

Orange County Public Schools



WINNER

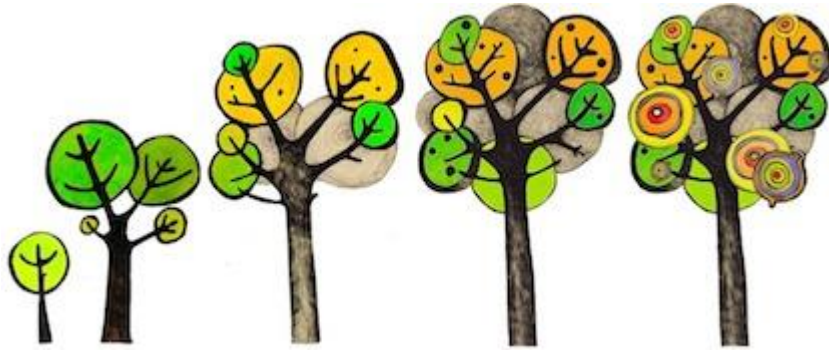
the broad prize
for urban education



The Evolution of a Successful
School-Based Mental Health Model

11/6/2015

- Community/School conversations around unmet MH needs of children

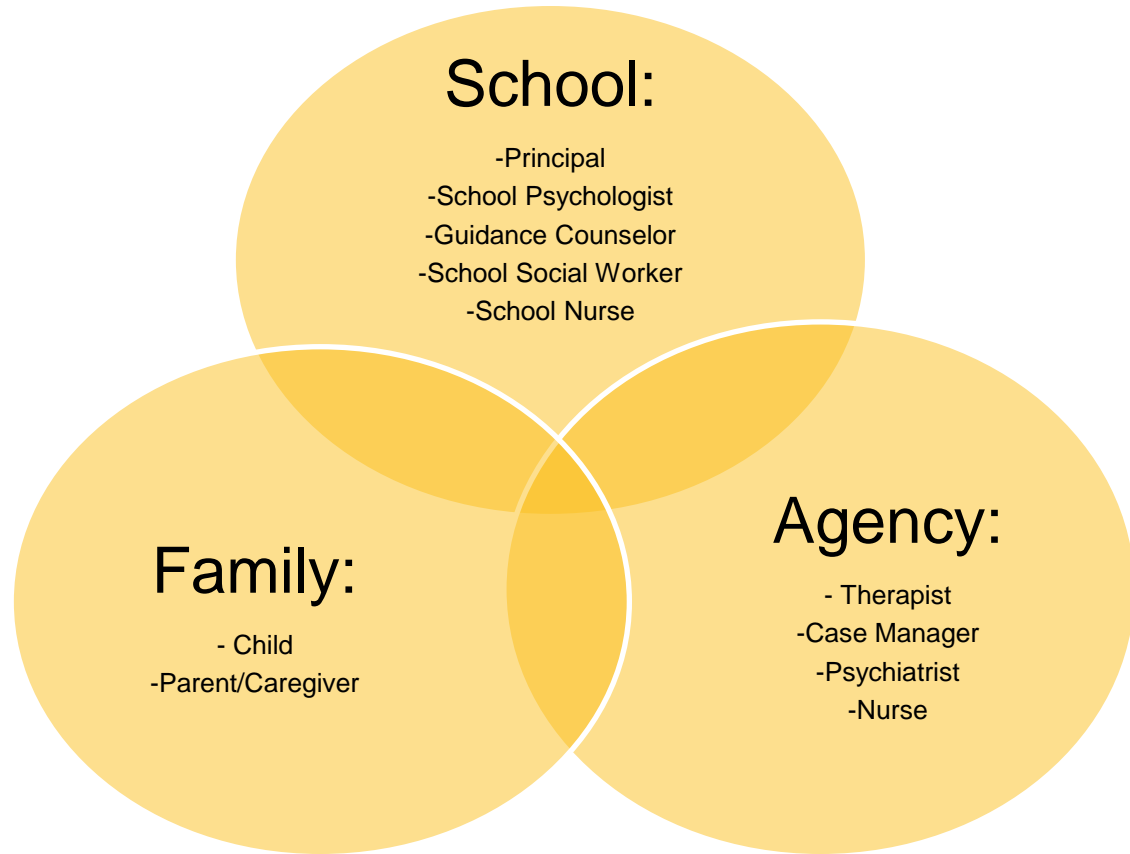


HOW IT ALL BEGAN

The early 1990's

- Intent: serve most severe SED students
- 2 Special Day Schools and 1 Elementary Site
- 2 Community Mental HealthPartners
- Cooperative Agreement defined roles and expectations of the partnership

Monthly Team Meetings



Funding Streams

- Medicaid Billing
 - Case management
 - Therapy
 - Psychiatrist/medication monitoring
- Cost Sharing by School District
 - Psychiatrist monthly visit at school sites
- Family Services Planning Team(FSPT) state funding for non-Medicaid billable services such as mentoring, tutoring, karate class, art classes, modeling lessons

Model Adapts

- Original model existed for 3 yrs.
- Needed to adapt
 1. Too costly for full continuum (funding)
 2. Expansion to more schools
 3. Education focus on least restrictive setting (move toward gen. ed.)
- In home/ In school model defined

Expansion Phases

- Elementary pilot sites were successful
- More schools requesting services
- Desire to serve more than just SED (include at-risk and gen. ed. population)
- Number of schools increased to 15 in three years
- Number of provider agencies increased in relation to additional schools.

District-wide Expansion

- Presentation to all Principals
- Not all schools opted in
- Designated point person at schools that opted in
- Clearly defined roles and responsibilities of each party

All Good Things Take Time

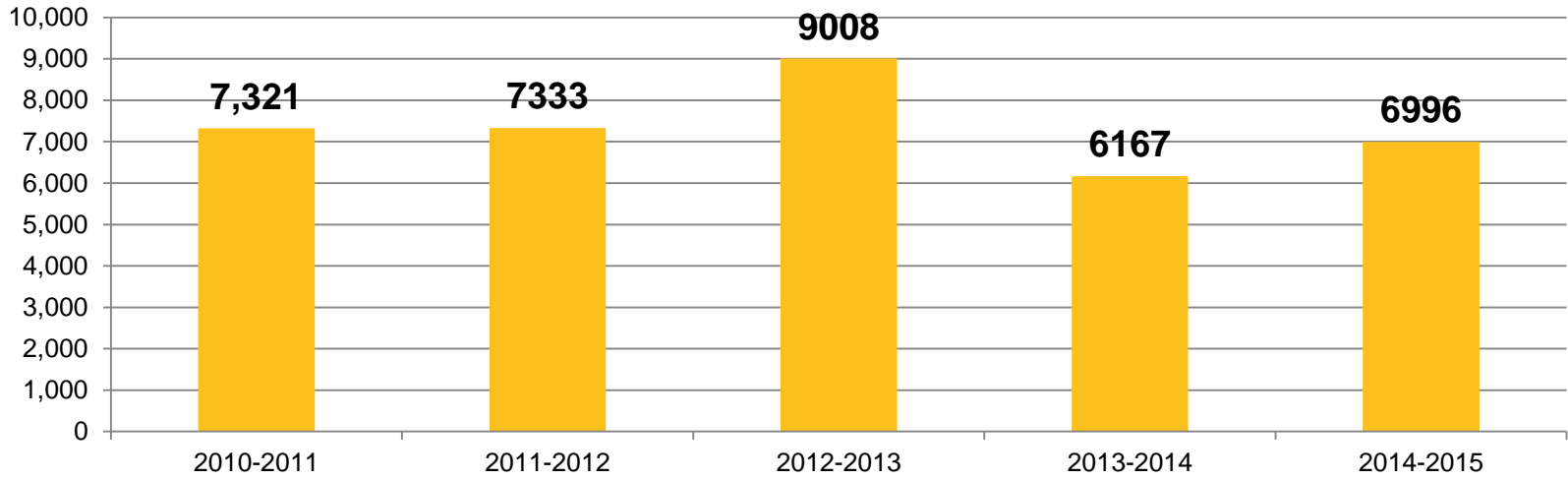
- Word spread, need continued,
- opt-in increased ~85% of schools in district

The Model Today

- 14 provider agencies
- Formal Cooperative Agreement
- Pull-out MH counseling service only
- Evaluation of agency performance
- Outcome oriented

Snapshot of Community Provider Services

OCPS Students Served by Community Mental Health Agency Partners



of Cases served by 19 community agencies

Most Common Areas Addressed in Counseling

- Hyperactivity
- Depression
- Social Skills
- Anxiety
- Lack of respect for authority
- Poor peer relationships

Bridging the Gap – Internal Supports and the Role of DMHC's



District Mental Health Counselors – History

- December 2004 – 4 LMHCs were hired to join the ESE Department in OCPS.
 - I.D.E.A. funded instructional salaried positions.
- In response to FLDOE focus on IEP goals for SED population:
 - Focus on Counseling As A Related Service goal on IEP.
- Supported 42-49 schools each
 - Majority of support at our four intensive sites with large SED populations.

District Mental Health Counselors - History

- Existing school- based support staff (SSW, Guidance, SP) could not meet need for intensive MH support.
- More DMHCs hired over time;
 - Currently 11 (2 per Learning Community plus one Lead)
- School culture became more accepting of Mental Health connection to student achievement.
- National tragedies putting spotlight on mental health

Why Build Internal Supports?

- Fill the gaps that existed:
 - funding issues and limitations of community providers
 - roles of existing support staff changed from social-emotional supports to academic rigor.
 - Federal mandate of No Child Left Behind- academic testing, academic progress, school grades = less social-emotional emphasis.
 - Improve mental health training and knowledge of teachers/staff.

Coordinating System of Supports

- Identification of single contact person to facilitate referrals in every school – recipient of all mental health information, updates to referral process, etc.
 - Assistance to schools in linkage to community agency services.
- Collaboration with Behavior Analysts, Behavior Coaches, School Psychologists, School Social Workers, and Guidance Counselors.
- Liaisons for community agencies- problem-solving, troubleshooting, etc.

Student-Related Support:

- **Brief Individual and Group Counseling**
- **More intensive support in the District's 11 E/BD units: smaller setting with more behavior supports**
- **Mental Health Consultation for Specific Students**
- **Presence in IEP meetings**
- **Presence in Discipline meetings**
- **Presence in Hospitalization Re-entry meetings ("Baker Act")**
- **Student Observations**

Professional Development and Training

- Professional Development for Teachers – created training: “Mental Health Disorders in Children and Adolescents: Behaviors, Symptoms and Classroom Interventions” (affectionately called Mental Health 101)
- Additional trainings: Community agency counseling referral process, “Baker Act” informational training, MH 101 parent version.

Snapshot of 11 Internal DMHC Supports 2014-15 Data

- 243 students received direct DMHC counseling services.
 - 850 individuals and 140 groups
- 445 students received indirect mental health support via participation in IEP meetings, student observations, staffings, and case management.
- 140 students received clinical observations.

Snapshot of 11 Internal DMHC Supports 2014-15 Data

- 701 school consultations via MH informational meetings, EBD team meetings, community provider linkage and assistance.
- Responded to 18 crisis situations, both school based or individual students.
- 40 mental health trainings provided.



From Building Capacity to Improving Quality

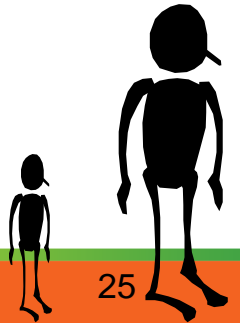
After establishing capacity, we have moved toward a focus on quality of service and impact on student outcomes.



**WHILE THE
CHALLENGES ARE
GREAT, SO ARE THE
OPPORTUNITIES.**

Challenges to address

1. Staff turnover at schools ———> knowledge gaps about school based counseling procedures.
2. Site based management of schools: principals making independent decisions about providers.
3. Lack of a communication loop between schools and therapists.
4. Agencies using the school as a “convenient location” for services, and not being invested in improving school functioning of student.

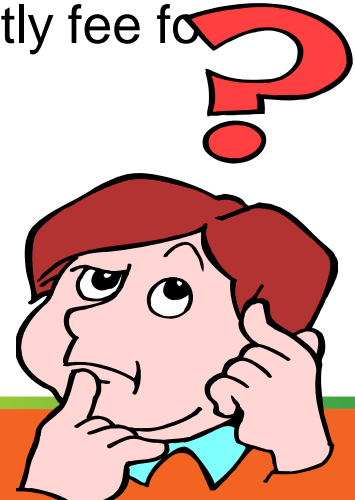


Heavy rain showers remind me of challenges in life.
Never ask for a lighter rain.
Instead pray for a better umbrella...



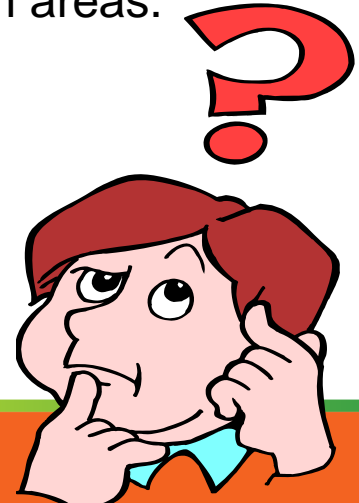
Lessons Learned

1. Part of responsibility of the DMHC now—educating contact persons at each school every single year.
2. Increased efforts to inform about procedures through newsletters, emails, meetings.
3. Root issue is funding structure of provider agencies—mostly fee for service (staff paid only for time spent on direct services).
 - Implemented required document for therapists to complete 1x/mo (update schools on student progress in counseling).
 - Implemented a formal procedure and document to “ensure” communication on status of referrals.



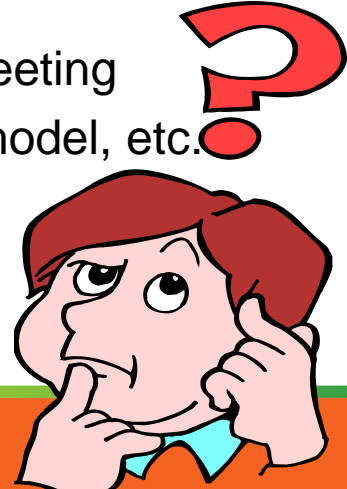
Lessons Learned

4. Put in place several things to end the “silos” of the 2 different systems (MH and ED)
- Agency requirements for supervision written into formal agreement with school board.
 - Included elements about student improvement in agency performance evaluation rubric.
 - Created procedural documents to address biggest problem areas. Agency therapists required to read and sign.
 - Suicidal or aggressive students
 - Abuse reporting to authorities
 - Documents needed to gain access to students
 - Monthly communication requirement
 - Role in a school mental health crisis
 - Outcome data requirements
 - Clearly defined scope of services in Cooperative Agreement



Lessons Learned

- Created recorded webinar trainings for providers and required completion by all therapists.
- Required attendance at School Based Services Orientation each school year.
- Agencies attend a monthly school-based services provider meeting to discuss service delivery issues, and best practices of the model, etc.



Quality Improvement Initiatives

- Annual survey to schools
 - feedback on each agency's performance, including if school sees improvement in student's academics or behavior.
- Formalized annual evaluation of agencies performance.
- Data collection required
 - standardized assessment with pre/post data showing outcomes.
 - Agencies required to get feedback from parent/caregiver or teacher regarding outcomes.

Ongoing Challenges:

- Keeping “good” agencies, and eliminating the “bad”
 - Keep pressure on agencies to perform
- Keeping the environment non-competitive between provider agencies
- Knowing what to micromanage with available resources
- Limited ability to collect data (especially impact data) without the help of tech. support. Need to tap into current data tracking systems for things such as discipline, grades, attendance, etc.

Questions and Discussion

- What mental health needs do your students have?
- What gaps exist in your school mental health supports?
- What elements could you duplicate in your school district?
- What challenges do you anticipate?

For more information:

JoDee Buis

SEDNET Project Manager, Orange County Public Schools

Jodee.buis@ocps.net

Lisa Diamond

District Mental Health Counselor, Orange County Public Schools

Lisa.diamond@ocps.net