Improving behavioral health access for students:

Observations about organization-level efforts to strengthen collaboration between community mental health agencies and school districts

Tom Perlet, Children's Behavioral Health Director, Riverbend
Stefanie King, MTSS-B Consultant, NH Department of Education

NH MTSS-B TECHNICAL ASSISTANCE CENTER | RIVERBEND COMMUNITY MENTAL HEALTH, INC | NH Department of Education Office of Social & Emotional Wellness

Session Objectives

- Explore the benefits and challenges of providing coordinated behavioral health care for youth in schools from an organizational standpoint.
- Highlight how the NH MTSS-B framework has helped school districts and community partners build integrated delivery systems for mental health and substance misuse treatment services.
- Discuss observations and brainstorm solutions to overcoming organization-level barriers to service provision and care coordination for youth in schools.

NH Department of Education Office of Social & Emotional Wellness

Agenda

- Warm-up
- Why integrate systems?
  - NH's youth mental health needs
  - NH System of Care Law and Grant
- What is MTSS-B?
  - Framework overview
  - Benefits and barriers to integrating care - Activity
- Lessons learned
  - Voices from the field
  - Case examples
  - Small group discussion
- Moving forward

NH Department of Education Office of Social & Emotional Wellness

Who's in the room?

Warm-Up Activity: Spectrum

There are more benefits than barriers to coordinating behavioral heath care between schools and community agencies.

Behavioral health services can be delivered effectively in school settings.

It is easy to monitor progress toward a youth's behavioral health goals.

The greatest barriers to organization-level collaboration come down to personal barriers.

Agree — **Disagree**

U.S. Department of Education
Office of Social & Emotional Wellness

Why integrate school and community mental health systems?

U.S. Department of Education
Office of Social & Emotional Wellness

In an average NH class of 20 students...

9 have lived with someone who was depressed, mentally ill, or suicidal

2 did not go to school because they felt unsafe at school, or on their way to or from school

3 have seen someone get physically attacked, beaten, stabbed, or shot in their neighborhood

2 have experienced sexual violence

5 have been bullied (either on school property or electronically)

3 have been the victim of teasing because someone thought they were gay, lesbian, or bisexual

7 have felt their mental health is most of the time or always not good (including stress, anxiety, & depression)

8 have felt so sad or hopeless they stopped doing their usual activities

4 have seriously considered attempting suicide

...and among students who report having felt sad, empty, hopeless, angry, or anxious:
fewer than 1 in 5 feel they most of the time or always get the kind of help they need

Office of Social & Emotional Wellness

Statistics drawn from state averages from the 2023 NH YRBS Survey, representing approximately 12,500 student voices from NH

The Need

Youth need for mental healthcare is unmet:

14-20% of youth (age 8-15) experience a mental, emotional, or behavioral disorder, but...

fewer than **½** receive treatment,

and **50%** of all mental illness begins **by age 14**.

Without appropriate supports, students at greater risk of:

- Chronic absenteeism
- Reduced academic achievement
- Suspension/expulsion
- School drop out
- Substance use
- Risky sexual behavior
- Violence
- Suicide

Schools are the most common loci of mental health care for youth
(Duong et. al., 2020)

Early detection = improved academic achievement.

Schools are a hub for prevention:

60-80% of youth who receive mental health services do so in schools

Office of Social & Emotional Wellness

The System of Care Law (RSA 135-F): Key Points

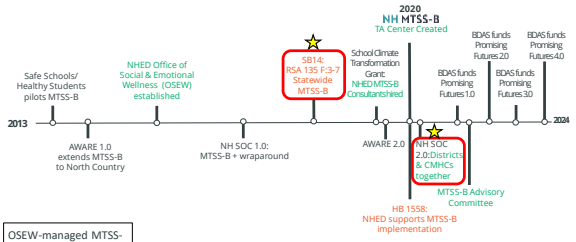
DHHS & NHED are required to lead **collaborative efforts** to develop an integrated and comprehensive behavioral healthcare system for youth in order to

- increase service effectiveness
- improve behavioral and educational outcomes
- reduce costs
- keep youth in their homes and communities

135-F:3, III - The system of care shall have the following characteristics...
(I) Statewide use of the multi-tiered system of supports for behavioral health and wellness, or **MTSS-B,** in NH schools to address NH students' social, emotional, and behavioral health needs

Office of Social & Emotional Wellness

Infrastructure to Support MTSS-B's Growth in NH



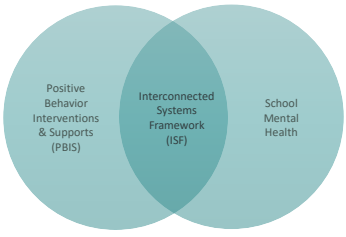
NH Multi-Tiered System of Supports for Behavioral Health and Wellness (MTSS-B)

What is MTSS-B?

Bureau of Student Wellness & Nutrition

NH MTSS-B
TECHNICAL ASSISTANCE CENTER

The MTSS-B framework



Interconnecting School Mental Health and School-Wide PBIS

NH MTSS-B

What is the MTSS-B framework? Simply defined…

A comprehensive system of social, emotional, and behavioral supports to promote student wellness and improve engagement in learning

- System of Care values
- Essential ingredients
- Strategies & routines

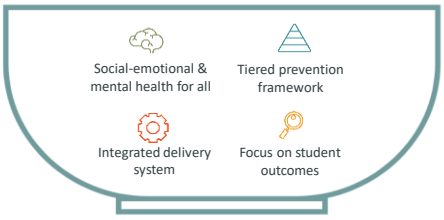
NH MTSS-B

NH System of Care values (RSA 135-F)

- Community Based
- Family Driven
- Youth Guided
- Culturally & Linguistically Competent
- Trauma Informed

NH MTSS-B

Essential ingredients



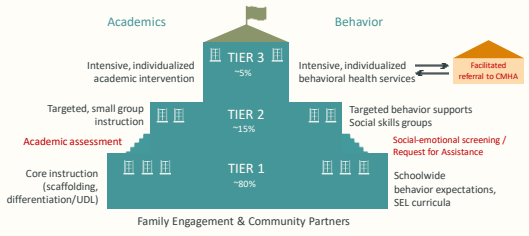
NH MTSS-B

Strategies & routines

- Team-based decision making
- Use of school & community data
- Evidence-based practices across tiers
- Early access through comprehensive screening
- Ongoing coaching & performance feedback
- Progress monitoring for fidelity and impact

NH MTSS-B

Schools provide academic **and** behavioral health supports, but they can't do it alone…



NH MTSS-B

Forming school-community partnerships

MOBILIZE PEOPLE

Community Resource Mapping

Goal: to improve awareness and utilization of existing services in the support of student and family social-emotional and behavioral health.

Community Resource Mapping Tool

NH MTSS-B

Collaborative teams drive the work

All teams integrated and representative:

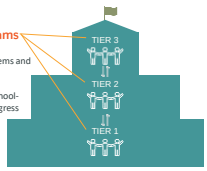
- ✓ District/school leadership
- ✓ School behavioral health
- ✓ CMHC admin/clinicians
- ✓ Wellness Staff (e.g. nurse)
- ✓ Community partners
- ✓ Youth
- ✓ Family
- ✓ Teachers / Support Staff

District-Community Leadership Team (DCLT)

- Sets district/community-wide goals & priorities
- Establishes/maintains community partners
- Secures/allocates human/ financial resources and training to support school-level implementation
- Monitors district-wide implementation & progress

School-Based Teams

- Sets school-wide goals
- Implements efficient systems and supports at all 3 tiers
- Monitors student-level, intervention-level, and school-level implementation progress



Integration of the Community Mental Health Agency

An MOU that supports integration may describe roles/responsibilities for…

Planning and implementation	Provision of Tier 3 services
DCLT participation	Provision of Tier 2 supports
School team participation	Contribution to Tier 1 supports
Data sharing	Communication & confidentiality
Facilitated referrals	Progress monitoring
Access to services	*School liaison position*

Role of the CMHA in MTSS-B Guidance Community Mental Health Agency MOU Guidance

Integration of the Community Mental Health Agency

School Liaison - A provider from the partnering CMHA who…

- Serves as the primary point of contact with the CMHA at the district and school levels
- Actively participates in District-Community Leadership Team meetings, as well as school-based team meetings (when appropriate)
- Provides behavioral health consultation and training for school admin and staff
- Serves as an internal coach and support for school-based behavioral health staff
- Provides Tier 2 and Tier 3 services on school grounds

Benefits and barriers to integration

Benefits: Both Targeted and General

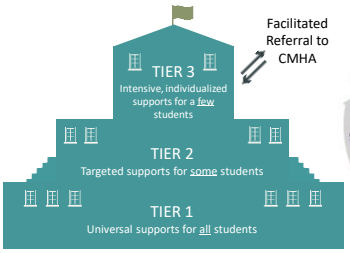
Integrated SBMH systems not only help **youth in need** access care…

they have positive effects on **whole school** climate and behavior.

(Duong et. al, 2021; DeGirolamo et. al., 2020)

Office of Social & Emotional Wellness

Barriers: Different Languages and Systems



Facilitated Referral to CMHA

Office of Social & Emotional Wellness

Activity

Based on YOUR observations, what are some of the organization-level **benefits** of and **barriers** to collaboration between schools and community agencies?

What are some possible ways to **overcome the barriers**?

If it isn't already happening, **how might you begin** to mobilize people in and out of schools to collaborate to support youth mental health?

Office of Social & Emotional Wellness

Lessons learned from the SOC grant

Office of Social & Emotional Wellness

Overall reflection: It's better, but there's still work to do…

Office of Social & Emotional Wellness

Key Respondent Interview (KRI) themes over time

Spring 2022

Be open to differing needs

Clear, concise communication is key

Workforce shortages and turnover can strain relationships

Spring 2023

Flexibility improves efficiency

Challenges to expansion and sustainability

Shifting time balance

Spring 2024

Moving from reaction to prevention

Delivering evidence-based practices

**Key respondents included 4 SOC grant-funded school liaisons and 4 CMHC Children's Directors*
Data analyzed by the Behavioral Health Improvement Institute with funding from SAMHSA

Office of Social & Emotional Wellness

Pre-SOC: Relationship Between Districts and CMHCs

- Crisis management
- Limited relationship - one-off requests
- Co-located relationships but with very limited caseloads/access
- Little communication on shared clients
- Absence of regular and systematic collaboration
- No facilitated referral processes

Before SOC it was mostly crisis management--well past the point of early intervention. -NHS

What changed?

District implemented the MTSS-B framework; district and CMHC created shared mission/vision/goals and action plans

Regular, scheduled meetings

School liaison position added

Shared PD opportunities

Office of Social & Emotional Wellness

Post-SOC: Positives

- Structured, collaborative relationships between the CMHC and school districts
  - Streamlined referral process
  - Regularly scheduled contact points
- Shared knowledge
  - Schools have greater knowledge of clinical presentation
  - CMHCs have greater knowledge of school systems
- Expanded service provision in schools
  - Creation of groups/clubs focused on mental health
  - More evidence-based practices are being offered in schools (7 challenges, RENEW, Coping Cat, CBITS/Bounce Back, DBT)
- Greater awareness of progress monitoring
  - Goal-oriented interventions

"SOC brought a lot of structure to the relationship, it really forced a relationship and got everyone on the same page" -SMH

"Relationship building is very important and is also humbling as Districts ask us to return to this partnership year after year." -GNMH

"Now there are fewer crisis calls because there is more prevention work." -NHS

Office of Social & Emotional Wellness

Post-SOC: Ongoing Challenges

- Prioritization of behavioral health by districts
- Scheduling
  - On the hour vs. school schedules
  - The golden hour (3-4pm)
- Productivity expectations
  - Billable vs. non-billable hours
- Family engagement
- Data sharing
  - Different systems, privacy laws (HIPPA/FERPA), and parent preferences
  - Progress monitoring

"Districts are very different. The one that doesn't buy in to mental health didn't ask for much…" -SMH

"Children who are referred for SBMH usually have barriers to access care during office-hours, so clinicians having to call parents or schedule a family session to have consistent check ins with the family. When [youth are seen] in office, it is easier to have parent contact/check ins." -GNMH

Office of Social & Emotional Wellness

Case Example: Northern Human Services

- Grant allowed for shared PD and aligned screening tool usage
- Fast-track referrals from school personnel; school personal triage high-need clients
- NHS supplies schools with their new client packets NHS uses up to 6 ES slots to bridge care for high-need clients until a regular provider is available
- Remote sessions offered during school hours reduces barriers to access

"We as an agency decided to prioritize calls from the district. We trust the district to triage." -NHS

Office of Social & Emotional Wellness

Case Example: Seacoast Mental Health

- Sustained 1 school liaison using blended funding
  - Eliminated productivity expectations
  - Contracts from schools cover non-billable hours (e.g. team meeting consultation, PD on mental health topics, RENEW training)
- Strategically identifying schools that would be high-impact loci for co-located clinicians
- Reconsidering open access process

"The open access model at Seacoast was challenging in that [our liaison] would just instruct them to access the open access intake process. It frustrated families." -SMH

Office of Social & Emotional Wellness

Case Example: Greater Nashua Mental Health

- Went from not having relationships with/clinicians in any school to being in 12 schools
- Schools used to handle the bulk of the initial conversation, now the schools identify the child, get permission from parents, and GNMH clinicians initiate the intake process
- Eliminated the waitlist for school-based services

"As need has grown, it was too much to put on the schools [to determine who needed what kind of services and where]; now the school identifies the child, gets the okay from the parent(s), and then GN initiates the referral process. This was helpful logistically and also for determining the clinical appropriateness for school-based services." -GNMH

Office of Social & Emotional Wellness

Case Example: Riverbend

- Changed policy from parents having to initiate a referral call to the agency initiating the call and developing a policy for being able to confirm the referral went through
- Tier 2 service provision has significantly increased
- Monthly Case Review meetings with many of our catchment schools

"As we have entered into more MOUs and agreements with schools in our catchment, we have been able to increase collaboration and communication that has allowed for more consistent and effective care for our clients." - RCMH

Office of Social & Emotional Wellness

Small Group Discussion

What integration efforts in the case examples stand out to you?

What are your key learnings/takeaways from these cases?

Office of Social & Emotional Wellness

Moving Forward…

Recommendations

- Expect it to work
- Start the conversation
- Collaborate to systematically support Tier 1 prevention efforts
  - Work to improve mental health literacy and trauma-informed care in schools
- Expand Tier 2 services (group-based care) on school grounds
- Braid funding to sustain school liaisons

"Buy in from top down has been a very big indicator for progress on this area. Superintendent down; CEO down in the CMHC." -SMH

(Stratford, Temkin & Supplee, 2023)

References

Eklund, K., Meyer, L., Splett, J., Weist, M. (2020). Policies and practices to support school mental health. In: Levin, B.L., Hanson, A. (eds) Foundations of Behavioral Health. Springer, Cham. https://doi.org/10.1007/978-3-030-18435-3_7

Duong, M.T., Bruns, E.J., Lee, K. et al. (2021). Rates of mental health service utilization by children and adolescents in schools and other common service settings: A systematic review and meta-analysis. Adm Policy Mental Health 48, 420–439. https://doi.org/10.1007/s10488-020-01080-9

DiGirolamo, A. M., Desai, D., Farmer, D., McLaren, S., Whitmore, A., McKay, D., Fitzgerald L., Pearson, S., and McGiboney, G. (2021). Results from a statewide school-based mental health program: Effects on school climate. School Psychology Review, 50(1), 81–98. https://doi.org/10.1080/2372966X.2020.1837607

Stratford, B., Temkin, D., Supplee, L. (2023). Supporting the scale-up of school mental health systems through evidence-based policy. In: Evans, S.W., Owens, J.S., Bradshaw, C.P., Weist, M.D. (eds) Handbook of School Mental Health. Issues in Clinical Child Psychology. Springer, Cham. https://doi.org/10.1007/978-3-031-20006-9_37

Behavioral Health Improvement Institute at Keene State College. (2024). NH MTSS-B Technical Assistance Center. https://nhmtssb.org