DC Fiscal Policy Institute

UNLOCKING OPPORTUNITIES: SERVICES THAT HELP POOR CHILDREN SUCCEED IN THE CLASSROOM

Part 4: Helping Students Facing Mental Health Challenges

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Improving mental health services provided through schools is a critical part of improving school outcomes in the District. Children who grow up in poverty are exposed to high levels of trauma and stress that impacts their ability to do well in the classroom.

Schools are the largest provider of mental health services across the country and a logical place to identify students with mental health needs. Moreover, children are more likely to engage in mental health services in a school setting compared to other outside services.

> "Over the past 20 years, policies and programs that integrate mental health services into the schools have burgeoned, and research continues to demonstrate their positive impacts on educational and mental health outcomes."
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> "The Impact of School Mental Health: Educational, Social, Emotional, and Behavioral Outcomes," University of Maryland, School of Medicine, Center for School Mental Health.

The District provides a variety of services to address the mental health challenges of students in schools, but they are not found at all schools, and many schools have mental health staff with caseloads that are too large to provide adequate services. The Children's Law Center (CLC) estimates that 5,000 DC children are in need of mental health services, but not receiving them, and that many children are forced to wait far too long to see a mental health professional.

The District should increase services and funding to better meet the mental health needs of students in the following ways:

- **Expand Access to School Mental Health Programs:** The District set a goal of having a mental health program in every school by 2016-17, but currently only 36 percent are covered.
- **Expand the Use of Positive Behavior Intervention and Supports to all Schools:** These programs, which focus on encouraging desired behaviors rather than punishing negative behavior, increase attendance, and reduce the need for suspensions and special education referrals.
- **Create Trauma-Sensitive School Environments in All Schools:** DCPS uses a number of programs that can help students address trauma, but they are not available system-wide and often are only available to a small number of students with the greatest needs. Schools in Massachusetts, San Francisco, Washington State and Wisconsin have all implemented trauma-sensitive environments serving all students.
- **Increase the Availability of School Social Workers and Psychologists:** More than one-third of DC schools have too few social workers and psychologists to meet the needs of their students.
- **Improve Data Sharing across Agencies Serving Children and their Families:** Children with socio-emotional needs and their families often receive services from multiple District agencies. But a lack of information sharing

across agencies can mean that efforts are duplicated, unnecessarily re-started, and problems facing the child and family are not fully understood by the various agencies working with them.

Background: The Mental Health Challenges of Low-Income Students.

Low-income children are more often exposed to trauma and stress during their developmental years, leading to high rates of emotional or social problems.[1] These children are more likely to have problems in school, be absent, suspended or expelled, or drop out.[2] Exposure to trauma and stress makes it hard for children to develop secure attachments to caregivers that help them handle stress in their lives.[3] Repeated exposure can lead to chronic, toxic stress which hinders development of key skills necessary for learning, including memory, attention, and language.[4]

Research has found that children with toxic stress performed worse on academic tests than their unstressed counterparts.[5] According to Paul Tough, the lack of these "executive function" skills can impact how well children do in the classroom where they need to concentrate, interact with others, sit still and follow instructions.[6] Constant exposure to trauma can make kids feel unsafe, even at school, and that lack of safety can make them more likely to act out or withdraw at school in response to stress. This can make it more likely that students are disciplined at school and/or are not prepared to learn.

The Department of Behavioral Health estimates that the incidence of mental health illness in DC is similar to the incidence nationally. This would mean that about one in four to five DC children meets the criteria for a severe mental health disorder and one in 10 has a serious mental health problem that impacts their ability to function day-to-day.[7]

Schools, working with mental health organizations, are a critical provider of mental health services. Locating mental health services in schools leads to greater accessibility and use of mental health services. One study found that 96 percent of students who were referred for assistance in a school with a SMH program began services, while just 13 percent of students referred to community based clinical treatment began services.[8]

Given the number of children with unmet mental health challenges in DC, a strong system of supports for DC students can play a critical role in making sure students are attending school ready to learn.

What DC Does to Help Students with Mental Health Challenges.

Mental health

[1] Evans, G. W., "*The Environment of Childhood Poverty*", American Psychologist, Vol. 59, No. 2, February/March 2004, pgs. 77-92

[2] Stagman, S. & Cooper, J., "Children's Mental Health: What Every Policymaker Should Know," National Center for Children in Poverty: Mailman School of Public Health, Columbia University, April 2010. Available at: http://www.nccp.org/

[3] Tough, Paul, "How Children Succeed: Grit, Curiosity, and the Hidden Power of Character," Houghton Mifflin Harcourt Publishing Company, New York, NY (2012).

[4] Evans, G.W; Brooks-Gunn; J. & Klebanov, P., "Stressing Out the Poor: Chronic Psychological Stress and the Income-Achievement Gap," Pathways Magazine, Winter 2011, Stanford Center on Poverty and Inequality.

[5] Evans, G.W; Brooks-Gunn; J. & Klebanov, P., Winter 2011.

[6] Tough, Paul (2012)

[7] Children's Law Center, "Improving the Children's Mental Health System In the District of Columbia," (2012), available at www.childrenslawcenter.org

[8] Center for School Mental Health, "The Impact of School Mental Health: Educational, Social, Emotional, and Behavioral Outcomes," University of Maryland School of Medicine. Available at: http://csmh.umaryland.edu/Resources/Reports/CSMH%20SMH%20Impact%20Summary%20July%202013.pdf

services in most DC Public Schools are provided by a school psychologist, social worker or counselor. Some schools also provide additional services supported by the Department of Behavioral Health.

The vast majority of DCPS schools have both a school social worker and psychologist. However, school psychologists focus largely on special education: conducting needs assessments, designing interventions for students, and evaluating progress. Social workers provide counseling, home visits, assessments, and other services to help address students' emotional and social growth. They also provide significant support to students enrolled in special education services.

In school year 2014-15, DCPS has 77 full-time equivalent psychologists in schools and 18 in the central office. All but 14 schools have at least a half-time psychologist, and 44 percent have a full-time, or more than full-time psychologist(s). DCPS also employs 162 full-time equivalent social workers in schools and five in the central office. All but five schools have at least one part-time social worker, and 81 percent have a full-time, or more than one full-time, social worker(s).

DC Public Schools meets the industry standard for the ratio of psychologists and social workers to students on a city-wide basis. However, not all schools meet the industry standard. The National Association of School Psychologists recommends one psychologist for every 500 to 700 students. Across the system, DCPS has a ratio of approximately 502 students per psychologist, the lowest in the region.[9] On a school by school basis however, just under two-thirds of schools also meet this threshold, but approximately 1 in 3 do not. Twelve of these schools have no school psychologist. In the past, central office social workers have been used at schools to help with service delivery.

The School Social Work Association of America recommends one social worker per 400 students. Across the system, DCPS has a ratio of one social worker per 286 students. But on a school by school basis, just under two-thirds of schools meet this threshold. Of the schools that do not meet this threshold, more than half are located in zip codes where 20 percent or more of the children live below the poverty line. Five of these schools do not have social work positions. In the past, central office social workers have been used at schools to help with service delivery.

DCPS offers five evidence-based services to assist students with mental health needs:

- **Mental Health Consultation**. This voluntary practice is available in all schools and makes social workers available on a weekly basis to give feedback to teachers who are struggling with work related concerns such as teacher/student power struggles or problem classroom behaviors. A 2012 pilot of the program in 18 elementary schools showed that nine in ten students who participated in the program reduced their behavior infractions.[10]

[9] Thompson, Tisha, "Most D.C. Area School Districts Fall Short of Recommended Number of Psychologists," NBC-4, available at: http://www.nbcwashington.com/investigations/Most-DC-Area-School-Districts-Fall-Short-of-Recommended-Number-of-Psychologists-258546661.html?_osource=SocialFlowFB_DCBrand

[10] Information on the 2012 pilots for the Mental Health Consultation, CBITS and SPARKS are from a DC Public Schools fall 2012 powerpoint entitled: "Evidence Based Practices and Treatments." Contact the authors for a copy of the powerpoint.

- **Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)**. CBITS provides 1-2 individual sessions and 10 group sessions for children who have been exposed to trauma and are experiencing post-traumatic stress symptoms. The service is available at all DC middle schools, two alternative schools and six education centers. A 2012 pilot in three middle schools found that CBITS improved attendance, reduced behavior infractions, reduced post-traumatic stress symptoms, and improved functioning for participants.
- **Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)**. SPARCS provides interventions for children experiencing complex post-traumatic stress disorder symptoms. This program is available in all DC public high schools, nine middle schools, five education campuses, and four alternative school settings, including the Youth Services Center and Incarcerated Youth program. A 2012 pilot operated in six high schools found that SPARCS improved attendance, reduced behavior infractions, reduced post-traumatic stress symptoms, and improved functioning for participants.
- **Cannabis Youth Treatment (CYT).** CYT is a brief five-session treatment intervention available for adolescents in all DCPS high schools. The primary goal of CYT is to reduce and/or eliminate marijuana use and associated problems that affect students.
- **Child Centered Play Therapy (CCPT).** This treatment approach is a time-limited, evidence-based early intervention to help young children learn how to self-regulate emotions and develop improved executive functioning skills. Child Centered Play Therapy is a 14-week program that includes a parent intake and follow-up session, 4 child assessment sessions, and 10 play therapy sessions. The therapy is offered in 90 percent of all elementary schools.

DCPS also uses positive behavioral intervention and supports (PBIS) in nine schools, using the "Students Forward" model.[11] PBIS is a prevention and intervention program that focuses on teaching desired positive behaviors rather than on suppressing negative behaviors. It includes a review of the school's discipline policy and uses positive reinforcement to encourage more behaviors to be dealt with in the classroom rather than a trip to the principal's office. National research shows that PBIS reduces discipline, behavioral problems, and referrals to counseling and special education services.[12]

School Mental Health Program. The School Mental Health Program (SMH), operated by the DC Department of Behavioral Health (DBH), provides full- or part-time clinicians in participating schools. Unlike school psychologists, who must also spend a significant amount of time on special education services, SMH clinicians are solely focused on mental health services. In school year 2014-15, the program operates in 46 public schools and 15 charter schools, with about half located in Wards 7 and 8. (See **Table 1**.) The program also plans to expand to additional six DC public schools and 2 public charter schools in school year 2014-15. Just under three-quarters of the programs

[11] The schools are: Eliot Hine Middle School, Hart Middle School, Jefferson Academy Middle School, Johnson Middle School, Kelly Miller Middle School, Kramer Middle School, Sousa Middle School, Stuart Hobson Middle School, and Cardozo High School.

[12] Barrett, S., Eber, L., and Weist, M. (Eds.), "Interconnecting School Mental Health and School-Wide Positive Behavioral Support," University of Maryland School of Medicine, Center for School Mental Health. Available at: http://csmh.umaryland.edu/Resources/Reports/index.html

operating in DCPS have full-time staff, while in public charter schools, three-fourths do.

Table 1
Locations of School Mental Health Programs by Ward, SY 2014-15

Ward	Number of School Mental Health Programs
1	9
2	1
3	1
4	4
5	7
6	8
7	13
8	19

The program provides prevention and early intervention services for the entire school. It also provides individual, group and family counseling services for students with higher needs. Almost 1,700 students were referred to the SMH program in 2013-14 by Primary Project staff, teachers, administrators, school counselors and social workers, and families. Over two-thirds of those referred were assessed and referred to care. Of those 1,200 referrals, 630 students received treatment services from a clinician and 200 were referred to outside mental health services. Clinicians are expected to maintain a caseload of 12-20 children across school placements, depending on referrals and needs. **Table 2** (see next page) displays the demographics of the children seen for treatment.

DBH uses the Ohio Scales outcome measurement tool to look at the effectiveness of the treatment programs. The tool measures problem severity and functioning every 90 days over the course of treatment. Of the parents, students, and clinicians who completed the forms, all reported fewer behavioral and emotional symptoms and improved everyday functioning after treatment.

Legislation adopted in 2012, the South Capitol Street Memorial Amendment Act, set a goal of having mental health programs in 50 percent of DC schools by school year 2014-15 and in all schools by 2016-17.[13] Yet funding through FY 2015 is only sufficient to locate the program in 77 schools (36 percent of all schools), even with additional funding over the past two years to add 25 schools.

The District will need to provide additional funding to expand the program and meet the goal of full coverage.

Primary Project. The Primary Project, operated by the Department of Behavioral Health, is an early intervention program aimed at identifying and treating socio-emotional problems before they develop into more serious socio-emotional or mental health issues. Primary Project serves children in pre-school through 3rd grade who have mild problems with socio-emotional adjustments to the classroom. The program was implemented in 19 DC public schools, four DC public charter schools, and 17 child development centers in school year 2013-14. More than three-fourths of the sites are DC public schools, and half are in schools in Wards 7 and 8.

Children with mild difficulties receive one-on-one assistance from a DBH Child Associate. Children needing more intensive services are referred to an appropriate professional, such as a DBH school mental health clinician. In school year 2013-14, over 3,000 children were screened with the

[13] A19-0344, "The South Capitol Memorial Amendment Act of 2012"

program and 558 were referred to the Primary Project for services.

Table 2 Demographics of Children in Treatment Who Completed Clinical Forms in SY 2011-12 (total 462)		
Grade Level of Student		
PK-2nd Grade	112	25%
Grades 3-4	53	12%
Grades 5-6	77	17%
Grades 7-8	133	29%
Grades 9-12	77	17%
Total	452	
Sex		
Male	226	49%
Female	234	51%
Total	460	
Age		
3-5 years	24	5%
6-10 years	168	37%
11-13 years	157	34%
14+ years	109	24%
Total	458	
Race/Ethnicity		
African American	399	86%
Hispanic	52	11%
White	4	1%
Other	7	2%
Total	462	
Source: Department of Behavioral Health		

Early evaluations indicate that the program is helping students make positive adjustments to the classroom. Teachers reported that participating students improved their task orientation, behavioral control, assertiveness and peer social skills.[14] In school year 2014-15, the Primary Project expanded to 56 locations, up from 40 the previous school year.

Improving Services for Children with Mental Health Challenges. Students getting school-based mental health services see improvements in test scores, attendance and grade point averages as well decreased behavioral problems and an improvement in social functioning.[15] Evidence from DC's school mental health program found that parents, clinicians and students all reported fewer behavioral and emotional symptoms after treatment and everyday functioning improved.

These findings suggest that strengthening the District's mental health services in school settings is an important part of helping unlock the potential of all students, especially low-income students.

Expand Access to School Mental Health Programs. The District should act as quickly as possible to expand the School Mental Health (SMH) program to all DC public schools and public charter schools. The District is already behind the goal of reaching 50 percent of schools by the 2014-15 school year. With current funding supporting programs in 77 schools, or 36 percent of all schools, DC would need to add 137 schools over the next two school years, which would cost about $11million.[16]

The District should also look to expand the Primary Project program to more high-need elementary schools and child development centers. Helping

[14] Data received via email from the Department of Behavioral Health. Contact the author for more details.
[15] Center for School Mental Health, "The Impact of School Mental Health: Educational, Social, Emotional, and Behavioral Outcomes," University of Maryland School of Medicine. Available at: http://csmh.umaryland.edu/Resources/Reports/CSMH%20SMH%20Impact%20Summary%20July%202013.pdf
[16] This report assumes an average cost of $77,333 per school based on FY 2015 funding per school.

to identify children early on who need additional socio-emotional support can make it easier for both teachers, students and their families to address issues before they reach a crisis level.

Expand the Use of Positive Behavior Intervention and Supports to all Schools.

As noted, the District uses Positive Behavior Intervention and Supports in nine DC public schools. Schools that have implemented PBIS effectively have seen reductions in discipline issues and reduced referrals to counseling and special education services.[17] DC should expand the use of PIBS to all schools, starting with high-needs schools first.

Create Trauma-Sensitive School Environments in All Schools.

Schools can play a key role in how students who experience trauma adjust to the classroom by changing the entire school environment to allow students to feel safe and supported.[18] DCPS uses a number of programs that can help students address trauma, such as Positive Behavioral Intervention and Supports (PBIS), Cognitive Behavioral Intervention for Trauma in Schools (CBITS) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). Yet, in the case of CBITS and SPARCS, they are only available to a small number of students with the greatest needs in schools. And PIBS is only available in nine DC schools.

More work needs to be done to ensure that DC's schools are truly trauma-sensitive. According to a forthcoming paper by the Children's Law Center on trauma sensitive schools, other cities and states, such as Massachusetts, San Francisco, Washington State and Wisconsin, are leading the way in this area and have created models for trauma-sensitive school environments that rely on different school-wide programs than DCPS is currently using. All staff who interacts with students must understand trauma, how it impacts children and how to respond appropriately so that students feel safe.

The positive results from DC's CBITS and SPARCS services highlight how addressing trauma can benefit both the students and the school. Expanding trauma-sensitive environments to all students in the school can help ensure a wider range of children experiencing trauma can benefit, not just those with the most severe needs.

Increase the Availability of School Social Workers and Psychologists.

School social workers are key providers of mental health services in schools. Yet, more than one-third of DC Public Schools have too few social workers to meet the needs of their students. In addition, more than one-third of DC Public Schools have too few psychologists to meet the needs of students. DC should expand the number of social workers and psychologists at schools where the number students per social worker and/or psychologist is above the recommended threshold, starting with the highest poverty schools first.

[17] Barrett, S., Eber, L., and Weist, M. (Eds.), "Interconnecting School Mental Health and School-Wide Positive Behavioral Support," University of Maryland School of Medicine, Center for School Mental Health. Available at: http://csmh.umaryland.edu/Resources/Reports/index.html

[18] Tishelman, A.C., Haney, P., Greenwald O'Brian, J and Blaustein, M. (2010), "A Framework for School Based Psychological Evaluations: Utilizing a "Trauma Lens," Journal of Child and Adolescent Trauma, 3(4): 279-302, 280.

Case Study: An Approach to School Turnaround for High Poverty Schools

The District is using a targeted model – called Turnaround for Children model – which provides a "fortified environment" for students with greatest need – those with behavioral and academic challenges. Turnaround for Children schools provide positive behavioral supports to reduce stress, build positive relationships with adults and fellow students, and ultimately boost readiness to learn.

A central component of the Turnaround model is the development of a student support system, both inside and outside of the school. A trained social worker is placed inside the school, and special intervention teams are created to discuss and monitor interventions for at-risk students. Outside of the school, connections are made with community mental health partners and other social service providers to meet the needs of students with more urgent challenges.

Turnaround for Children schools also provide professional development for teachers to build a safe, supportive classroom environment. Instructional coaches train teachers on ways to improve student engagement and effectiveness of classroom, including constructive approaches to disruptive behavior. Turnaround also works with school leaders to ensure complete buy-in and help them develop a data-driven plan to improve overall school performance.

This model was initially implemented in New York, where intensive services led to suspensions falling 27 percent, severe incidents falling 18 percent, and chronic absenteeism falling 11 percent.[1]

Turnaround is currently in use in five DC Public Schools -- Wheatley, Orr, Henley, Patterson, and Walker Jones – with possible expansions to additional schools. Estimated to cost about $300,000 per school annually, the program is currently funded with a combination of public (Title I) and private dollars.

For more information, see www.turnaroundusa.org

Improve Data Sharing Across Agencies to Ensure a Comprehensive Continuum of Care for Children and their Families.

Children with socio-emotional needs and their families are often receiving services from multiple District agencies. But a lack of information sharing across agencies can mean that efforts are duplicated, unnecessarily re-started, and problems facing the child and family not fully understood by the various agencies working with them.

In its review of the disappearance of Relisha Rudd from the DC Family Shelter, the District acknowledged this problem and recommended that the Department of Behavioral Health, Department of Human Services and Child and Family Services review their policies and amend them as needed to facilitate proper information sharing. In addition, they recommended that a cross-agency task force be created to identify families most at-risk and how best to serve them.[19] DC should work quickly to implement these recommendations as well as ensure that the appropriate staff at DCPS and public charter

[19] Government of the District of Columbia, Office of the Deputy Mayor for Education and Office of the Deputy Mayor for Health and Human Services, "Summarized Findings and Recommendations: Review of Interactions with RR and Her Immediate Family and District Government Agencies," September 2, 2014.

schools also have access to critical information when treating children with socio-emotional needs. It is important though that this be done in a way that doesn't interfere with families' rights to confidentiality under current law.