thousands of children in DC are the victims of trauma, abuse, and neglect. Many of these children have been sexually abused and are left struggling with venereal diseases, intrauterine damage, and emotional problems. Many others were exposed to drugs, AIDS, alcohol, and tobacco while in utero. Thousands of children do not receive the nourishment needed to develop and grow at an acceptable rate.

Not all parents who neglect or mistreat their children are malicious; some simply have not been given proper instruction, and do not receive help from their own parents and grandparents. Recently, a young mother was charged with the manslaughter of her infant; during the trial, she said that “no one taught me how to care for my child.”

DC children’s problems can be so severe that Dr. Joshi, current chair of the Department of Psychiatry at Georgetown University [**Dr. Granatir: Is this his title? Also, what is his first name?**] reported higher rates of posttraumatic stress disorder among them than among the children he visited in Bosnia and Kosova a year after the conclusion of hostilities there.

Many children who experience trauma, abuse, and neglect suffer from anxiety, depression, fear of violence, suspicion, and mistrust of adults. Furthermore, many of them are not ready and eager to learn and do not have parents who are enthusiastic about the learning and development processes. As a result of these barriers to learning, it is not uncommon for children to be misdiagnosed as learning disabled and placed in special education classes, when mental health services are actually what they require.

The Miner School Project

The situation is not hopeless, however. Steps are being taken to provide children and adolescents in DC with the mental health services they need. A prime example of the efforts being made is The Pilot Project of Enhanced Mental Health Assistance at Miner

^{1*} Dr. Granatir acknowledged that these numbers are the only ones available. They are, however, considered very low by DC mental health advocates.

Elementary School, begun in the fall of 1998 and modeled after similar programs in Dallas. The project is a partnership of many agencies and is supported by CYSA. The project's main focus is to bring together health professionals from several disciplines in order to form a complete on-site mental health team. The Northwest Family Center provides social workers, the Commission on Mental Health Services supplies third- and fourth-year psychiatry residents, and George Washington University furnishes doctoral students in psychology. This project works in large part because of the interest and involvement of the Miner School and of Sheila Holt, the school guidance counselor. Ms. Holt, a 27-year veteran of DC Public Schools, is an enthusiastic and active counselor, and the Northwest Family Center is a willing partner.

Additional Programs

Granatir concluding by reiterating that, as previously mentioned, steps are being taken to provide school-based mental health services in more DC schools and to offer more intensive services through community agencies, such as the Child and Family Center in Northeast Washington. **[Dr. Granatir: is this in NE?]** Clearly, these expansions are necessary in order to ensure that children do not “get lost in the shuffle” and to provide appropriate and quality services to children who suffer from mental health problems.

Questions and Answers

Announcement: DC recently received a large federal grant to build a mental health system that will be integrated in 17 charter schools. These charter schools serve a demographic population similar to the school system's general population. Currently, 2 charter schools serve children in the juvenile justice system, and at another school, all students are in special education. This grant offers DC a fantastic opportunity to determine how schools can build on resources and, in particular, to partner with agencies that work to prevent mental health problems and promote better mental health. Our goal is to create teams of mental health workers in schools, and to provide these teams with the support of a community coordinator. The teams will adopt a whole-school approach by examining the school climate and also by working with the police to improve communities. In addition, school-based positions for mental health professionals will be available in the near future.

Eve Brooks, Safe School/Healthy Student Initiative

Q: How would you recommend that care be provided for those children who attend school sporadically because of the severity of their mental health problems? How can SBMHCs provide services to that population?

Jennifer Almy, Georgetown Public Policy Institute

A: Obviously, this is a big problem. Diane Powell of the DCPS is working with the Metropolitan Police Force to encourage officers to pick up truants and bring them to

SBMHCs, and not just for punishment. A similar concern exists regarding children who have been suspended from schools and are not allowed to access services. I believe that we need to work with the schools to find new forms of punishment that may not be so detrimental to children's health.

Bill Granatir

A: Some school-based centers do provide home-based services for those who cannot access the schools. In addition, **some references are available that address** transitional programs that can be coordinated as part of the school-based approach.

Olga Acosta

Q: I attend meetings with teams of teachers to discuss delinquent students, and it concerns me that there is rarely a mental health professional present. After I visit the homes of these children, it frequently becomes apparent that the problem is in the home and that the family needs mental health services. My question is, how can we work to include more people in these meetings in order to provide more appropriate services?

A. Osekre, Youth Services Administration

A: The key is to plan and organize before the meetings. As a group, we need to identify the essential stakeholders, including agencies, teachers, parents, and other children. All too often, parents and children are excluded, which is too bad, because the youth know the "hangout" spots of other troubled children and adolescents. Also, parents know a lot more than researchers and health professionals think they might.

Olga Acosta

Q: I would like to know more about any existing research that examines how children's emotional well-being is affected by family structure.

Yvonne Keyes, children's advocate

A: There is a large body of research suggesting that family structure has an effect on children's outcomes. The evidence clearly shows that children growing up in a two-parent household do better, on average, than those who do not. However, there certainly are children who benefit by getting out of an abusive or dangerous situation.

Donna Morrison, Georgetown Public Policy Institute

A: A 30-year research project found that the quality of early-childhood education is also an important indicator of children's well-being. In this study, 35 percent of people who attended intensive programs [**Dr. Granatir: Can you clarify whether you are referring to regular preschool experiences, or to special programs for at-risk children?**] in early childhood were more likely to attend college than those who did not. I believe we need to place more emphasis on primary intervention projects and to shift toward early childhood care with the goal of decreasing special education referrals.

Bill Granatir

Q: In the past, I worked with non–special education DCPS children who had mental health problems. I was troubled by the lack of parental involvement and the inadequate training for teachers and principals. Have programs been implemented to provide training for principals and teachers about how to work with children with mental health needs and how to identify and provide necessary services?

Marvin Sessions, For the Love of Children

A: I have been working with the DCPS to provide in-service training for teachers, principals, and counselors, but it has been a challenge to find times that work for all involved. At Turner Elementary School, there are programs that work to help teachers and principals understand what is normal versus abnormal behavior. The staff of both the DCPS and CYSA know that training is critical. Although scheduling has been a problem, I am pleased about the increased dialogue between the agencies.

Deborah Hobbs

Q: I have two questions. First, how are successful programs funded? Second, are children afraid to access mental health care in front of their peers because of the stigma attached to mental illness?

Jean Lim, National Center for Education in Maternal and Child Health

A: The most successful programs receive a variety of different types of funds, including federal block grants, grant funds, **and state and local funding**. The funding aspect requires collaboration and partnerships between agencies, just as creating a successful program does. For example, in Baltimore, the **Baltimore city public** schools and the **city** health department have coordinated their funding, and the **School Mental Health Program** works with them on a **contractual** basis **to provide the actual services**.

In response to the question about stigma, the convenient location does raise some challenges, as it can be difficult to disguise the reason for a child’s visit to a counselor. It is possible to use the mental health professional’s appearance in the classroom to pick up the child as an opportunity to normalize the issue of mental illness and to educate all students and teachers about mental health problems.

Olga Acosta

A: From what I have noticed at the HD Cook School program, children in elementary school are not concerned with stigma, and at the Miner School all the young children want to talk to me. High school students are more likely to avoid care because of the stigma attached to seeking help.

Bill Granatir

Q: I believe that many pregnant teenagers are struggling with mental illness. Are there specific school-based programs to help them receive needed and appropriate treatment?

Ernestine Johnson, Commission on Mental Health Services

A: Yes. On the national level, there are many evidence-based prenatal and early infancy programs that use home-based visits to help these young women bolster their self-esteem and encourage them to continue their education.

Shalini Madan-Benson

A: CYSA is currently working to formalize an agreement with the DC Early Intervention Program to staff and run school-based programs. These programs will address early childhood development issues and will provide training and development [**Deborah: What do you mean by “provide development” here?**] to adolescent females.

Deborah Hobbs

Commentary: Without minimizing the importance of providing mental health services in schools, I would like to point out that it is impossible to separate mental health needs from physical health needs. In a model that is being implemented around the country, SBHCs provide comprehensive health care to children. By providing these services in a visible place, it is possible to show that receiving health care is both beneficial and normal. Furthermore, providing comprehensive health care also creates new funding sources and can encourage a shift toward providing preventive physical and mental health care for children.

John Schlitt, National Assembly on School-Based Health Care

Commentary: CYSA is making an effort to involve all stakeholders who work with children, not just those who address mental health issues. We have reinstated monthly meetings in order to increase collaboration among all organizations and agencies that serve children in DC.

Deborah Hobbs

Q: I am in favor of a shift toward preventive approaches to working with children who have mental health problems. Are there school-based programs that are working to provide preventive mental health care?

Susan Blake, Institute for Mental Health Initiatives

A: Many communities are addressing preventive care by examining the community's strengths and identifying existing protective factors. For example, Baltimore City has incorporated an assets checklist to help practitioners and residents identify the **resources available to children in need.**

Olga Acosta

A: The Web site www.mentalhealth.org has excellent information on prevention programs in its preventing-violence section. This entire site also has an extensive compendium of mental health resources.

Shalini Madan-Benson

Commentary: I think it is essential that parents be included in this entire process. Kansas City is one community that has successfully involved parents in its programs, and its school counselors work to provide mental health care to the children and families, without regard for the family's financial situation.

Jean Phillips, Community of Hope

Commentary: This is an excellent point. Schools and providers need to encourage parental involvement in the process and to take additional steps to invite parents to the table. I would, however, like to point out that this is not easy to do. **Some** parents are **in need of support** themselves and are not interested in or able to participate in a positive way. The Dallas programs do have a strong family involvement component; 93 percent of the services provided are family-based, and their services are structured to empower families to become involved.

Olga Acosta

Commentary: Involving parents often requires additional time and effort on the part of the principals, the teachers, and the mental health team. I agree that it is extremely important, but it can be a time- and energy-intensive process.

Bill Granatir

Commentary: I would like to add that it is possible, as parents, to become involved in our children's schooling and health care. It takes work, but we, as parents, must insist on participating, because it does make a tremendous difference in the lives of our children.

Dona Farris Jenkins, Beacon House