From the Ground Up: Designing, Implementing, and Sustaining a Tier-III Mental Health Transition Program

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Methuen, Massachusetts
Overview of Presentation

An Identified Need
- Tier-III mental health service delivery in schools
- Mental-health related absences - how are we supporting students’ return to school?
- Data on MHS-specific need

Consultation: BRYT Model
- Existing program model in MA & beyond
- 4 Domains of BRYT model
- Making the hypothetical tangible - what do we need to make this successful at MHS?

Implementation & Sustainability
- Grant funding
- Advocacy
- Consultation
- Building & maintaining buy-in from school and community stakeholders
- Data-tracking

Data Tracking, Progress Monitoring
- How do we know the impact we’re having?
- Cognitive-Behavior Therapy; Dialectical Behavior Therapy
- Progress monitoring

Case Study
- Overview of student data from re-entry to termination from Bridge program during 2018-19 school year
An Identified Need
National Context of Mental Health Needs

20% of students will experience a mental health problem of mild impairment.

10% of students will experience a mental health problem of severe impairment.

“Half of all lifetime cases begin by age 14; three quarters have begun by age 24. Thus, mental disorders are really the chronic diseases of the young.”

-National Institute of Mental Health (2019)
National Context of Mental Health Needs (cont.)

Fact: 1 in 5 children ages 13-18 have, or will have a serious mental illness.¹

- 20% of youth ages 13-18 live with a mental health condition¹
- 11% of youth have a mood disorder¹
- 10% of youth have a behavior or conduct disorder¹
- 8% of youth have an anxiety disorder¹

National Alliance on Mental Illness (NAMI) (2019)
National Context of Mental Health Needs (cont.)

300%
Over the past 20 years, the number of students hospitalized for psychiatric disorders has increased by nearly 300 percent.³

5
In a typical class of 25, five students will experience a mental health problem that gets in the way of school and daily routines.⁴

1/2
Roughly half of all psychiatric disorders begin in the teenage years.⁵

50%
About 50 percent of students aged 14 and over diagnosed with emotional and/or behavioral disorders drop out of school.⁶

3,041
Suicide is attempted on average 3,041 times each day by youth in grades nine through 12 nationwide.⁷

BRYT Notes (2018). The Brookline Center for Community Mental Health
National Context of Mental Health Needs (cont.)

- **Impact**
  - **50%**
    - 50% of all lifetime cases of mental illness begin by age 14 and 75% by age 24.\(^1\)
  - **10 yrs**
    - The average delay between onset of symptoms and intervention is 8-10 years.\(^1\)
  - **37%**
    - 37% of students with a mental health condition age 14 and older drop out of school—the highest dropout rate of any disability group.\(^1\)
  - **70%**
    - 70% of youth in state and local juvenile justice systems have a mental illness.\(^1\)

- **Suicide**
  - **3rd**
    - Suicide is the 3rd leading cause of death in youth ages 10 - 24.\(^1\)
  - **90%**
    - 90% of those who died by suicide had an underlying mental illness.\(^1\)
The city of Methuen is located approximately 26 miles north of the heart of Boston. Seated adjacent to the southern border of New Hampshire, major neighboring cities include Lawrence & Lowell, MA, and Nashua, NH. Methuen Public Schools serves approximately 7,000 students, and the high school sits at an enrollment of about 2,000 students.
Methuen: Risk Factors + National Data

Low SES population
- One of the most replicated findings regarding mental health suggests that low SES populations are at an increased risk for developing mental health problems (McLaughlin et al., 2012)
- Decreased access to community mental health

Higher than average rate of DCF-involved youth
- Exposure to trauma
- Insufficient support networks
- High rate of transition between placements (MA Department of Children & Families, 2017)

High mobility rate
- Higher than average rate of students who require acclimation and need to reestablish a support network, sometimes while contending with ESL challenges (Adkins et al., 2016)

Below average educational attainment per capita
- Parental educational attainment impacts children’s emotional and cognitive development (McGill University, 2016)

Regionally located in an area with a high-incidence of opiate use
- Caregiver, family, & student drug use impact on mental health (NIDA, 2017)
Mental Health Needs at Methuen High School

*The Case for Ramped-Up Tier-III Support*

- **District-wide universal mental health screening** - PHQ-9 & GAD-7
- **Tier-I: Universal Supports and Interventions; Promotion & Prevention Practices**
  - Promoting positive mental health in ALL students
  - SEL, PBIS, Connections
- **Tier-II: Targeted/Selected/Group Supports and Interventions**
  - Focus on students at-risk of developing a mental health challenge
  - Group Therapy
- **Tier-III: Intensive/Individualized Supports and Interventions**
  - Focus on students experiencing a mental health challenge
  - *Increased need for intensive Tier-III support*
Why Mental Health in Schools?

Due to many barriers to receiving quality community-based care, public schools are often the safety net for students with mental health and medical disorders.

- Lack of hospital care
- Lack of aftercare resources
- Inadequate insurance coverage
- Lack of outpatient mental health treatment
- Limitations of special education funding
- DCF policies
- Fragmented service systems

The Brookline Center for Community Mental Health (2019)
Mental Health Services in the Community

- Students who are able to bypass the barriers to receiving mental health services in the community show extraordinarily low rates of persistence in treatment.
- Attrition rates increase drastically after each session.
- What does this mean for school mental health providers?

We cannot assume that anyone else is going to provide mental health services to our students.
Notable findings in the case for therapeutic services in schools

- Over the past 4 years, between 5-9% of students at MHS scored within the Moderately Severe and Severe ranges on the Patient Health Questionnaire-9 (PHQ-9), a nine-item depression scale
  - Following identification and provision of services to 189 students, 87.5% of students reported a decrease in symptom presentation
- Over the past 4 years, between 13-23% of students at MHS scored within the Moderate and Severe ranges on the Generalized Anxiety Disorder-7 (GAD-7), a seven-item anxiety scale
  - Following identification and provision of services to 162 students, 78.9% of students reported a decrease in symptom presentation

We know that screening students for mental health issues can and will identify students who are struggling, and that providing therapy in schools can and will make the difference for many of these students. How are we servicing students who might need more support or who have experienced a mental health crisis that causes them to miss a substantial amount of school?

Crocker (2019)
Case Vignette: Jessica, a senior at your school, has struggled with depression off and on throughout high school, but has maintained good attendance, grades, and extracurricular/peer engagement for the past three years. However, as a result of a family member’s cancer diagnosis and some peer conflict, Jessica’s mood has deteriorated, she has missed several days of school, her grades have slipped, and she has been withdrawing from the things that she previously enjoyed. Recently, Jessica disclosed that she has been having suicidal ideation and was referred for psychological evaluation, where she was then referred to a 10-day partial-hospitalization program. She is now returning back to school after missing 14 consecutive school days.

Turn & talk with your neighbor about the following questions:

1. In order for Jessica to successfully return back to school, what supports are she and her family likely to need? Consider from both an academic and social-emotional standpoint.
2. In your school, what would be her likely experience, and how does that compare to the supports you just described?
Consultation: BRYT Model

Developed & sustained by the Brookline Center for Community Mental Health, Brookline, MA
Overview of BRYT Model

Staff, Services, Space, Students

1. **Staff**: 1.0 FTE clinician (school counselor, adjustment counselor, or social worker); 1.0 FTE academic coordinator (teacher or classroom aide/tutor)
2. **Space**: dedicated, private space in school; near an exit; academic and therapeutic space; accessibility of private meeting space
3. **Services**: 4 domains: academic coordination, clinical care, family engagement, care coordination
4. **Students**: program cap; priority population

**Academic Coordination**
- Academic support (tutoring)
- Communication/negotiation with teachers
- Teacher support

**Clinical Care**
- Intentional clinical support tailored to students’ presenting problems
- On-demand supports
- Crisis intervention (when needed)

**Family Engagement**
- Frequent, culturally-appropriate communication with parents
- Sharing progress/needs
- Offering support & learning/leadership opportunities

**Care Coordination**
- Communication/collaboration with in-school and out-of-school service providers
- Connection to outside service providers as needed

The Brookline Center for Community Mental Health (2019)
Priority Population

**Category H:** Students returning from hospitalization who have missed at least 5 consecutive school days and are identified through the referral and entry process as in need of the Bridge program.

**Category N:** Students who have not been hospitalized but have missed extensive amounts of instruction and are judged as in need of, but have yet to access, intensive mental health supports and are at serious academic risk due to related behaviors such as school avoidance.

The Brookline Center for Community Mental Health (2019)
BRYT Network Statistics (2017)

<table>
<thead>
<tr>
<th>COUNTING ON CARE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>85%</td>
<td>85% of participants graduate or are on track to graduate by the end of the year.</td>
</tr>
<tr>
<td>8%</td>
<td>BRYT participation reduces the dropout rate for students with serious mental health issues from 50% to 8%.</td>
</tr>
<tr>
<td>113,300</td>
<td>Across Massachusetts, 102 BRYT Network schools create a mental health safety net for more than 113,300 students.</td>
</tr>
</tbody>
</table>
Bridge Room at MHS
BRIDGE ALUMNI
ADVICE WALL

WHAT'S ONE THING THAT
YOU'LL MISS OR TAKE AWAY
FROM BRIDGE?

1. The family of solidarity.
2. The best coffee in town.
3. The student activities community and fun.
4. The sense of belonging.
5. The quirky staff members.
6. The amazing food.
7. The diversity of cultures and perspectives.
8. The open-mindedness.
9. The beautiful campus.
10. The lifelong friendships.

WHAT WOULD YOU TELL A STUDENT ENTERING BRIDGE FOR THE FIRST TIME?

1. Enjoy the experience and be open to new things.
2. Get involved in activities and organizations.
3. Make new friends and connections.
4. Take advantage of the resources available.
5. Balance your time between academics and extracurricular activities.
6. Stay positive and, when things don't go as planned, be flexible.
7. Embrace the challenge and growth.
8. Seek out mentors and advisors for guidance.
9. Take care of your mental and physical health.
10. Remember, Bridge is not just about the courses, but the journey as well.
Implementation & Sustainability
Our Implementation Timeline

17-18 School Year
- Identify need, consult, and advocate for program

August 2018
- Hire new staff - $ from Title IIA/IVA grant

Ongoing (18-19 School Year)
- Provide updates to Superintendent & Director of Student Services

Ongoing (18-19 School Year)
- Track & organize data - psychosocial, academic, attendance

June 2019
- Share & report out on data to advocate for program sustainability - Accountability Report
Our data related to advocacy, implementation, & sustainability 2018-19

The most common diagnoses serviced through the Bridge program during the 2018-19 school year were *anxiety and mood disorders.*
Almost half of the students serviced in Bridge during the 2018-19 school year were not receiving therapeutic services outside of school for a variety of reasons before referral to the program. This further makes the case for the importance of making student support available in school.

<table>
<thead>
<tr>
<th>Clinical Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Therapy</td>
<td>56%</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>13%</td>
</tr>
<tr>
<td>Psychotropic Medication</td>
<td>31%</td>
</tr>
<tr>
<td>Hospitalized (Behavioral Issue)</td>
<td>25%</td>
</tr>
<tr>
<td>Hospitalized (Medical Issue)</td>
<td>0%</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>13%</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>31%</td>
</tr>
<tr>
<td>Court-Involved</td>
<td>0%</td>
</tr>
<tr>
<td>Residential School</td>
<td>0%</td>
</tr>
<tr>
<td>Nothing Checked</td>
<td>31%</td>
</tr>
</tbody>
</table>
These data in the adjacent chart reflect program-wide admission and termination symptom presentation and school functioning as generated through the Child and Adolescent Functional Assessment Scale (CAFAS).
Sustainability

What type of data did we collect to make the case for Bridge continuing past year 1?

- Attendance - days and blocks
- Psychosocial data
- # of weeks in the program by student
- # referrals and program students
- Students tracked to drop out and prevented
- Grades and credit attainment
- Program graduates
- Home-hospital tutoring* prevention
- Qualitative data from parent/student/staff observations

<table>
<thead>
<tr>
<th>Student</th>
<th>Weeks in Bridge</th>
<th>$ District Saved w/o Home Hospital Tutoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student 1</td>
<td>29</td>
<td>$6,960</td>
</tr>
<tr>
<td>Student 2</td>
<td>29</td>
<td>$6,960</td>
</tr>
<tr>
<td>Student 3</td>
<td>12</td>
<td>$2,880</td>
</tr>
<tr>
<td>Student 4</td>
<td>6</td>
<td>$1,440</td>
</tr>
<tr>
<td>Student 5</td>
<td>17</td>
<td>$4,080</td>
</tr>
<tr>
<td>Student 6</td>
<td>26</td>
<td>$6,240</td>
</tr>
<tr>
<td>Student 7</td>
<td>13</td>
<td>$3,120</td>
</tr>
<tr>
<td>Student 8</td>
<td>8</td>
<td>$1,920</td>
</tr>
<tr>
<td>Student 9</td>
<td>14</td>
<td>$3,360</td>
</tr>
<tr>
<td>Student 10</td>
<td>4</td>
<td>$960</td>
</tr>
<tr>
<td>Student 11</td>
<td>10</td>
<td>$2,400</td>
</tr>
<tr>
<td>Student 12</td>
<td>9</td>
<td>$2,160</td>
</tr>
<tr>
<td>Student 13</td>
<td>9</td>
<td>$2,160</td>
</tr>
<tr>
<td>Student 14</td>
<td>12</td>
<td>$2,880</td>
</tr>
<tr>
<td>Student 15</td>
<td>8</td>
<td>$1,920</td>
</tr>
<tr>
<td>Student 16</td>
<td>19</td>
<td>$4,560</td>
</tr>
</tbody>
</table>

Total: $54,000

*HHT: $240 per week per student paid by the district if student is unable to attend school due to medical/mental health reasons (over 14 days)
Data-Tracking & Progress Monitoring
Activity #2: Turn & Talk

How do we know the impact we are having with our students through Tier-III services?

Turn & talk with your neighbor about the above question. In your discussion, consider the following discussion questions:

1. How do we make informed decisions about a student’s progress in therapy?
2. What language do we use to share with students regarding their progress in therapy?
3. When do we adjust our practice?
4. How do we determine when to terminate therapeutic services?
The simple answer to these questions... DATA!!
The Case for Data

- How we know how we’re doing
- Making adjustments to practice
- Tracking symptom presentation & emotional regulation - is student improving in **target areas**?
- **Teachable moments** - naming student’s progress, visual representations - does this reflect your experience?
  - Allows for better conversation regarding what’s working, what’s not working - goal setting
- Therapy is not (and **should not** be) forever - informs **timeline for termination**
Cognitive-Behavioral Therapy & Dialectical Behavior Therapy: a Hybrid Approach

**CBT**
- Thoughts, feelings, behaviors
- Structured, short-term, goal-oriented, focus on present
- Starts with psychoeducation about the illness/presenting problem(s) → learn about skills to practice to challenge unproductive thoughts, feelings, and behaviors
- **Weekly clinical sessions** to track progress

**DBT**
- Based on CBT with a greater focus on emotional and social aspects
- More **frequent exposure to therapist** & skill-building, longer treatment
- Greater focus on validation, acceptance, and relationships
- Changing behavior in the moment to change thoughts, feelings, & behaviors long-term
- Frequent check-ins

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*Which of these evidence-based therapeutic approaches works best for your students and your practice? Be intentional & consistent!*

Data is paramount in decision-making

What types of data do we track?

Student attendance by day & class block (≥80% day/class attendance is a good indicator of readiness for graduation)
  ● Tracked via school-wide student-management software

Student grades
  ● Tracked via school-wide student-management software & through collaboration with teachers

Psychosocial progress - has the student decreased adverse symptom presentation in the areas of concern?
  ● Baseline data upon student admission to program & biweekly screeners using same measurements
  ● *ex.) Student X presents with depressive symptoms as reflected in conversation with you (the counselor) and in PHQ-9 & BADS-LF data. Has he expressed changes in these symptoms as recorded over time? Have his scores on biweekly screeners gone down to the point that they are no longer in an actionable range?*

Student engagement - is student engaged in school & feel ready to transition back to full schedule?
Has this engagement increased from time of entry to graduation?
  ● Baseline & biweekly data - same measurements throughout
Tracking Data

**Google Suites: Forms, Sheets**

- Student takes **same** screeners biweekly via password-protected Google Forms and/or paper-based screeners
- Graphical representation of data
  - **Talking points** with student
  - Psychosocial data - **decrease** in symptom presentation maintained over time suggests **readiness** for termination
  - Individual student vs. program-wide data - **program sustainability**
Psychosocial Progress Monitoring

- School-wide passive consent policy
- Choosing screeners based on presenting problems
  - Not everyone has anxiety and depression
  - Mental health concerns present **differently** in different people, and can even change in symptom presentation in the same person over time
- **Example: Behavioral Activation for Depression Scale - Long Form (BADS-LF)**
  - Scale produces one overall score and four subscores each targeting a different form of depressive symptom presentation
    - **Activation subscale (AC):** Higher score indicates greater levels of behavioral activation
    - **Avoidance/Rumination subscale (AR):** Higher score indicates greater avoidance/rumination behaviors
    - **Work/School Impairment subscale (WS):** Higher score indicates greater work/school impairment
    - **Social Impairment subscale (SI):** Higher score indicates greater social impairment

Kanter et al. (2007)
### BADS-LF Sample Items

<table>
<thead>
<tr>
<th></th>
<th>AC</th>
<th>AR</th>
<th>WS</th>
<th>SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. I did things to cut myself off from other people.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>21. I took time off of work/school/chores/responsibilities simply because I was too tired or didn’t feel like going in.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>22. My work/schoolwork/chores/responsibilities suffered because I was not as active as I needed to be.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>23. I structured my day’s activities.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>24. I only engaged in activities that would distract me from feeling bad.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>25. I began to feel badly when others around me expressed negative feelings or experiences.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

**Activation subscale (AC):** Higher score indicates greater levels of behavioral activation  
**Avoidance/Rumination subscale (AR):** Higher score indicates greater avoidance/rumination behaviors  
**Work/School Impairment subscale (WS):** Higher score indicates greater work/school impairment  
**Social Impairment subscale (SI):** Higher score indicates greater social impairment  

Kanter et al. (2007)
Case Study - MHS Bridge
Student 2018-19
Details of Referral

- Student presenting with depressive symptoms related to recent breakup, declining grades, self-image issues, and overall feeling of lack of purpose/direction (September 2018)
- Referral for psych evaluation due to suicidal ideation (October 2018)
- Student receiving individual therapy with school counselor & went through depression group counseling at MHS; still exhibiting sporadic absences from school, parents expressing concern (November-December 2018)
  - Unable to engage in group therapy services - attended one session then was absent during the rest of the group meetings
- Referred to & added to Bridge (December 2018)
- Graduated from Bridge (May 2019)
  - 19 weeks formally enrolled in program, experienced a 5-week absence due to health issues (pneumonia, flu) - graduated 6 weeks after return from illnesses
Results:

Student entered Bridge after attending 0% of classes. Slight increases over time, with a few decreases due to absences. Upon time of Bridge graduation, student maintained 90% class attendance per day per week over a 3-week period.
Psychosocial Data

Results:

100% decrease in depressive symptom presentation over 12 weeks, moving from Moderate to None-Minimal range (PHQ-9)
100% decrease in anxiety symptom presentation over 8 weeks, maintaining None range (GAD-7)
Results:

146.6% increase in behavioral activation over 14 weeks, moving from Low-Average to High level of activation (scale= 0-150) (BADS-LF)
Results:

11.1% increase in self-esteem over 12 weeks, maintaining in the Normal range (RSES)
Results:

4.7% increase in student engagement over 8 weeks, maintaining in the High Engagement range (SEI)
Wrap-Up, Questions, & Contact Information

Questions?

For further information or follow-up conversation, contact:

**Alison Sumski, Bridge Program Support Specialist, ansumski@methuen.k12.ma.us**
References


