IMPROVING OUTCOMES FOR CHILDREN IN SCHOOLS:

Expanded School Mental Health

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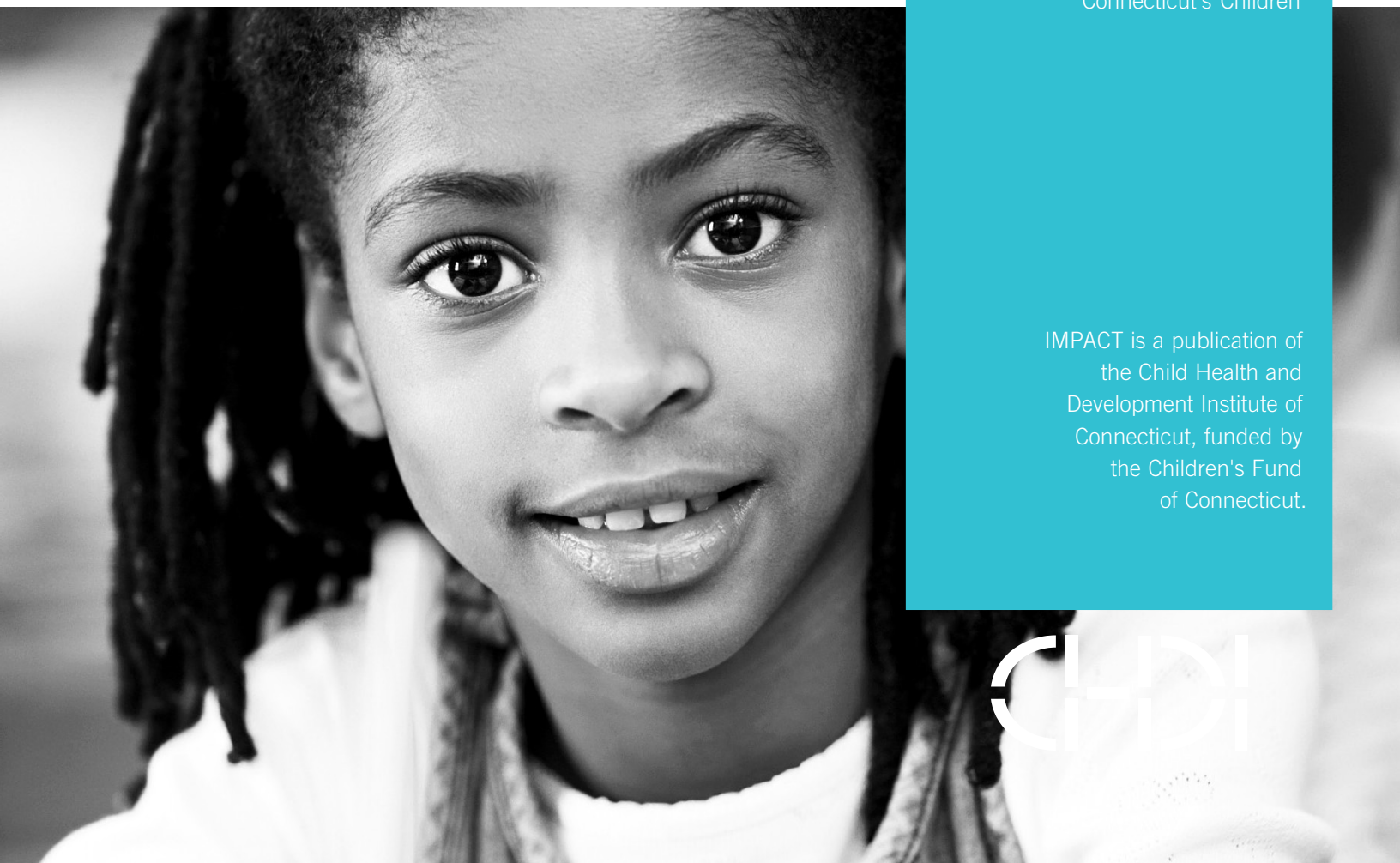

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About the Child Health and Development Institute of Connecticut:

The Child Health and Development Institute of Connecticut (CHDI), a subsidiary of the Children's Fund of Connecticut, is a not-for-profit organization established to promote and maximize the healthy physical, behavioral, emotional, cognitive and social development of children throughout Connecticut. CHDI works to ensure that children in Connecticut, particularly those who are disadvantaged, will have access to and make use of a comprehensive, effective, community-based health and mental health care system.

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IMPROVING OUTCOMES FOR CHILDREN IN SCHOOLS:

EXPANDED SCHOOL MENTAL HEALTH

INTRODUCTION

Over the last several years, Connecticut has established one of the country's most extensive arrays of children's mental health evidence-based practices delivered in home and community settings. Despite this investment and expansion of high quality services, the mental health system of care continues to lack the full capacity that is needed to ensure the delivery of care to all youth in Connecticut with mental health needs. National data indicates that about one in five youth currently experience a diagnosable and treatable emotional-behavioral problem, which, when applied to Connecticut, represents about 160,000 children and adolescents in our state in need of mental health care. Of those children, only about 20% are able to access the care they need and deserve, leaving approximately 125,000 Connecticut youth struggling with untreated mental health concerns. Unmet mental health needs have important implications for individual student achievement and the educational system as a whole. Research has shown positive impacts across a variety of indicators, including academic performance[1], through school mental health programs that address students' unmet social and emotional needs. Yet, the unmet mental health needs of students may be an important and largely unrecognized influence on broader indices of student achievement in school districts and statewide educational systems.[2]

In addition to their primary mandate to educate youth, public schools are widely considered a primary developmental context for youth outside the home and are increasingly becoming the setting for access to a wide array of physical and mental health services. Despite the enhanced array of community-based and in-home mental health care options, children receive mental health services in schools more frequently than any other setting.[3] Delivery of mental health services in schools is a desirable complement to our community-based system of care, which has often struggled to achieve the capacity needed to meet the growing demand for services. Mental health services in Connecticut schools are delivered by a combination of school-employed and school-linked clinicians. *School-employed clinicians* working for the schools or districts directly include school counselors, school social workers, and school psychologists. *School Linked clinicians* are typically community-based service providers, rather than school employees,

and are co-located in the school or easily accessible directly through school referrals. These include mental health clinicians distributed among about 80 school-based health centers across the state. While access to school-based health centers has recently expanded in Connecticut, available services fall short of meeting the needs of 1,017 public K-12 schools in the state. Furthermore, continued funding challenges are an ongoing threat to maintaining or expanding the current level of care.

In the school setting, social workers are among the most readily accessible mental health clinicians and are instrumental in preventing and managing emotional-behavioral crises among students. School social workers deliver direct care to students and provide consultative services to teachers who are tasked with educating all students, including those who struggle with emotional or behavioral problems. The National Association of Social Work recommends a maximum ratio of 250 regular education students to each school social worker,[4] yet it is common to find social workers in Connecticut schools serving a much larger caseload. There are about 1,000 certified school social workers for Connecticut's 530,000 K-12 students, yielding a statewide ratio of about one social worker for every 530 students. According to the State Department of Education, about 15% of Connecticut school districts do not employ a social worker among student support staff. In districts that do have a social worker, these professionals are often overextended, providing services to students across several schools within their district. Insufficient numbers of school social workers create a gap in access to school-based mental health services as well as community-based services, directly impacting the ability of affected K-12 students to function in the classroom. The State's fiscal problems only add to the challenges facing our already overextended school-based mental health service system.

Teachers and staff often lack the skills and necessary supports required to manage the mental health needs of their students. Teachers often feel ill-equipped to manage emotional dysregulation and disruptive behavior in the classroom, which can negatively impact the general learning environment for all students. School personnel (e.g., administrators, school resource officers, teachers) who are unprepared to manage the emotional

Schools can provide a safe, secure, and accessible base for improving mental health outcomes by serving as a hub for school-based and school-linked services in the community.

and behavioral challenges of students may rely excessively on exclusionary discipline practices such as suspension, expulsion, and arrest, contributing to poor student outcomes and the widening of our state's achievement gap.[5] The tragic shooting at Sandy Hook Elementary School in December 2012 ignited a sense of urgency among state leaders and policymakers to address mental health and safety in our schools; however, without a well-articulated framework to guide policy development and systems reforms, we can potentially miss a critical opportunity to strengthen and improve school-based mental health services in Connecticut.

This report proposes a potential solution. Schools can provide a safe, secure, and accessible base for improving mental health outcomes by serving as a hub for school-based and school-linked services in the community. This *expanded school mental health* framework provides guidance for organizing and focusing Connecticut's efforts towards improving students' mental health, academic functioning and safety. The report reviews factors critical to promoting expanded school mental health and positive developmental outcomes for youth including: classroom-based approaches, effective crisis response, transition supports, home-school connections, community collaborations, and student and family assistance. The Connecticut School-Based Diversion Initiative (SBDI) is described as an example of how the principles of expanded school mental health have been applied in order to divert youth with mental health needs from school-based arrest and instead link these students with effective school- and community-based mental health services and supports.

BACKGROUND

The importance of school mental has risen to the forefront of national attention and is part of a broader strategy for transforming the nation's mental health system. The role of expanded mental health services and supports was deemed a central component to strengthen the nation's child and adolescent mental health system in the final report of the President's New Freedom Commission on Mental Health established by President George W. Bush in 2002. Recommendation 4.2 of the *Achieving the Promise: Transforming Mental Health Care in America*[6] report called for policymakers to "improve and expand school mental health programs." Other relevant recommendations included: reducing the stigma of seeking care, implementing a strategy for suicide prevention, screening for co-occurring mental and substance use disorders and linking with integrated treatment strategies as priorities for systems transformation.[7]

Table 1: Major Youth-Focused Efforts in Connecticut: 2008-2013	
2002-2008	• The Partnership for Kids (PARK) Project in Southwestern Connecticut
2008	• Connecticut School-Based Diversion Initiative
2010	• Creation of Achievement Gap Task Force • Juvenile Probation revised intake process to reduce non-serious in-school arrests • Juvenile court jurisdiction raised to age 16
2011	• Public Act No. 11-232: An Act Concerning the Strengthening of School Bullying Laws • Creation of model memorandum of agreement (MOA) between school administrators and police
2012	• Creation of Interagency Council for Ending the Achievement Gap • CT Legislature passed budget to increase number of School-Based Health Centers more than 25% • Juvenile court jurisdiction raised to age 17
2013	• Creation of Bipartisan Task Force on Gun Violence Prevention and Children's Safety - Gun Violence Prevention Working Group - School Security Working Group - Mental Health Service Working Group • Creation of Sandy Hook Advisory Commission

The call for mental health reform has reached Connecticut as well. Over the last five years, policymakers and stakeholders in mental health, juvenile justice, education, and other systems have developed various school-related strategies and initiatives designed to improve developmental outcomes and mental health for Connecticut's children. A selection of these efforts is summarized in Table 1. Together, they address multiple converging challenges that confront Connecticut youth including school-based arrests, academic achievement, bullying, school climate, and overall mental health and school safety. Although these efforts vary in the degree to which they directly involve or affect schools, they have much in common.

From 2002-2008, the Partnership for Kids (PARK) Project was federally funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) in Bridgeport as a school-based systems-of-care initiative to meet students' mental health needs by promoting collaboration between mental health community collaboratives and local school districts. PARK's systems-of-care approach

prioritized family-driven, culturally competent, community-based care coordinated through collaborative partnerships among schools, providers, and families.[8] The PARK Project demonstrated positive outcomes at the school and local levels[9]; however, these results and collaborations were not expanded statewide.

Another area of emphasis in Connecticut is the state's achievement gap—a measure of academic performance that contrasts the achievement of low-income students to their more affluent peers. Connecticut students have demonstrated the widest achievement gap in the U.S. The Achievement Gap Task Force (2010) and the Interagency Council for Ending the Achievement Gap (2012) were created in an effort to begin closing this gap.

One of Connecticut's most significant challenges contributing to the achievement gap is a disproportionate academic and disciplinary outcome for youth from diverse racial and ethnic backgrounds and with disabilities, including emotional and behavioral disorders. According to a 2012 study published by UCLA's Center for Civil Rights,[10] Connecticut schools suspended and expelled black and Hispanic students at some of the highest rates in the U.S. during the 2009-10 school year. Connecticut posted the third-highest gap in suspension rates between black and white students and the third highest suspension rates for black students with identified disabilities. Connecticut had the highest suspension rate for Hispanic students with disabilities in the nation. At the local level, the suspension rate for Hispanic students in Hartford was the nation's highest at 44%, and Bridgeport schools suspended 73% of all black students in special education that year.

Students who are suspended or expelled are at a significantly higher risk for dropping out of school and for entering the juvenile justice system than their peers. School-based arrest rates tend to disproportionately affect children from racial and ethnic minority backgrounds and youth with mental health needs; in fact, about two-thirds of youth in juvenile detention facilities have diagnosable mental health problems.[11,12] Multiple data sources[13,14] indicate that schools are a growing source of arrests as a result of rigid, zero tolerance discipline policies that punish youth for typical adolescent behavior or what is often the expression of an unidentified and untreated emotional or behavioral problem. This phenomenon is often referred to as the "school to prison pipeline[15]." Despite national crime data indicating that school violence has declined by nearly 70% from 1993 to 2008[16], school-based arrests continue to plague vulnerable students, especially students from black and Hispanic backgrounds and students with disabilities, including mental health conditions. According to the Connecticut Judicial Branch, in the 2011-12 school year, 19% of all juvenile arrests that were processed in the courts originated from incidents in school buildings.

Connecticut has successfully undertaken a number of recent efforts toward juvenile justice reform that begin to address this challenge. Until 2010, Connecticut was one of only a few states that

processed the criminal cases of 16- and 17-year old adolescents through the adult justice system. After a successful campaign by advocates and other stakeholders, Connecticut law was changed to include 16-year olds in the juvenile justice system, and in 2012 the law was extended to include 17-year olds. In a further effort to decriminalize what may be dysregulated behavior due to emotional/behavioral problems, juvenile probation revised its intake process in 2010 to reduce the number of non-serious in-school arrests. In 2011, a model memorandum of agreement was drafted and disseminated to enhance communication and collaboration between local school districts and police departments, and the legislature strengthened school climate and bullying laws. Juvenile justice reforms such as these have resulted in positive outcomes for youth in Connecticut through improved collaboration and accountability[17] and integration with ongoing education reforms.

The accelerating trend toward improving school climate and boosting access to social-emotional support services for students was bolstered in the wake of the tragic Newtown shootings on December 14, 2012. Governor Dannel Malloy created the Sandy Hook Advisory Commission and the General Assembly organized the Bipartisan Task Force; both groups were tasked with enhancing youth mental health services, improving school safety, and reducing gun violence. The increased awareness of the importance of school safety and addressing the mental health needs of our children and youth has inspired legislative and policy reform efforts and created the opportunity for system improvements and reform.

Table 2: Key features of converging crises affecting Connecticut youth

1. There are about 160,000 children and adolescents with unmet mental health needs.
2. Emotional/behavioral problems affecting youth are often expressed as dysregulated behavior in the school setting.
3. Dysregulated behavior often leads to rule breaking among youth, and under-resourced schools are over-relying on exclusionary discipline (suspension, expulsion, arrest) to manage these challenges.
4. Youth exposed to exclusionary discipline are more likely to drop out of school, less likely to receive much-needed mental health services and supports, and more likely to end up in the juvenile justice system.
5. There is a shared economic and social burden for all Connecticut citizens linked to avoidable school failure, untreated mental illness, and excessive juvenile arrests among children and adolescents.

Expanded school mental health has emerged as the most widely accepted framework for capturing the evolution of the field of school mental health over the last twenty years.

EXPANDED SCHOOL MENTAL HEALTH

An examination of the key features of converging crises facing Connecticut, and the efforts that have been undertaken to address them, reveals that the mental health and school systems are critical and interrelated targets for systems transformation. **Expanded school mental health** extends beyond traditional services provided by school-hired staff, such as social workers, counselors, and school psychologists, and bolsters this approach by engaging community-based services and supports in a comprehensive, collaborative model for supporting healthy student development. Mark Weist and colleagues at the University of Maryland Center for School Mental Health have conceptualized and defined the expanded school mental health construct as follows: "…close collaboration between families, schools, and community agencies (e.g., mental health centers and health departments) to develop a full array of effective mental health promotion and intervention to youth in both special and general education in schools."[18] Expanded school mental health has emerged as the most widely accepted framework for capturing the evolution of the field of school mental health over the last twenty years.

In addition to providing a definition of expanded school mental health, investigators at the Center for School Mental Health led a five-year effort to develop an associated set of best practice principles. The resulting ten principles (see Table 3) are consistent with System of Care values in that they establish expanded school mental health services as accessible, strengths-based, evidence-based, culturally-informed, coordinated, collaborative, and guided by quality improvement activities.

Table 3: Ten Principles for Best Practice in Expanded School Mental Health[18]

1. All youth and families are able to access appropriate care regardless of their ability to pay.
2. Programs are implemented to address needs and strengthen assets for students, families, schools, and communities.
3. Programs and services focus on reducing barriers to development and learning, are student and family friendly, and are based on evidence of positive impact.
4. Students, families, teachers and other important groups are actively involved in the program's development, oversight, evaluation, and continuous improvement.
5. Quality assessment and improvement activities continually guide and provide feedback to the program.
6. A continuum of care is provided, including school-wide mental health promotion, early intervention, and treatment.
7. Staff are held to high ethical standards, are committed to children, adolescents, and families, and display an energetic, flexible, responsive, and proactive style in delivering services.
8. Staff are respectful of, and competently address developmental, cultural, and personal differences among students, families, and staff.
9. Staff build and maintain strong relationships with other mental health and health providers and educators in the school, and a theme of interdisciplinary collaboration characterizes care.
10. Mental health programs in the school are coordinated with related programs in other community settings.

The UCLA Center for Mental Health in Schools has contributed to the concept of expanded school mental health by developing the Framework for a Comprehensive System of Learning Supports. The "Framework," developed by Adelman and Taylor,[19] outlines six intervention content areas critical to expanded school mental health services: 1) classroom-based approaches; 2) crisis response strategies; 3) transition supports; 4) home involvement in schooling; 5) community outreach; and 6) family assistance. Table 4 lists each of these six areas and the developers' recommendations for associated interventions. Taken together, the ten principles developed by The University of Maryland and the Framework developed by UCLA provide Connecticut with a set of comprehensive guidelines for implementing expanded school mental health initiatives.

Table 4: Comprehensive System of Learning Supports[19]

Target	Intervention
Classroom-Based Approach	• Open the classroom to available supports • Use classroom management strategies to reduce out-of-class referrals • Enhance and personalize professional development
Crisis Response	• Address crises immediately so students can resume learning • Provide follow-up services as indicated • Form a school-focused crisis team to formulate a response plan • Work with neighborhood schools and community agencies to integrate planning efforts
Transition Supports	• Welcome and social support programs for newcomers • Provide daily transition programs • Offer summer or inter-session programs, including catch-up, recreation, and enrichment
Home Involvement in Schooling	• Provide support services for family members at home, addressing basic needs and education • Improve communication mechanism for connecting home and school • Recruit families to strengthen school and community
Community Outreach	• Plan and implement outreach to recruit a wide range of community resources • Reach out to students (and their families) who don't come to school regularly • Connect school and community efforts to promote child and youth development
Student and Family Assistance	• Provide extra support as soon as needed in the least disruptive manner possible • Enhance access to direct interventions for physical and mental health, and economic assistance • Develop mechanism for resource coordination and integration to avoid duplication and promote braided funding

Case Example: The Connecticut School-Based Diversion Initiative

The Connecticut School-Based Diversion Initiative (SBDI) is one example of how the expanded school mental health concept has been implemented in a school setting to meet the needs of at-risk students. The initial four years of SBDI implementation have resulted in a number of lessons learned among statewide stakeholders that may inform future efforts in Connecticut to develop an effective system of school-based mental health care.

SBDI BACKGROUND

SBDI was initially developed in 2008 with funding from the John D. and Catherine T. MacArthur Foundation's Models for Change Mental Health/ Juvenile Justice Action Network. The funding was awarded to the Connecticut Judicial Branch's Court Support Services Division (CSSD), which then selected the Connecticut Center for Effective Practice (CCEP), a division of the Child Health and Development Institute of Connecticut (CHDI), to coordinate and implement SBDI in schools beginning in the 2009-10 school year. Since that time, CSSD has partnered with the Department of Children and Families (DCF) and the State Department of Education (SDE) to jointly fund and oversee SBDI as a comprehensive model to address the concerns of school-based arrests and lack of access to community-based services. This collaborative funding approach has supported staffing of two part-time coordinators and a part-time project director at CHDI (staffing total of 1.2 FTE) and the expansion of the SBDI model, which has served 17 schools in nine Connecticut communities as of the 2012-13 school year (see Table 5).

SBDI: A BRIEF OVERVIEW OF A MODEL SCHOOL-BASED INITIATIVE

SBDI is a school-based initiative with three primary goals: 1) reduce the frequency of discretionary in-school arrests, expulsions, and out-of-school suspensions; 2) link youth who are at risk of arrest to appropriate school- and community-based services and supports; and 3) build knowledge and skills among school staff to recognize and manage behavioral health crises in the school. These goals are achieved through a number of core activities, briefly described below.

Training and professional development. Participating schools receive training and professional development activities to enhance competencies in the areas of mental health and

Table 5: Schools and Communities Participating in SBDI	
2009-10	Bridgeport: Luis Muñoz Marin School Southington: Joseph A. DePaolo Middle School; John F. Kennedy Middle School
2010-11	East Hartford: East Hartford Middle School Meriden: H.C. Wilcox Technical High School
2011-12	Manchester: Illing Middle School; Manchester High School Stamford: Cloonan Middle School; Westhill High School Waterbury: Crosby High School; Enlightenment School; Wallace Middle School
2012-13	Hartford: Academy of Engineering and Green Technology at Hartford Public High School; Culinary Arts Academy at Weaver High School; Sarah J. Rawson School New Britain: New Britain High School Waterbury: Crosby High School; Enlightenment School; Wallace Middle School; West Side Middle School

juvenile justice. These professional development activities are offered to school administrators, teachers, school social workers and psychologists, school resource officers, and other relevant personnel. Classroom teachers primarily receive training in areas that are most relevant to their day-to-day functioning, including effective classroom behavior management strategies and recognizing potential mental health symptoms. Other school personnel (e.g., administrators, school social workers and psychologists, school resource officers) receive training on how to link youth to school- and community-based services and supports. Through these activities, a number of school personnel develop or enhance core mental health and juvenile justice competencies that directly benefit students.

Enhanced linkages to school- and community-based services and supports. As described earlier in this report, most Connecticut schools do not have the recommended ratio of school social workers to student population, and these professionals often are "shared" across multiple schools within a district. With insufficient in-school capacity to address the number and severity of student mental health needs, SBDI staff work with school personnel to create new and enhance existing linkages with community-based mental health services and supports. A key service in this effort is Emergency Mobile Psychiatric Services (EMPS). EMPS provides mobile access to crisis stabilization services, screening and assessment, brief treatment, referral, and linkage to ongoing services and supports (as needed). Clinicians are available quickly, often in 30 minutes

"I feel comfortable with the School-Based Diversion Initiative in our school because it reduces the need to involve police and gets to the bottom of mental health issues." - *Hartford Teacher*

or less, which can provide school personnel with an alternative to arrest for students who are suspected to have unmet mental health needs. EMPS Crisis Intervention Services are provided free of charge to all Connecticut children, regardless of insurance status and the EMPS model has been shown to improve service delivery and child outcomes across the state[20]. Another important community-based service is Care Coordination, which uses a Wraparound approach to link students and their families to needed resources in the community to help promote healthy development and outcomes. Care Coordination services are funded by DCF and provided through local community-based children's mental health clinics and are specifically designed to serve youth with complex behavioral health needs across multiple service systems. In addition, SBDI staff work with schools to link them to Connecticut's system of care mental health collaboratives, Local Interagency Services Teams (LISTs), Youth Services Bureaus (YSBs), and other community services and supports that can help address unmet academic, health, and mental health needs.

School disciplinary policy consultation. Many schools do not adequately recognize the connection between student misbehavior and unmet mental health needs; in fact, between 60 and 80 percent of youth involved with the juvenile justice system have a diagnosable mental health condition. Recent juvenile justice reform efforts capitalize on a recognition that youth at risk for juvenile justice involvement often are better served in the less costly and less restrictive children's mental health system, where they often experience superior long-term outcomes relative to arrest and juvenile justice system placements (e.g., juvenile detention facilities). SBDI works with participating schools to ensure that their disciplinary policies and practices hold students accountable for misbehavior by strengthening existing in-school structures for discipline, while also ensuring that students are not arrested unnecessarily for relatively minor and/or non-violent behavioral incidents. A graduated response model for school discipline is adopted in participating schools in order to help them implement progressive discipline actions based on the frequency and severity of the behaviors they encounter. The graduated response model calls for use of less restrictive and severe disciplinary approaches whenever possible, and law enforcement involvement only as a last resort and for the most serious behaviors. Schools are encouraged to employ discipline strategies that emphasize the principles of restorative justice, which is an approach aimed at reducing conflict in a manner consistent with teaching and learning, rather than through exclusionary discipline or punishment. Examples of restorative practices in school discipline include mediation, group conferencing, and referral to a community-based juvenile review board.

SBDI AND THE EXPANDED SCHOOL MENTAL HEALTH FRAMEWORK

On the surface, SBDI is an example of a successful initiative with a relatively narrow set of goals focused on reducing school-based arrests. After several years of implementation, SBDI stakeholders have realized that the model and its lessons learned are relevant to the development of more comprehensive expanded school mental health initiatives. SBDI enacts the ten principles for best practice in expanded school mental health described by the University of Maryland (see Table 3) and addresses many of the six targeted intervention areas of expanded school mental health identified by the UCLA Center for Mental Health in Schools (see Table 4). To review, those six targeted intervention areas include: school and classroom-based approaches, crisis response strategies, transition supports, home involvement in schooling, community outreach, and family assistance. In Table 6 below, core SBDI activities are categorized according to these six targeted intervention areas. Because an individual activity may serve multiple purposes, some activities are listed on multiple targeted areas.

Table 6: SBDI Comprehensive System of Learning Supports

Target	Intervention
Classroom-Based Approach	• Staff training and professional development workgroups - Crisis de-escalation and effective classroom behavior management strategies (e.g., Good Behavior Game) - Understanding adolescent development and recognizing child trauma - Promoting positive school climate and connectedness • School discipline policy consultation and Graduated Response Model development
Crisis Response	• Increase awareness of, and referrals to, participating schools' local EMPS teams as an alternative to arrest • Staff training and professional development workgroups - Effective collaboration with EMPS and Care Coordination - Developing and implementing the Graduated Response Model - Restorative justice practices as alternatives to arrest • Establish Memoranda of Agreement - School and local EMPS team - School and local law enforcement agency • School discipline policy consultation and Graduated Response Model development

Table 6: SBDI Comprehensive System of Learning Supports (*continued*)	
Transition Supports	• Foster integration of school representatives into local and regional collaborative groups (e.g., community collaboratives, LISTs) • Promote best practices for family engagement - Linkage to family-based services (e.g., Care Coordination, Wraparound-based care, in-home treatment models) - Foster communication between home, school, and providers • Link to state level school climate initiatives • Staff trainings and professional development workgroups
Home Involvement in Schooling	• Engage and increase empathy for families with mental health needs (e.g., "Parents and Teachers as Allies" program of NAMI-CT) • Promote use of evidence-based and best practices in family engagement - Link to family-based services (e.g., Care Coordination, EMPS, Wraparound-based care, in-home treatment models) - Foster communication between home, school, and community-based providers to address the needs of at-risk students • Memoranda of Agreement - School-local EMPS team - School-police
Community Outreach	• Support community-level workgroups to facilitate development and implementation of Graduated Response Model and MOA with police and community agencies • Staff training and professional development workgroups - Effective collaboration with EMPS and Care Coordination - Understanding and partnering with the juvenile justice system - Overview of the Connecticut behavioral health system • Foster integration of school representatives into local and regional collaborative groups (e.g., community collaboratives, LISTs) • Facilitate local level collaborations through SBDI blended state funding structure between CSSD, DCF, and SDE
Student and Family Assistance	• Foster integration of school representatives into local and regional collaborative groups (e.g., community collaboratives, LISTs) • Promote best practices for family engagement - Link to family-based services (e.g., Care Coordination, Wraparound-based care, in-home treatment models) - Foster communication between home, school, and providers through EMPS utilization

Teachers often appreciate and benefit from additional training and skill development opportunities to help them deal effectively with behavioral incidents without inadvertently escalating the problems.

Further examples are provided below to demonstrate the ways in which SBDI activities conform to key areas of the expanded school mental health framework.

School and classroom-based approaches. Behavioral incidents that place students at risk for arrest often occur within the classroom environment; however, competencies to address mental health needs, manage difficult behaviors, and reduce risk for juvenile justice involvement are not generally a part of teacher training programs or in-service training. Teachers often appreciate and benefit from additional training and skill development opportunities to help them deal effectively with behavioral incidents without inadvertently escalating the problems. Through SBDI, classroom teachers are able to build awareness and skills around healthy adolescent development, identification of possible emotional and behavioral health challenges, and evidence-based strategies for classroom behavior management and crisis de-escalation (e.g., Good Behavior Game). These topics are facilitated by local experts in the community in order to build community capacity and promote sustainability after SBDI ends.

The SBDI approach also ensures that professional development needs are addressed beyond the classroom. Administrators, school resource officers, and school social workers and psychologists often are the critical decision makers when deciding how to hold students accountable for behavioral incidents, and also act as "gatekeepers" for mental health service referrals. SBDI staff work with these individuals to develop a graduated response model of discipline intervention, based on the model developed in Connecticut by the Juvenile Justice Advisory Committee. A graduated response model is a structured approach to responding to in-school behavior incidents using a tiered model of disciplinary interventions based on intensity and frequency of problem behaviors. Minor policy violations and non-violent behaviors are addressed at the classroom level, administrative interventions are reserved for more serious or repetitive offenses, and formal interventions by law enforcement/ school resource officers are used only as a last resort. At any stage in the disciplinary process, if school personnel detect a possible mental health concern, they are encouraged to refer students to school- and community-based services and supports (e.g., EMPS, Care Coordination) as preventative and early interventions. Schools are also encouraged to incorporate restorative justice practices such as mediation, peer support, and referral to community-based review panels (e.g., Juvenile Review Boards) and strengthen home-school-community connections whenever possible.

Crisis response strategies. Youth experiencing an acute behavioral health crisis in school can be particularly vulnerable to unnecessary police intervention and arrest. They require behavioral health services and supports that are often not readily or rapidly available within schools. To address this need, SBDI facilitates a stronger connection between schools and their local EMPS team to enhance existing school-based services and ensure the availability of crisis

response. EMPS is a statewide mobile crisis response program that responds to schools quickly—often within 30 minutes—to support students experiencing behavioral health challenges. EMPS is available statewide to every school and community free of charge. They offer mobile response, crisis stabilization, assessment, brief treatment, and linkages to ongoing care provided by specialized clinicians. Follow-up services through EMPS are generally provided in the school or the student's home. Schools have historically underutilized this resource due to a lack of awareness, and in some cases, a history of inconsistent collaboration with the broader mental health provider community. SBDI facilitates development of a Memorandum of Agreement (MOA) between the school or school district and the local EMPS provider to promote increased utilization, strengthen relationships, and build mutual support.

In addition, part of the process for establishing a graduated response model of discipline intervention involves MOA development between school districts and their local police departments. Through collaborative workgroups, SBDI helps schools develop a written agreement that clearly articulates the roles and responsibilities of schools and police in implementing alternative discipline and crisis response policies and practices. These agreements can be helpful to schools and police as they work together to support school safety, promote effective interventions, and ensure appropriate use of diversion from exclusionary discipline.

Transition supports. The expanded school mental health framework incorporates supports for students during transition periods as a way to promote improved youth outcomes. School transitions such as changing schools, advancing between grade levels, and even daily schedule changes can restrict school engagement and trigger emotional dysregulation, particularly for students receiving or in need of educational or behavioral services. Structured activities during transition periods may include efforts such as welcoming and orienting students and families who are new to the school, offering counseling or summer bridge programs for students entering a new grade, or providing before and after school activities for students. These efforts help prevent emotional-behavioral challenges, promote school connectedness, enhance social development, and improve positive attitudes towards school.

SBDI enacts this principle of transition supports primarily through promoting positive school climate and primary prevention at the school level and linking schools to state-level school climate initiatives and resources. To promote transition supports at the secondary and tertiary levels of prevention, SBDI facilitates workgroups with school staff to improve communication between the school, home, and community to provide and monitor services and supports to individual students. Workgroups typically involve a small group of key individuals (e.g., school social workers, guidance counselors, school psychologists, special education teachers, paraprofessionals, safe school climate specialists/coordinators, administrators, and school resource officers or security personnel)

EMPS is a statewide mobile crisis response program that responds to schools quickly ... to support students experiencing behavioral health challenges.

who are directly involved in behavior management, enforcement of discipline policies and procedures, referrals for students to interventions and supports, and interactions with community-based providers. Workgroups allow staff to problem-solve, brainstorm, discuss, and interact with topic experts and local providers around service delivery processes; to enhance interagency communication and collaboration; increase the capacity of staff to manage behavioral health crises in schools; improve access and support for families; and facilitate the service referral and follow-up process, resulting in better transitions and outcomes for students.

Home involvement in schooling. Reducing barriers to youth development and learning is a key component of SBDI consultation to schools. When students are referred to EMPS by schools, SBDI staff work closely with school personnel and EMPS providers to ensure that post-referral communication and coordination of treatment efforts are consistent and generalizable across developmental settings including the home, school, and community. Additionally, SBDI supports schools in developing and customizing building-level efforts to engage parents of at-risk students. For example, as a result of participation in SBDI, one participating school initiated a program for suspended students that provided home visits by the school social worker and school resource officer to build relationships with the family and address barriers in order to reduce the risk of subsequent suspension and possible arrest. Even though SBDI staff do not work directly with students and their families, the training, consultation, and community linkages facilitated by SBDI are grounded in best practices for improving the home-school connection.

Community outreach. To facilitate ongoing services for students with multiple or intensive needs, SBDI promotes the integration of schools into local and regional interagency collaborations including local care coordination providers, system-of-care community collaboratives for youth with mental health needs, and LISTs for youth with juvenile justice involvement. These resources have always been available to schools, but many of these collaborative entities have historically struggled to reach school personnel and achieve an active level of school participation. As described earlier, discipline policies and practices are revised by a workgroup of school professionals, and other key community stakeholders such as EMPS and other community mental health providers, local law enforcement, court and probation staff, and families. This community stakeholder group provides oversight to the development and implementation of a graduated response model and helps ensure development of MOAs with police or service agencies. Finally, SBDI achieves community collaboration and outreach at the state level through a blended funding structure that involves three state agencies: CSSD, DCF, and SDE. This collaboration helps to align the goals and priorities of multiple state agencies that often have much in common when it comes to their desire to meet the needs of at-risk youth.

Student and family assistance. EMPS services are a critical point of access and first step to facilitating referrals to link students with appropriate community-based services. EMPS also works to coordinate access to ongoing supports as needed to address student needs and improve behavioral and academic outcomes. Specific community-

based services such as Care Coordination employ a strengths-based, family-driven, team-based approach to encourage information sharing and parent-led decision making, resulting in development of a family care plan that is shared and monitored among all team members. It is a common goal of Care Coordination to ensure that students and their families have access to the resources they need to promote school success and healthy development for students and their families. Through SBDI, school personnel also become more aware of locally available services and build empathy and understanding of the family experience for caregivers of youth with emotional and behavioral challenges.

SBDI OUTCOMES

SBDI staff collect and track key indicators at the school and community levels to assess changes in rates of arrest, suspension, expulsion, and EMPS referral as a result of enhanced school mental health and discipline policies and practices implemented during SBDI participation. Results of data collected from an initial sample of participating SBDI schools in the 2010-2012 school years indicate:

- In-school arrests decreased 50-69% per school
- On average, in-school suspensions dropped by 9% and out-of-school suspensions dropped by 8%
- EMPS utilization tripled, while ambulance calls decreased by up to 22%

Data from all 17 participating schools indicate the following results for the 2012-13 school year:

- School-based court referrals decreased 19% across SBDI schools, with one inner-city school decreasing by 92%
- EMPS referrals from SBDI schools increased 44% overall

SBDI also partners with Dr. Maria O'Connell to conduct an external evaluation of the initiative. Data comparing EMPS crisis intervention utilization rates and CSSD court referral data for communities with SBDI compared to similar communities without SBDI indicated that:

- Communities participating in SBDI during the 2010-11 school year had a significantly higher rate of referral to EMPS compared to non-SBDI comparison communities (see Figure 1).
- Youth served by EMPS had fewer subsequent court referrals the following year (11%) compared to those referred directly to court (42%) for an in-school behavior incident, regardless of prior court involvement.
- Youth initially referred to EMPS specifically for disruptive behavior had fewer subsequent court referrals (12.5%) compared to those initially referred to court (41.3%, see Figure 2).

Figure 1: Increased Rate of Referrals to EMPS Crisis Intervention in SBDI Communities and Non-SBDI Comparisons

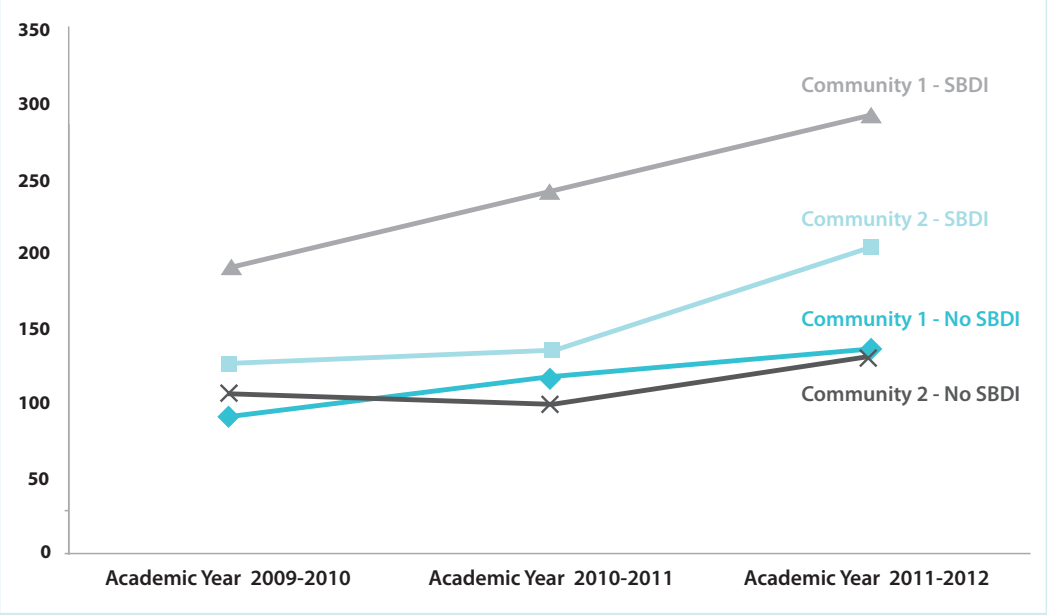

Figure 2: Reduced Subsequent Juvenile Court Involvement for EMPS-Referred Youth

		Youth referred to EMPS for disruptive behavior or CSSD		
		Initial Referral System		
		EMPS	CSSD	Total
No Subsequent CSSD Involvement	N	224	537	761
	%	87.5%	58.7%	65.0%
Subsequent CSSD Involvement	N	32	378	410
	%	12.5%	41.3%	35.0%
	Total	256	915	1171

Of youth who were initially referred to EMPS for disruptive behavior, only 12.5% had subsequent CSSD involvement, compared to 41.3% of youth referred to CSSD

"I believe that our staff is more knowledgeable about the problems and issues that affect our students and that it's NOT JUST a blame game anymore. We just need to work together to get students the help they need!" - *Hartford Teacher*

SUMMARY

The expanded school mental health framework is an innovative approach to enhancing school- and community-based services and ensuring that students' mental health needs are met so as to promote positive outcomes. Ten principles and six targeted intervention areas have been developed that have guided national implementation efforts. The six targeted intervention areas may offer the most promise for guiding expanded school mental health efforts: classroom-based approaches, effective crisis response services, transition supports, home-school coordination, community collaboration, and student and family assistance. In Connecticut, SBDI is just one example of how the principles of expanded school mental health can be implemented in school settings to achieve positive outcomes for schools and students. Recommendations based on the lessons learned from SBDI implementation may be useful for guiding and organizing the state's efforts towards improving the mental health and academic outcomes for youth.

Additional expanded school mental health efforts are required in order to ensure that students have access to school- and community-based services. In the current climate of limited capacity and expanding needs following the tragedy at Sandy Hook, a well-articulated framework is urgently needed to guide policy development and systems reform utilizing existing resources. The following recommendations are provided to guide integration of expanded school mental health principles through a comprehensive framework for systems collaboration.

RECOMMENDATIONS

1. **Use the expanded school mental health framework, and its ten principles and six targeted intervention areas, to plan and develop a statewide system of school-based mental health services and supports.** As outlined in this report, the ten principles and six targeted intervention areas of expanded school mental health can help guide comprehensive efforts to develop an effective system that works for all students. This framework may be helpful for aligning the various ongoing efforts within the state into a comprehensive and coordinated strategy.

2. **Ensure that school personnel receive adequate in-service training in mental health competencies.** Competencies can be identified that are differentiated by the roles and responsibilities of one's position within the school (e.g., administrators, school resource officers, social workers and psychologists, classroom teachers) and training can be offered to ensure that all school personnel are prepared to meet the mental health needs of students.

3. **Expand the number of school social workers and psychologists to minimum standards.** Connecticut should consider investing the necessary resources to ensure that schools have the capacity to meet the mental health needs of students.

4. **Ensure that the community-based mental health system has the capacity to meet the current demand for services.** Services such as EMPS and Care Coordination are important resources to schools but are underutilized. Increased school awareness and utilization of these services can be met with sufficient resources to ensure that these services are prepared to meet growing demand over time.

5. **Require MOAs between schools and community mental health providers, and between schools and their local law enforcement agencies.** Building partnerships between and among schools, community mental health agencies, and local law enforcement through initiatives such as the School-Based Diversion Initiative (SBDI), which provide models for diversion and community collaboration, are effective ways to specify roles and responsibilities when it comes to expanded school mental health efforts and juvenile justice reforms.

6. **Support legislation that addresses the need for expanded school mental health initiatives.** A number of excellent bills have been proposed to address the areas described in this report but not all have been passed. State advocacy organizations can continue to garner widespread support for legislation that addresses the need for expanded school mental health initiatives.

7. **Systematically reduce over-reliance on exclusionary discipline practices such as arrest, expulsion, and out-of-school suspensions.** Though Connecticut has made tremendous progress in this area, there are still too many students being excluded from the normal school experience because of relatively minor or non-violent behavioral incidents. Schools (especially those with higher rates of arrest, expulsion, and suspension) can be encouraged or required to implement reforms to their disciplinary policies and practices by developing and implementing a graduated response model of disciplinary intervention and taking other steps that hold students accountable for misbehavior but keep them in school whenever possible.

8. **Strengthen school and community capacity to respond to crisis behavioral health concerns.** Schools can be required to develop plans that take into consideration the mental health needs of students in times of crisis. EMPS is a key community-based service for building school and community capacity in this area.

9. **Provide incentives for schools and communities to ensure that schools are active and full participants in local community collaboratives and Local Interagency Services**

Teams (LISTs). Collaboration between schools and community partners is necessary for an enhanced school mental health framework to be successful, yet limited staffing of key school personnel serves as a barrier preventing their attendance at community meetings during the school day. Incentives that reduce these barriers in the form of release time or staff coverage to attend meetings, technology that allows for phone or video conferencing, and structured agendas that prioritize information relevant to schools at a designated time in the meeting are examples of strategies to increase participation and collaboration.

10. **Support the expansion of school-based health centers in Connecticut.** School-based health centers are an effective way to meet the health and mental health needs of all students, including those who are at highest risk for negative outcomes. To be most effective, full access to mental health services, including crisis intervention, mental health screening, and counseling, must be fully included in the scope of service.

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