Harris County School Behavioral Health Initiative

A Community Collaboration



Recommendations to Improve Prevention, Identification, and Treatment of Behavioral Health Issues Among Students

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MHA Mental Health America of Greater Houston

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EXECUTIVE SUMMARY

Harris County currently is home to approximately 525,761 children ages 9-17.[i] National prevalence estimates indicate that 20%, or about 105,152, of these children have a mental illness or addictive disorder that causes at least some level of functional impairment.[ii] At least 5%, or 26,288, have a Serious Emotional Disturbance (SED) that results in significant functional impairments that can affect both home and school activities.[iii]

About half of lifetime cases of mental illness begin by the age of 14, making these illnesses "the chronic disorders of [the] young."[iv] Youths with behavioral health issues may experience challenges such as academic underachievement, criminal justice involvement and even suicide. In fact, "more than one-quarter of the total costs for mental health treatment services among adolescents were incurred in the education and juvenile justice systems."[v]

Due to recent national tragedies, renewed attention has been given to the importance of meeting the behavioral health (mental health and substance abuse) needs of children and youths. In response to the Sandy Hook Elementary School shooting, almost 200 national organizations, including the National Education Association, American Federation of Teachers and National Association of State Boards of Education, have called for "a balanced approach to preventing violence and protecting students," including "programs that support the social, emotional, and behavioral needs of students."[vi] Because a significant portion of a child's time is spent at school, schools provide a "captive" audience for the initiation of these interventions.

However, many schools have struggled to meet the behavioral health needs of their students for a number of reasons. A survey of seven school-based mental health care sites in Texas found that counselors face difficulties in providing appropriate levels of mental health services to students; teachers lack experience in recognizing early signs of mental health issues and oftentimes cannot identify available services in the community; and financial constraints keep many schools from adequately meeting the needs of students with mental health problems who are not eligible for services under federal law.[vii] A report by the Illinois Children's Mental Health Partnership noted that schools also face "immense pressure to focus on external accountability and test scores".[viii]

In order to help school districts better address these issues, Mental Health America of Greater Houston (MHA) led the Harris County School Behavioral Health Initiative, a year-long, community-wide initiative aimed at ensuring students are identified early and able to receive needed services. The initiative convened school district personnel, behavioral health providers, child-serving and education-related agencies, and parents to develop recommendations to improve the prevention, identification, and treatment of behavioral health issues among students. The following recommendations represent the culmination of this work.

Recommendations for the Texas Legislature

- Restore the $5.4 billion in education funding cuts made during the 82nd Legislature
- Restore the almost $13 million in funding cuts made to Communities in Schools during the 82nd Legislature
- Increase funding for substance abuse prevention, intervention and treatment for children and adolescents
- Increase funding for children's mental health treatment services
- Designate at least 5% of current funding for children's mental health treatment services to prevention programs, such as mental health literacy, personal safety, and suicide prevention
- Appropriate General Revenue funds to increase grants for school-based health clinics
- Require, in educator preparation programs, that teachers receive training in the detection and education of students with behavioral health issues

Recommendation for the State Board of Education

- Adopt comprehensive standards in Social and Emotional Learning for kindergarten through 12th Grade

Recommendation for Harris County Commissioners Court:

- Increase funding for the Community Youth Services program

Recommendation for the Department of State Health Services (DSHS), in conjunction with the Texas Education Agency (TEA) and Regional Education Centers

- Compile a list of the following programs and tools from which school districts may choose to implement:
    - Best practice-based, culturally competent universal prevention (including violence-prevention), mental health promotion and positive youth development programs
    - Validated mental health and substance abuse screening instruments that school districts can use to identify students with mental health and substance abuse issues
    - Best practice-based, culturally competent mental health and substance abuse interventions

Recommendations for School Districts

- Require teachers, nurses, counselors, principals and all other appropriate personnel to receive culturally competent training in how to recognize and appropriately respond to signs of behavioral health issues in students
- Implement best practice-based culturally competent mental health and substance abuse interventions

- Implement a best practice-based, culturally competent universal prevention program in each school
- Implement Positive Behavioral Interventions and Supports (PBIS), or programs with similar components, district-wide with fidelity
- Implement curricula focused on social skills and good decision-making
- Offer opportunities for parents and students to receive education about signs of behavioral health issues in students, as well as parent support groups
- Adopt clear and comprehensive policies that ensure students who are identified or referred receive appropriate interventions and/or referrals for services at the lowest appropriate level, including ensuring that:
    - Evaluations for Section 504 services are integrated into the RtI process;
    - The RtI process has sufficient flexibility, including providing parents and external psychological/psychiatric evaluations with a "fast-track" to a special education or Section 504 evaluation; and
    - A process exists for referring students with identified behavioral health issues who are not eligible for special education or Section 504 services to appropriate community services
- Work with community agencies/advocates to ensure parents have information about their rights regarding referral to, and during, the Special Ed/Section 504 processes
- Implement strategies to improve school disciplinary policies, including
    - Reviewing and revising student codes of conduct to minimize discretionary removals, as well as time spent in out-of-school placements
    - Reviewing data on disciplinary placements among campuses and helping campuses with high numbers of placements to develop and implement alternative strategies, including progressive sanctions
- Collaborate with out-of-school district placement entities to provide transitional service plans for returning students
- Ensure at least one licensed behavioral health professional at each school
- Ensure at least one nurse at each school
- Create a dedicated "navigator" position in schools to help coordinate behavioral health interventions and referrals
- Partner with universities to fill appropriate behavioral health/navigator positions with interns/fellows
- Develop strategies to enroll more students in Medicaid and the Children's Health Insurance Program
- Centralize some decisions about behavioral health interventions at the district level and show support for their implementation
- Designate appropriate space to be used for behavioral health interventions
- Partner with community agencies to provide behavioral health services using tele-health technology
- Host an annual "agency fair" so school administrators are knowledgeable of available programs to support their schools' behavioral health initiatives
- Partner with community agencies to conduct comprehensive needs assessments for at-risk student populations

- Request parental permission to obtain and share important data with other agencies by whom a student is being served in order to foster a team of support for the student

Recommendations for Community Organizations that Provide School-Based Services

- Routinely track data on student outcomes and share with school personnel
- When possible, provide behavioral health interventions before or after school
- Ensure that behavioral health services are integrated into school-based medical services

Recommendation for Community Behavioral Health Providers

- Review their utilization data for children's behavioral health services and seek to coordinate the provision of services on-campus

Recommendations for Community Behavioral Health Advocates

- Conduct an anti-stigma, public awareness campaign regarding children's mental health issues
- Develop a policy paper for school districts explaining the link between behavioral health and academic performance

HARRIS COUNTY SCHOOL BEHAVIORAL HEALTH INITIATIVE:
A COMMUNITY COLLABORATIVE
FEBRUARY 2013

More children and adolescents attend public schools in Harris County than in any other county in Texas, which also means it has the state's largest population of students who are dealing with a mental, emotional or behavioral issue.

Research continues to show that these problems can significantly impair a young person's family and peer relationships, as well as academic achievement. Failure to appropriately address these issues places a significant burden on our schools and other local systems.

HISTORY OF INITIATIVE AND REPORT DEVELOPMENT

In April 2012, Mental Health America of Greater Houston (MHA) received a one-year planning grant from the Mental Health America of Greater Houston Foundation for a collaborative initiative to develop recommendations to better address the needs of students with behavioral health (mental health and substance abuse) issues.

The first meeting of the Harris County School Behavioral Health Initiative (SBHI) was held on April 18, 2012, and convened over 50 individuals representing almost 40 organizations, including school districts, behavioral health providers, child-serving and education-related agencies, and parents. Of particular note is that 10 of the 20 main school districts in Harris County, representing over 500,000 public school students, were in attendance. A full list of organizations that participated throughout this process can be found in Appendix A. The purpose of the initiative—to improve the prevention, identification, and treatment of behavioral health issues among students—was affirmed. There also was broad consensus regarding the need to develop a coordinated effort aimed at improving outcomes for students with mental health and substance abuse issues.

At the second meeting of the SBHI, workgroup participants agreed to participate in specific committees to address the behavioral health needs of students. The committees were Prevention, Identification/Evaluation, and Intervention/Treatment. The committees met several times throughout the process to determine current system gaps and develop recommendations on how those gaps can be bridged.

Simultaneous with the work of the committees, several other activities took place, including the:

- Review of state and federal laws that govern the identification and treatment of students with behavioral health issues, including the Individuals with Disabilities Education Act and Section 504 of the Rehabilitation Act, as well as relevant state regulations;

- Creation of system "maps" of four school districts to determine their policies related to prevention, identification and treatment of mental health and/or substance abuse issues;

- Examination of national evidence-based and promising school behavioral health programs. These included best practices related to prevention, identification, and intervention;

- Completion of 32 individual interviews with key community members to obtain their views of how school behavioral health processes currently are working and ways in which they can be improved;

- Execution of site visits to locations that have been recognized statewide or nationally for innovative and best practice-based school mental health initiatives. The sites included:
    - San Antonio, TX to view the district-wide model of Positive Behavioral Interventions and Supports (PBIS) operating in the San Antonio Independent School District;
    - Cleveland, OH to view the School Community Mental Health Project, a collaborative serving students in 110 schools in the Cleveland Metropolitan District who are at risk for or have social, emotional, and/or behavioral problems; and
    - Baltimore, MD to tour the University of Maryland School Mental Health Program, a longstanding, interdisciplinary and effective program providing mental health promotion and intervention to youth in 27 Baltimore City schools; and

- Collection of data from the 20 main Harris County school districts related to special education categorization, racial patterns, and disciplinary placements.

Initial recommendations were developed through each of the preceding activities and presented to the full workgroup at a half-day retreat in October. By the conclusion of the retreat, the workgroup members had come to consensus on 30 recommendations and recommended an additional 14 for further review. At the final retreat, consensus had been reached on a total of 37 recommendations, which will be explained in further detail in this report.

COMMITTEE DISCUSSIONS—KEY ISSUES AND BARRIERS TO CARE

Each of the workgroup committees met twice over the summer and once again during the retreat. The committees discussed a number of key issues and barriers to care that ultimately formed the basis for many of the recommendations.

Prevention Committee

Deliberations of the Prevention Committee centered on a few key barriers to the implementation of successful school-based prevention programs. While the prevention of substance use and suicide among children is well-established and many programs effectively address these issues, prevention of mental health disorders is newer territory. Because research has long-emphasized the genetic component to a child's development of a mental illness, many prevention efforts have focused on early intervention ***after*** the onset of an illness. More recently, however, research has

demonstrated that "evidence-based interventions that target risk and protective factors at various stages of development can prevent many problem behaviors and cases of [mental, emotional and behavioral] disorders."[ix]

With this in mind, and based upon definitions developed by the National Research Council and Institute of Medicine Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults, committee discussions focused largely on mental health promotion interventions and universal preventive interventions (See Box 1).

Box 1

Definitions of Promotion and Prevention Interventions

***Mental health promotion interventions*:** Usually targeted to the general public or a whole population. Interventions aim to enhance individuals' ability to achieve developmentally appropriate tasks (competence) and a positive sense of self-esteem, mastery, well-being, and social inclusion, and strengthen their ability to cope with adversity.
Example: Programs based in schools, community centers, or other community-based settings that promote emotional and social competence through activities emphasizing self-control and problem solving.

***Universal preventive interventions*:** Targeted to the general public or a whole population that has not been identified on the basis of individual risk. The intervention is desirable for everyone in that group. Universal interventions have advantages when their costs per individual are low, the intervention is effective and acceptable to the population, and there is a low risk from the intervention.
Example: School-based programs offered to all children to teach social and emotional skills or to avoid substance abuse. Programs offered to all parents of sixth graders to provide them with skills to communicate to their children about resisting substance use.

***Selective preventive interventions*:** Targeted to individuals or a population subgroup whose risk of developing mental disorders is significantly higher than average. The risk may be imminent or it may be a lifetime risk. Risk groups may be identified on the basis of biological, psychological, or social risk factors that are known to be associated with the onset of a mental, emotional, or behavioral disorder. Selective interventions are most appropriate if their cost is moderate and if the risk of negative effects is minimal or nonexistent.
Example: Programs offered to children exposed to risk factors, such as parental divorce, parental mental illness, death of a close relative, or abuse, to reduce risk for adverse mental, emotional, and behavioral outcomes.

***Indicated preventive interventions*:** Targeted to high-risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental, emotional, or behavioral disorder, or biological markers indicating predisposition for such a disorder, but who do not meet diagnostic levels at the current time. Indicated interventions might be reasonable even if intervention costs are high and even if the intervention entails some risk.
Example: Interventions for children with early problems of aggression or elevated symptoms of depression or anxiety.

Source: ***Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.*** *Washington, DC: The National Academies Press, 2009.*

The need to increase mental health promotion and social and emotional development in schools was a significant focus of the committee discussions. Because of the demonstrated success of early prevention efforts and the extensive research on the benefits of healthy early childhood development, the committee also cited the need to implement prevention interventions well before a child ever enrolls in school. Though not the initial focus of the SBHI, this has been noted as an area for further review.

Another perceived barrier to the implementation of prevention interventions in schools included the lack of awareness among school district personnel regarding the positive correlation between good behavioral health and academic performance. As a result, administrators and personnel may find it difficult to focus on mental health promotion and positive youth development because they are more readily identified as "support services" than as critical components of academic performance. Teacher buy-in presented another possible barrier to prevention efforts, as committee members felt most teachers already have their plates full without adding "one more thing."

Identification/Evaluation Committee

A Parent's True Struggle with Her Son's Mental Illness

Life with Brian during those early years was full of turmoil and while home was often a living hell, being in school was even more challenging. I didn't want to admit it to anyone at the time, but I was so angry and resentful towards Brian. I was a good mother, but I was seething underneath. Imagine, I was always a good student in school. I cared about learning and respected my teachers. I couldn't fathom that I had a child who caused such chaos in school. I was so embarrassed and angry because I thought his illness was a reflection of me.

Much of the discussion related to barriers in identifying students with behavioral health problems focused on parents and teachers as being on the "front lines" of identification. Committee members felt that, despite the extensive time parents and teachers spent with their children and students, both groups lacked the tools that would help them more effectively recognize when children were battling mental health and substance abuse issues. Ensuring that parents and teachers are equipped with that knowledge was considered the key to promoting early intervention and improving outcomes for children down the line.

Another issue related to parents is their hesitation in coming forward with concerns about their child due to a lack of understanding about mental illness and fear of being labeled or experiencing discriminatory behavior. Unfortunately, many of these fears are steeped in reality, as significant stigma against mental illness still exists in our society. Therefore, working to reduce stigma in the community at-large, but specifically among parents of school-age children, was identified as another important need.

Finally, in relation to parents, committee members cited the lack of information parents have about the specific evaluation processes at their children's schools. Determining a student's eligibility for school support as a

result of a mental illness is largely governed by a complex set of processes specified in federal laws, such as the Individuals with Disabilities Education Act (IDEA), which governs special education services, and Section 504 of the Rehabilitation Act, which requires reasonable accommodations for people with disabilities. In addition, schools in Texas are increasingly relying upon the Response to Intervention (RtI) process to "screen out" students who do not need special education or Section 504 services. While these processes include parental safeguards, many parents are unaware of them, making it more difficult for them to effectively advocate for their children. Ensuring that parents receive education about these processes and their rights is another important issue.

Another barrier was the difficulty in identifying students with mental health needs who may not exhibit declining academic performance or other behaviors more commonly associated with a mental illness. Although these students may also be in need of school supports (though likely not through special education or Section 504), they oftentimes are not identified. Committee members felt this was an important issue to address as well.

Intervention/Treatment Committee

The Intervention/Treatment Committee discussed a number of different barriers to implementation of effective school-based intervention programs. Chief among these barriers was lack of funding. School districts are still reeling from the $5.4 billion funding cut during the last legislative session and are struggling just to meet the academic needs of their students, let alone the needs that are often considered auxiliary. In the wake of the legislative budget cuts, many support services staff positions were eliminated. The days when virtually all school campuses had both a school counselor and school nurse are long gone. Even when grant funds are secured to implement school behavioral health interventions, many programs end because they lack a sustainable funding source once the grant ends. Therefore, increasing funding for interventions—legislatively or otherwise—remains a great need.

The lack of consistency in the intervention programs available to schools was another identified issue. While somewhat understandably there is a wide variation of counseling and treatment options across school districts, the variations can be just as broad across campuses within the same district. This variation can cause disruption of services to students who move from one campus or district to another.

Committee members also had the perception that the most prevalent behavioral health interventions for students were short-term or crisis-focused. Virtually all schools have some type of "crisis response team," but the longer term services beyond that are limited. Another cited issue was the lack of interventions for students with mental health issues that are not behavior or academic related. Because many school behavioral health interventions are paid for with dedicated funds flowing from IDEA, students who do not meet the criteria for special education or even Section 504 services are many times left with no support.

The last major area the committee discussed related to intervention programs is the lack of data sharing among schools and other child-serving agencies, such as the Mental Health and Mental Health Retardation Authority of Harris County, the Harris County Juvenile Probation

Department and Harris County Protective Services. While it was agreed that many students with behavioral health issues are served in one or more of these systems, communication between these entities and school districts is not routine. Even with the passage of legislation during the 82nd Legislative Session authorizing data sharing among these and other agencies, many of the workgroup participants from these agencies admit that their data sharing is limited. One of the reasons for this is continuing concerns about what is allowed under the Health Insurance Portability and Accountability Act and the Family Educational Rights and Privacy Act. Nevertheless, data sharing among these entities was deemed a major need in order to reduce duplication of services and utilize limited funds more efficiently.

SYSTEM MAPPING

The system maps tracked the processes that school districts utilize to initially recognize signs of behavioral health problems in students, screen them, refer them to appropriate services, either on- or off-campus, and monitor them for academic and behavioral improvement. The system maps were developed for four school districts—Cy Fair Independent School District, Aldine Independent School District, La Porte Independent School District, and Channelview Independent School District. It must be noted that the processes were tracked at the district level, so some variability exists among each campus. The individual system maps can be found in Appendix B.

A True Story About Teacher/Parent Collaboration

James*, a middle school student with Bipolar Disorder, had difficulty sitting through classes. An experienced math teacher, who recognized James's special ability with math, asked that he be put into her class and that his mother attend the class as well to help with James' mood management. The mother was there to gently touch him on the shoulder if he was becoming agitated, and take him out of the class. He was able to do well in math that year.

**Name has been changed to protect identity*

While the system maps involved small, medium-sized and large school districts, some processes were similar across them all. All four districts have implemented one or more universal prevention programs, most notably Positive Behavioral Interventions and Supports (PBIS). Another similarity is that the primary process all of the districts use to identify students and ensure they receive proper services is Response to Intervention (RtI).

RtI is a process of observation, data gathering, and tiered intervention that seeks to correct students' academic (and to some extent, behavioral) challenges. Many believe it roots out unnecessary referrals to special education by identifying and mitigating these factors early on. RtI gained validation through the authorization of IDEA in 2004. The Act refers to RtI as "scientific, research-based interventions" in helping to determine whether a child has a Specific Learning Disability (SLD).[x] Emotional Disturbance (ED), which is the special education category under which most eligible students with behavioral health issues would fall, is explicitly excluded as an SLD. Yet, in many school districts, students suspected of having a behavioral health issue were required to go through the

RtI process before being referred for a special education or Section 504 evaluation.

After reviewing the various school district identification processes through the system mappings, there were five major findings, many of which involve RtI:

- ***Without flexibility, RtI can delay receipt of needed special education or Section 504 services.*** The system maps demonstrated two ways in which RtI can be implemented that may unintentionally delay a student's ability to receive services: 1) Requiring students to engage in a specific intervention for a minimum period of time before advancing to the next intervention and 2) Requiring students to move through the interventions sequentially rather than allowing them to bypass certain interventions to receive a special education or Section 504 evaluation. Such rigidity can result in a student waiting weeks or even months before ultimately receiving needed services.

- ***Parental observation and external psychiatric or psychological documentation did not always provide a "fast track" to a special education or Section 504 evaluation.*** There are many channels through which students may first be referred to the RtI process, including observations from teachers, counselors, nurses or other administrators. However, if a parent brings concerns about his or her child to the attention of a school, or even has supporting psychiatric or psychological documentation, the student many times goes through the same process as a student who lacks that documentation. This again can lead to delays in the provision of needed services to students.

- ***The integration of Section 504 evaluations into the RtI/identification processes is not always clear.*** While a special education evaluation usually is the last step in the school district RtI processes, it is often unclear exactly where and how in the process a student is referred for a Section 504 evaluation. This lack of clarity can create confusion for staff people involved in the process, as well as for parents.

- ***There was not always a clearly delineated process to ensure services/referrals for identified students that are not eligible for Special Ed/Section 504.*** As previously discussed, services for students who are not eligible for special education or Section 504 but still need support are sorely lacking.

- ***Few specific processes or services are available to address DAEP/juvenile justice-involved kids.*** Although IDEA authorizes grants to school districts to provide transitional services for special education students who are returning from an alternative education setting, specified grants are not available for general education students who have received these placements. A significant number of students with behavioral health issues—both within special education and the general education setting—have had disciplinary placements or been involved in the juvenile justice system. The lack of transition services can make their successful reintegration into their home school even more difficult.

A True Story of a School Working to Meet a Child's Needs

Brian's ARD committee discussed placing him in a behavioral class, but the behavioral class teacher didn't think he could provide Brian with an appropriate education since Brain was so intellectually gifted. I was amazed at this level of concern for my son who was causing such extreme chaos on a regular basis. The principal of that school had a special education background, and I think that played a part in how hard they worked with us.

While the findings described above do not apply equally to each of the school districts whose processes were mapped, these are the most significant issues that need to be addressed.

CONFIDENTIAL INTERVIEWS

The confidential interviews were conducted in October 2012 with 32 key stakeholders in the community. The stakeholders fall into one or more of the following categories: 1) Advocates/Child-Serving Agencies who do not provide services in schools but advocate for or provide services in some form to children); 2) School-Serving Agencies who do provide services, whether free or for contract, in schools; 3) Parents of children who have behavioral health issues; 4) Private behavioral health providers who may or may not deliver services in schools; and 5) School district staff or board members. A full list of the individuals who participated in the confidential interviews can be found in Appendix C.

While the individual observations and comments of the interviewees will remain confidential, the recurrent themes expressed by the various groups will be explored below. There were many overlapping concerns among the groups.

Advocates/Child-Serving Agency Concerns:

- Teachers lack training in how to recognize the signs of behavioral health issues among their students
- A lack of funding hinders the implementation of strong behavioral health intervention programs
- The lack of communication between schools and various entities (e.g. juvenile justice/mental health/child protective services) results in duplicated services
- Parents lack of knowledge of how to effectively advocate for their children
- Zero-tolerance policies have perpetuated a system in which students with behavioral health issues often end up with disciplinary placements
- Not enough Community Youth Services workers are available to provide services at every school that desires them
- A perception exists that schools are hesitant to identify behavioral health issues among their students due to the potential monetary commitment it requires
- Schools lack enough behavioral health professionals to appropriately meet the needs of their students
- Those who were trained as behavioral health professionals (i.e. school counselors) are bogged down with administrative work and therefore limited in the behavioral health services they can provide

- A perception exists that schools are more interested in focusing on the "80%" of students who do not have behavioral health or other problems
- Section 504 processes are not always clearly defined
- A perception exists that schools spend too much money on punitive discipline policies that don't work
- Parents lack knowledge about available community behavioral health resources
- Students are not always appropriately identified as needing special education or other services until they penetrate another system (i.e. juvenile justice)

School-Serving Agencies

- Schools are forced to place a heavy emphasis on standardized testing
- Support for prevention and intervention programs is largely dependent upon principals, reducing the potential for consistency across a school district
- Staff turnover in schools can be high, which oftentimes poses problems for prevention/intervention program stability
- A perception exists that schools are hesitant to identify behavioral health issues among their students due to the potential monetary commitment it requires
- Schools lack enough behavioral health professionals to appropriately meet the needs of students
- Those who were trained as behavioral health professionals (i.e. school counselors) are bogged down with administrative work and therefore limited in the behavioral health services they can provide
- A lack of funding hinders the implementation of strong behavioral health intervention programs
- A perception exists that schools focus on the "squeaky wheels" only when a crisis situation arises
- Many children arrive at schools already behind developmentally
- Stigma keeps students and parents from wanting to participate in behavioral health programs
- Schools lack available space for the provision of on-site behavioral health services.

Parents

- It is difficult to get the attention of appropriate administrators to look at a child's behavioral health issues
- A perception exists among teachers and administrators that behavioral health issues are the fault of "bad parenting"
- Teachers lack training in how to recognize the signs of behavioral health issues among their students
- Schools lack enough behavioral health professionals to appropriately meet the needs of students
- Parents lack knowledge about children's behavioral health issues
- Parents lack knowledge about schools' evaluation/referral processes
- Parents lack knowledge about how to effectively advocate for their children

Private Providers

- Support for intervention programs is largely dependent upon principals, reducing the potential for consistency across a school district
- School districts lack effective identification/referral processes to make sure the right students are taking advantage of the services provided
- A lack of funding hinders the implementation of strong behavioral health intervention programs
- Schools lack available space for the provision of on-site behavioral health services
- Teachers lack training in how to recognize the signs of behavioral health issues among their students

School Districts

- A lack of funding hinders the implementation of strong behavioral health intervention programs
- Schools cannot control factors within the home and in the community that may affect a child's behavior
- Schools lack enough behavioral health professionals to appropriately meet the needs of students
- Efforts to prevent over-identification of certain populations may lead to under-identification
- If not implemented correctly or to fidelity, RtI can delay receipt of special education services
- Behavioral health resources are lacking in the community

While the individuals interviewed have a wide range of backgrounds and experiences, it is important to note that there were many recurrent concerns raised regarding the provision of school supports for students with behavioral health issues. These include lack of training for teachers in recognizing behavioral health issues, lack of awareness among parents of children's behavioral health issues and the school processes to identify them, lack of funding, lack of behavioral health professionals in schools, lack of consistency among school district campuses, and lack of space to provide services.

NATIONAL BEST PRACTICES RESEARCH

The national best practices research focused on strong models related to prevention, identification/screening, and intervention for behavioral health issues. However, because there are hundreds of best practice-based prevention, identification and intervention programs, rather than listing each of them, this area will focus on general principles that underlie successful programs. Websites references for best practice-based prevention, identification and intervention programs can be found in Appendix D.

Prevention

Prevention programs can address a number of different factors: the onset and/or intensity of mental illness, suicide, substance use and abuse, violence and aggression and behavioral problems. Successful prevention programs usually include multi-year programming, which has

A True Story of a School's Poor Response to a Behavioral Health Incident

Sam* was a middle school student with Bipolar Disorder. One day in the school library, he had a "meltdown" and became very agitated, to the extent that he pulled some books off the shelf, though no one was injured. The school police were called immediately. Sam was handcuffed and marched out of the school in front of all the other students. He was so humiliated that he never went back to that school and dropped out of school entirely within a few months.

*Name has been changed to protect identity

been shown to have longer lasting effects than single-year programs.[xi] Prevention programs also are best implemented before the onset of problem behavior and continue throughout a child's adolescence. Programming that promotes protective factors generally is more successful than programming that focuses on reducing negative behaviors, though important variations exist based upon age, sex, and race.[xii] The Center for Disease Control found that violence prevention programs that are universal and "delivered to all children in a particular grade or school, regardless of prior violence or risk of violence" are most effective.[xiii] Social and emotional learning programs also have been linked with improved behavior and academic performance.[xiv] For school-based programs, the inclusion of components that address a child's family and/or home environment tend to produce better outcomes. Whatever programs are implemented within a given school, maintaining fidelity to the original model is a key indicator of success.[xv]

Identification

Identification and screening programs for mental health and substance abuse issues can be very difficult to implement for a number of reasons. Large scale programs can be very expensive, there are concerns about violations of student and family rights, and incorrect identification can have negative consequences.[xvi] However, if appropriate services and supports are available, identifying students with behavioral health issues can improve their outcomes.

If a school decides to initiate such a program, it is important to first determine whether the screening will be universal or selective and then to choose a valid, reliable, culturally competent screening tool.[xvii] In order for schools to implement an effective identification program, the U.S. Substance Abuse and Mental Health Services Administration recommends the following steps:

- Ensuring both parents and students are informed about the purpose and process of the screening
- Obtaining and documenting parental consent and student "informed assent"
- Training all staff involved in the process
- Ensuring qualified providers can review and provide results to parents, as well as make appropriate referrals, etc.
- Ensuring confidentiality of results[xviii]

Intervention

Studies have found a number of common factors for effective school-based behavioral health interventions. Programs that are designed to address a specific type of behavior are more effective than broad-based interventions. Mutli-component interventions that target the school, the family and community also are more effective than single component programs. When the interventions were integrated into the classroom setting rather than delivered as separate components, the outcomes were more positive.[xix] Programs that included the use of "fear-inducing tactics and deliver[ed] information in only a didactic format" were found to be less effective than programs that did not.[xx] Finally, fidelity to the original program model is another indicator of success. Some other promising intervention practices, information about which can be found in the appendix, include:

- **Juvenile Re-Entry Programs.** Several states have enacted policies that facilitate the process by which students return to their home schools after incarceration. Some of these practices can be effectively adapted to students returning from disciplinary and other out-of-school placements (such as residential treatment).
- **Tele-Health Programs.** Programs in Kansas and in Lubbock, Texas successfully use tele-health services to provide school-based mental health services.

LOCAL DATA COLLECTION

Through the Texas Education Agency website and open records requests to the agency, data was collected on 20 local Harris County school districts for the 2010-2011school year. In addition, data was obtained regarding the number of youths who were found to have an Emotional Disturbance upon entry to the Harris County Juvenile Probation Department. A compilation of the data obtained for the individual school districts can be found in Appendix E. Major findings included:

- Of the close to 800,000 public school students enrolled in those Harris County school districts, almost 20% were African-American and over 50% were Latino, meaning that the cumulative majority of public school students in Harris County are minority.
- Special education students comprised just over 8% of the general population, while students categorized as having an Emotional Disturbance comprised only .49% of the population. With an estimated 5% of youths having a behavioral health issue that significantly impairs home and/or school activities, the number of students identified with ED seems to be under-represented.
- African-American students were over-represented among special education students; both African-American and Anglo students were over-represented among those categorized as ED.
- Disciplinary placements also were much higher among special education students and those categorized as ED. Special education students were more than twice as likely to be referred to a Disciplinary Alternative Education Program (DAEP) as the general population overall; students categorized as ED were more than four times more likely to be referred to a DAEP than the student population overall,

and more than twice as likely to be referred to a DAEP than other special education students.

- In 2011, 62% of youths who entered the Harris County Juvenile Probation Department had an Emotional Disturbance; 30% had a Severe Emotional Disturbance. This is an increase of 25% and 20% respectively when compared with 2008.

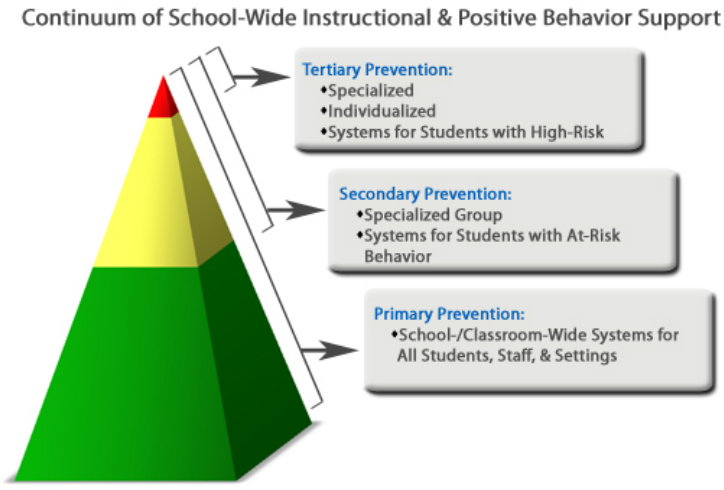
SITE VISITS

Small teams of SBHI participants made 3 site visits to San Antonio, Texas, Baltimore, Maryland, and Cleveland, Ohio to view empirically supported school-based prevention and intervention programs in action. Following is a description of the programs and key lessons learned.

San Antonio, TX

Positive Behavioral Interventions and Supports (PBIS) is framework for developing and implementing the best practices that facilitate positive academic and behavioral outcomes. The practices stress positive social skill development and positive reinforcement over punitive measures and operate based upon three tiers: Primary Prevention, Secondary Prevention, and Tertiary Prevention. Box 2 gives an illustration of the interventions for these three levels. PBIS has been associated with less exclusionary disciplinary policies, increased support for students with mental, emotional and behavioral issues, as well as improved academic achievement.[xxi]

Box 2



Source: OSEP Technical Assistance Center on Positive Behavioral Intervention and Supports

The San Antonio Independent School District first initiated Positive Behavioral Interventions and Supports (PBIS) in 2007 at 5 elementary school campuses. By 2009, PBIS became a district-wide initiative and is now operating in 85 of San Antonio ISD's 87 schools.

The training component of PBIS is very important. Each school that implements PBIS must send a 5-member team—including one administrator, one special education teacher, and three general education teachers—through a training program provided through the Region 20 Education Service Center. Each year of the 3-year training addresses one of the PBIS intervention tiers. After receiving the training, the teams are responsible for training the teachers and other staff on PBIS implementation on their respective campuses. In addition, each campus is assigned to a Behavior Specialist who serves as the "external" PBIS coach.

Equally important to training is the embedding of the program within school and district operations. PBIS is part of the District Improvement Plan, and its elements are incorporated into the RtI process. A principal's individual evaluation is based in part upon his or her implementation of PBIS, and an annual summary of the district-wide PBIS outcomes is shared with principals, the district leadership and the Board of Trustees. At the campus level, PBIS is part of the Campus Improvement Plan, is in the teacher and student handbooks, and parents are included in the campus PBIS efforts.

The district also makes available shared learning opportunities across campuses. Campuses are invited to participate in an annual PBIS showcase where they can share best practices and how they overcame barriers, hear from a top motivational speaker, and win door prizes, behavior games, and other instructional materials.

Data collection and progressive monitoring are also key elements of the district's PBIS efforts. The district has developed a "dashboard" to monitor schools' and the district's monthly implementation progress. The dashboard helps to identify both strengths and weaknesses. The Benchmarks of Quality (BoQ) is given annually in order to test a school's fidelity to implementation of Tier 1. An annual Summary Report is completed for each campus, which includes the BoQ scores, in-school and out-of-school suspension rates, and multi-year data on disciplinary referrals. Between the 2008-09 and 2010-2011 school years, 46 schools that had implemented PBIS had reduced their disciplinary referrals by 37%.

Now in its sixth year of implementation, the San Antonio Independent School District PBIS program continues to grow and improve. A few of the key barriers and lessons learned from this site visit include:

- **Teacher buy-in is critical.** Key personnel stated that teacher buy-in was just as important as student buy-in, if not more so. Teachers who do not support the program can hinder implementation efforts, so offering incentives for teacher participation is crucial.
- **Data collection and evaluation is key to program improvement.** San Antonio ISD has several layers of data collection and evaluation. The district is continuously monitoring program outcomes in order to identify and remedy any deficits.
- **Staff is held accountable for PBIS implementation.** School principals are evaluated in part based upon their successful implementation of PBIS.

Baltimore, MD

In 1989, the University of Maryland School Mental Health Program (SMHP) was founded in four schools in Baltimore City, representing an innovative model of a school-community partnership to promote student mental health. Based largely on the foundation of the SMHP, the University was then awarded federal funding to initiate the Center for School Mental Health (CSMH), one of two national training and technical assistance centers for mental health programming in schools.

The University of Maryland SMHP currently provides a continuum of effective mental health promotion, prevention and intervention to over 30 Baltimore City schools, building on students' strengths and addressing the needs of children and their families. Their interdisciplinary staff is comprised of psychologists, social workers, professional counselors, psychiatrists, and mental health trainees. During the past two decades, the Center and the SMHP have systematically developed model programs for implementing a full continuum of school mental health services and provided information for the development of similar programs nationwide.

In 2009, the Maryland State Department of Education and the Baltimore City Public Schools partnered with the University to establish an additional program, the Baltimore School Mental Health Initiative, focused specifically on augmenting existing school mental health services for K-8 students with emotional and behavioral disabilities in special education. The program provides a full array of mental health services within the school setting, including case management, to help students achieve academic success in the least restrictive environment.

In addition, the program provides: Mental health evaluations and psychiatric consultations; clinical services, including individual, group, and family counseling, which augment services provided by City Schools' staff; general education classroom presentations and prevention activities; teacher support, consultation, and professional development; family training; student and family referrals to community resources; and advocacy for students and their families.

This exemplary initiative emphasizes collaboration and consultation among all members of the school staff and child serving systems and has received national recognition for its quality mental health service for youth. Positive research outcomes also have been documented throughout the program's implementation. Key barriers and lessons learned from the site visit include:

- **Community partnerships increase the ability to enhance services.** City and county buy-in, as well as buy-in from the local medical school, has enabled the SMHP to expand and enhance its array of services offerings.
- **Incentives improve parental involvement.** The parental involvement and support group meetings included door prizes that helped encourage parents to attend.
- **Low staff turnover improves program continuity.** Some SMPH staff have been involved with the program for over a decade. They are welcoming and familiar to both students and parents, which helps to "normalize" the service offerings and reduce stigma.
- **Buy-in of school administration and staff is crucial.** School personnel are willing to facilitate the on-site program, making adequate and appropriate space available (not the "corner closet").

Cleveland, OH

The School Community Mental Health Project (SCMHP) is an impressive program serving 110 schools in the Cleveland Metropolitan School District. The program is overseen by the Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County (Board). The Board contracts with seven private non-profit organizations to provide the mental health services in the schools. Cleveland is very fortunate to have had these seven organizations already established in the Cleveland area.

The partnership, which includes the Board, the school district, and the service providers, meets once a month to share information, address issues of care coordination and service provision, and develop and implement new procedures. These meetings also evaluate programming, review individual school needs, and explore methods for improving collaboration, service delivery and outcomes for children, families and communities. The ongoing evaluation and procedure improvements are important program components.

The partnership provides in-school mental health assessments, individual and group counseling, consultation, and prevention services. The service providers also provide consultation to teachers, principals and staff, as requested. At least one service provider offers an afterschool program that is working very well. Each school has at least one licensed therapist, though some schools have more, depending upon need. The therapists have offices in the schools and the children/families see them there for therapy on an ongoing basis—families are not burdened by having to leave work and take the child out of school to see a therapist elsewhere. In addition, the therapist is seen around school and is considered a familiar and trustworthy figure, not a threatening, judgmental stranger.

All services are provided free of charge to the children and families. The services are funded largely by billing Medicaid because the vast majority of students in the district are enrolled in Medicaid. A small amount of additional funding is provided by the Board, which receives state and local funding, as well some federal funding funneled through the state. The funds provided by the Board allow the agencies to provide services that are not billable to Medicaid, such as consultation for teachers, principals and staff, or services for students not eligible for Medicaid. However, the funding received from Medicaid reimbursements and from the Board does not fully cover expenses. Therefore, the agencies pay for additional costs from their own funds, which they may have received through grants or other funding streams.

Overall, the Cleveland School Mental Health Project is a great model of how a collaboration between a small group of service providers can provide needed school-based mental health services to a very large population. Barriers and lessons learned include:

- **Parent education is key.** At one school, a significant percentage of children who were identified as needing treatment could not receive it due to lack of parental consent. Stigma continues to be a problem.

- **It is important to reach the family system.** Outcomes for the child improve when the family can offer appropriate support to the child. The whole family should be included in treatment services for children and youths.
- **Relationship-building is crucial.** The SCMHP has cultivated relationships and support at city, county, and state levels, as well as with a local university. They have a champion at the state level and support from the Ohio Department of Mental Health. Having relationships and support at all of these levels has been a facilitator in creating a "no wrong door" approach of system-wide coordination.
- **Engaging several agencies as providers better leverages services.** Using several service providers not only expands capacity, but also makes it possible to match the skills of the agency to the needs of the school.
- **Prevention programs complement intervention programs.** In addition to the services provided by the agencies, the district has adopted a universal prevention program.

CONSENSUS RECOMMENDATIONS

Based upon the aforementioned barriers to care and gaps in services that were identified throughout the SBHI process, as well as drawing upon national best practices, the following recommendations are being made:

Recommendations for the Texas Legislature

- **Restore the $5.4 billion in education cuts it made during the 82nd Legislature**

  The education budget cuts made during the 82nd Legislature were a devastating blow to many school districts. Thousands of teachers and other support staff were laid off around the state, leading to larger classes and, in many cases, less manageable classrooms. A school district's ability to implement effective programming to address the behavioral health needs of its students is largely dependent upon the restoration of the funding from the previous legislative session. Restoring these funds must be a legislative priority.

- **Restore the approximately $13 million in funding cuts made to Communities in Schools during the 82nd Legislature**

  Communities in Schools (CIS) is a comprehensive dropout prevention program serving the underserved children and youth in Texas. The program places a full-time social service provider on the school campus to offer a safety net for these students and develop a personalized plan to get them back on track and ensure they graduate from high school. CIS provides direct service to students in need of supportive guidance and counseling and connects students and their families to needed community resources. There are 28 Texas affiliates statewide working to reduce absenteeism and high risk behaviors, engage parents, and increase promotion and graduation rates. During the last legislative session, the Texas Legislature cut funding to Communities in Schools, which resulted in about 28,000 fewer students being served. It is important to restore this funding in order to improve and expand the school-based safety net services available for Texas children and youths.

- **Increase funding for substance abuse prevention, intervention and treatment for children and adolescents**

  The state of Texas sends up about $23 million annually to draw down over $120 million in federal block grant funds for substance abuse prevention, intervention and treatment services for children and adults. These funds are used for a variety of activities, including evidence-based prevention programming in both schools and in the community, awareness activities, and outpatient and residential services for children and adolescents. Substance abuse prevention activities are known to have a positive impact on reducing substance use among youths, and in the past several years, alcohol, tobacco and illicit drug use among middle and high school students has decreased.[xxii] Despite this, treatment services are still lagging. At the end of Fiscal Year 2010, 112 youths were on the statewide waiting list for substance abuse services, the vast majority waiting for residential treatment slots.[xxiii] Increased funding is needed in order to continue reductions in youth substance use and abuse, as well as to ensure that youths who develop these issues can receive needed treatment.

- **Increase funding for children's mental health treatment services**

  Legislative appropriations for children's mental health treatment services have remained relatively flat over the past several years at around $63 million annually, serving an estimated 12,000 children statewide per month. In Harris County in 2012, almost three quarters of children who needed services from the public mental health system did not receive them.[xxiv] As of July 2012, 286 children were on the statewide waiting list to receive ongoing mental health services, waiting an average of three months.[xxv] Delays in the receipt of treatment can lead children and families to deteriorate into crisis and increase the likelihood of emergency room utilization, school disciplinary placements and juvenile justice involvement. Ensuring that needed mental health services are available in the community is critical to reducing the costs and impact in schools and other local systems.

- **Designate at least 5% of current funding for children's mental health treatment services to prevention programs, such as mental health literacy, personal safety and suicide prevention**

  Currently, funding for ongoing children's mental health services is reserved for the delivery of needed mental health treatment and support services. While funding for these services must be increased significantly in order to adequately meet treatment needs across the state, an investment in prevention and mental health promotion programs also is needed. Suicide is the 3rd leading cause of death for youths ages 15 to 24.[xxvi] In Texas in 2012, there were 64,366 confirmed cases of child abuse and neglect, which oftentimes leads to the development of mental and emotional issues.[xxvii] In spite of the best efforts of parents, teachers, and other school personnel to keep students safe, students may engage in unsafe or hazardous behaviors or become victims of physical or sexual abuse, bullying, and internet dangers because they are uninformed about potential risks and do not

understand how to access appropriate help. It is imperative that all students know the warning signs of unsafe situations. Suicide prevention programs, mental health literacy programs such as Mental Health First Aid, and personal safety programs such as We Help Ourselves (WHO), are effective solutions to ensuring the safety of our children. Including funding for these types of programs in current children's mental health appropriations could eventually reduce the amount of funding needed for future treatment services.

- **Appropriate General Revenue funds to increase grants for school-based health clinics**

  School based health centers can facilitate children's access to behavioral health services. 75% of these centers provide mental health services, and one study demonstrated that students were 10 times more likely to make behavioral health visits if school-based health centers were accessible to them.[xxviii] According the Texas Association of School-Based Health Centers, as of February 2010, 89 centers were operating in Texas, including locally in the Channelview, Houston, Galena Park and Pasadena Independent School Districts. Currently, the state of Texas allocates about $1.8 million in federal Title V funds annually for grants to school-based clinics. The Department of State Health Services is responsible for distributing these grant funds to entities seeking to establish or expand school-based health clinics, but makes an average of only 2-3 grant awards per year. In order to expand accessibility to behavioral health services for children, the Legislature should appropriate General Revenue funds to establish and expand the number of school-based health clinics.

- **Require, in educator preparation programs, that teachers receive training in the detection and education of students with behavioral health issues**

  Throughout the SBHI process, an oft-mentioned need is training to help teachers recognize when students are experiencing behavioral health issues. Without appropriate training, teachers oftentimes inadvertently reinforce or intensify the very behavior they are trying to reduce. While some school districts across Texas already require some level of training in this area for teachers and/or administrators, training in educator preparation programs is virtually nonexistent. In order to help teachers detect and appropriately respond to behavioral health issues in students, the Legislature should require this training as part of an educator's initial preparation. Trainings also should be required for individuals trained through alternative certification programs and Teach for America.

Recommendation for the State Board of Education

- **Adopt comprehensive standards in Social and Emotional Learning for kindergarten through 12th Grade**

  Social and Emotional Learning (SEL) is a process to help students build the skills necessary for developing and maintaining successful relationships at home, school and in the community. A meta-analysis of over 200 SEL programs demonstrated the successful

outcomes of these programs, including "significantly improved social and emotional skills, attitudes, behavior, and academic performance that reflected an 11-percentile-point gain in achievement." [xxix] Texas currently integrates some SEL principles into its Texas Essential Knowledge and Skills (TEKS) guidelines to a limited extent. For instance, in the kindergarten TEKS, social development is mentioned only within the context of physical activity.[xxx] Currently, Illinois is the only state that has freestanding, comprehensive SEL standards for kindergarten through 12th grade.[xxxi] Because of the demonstrated benefits of SEL programs, the Texas State Board of Education should adopt comprehensive standards for all students from kindergarten through high school.

Recommendation for Harris County Commissioners Court:

- **Increase funding for the Community Youth Services program**

  The Community Youth Services (CYS) Program is a program of Harris County Protective Services that works with 13 Harris County school districts to reduce negative outcomes—such as delinquent behavior and dropping out of school—among at-risk students. The CYS workers provide case management and referral services to students and have been successful in reducing high-risk behaviors among participants. The cost for the CYS workers is shared evenly between Harris County and participating school districts. However, due to funding constraints, Harris County Protective Services currently is unable to provide enough CYS workers to meet the current school district demand. In order to increase the number of school districts receiving these services, Harris County Commissioners Court should increase funding for this program.

Recommendations for State Agencies

- **Compile a list of the following programs and tools from which school districts may choose to implement:**
  - **Best practice-based, culturally competent universal prevention (including violence-prevention), mental health promotion and positive youth development programs**
  - **Validated mental health and substance abuse screening instruments that school districts can use to identify students with mental health and substance abuse issues**
  - **Best practice-based, culturally competent mental health and substance abuse interventions**

  House Bill 1386, passed during the 82nd Legislative Session, required the Department of State Health Services (DSHS), with coordination from the Texas Education Agency (TEA), to develop and annually update a list of best practice-based early mental health intervention and suicide prevention programs that can be implemented in public elementary, junior high and high schools. The list ultimately compiled by DSHS is the list of programs approved by the Suicide Prevention Resource Center. While the programs included on the list further the goals of House Bill 1386, they do not address substance abuse and positive youth development programs and do not include mental

health and substance abuse screening tools. The list is posted on the DSHS website but is not included on the TEA website, where school districts are more likely to search. In order to truly be a resource for school districts seeking to implement best practice-based programs, DSHS, TEA and Regional Education Service Centers should work to expand the list to include mental health promotion and positive youth development programs, substance abuse prevention and intervention programs, as well as appropriate screening tools. The links to these resources also need to be easily accessible to school districts through the websites of each of the agencies.

Recommendations for School Districts

- **Require teachers, nurses, counselors, principals and all other appropriate personnel to receive culturally competent training in how to recognize and appropriately respond to signs of behavioral health issues in students**

  Outside of parents, teachers and other school personnel oftentimes have the most frequent interactions with students. As previously mentioned, if teachers are unable to recognize the signs of a behavioral health issue in a student, they may inadvertently reinforce or escalate the very behavior they are trying to reduce. On the other hand, if school personnel are trained to appropriately recognize signs of students' behavioral health issues, they can better manage their classrooms and help link students and their families to needed services, either on-campus or in the community. Several trainings are available to help educators and other personnel recognize and appropriately respond to these issues. NAMI of Greater Houston provides a free teacher in-service training called Parents and Teachers as Allies. Additionally, through a collaboration between the Department of State Health Services, Mental Health America of Texas and the Texas Suicide Prevention Council, free online trainings are available to many educators across the state. The *At-Risk for Middle School Educators* and *At-Risk for High School Educators* trainings help school personnel recognize the common indicators of behavioral health issues and approach students for appropriate referral and support services. San Angelo ISD in West Texas has required all of its high school staff to take the *At-Risk* training. Other school districts should follow suit and require this or similar trainings for their personnel as well.

- **Implement best practice-based culturally competent mental health and substance abuse interventions**

  As previously discussed, there are a number of school-based programs that effectively treat identified behavioral health problems. Targeted interventions that are multi-year and multi-component and implemented to fidelity yield the best outcomes. In light of the diversity of Harris County public school students, school districts should seek to implement empirically supported interventions that include the cultural competencies most appropriate for their school environment.

- **Implement a best practice-based, culturally competent universal prevention/mental health promotion/positive youth development program in each school**

  There are a host of violence, substance abuse, and suicide prevention programs, as well as mental health promotion and positive youth development programs that have been proven to be effective at improving social and emotional skills and academic success, while reducing delinquent behavior. As previously discussed, and similar to intervention programs, successful programs usually are multi-year and multi-component, and implemented to fidelity. School districts should aim to implement one or more of these best practice-base programs in each school.

- **Implement Positive Behavioral Interventions and Supports (PBIS), or programs with similar components, district-wide with fidelity**

  Positive Behavioral Interventions and Supports is an effective framework for promoting positive student behavior and reducing disciplinary referrals. Many campuses have adopted school-wide PBIS, but few school districts have been able to expand PBIS district-wide. In order to ensure the enduring success of PBIS, campuses often need an external support system. District level PBIS can provide that support and "improve the efficiency of resource use, implementation efforts, and organizational management."[xxxii] Therefore, school districts should provide district-level support for PBIS and seek to expand it district-wide.

- **Implement curricula focused on social skills and good decision-making**

  As previously discussed, positive youth development is an important way to increase the protective factors that can improve a child's behavioral health. Programming that incorporates the building and development of social skills and good decision-making is a key way to do that. School districts should seek to incorporate these aspects into existing curricula in order to help continue building these competencies in children.

- **Offer opportunities for parents and students to receive education about signs of behavioral health issues in students, as well as parent support groups**

  Another recurring theme throughout the SBHI process is the need to increase education and awareness for parents about children's behavioral health issues so they can better recognize when they need to seek help. The earlier this happens, the better the outcomes for both children and their families. Because school campuses are often considered a "hub" for a neighborhood or community, they are ideal locations for targeted parental programming in these areas. Local groups, such as the National Alliance on Mental Illness (NAMI) of Greater Houston and the Depression and Bipolar Support Alliance of Greater Houston already provide a number of free educational activities and support groups for parents. By partnering with these and other organizations to provide this programming on school campuses, school districts can make these services more accessible to parents.

- **Adopt clear and comprehensive policies that ensure students who are identified or referred receive appropriate interventions and/or referrals for services at the lowest appropriate level, including ensuring that:**
    - **Evaluations for Section 504 services are integrated into the RtI process;**
    - **The RtI process has sufficient flexibility, including providing parents and external psychological/psychiatric evaluations with a "fast-track" to a special education or Section 504 evaluation; and**
    - **A process exists for referring students with identified behavioral health issues who are not eligible for special education or Section 504 services to appropriate community services**

  This recommendation is aimed at streamlining the processes through which students with behavioral health issues are identified and referred to services. Ensuring that the RtI process has sufficient flexibility, including expediting the process when a parent initiates a concern or has a documented diagnosis from a behavioral health professional, will help reduce unnecessary delays in service. In addition, working to fully integrate Section 504 into the processes and including referrals for students with behavioral health issues who are neither eligible for special education nor Section 504 will help ensure that students who need services do not fall through the cracks.

- **Work with community agencies/advocates to ensure parents have information about their rights regarding referral to, and during, the Special Ed/Section 504 processes**

  Throughout the course of SBHI proceedings, it was apparent that parents often lack the information they need in order to make the best decisions and effectively advocate for their children during school evaluation processes. Disability Rights Texas (DRT), in conjunction with ARC of Texas, has developed a comprehensive guide to help parents through these processes. It includes information on eligibility for special education, the responsibilities of schools, parental rights, and other pertinent information under IDEA and Section 504. The guide can be accessed through the websites of both DRT and ARC of Texas, as well as in hard copy form. Schools should connect parents with resources such as these when a student with a suspected behavioral health issue begins moving through the RtI process.

- **Implement strategies to improve school disciplinary policies, including:**
    - **Reviewing and revising student codes of conduct to minimize discretionary removals, as well as time spent in out-of-school placements and**
    - **Reviewing data on disciplinary placements among campuses and helping campuses with high numbers of placements develop and implement alternative strategies, including progressive sanctions**

  According to Texas Appleseed, the "vast majority of student removals from school are made at the discretion of school districts," meaning that student violations are based primarily upon school district Code of Conduct violations rather than behavior requiring removal by Texas statute. [xxxiii] Discretionary placements may include out-of-school suspensions, Disciplinary Alternative Education Program (DAEP) placements for violations

such as disrupting class, using profane language or altercations, and Juvenile Justice Alternative Education Programs (JJAEP) placements for more serious behavior. Not only are disciplinary removals, such as out-of-school suspension, disruptive to student learning, they also can have an impact on school districts' per pupil funding, which is based upon average daily attendance. As previously mentioned, data in Harris County school districts show that students under the special education category of ED are twice as likely to be referred to DAEPs as all special education students, and four times more likely than the student population overall. While maintaining school safety and managing student behavior certainly are important, evidence suggests that zero tolerance and strict discipline policies have done little to improve school safety.[xxxiv] Alternatively, approaches such as progressive sanctioning in lieu of an automatic dismissal can help reduce disciplinary placements and reduce disruptions for students. School districts should begin following the evidence as it relates to school disciplinary policies and revise their policies to improve student outcomes.

- **Collaborate with out-of-school district placement entities to provide transitional service plans for returning students**

  While re-entry may be most closely associated with students who have spent time in state juvenile probation facilities, this process is just as important for students who have spent time in DAEPs, Juvenile Justice Alternative Education Programs, residential treatment centers and other settings. These entities should be required to give school districts timely notification of a student's release, as well as information about the support services they provided to the student (once they have obtained parental consent). School districts should designate an individual or team who is responsible for developing a transitional service plan for the student, including mental health and/or substance abuse referrals, obtaining parental consent for data sharing, if necessary, and ensuring that family and youth involvement is maximized throughout the process.

- **Ensure at least one licensed behavioral health professional at each school**

  The high prevalence of mental health and substance use disorders among children and adolescents makes it imperative for schools to have an adequate number of staff members to provide the behavioral health services students need. Unfortunately, most schools do not have a staff person solely dedicated to providing these services. In addition, school counselors, who historically were responsible for providing some of these services, are increasingly loaded down with administrative duties and have little time for counseling. They also are expected to handle increasingly large student loads. For instance, the counselor to student ratio in one local school district is 1:520 at the high school level. School districts should strive to make behavioral health services more widely available by increasing staffing to include a dedicated behavioral health professional on every campus.

- **Ensure at least one nurse at each school**

  A generation ago, it was routine for every school campus to have at least one school nurse. Today, however, many schools have a school nurse available only two or three days a week, if at all. According to the National Association of School Nurses, only 45%

of public schools have a full-time school nurse, while 25% do not have one at all.[xxxv] This can be particularly burdensome for children with behavioral health issues, as school nurses are often the only available qualified healthcare professionals to dispense psychiatric medication to students. School districts must work to reverse this downward trend in order to increase access to needed healthcare services for all children.

- **Create a dedicated "navigator" position in schools to help coordinate behavioral health interventions and referrals**

  Although schools must focus on meeting a child's academic needs, many children come to school with a complex set of issues, ranging from home life to peer relationships to medical conditions. Schools cannot be expected to provide every service necessary on every campus; however, they should be able to assist students and their families by linking them to available services in the school district or in the community. Programs like Communities in Schools and Community Youth Services provide these important "navigator" services to at-risk students. When students are able to access the help they need, both their academic and behavioral performance can improve. School districts should seek to partner with these programs and other available outlets to establish or increase navigator positions on their campuses.

- **School districts should partner with universities to fill appropriate behavioral health/navigator positions with interns/fellows**

  Students who are completing their postsecondary studies in behavioral health fields such as psychiatry, psychology, counseling, or social work can be a valuable source of staffing for school districts with tight budgetary constraints. These students usually must complete hundreds of field internship hours, and many of them have an interest in working in primary or secondary schools. School districts should partner with local and regional undergraduate and graduate programs in order to increase or enhance the behavioral health and navigator services they provide.

- **Develop strategies to enroll more students in Medicaid and the Children's Health Insurance Program**

  Limited funding was an oft-cited barrier to the provision of school-based behavioral health services, both by school districts and private providers. Medicaid is the single largest source of funding for mental health services, yet many Medicaid-eligible children are not enrolled. The same is true of children eligible for the Children's Health Insurance Program (CHIP). If all eligible students were enrolled in these two programs, this could provide a significant additional source of funding, as many services provided by various school district behavioral health staff positions (e.g., school psychologists and social workers), as well as by private providers are Medicaid- and CHIP-billable. School districts should partner with community organizations that promote Medicaid/CHIP enrollment and assist with application completion, consider hiring one or more staff persons to provide these services, and promote enrollment in these programs through other avenues, such as on their websites and in "take-home" folders to parents.

- **Centralize some decisions about behavioral health interventions at the district level and show support for their implementation**

  A recurrent concern among behavioral health providers and child-serving agencies that provide prevention and/or intervention services in schools is the difficulty in establishing new programs on other campuses within a school district because of the decentralized nature of operations. One interviewee described the process as akin to "trench warfare," slugging it out one school at a time. For this reason, successful programs that are demonstrating positive outcomes at one school may never have the opportunity to expand to other campuses. While the ultimate decision regarding which behavioral health interventions operate on a specific campus rightfully belongs to the principal, school district leadership should be aware of the successful programs operating on various campuses within the district and encourage and incentivize—not require—the expansion of these programs to other campuses, as appropriate.

- **Require schools to identify potential space to be used for behavioral health interventions**

  Another major barrier cited by private providers who sought to provide behavioral health services on school campuses was lack of space. The space necessary to provide these services does not need to be specialized, but must be large enough to accommodate a provider, a child and possibly parents, and to afford a certain level of privacy. While it would be infeasible to ask a school district to incur the costs needed to build out new space, encouraging district personnel to identify what space they have available at various campuses could facilitate the provision of needed services to its students.

- **Partner with community agencies to provide behavioral health services using tele-health technology**

  The shortage of behavioral health providers is a serious issue both statewide and nationally. In Texas, almost 90% of Texas counties, including six geographic areas and multiple healthcare facilities within Harris County, are designated Health Professional Shortage Areas for Mental Health.[xxxvi] Tele-health is one way to increase access to behavioral health services in light of the current workforce shortage. While these services historically were designed for rural areas, new rules are being proposed in Texas that would allow reimbursement for tele-health providers in urban areas as well. If these rules are adopted, school districts should enter partnerships with interested providers, such as hospitals and FQHC's, to use tele-health technology to establish or expand school-based behavioral health services.

- **Host an annual "agency fair" so school administrators are knowledgeable of available programs to support their schools' behavioral health initiatives**

  A number of different community organizations operate successful behavioral health and social support programs on school campuses—many of them free of charge. However,

many school administrators are not aware of these programs and the positive impact they can have on student learning and school climate. In order to help schools connect with these programs, school districts should host an annual "agency fair" that would invite community agencies to showcase their programs for school administrators and other staff members. School administrators can then decide which programs complement their current initiative and best meet the needs of their student populations.

- **Partner with community agencies to conduct comprehensive needs assessments for at-risk student populations**

  There are many different factors that place a student at-risk for school failure, as well as for behavioral health problems. These include high mobility (including homelessness and inadequate housing), lack of supportive peer or family relationships, abuse, neglect or maltreatment, and stressful life events, such as the death of a parent. If the appropriate protective factors can be strengthened or developed, a student's chance of success can increase significantly. School districts should partner with qualified professionals to conduct comprehensive bio-psychosocial assessments for students determined to be at-risk for behavioral health, suicide, and/or substance abuse concerns and use the data to plan effective interventions and provide necessary community linkages.

- **Request parental permission to obtain and share important data with other governmental agencies by whom a student is being served in order to foster a team of support for the student**

  The Federal Educational Rights and Privacy Act prohibits the disclosure of school education records without parental consent. There are very few exceptions, though in Texas, schools may share data with local or state juvenile justice agencies if it involves the agency's ability to serve the child and the agency agrees not to release the information to third parties. As previously stated, the information sharing among school districts and other child-serving government agencies can help reduce service duplication and promote a more efficient use of limited dollars. Despite these compelling reasons for information sharing, parental consent must be maintained in order to safeguard student privacy. Therefore, when it comes to a school district's attention that a student is being served in another system (e.g. child welfare, MHMRA), the school district should request parental consent to share student information to facilitate the coordination of needed services for the student.

Recommendations for Community Organizations that Provide School-Based Services

- **Routinely track data on student outcomes and share with school personnel**

  One of the ways in which administrators and other school personnel can be encouraged to support behavioral health interventions is to receive data on the benefits to their students. Oftentimes school-based health providers provide little information to school districts regarding their activities and the impact on student health, behavior or other outcomes. When school districts see the positive effect of these interventions on a regular basis, they

may be more supportive of continuing and expanding these programs.

- **When possible, provide behavioral health interventions before or after school**

  The primary focus of a school understandably is academic in nature. With the additional emphasis the state places on standardized testing, instructional time is precious, and schools often are hesitant to allow students to miss classes for non-academic purposes. Considering this reality, community agencies that seek to provide school-based behavioral health interventions should work with school administrators and staff to determine ways in which to minimize the amount of instructional time students have to miss, including the provision of services before or after school.

- **Ensure that behavioral health services are integrated into school-based medical services**

  The integration of behavioral health services into medical services can improve outcomes by "increasing early identification and coordinated early intervention for young child[ren] and families at risk of or experiencing behavioral health challenges."[xxxvii] Among school-based health centers, utilization surveys found that counseling for mental health issues was the top reason for student visits.[xxxviii] Although many school-based health clinics provide some level of behavioral health services, all clinics should include this offering in order to increase access to these services.

Recommendations for Community Behavioral Health Providers

- **Review their utilization data for children's behavioral health services and seek to coordinate the provision of services on-campus**

  Various hospital systems in Houston that provide behavioral health services also provide school-based services, including Memorial Hermann Health Care System and Harris Health System (formerly the Harris County Hospital District). Because hospitals may have access to resources otherwise unavailable to smaller community clinics, they have significant potential to establish one or more school-based clinics. Federally qualified health centers (FQHCs), which are charged with providing services at the neighborhood level and are able to bill services at an enhanced Medicaid rate, have an advantage as well. MHMRA currently serves approximately 5,000 children per year in its outpatient clinics, the largest provider of public children's mental health services in Harris County. However, with only four clinic locations, accessing needed services could be difficult for families. One way MHMRA, hospitals, and FQHC's can increase accessibility of behavioral health services is by partnering with schools to provide services at sites that are home to the highest concentration of their clients. Not only would this reduce the burden on parents, who often have to leave work in order to take their children to appointments, but it also could significantly reduce the no-show rate for clinics.

Recommendations for Community Behavioral Health Advocates

- **Conduct an anti-stigma, public awareness campaign regarding children's mental health issues**

  One of the major barriers to seeking out mental health services is stigma. Although significant strides have been made over the past several decades in normalizing mental illnesses as treatable medical conditions, the fear associated with such a diagnosis is still very real and particularly poignant among various cultural and linguistic groups. The more education people receive about this issue, the less fearful they will be. Therefore, local education and advocacy groups should partner to develop a children's mental health anti-stigma campaign that targets multiple cultural and linguistic groups and includes information about the prevalence, signs and symptoms of children's mental illness, the efficacy of treatment, and resources such as how to access help.

- **Develop a policy paper for school districts explaining the link between behavioral health and academic performance**

  A host of studies have been published that demonstrate the positive correlation between a student's mental and emotional health and his or her academic performance. While some behavioral health advocates can easily cite the related statistics, many school administrators are often unaware of this link. Therefore, local community behavioral health advocates should develop a policy paper for school districts that clearly demonstrates the academic benefits of school districts promoting good mental and emotional health.

CONCLUSION

In conclusion, the high prevalence of behavioral health issues among school-aged children and the potential impact these illnesses can have upon students, families and local systems make confronting these issues a community priority. Strengthening and developing children's protective factors through prevention and positive youth development programs is critical to preventing the onset of these illnesses and improving future outcomes. When problems begin to manifest, an important line of defense is ensuring that parents and school personnel are knowledgeable about how to recognize these issues so students are quickly referred to the appropriate services. And finally, targeted mental health and substance abuse interventions must be available, preferably on-campus, when students are in need of more specialized services.

Mental Health America of Greater Houston has been pleased to facilitate the deliberations and findings in this report and is committed to moving this process forward. Over the next several months, MHA will be meeting with elected officials, school district personnel and Board members, other and key decision-makers to ensure that these recommendations are implemented to the fullest extent possible.

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