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	Consultation: BRYT Model	Implementation & Sustainability	Data Tracking, Progress Monitoring	Case Study
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	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?	Grant funding Advocacy Consultation Building & maintaining buy-in from school and community stakeholders Data-tracking	How do we know the impact we're having? Cognitive-Behavior Therapy; Dialectical Behavior Therapy Progress monitoring	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."

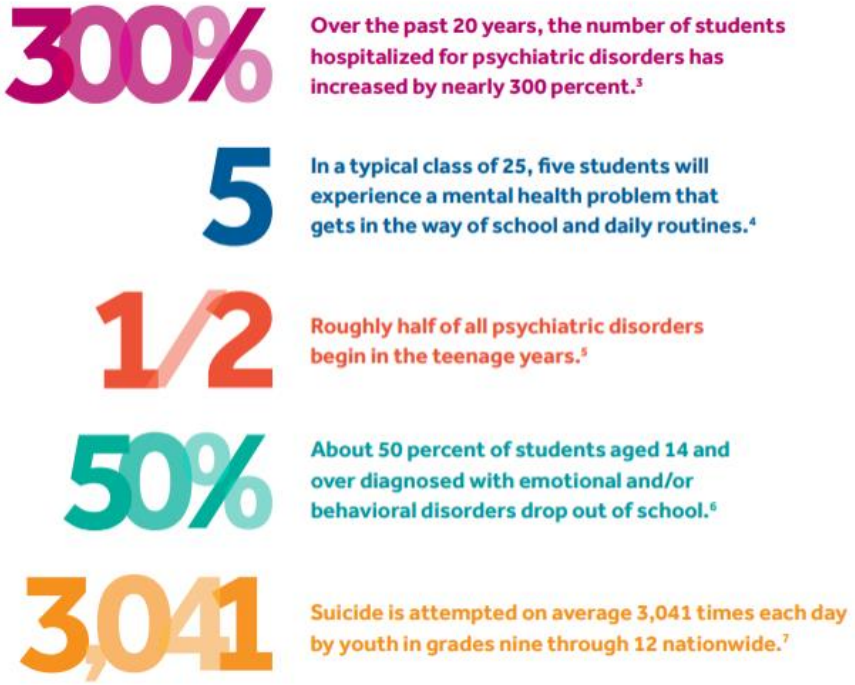
-National Institute of Mental Health

National Institute of Mental Health (2019)

National Context of Mental Health Needs (cont.)

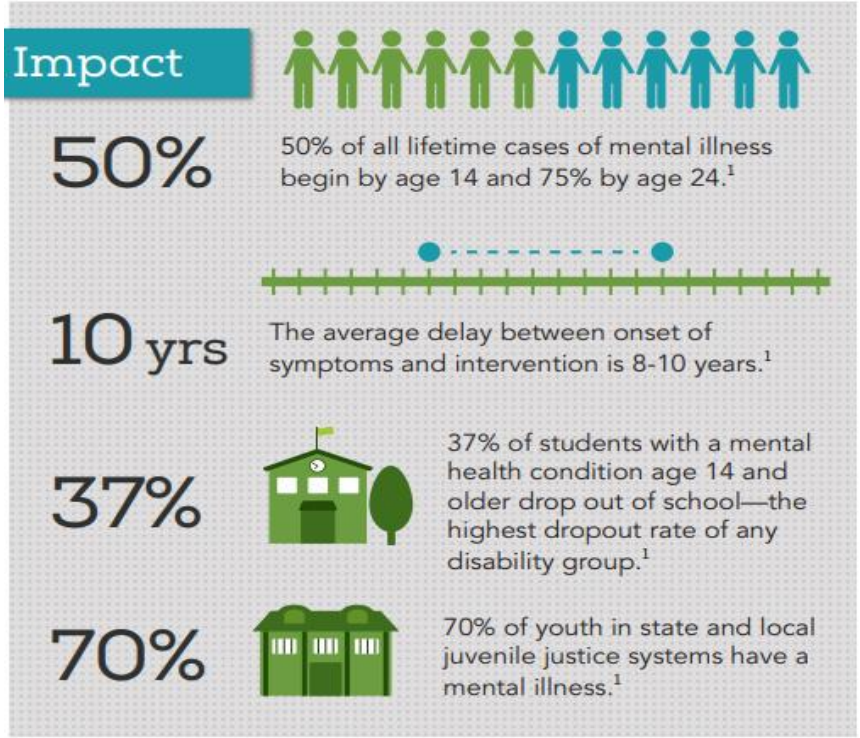
National Alliance on Mental Illness (NAMI) (2019)

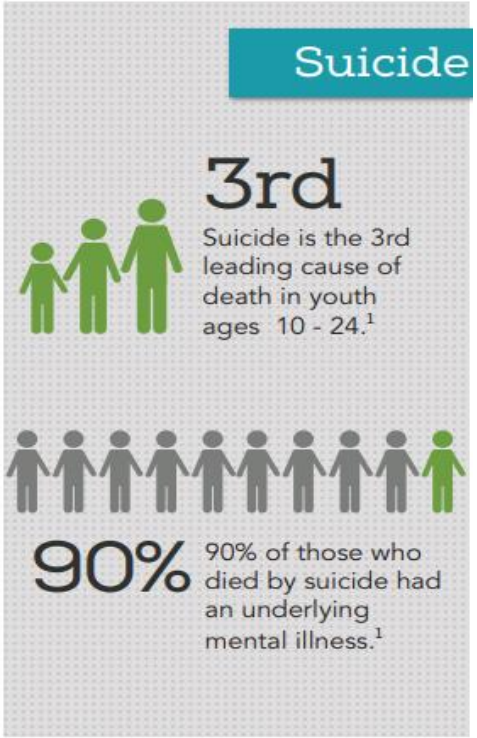
National Context of Mental Health Needs (cont.)



BRYT Notes (2018). *The Brookline Center for Community Mental Health*

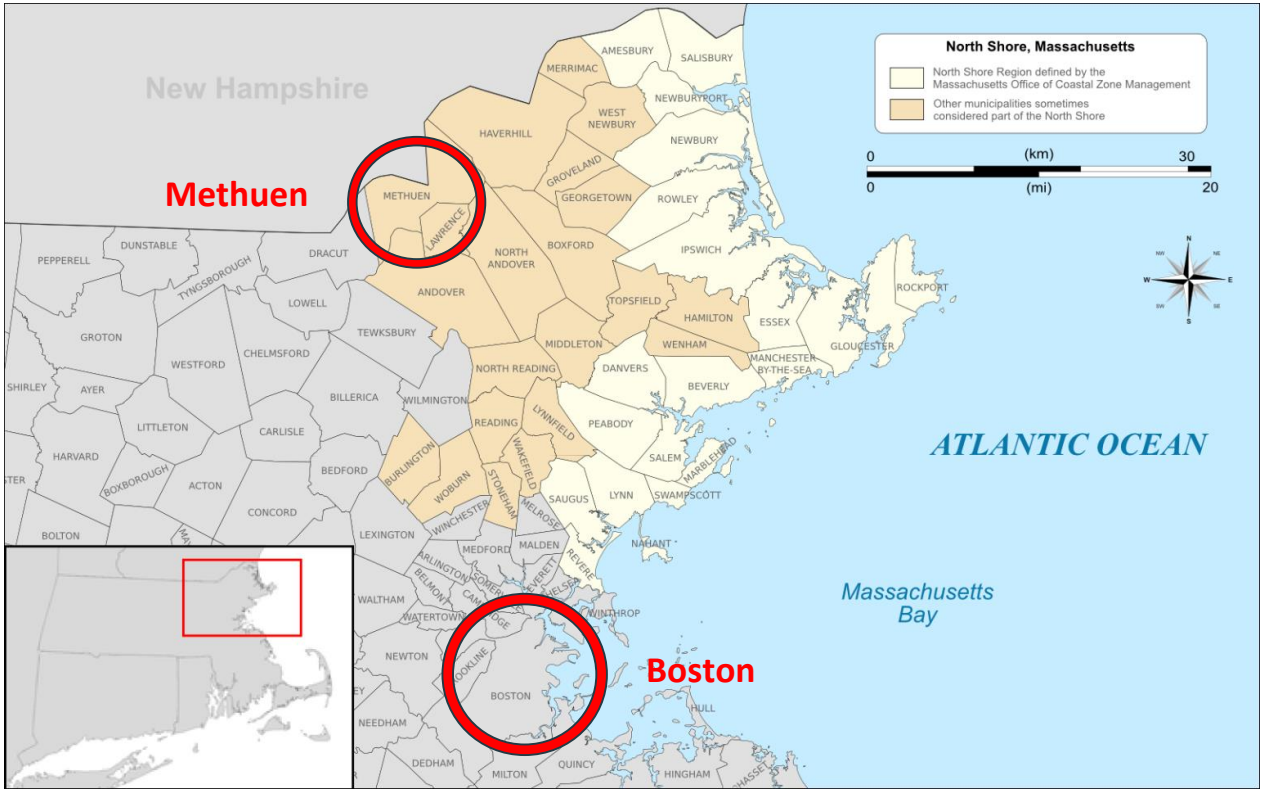
National Context of Mental Health Needs (cont.)





National Alliance on Mental Illness (NAMI) (2019)

Methuen Relative to Boston, MA



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 at 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)

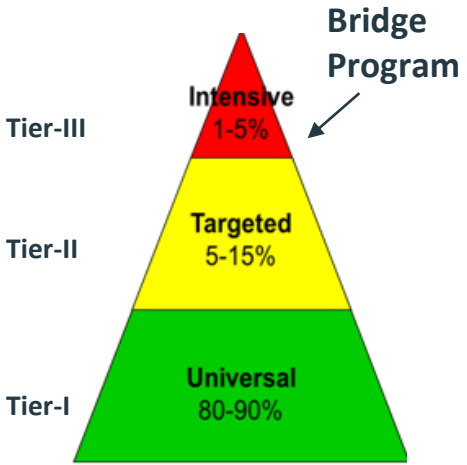
Regionally located in an area with a high-incidence of opiate use

- 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?

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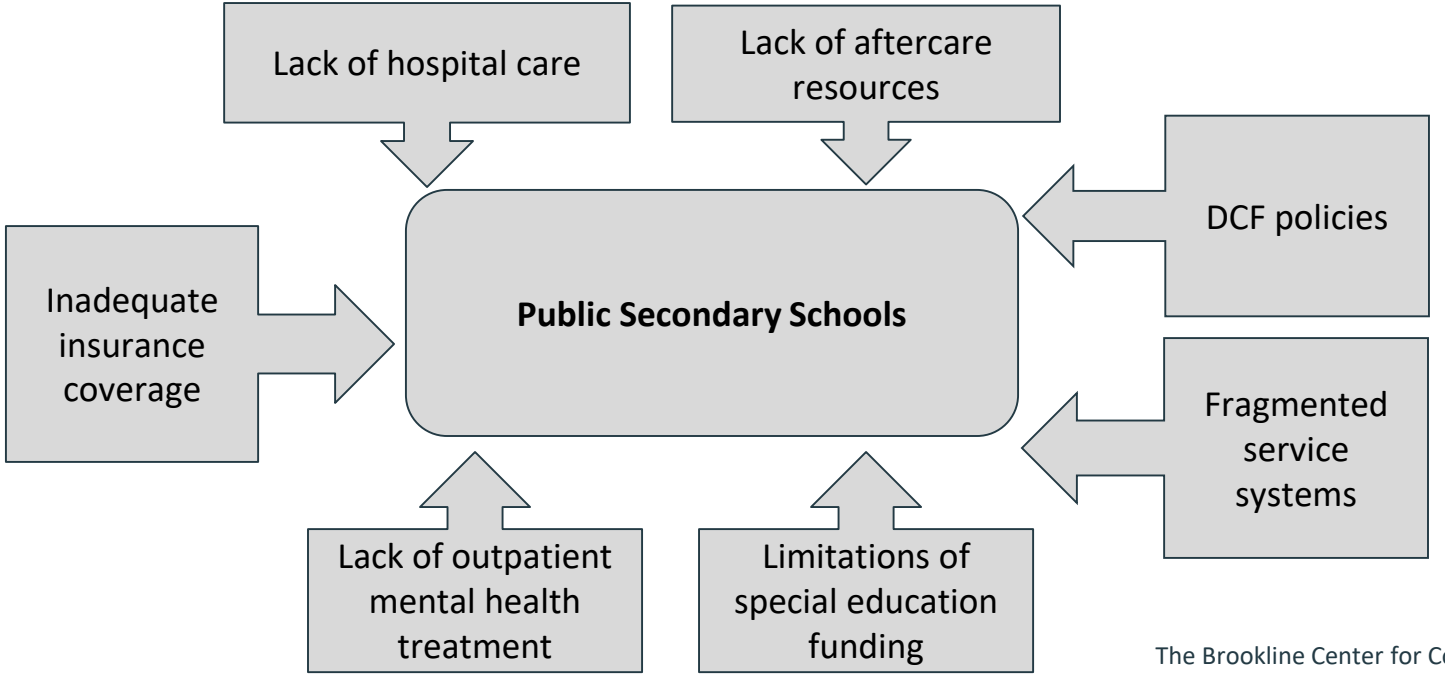
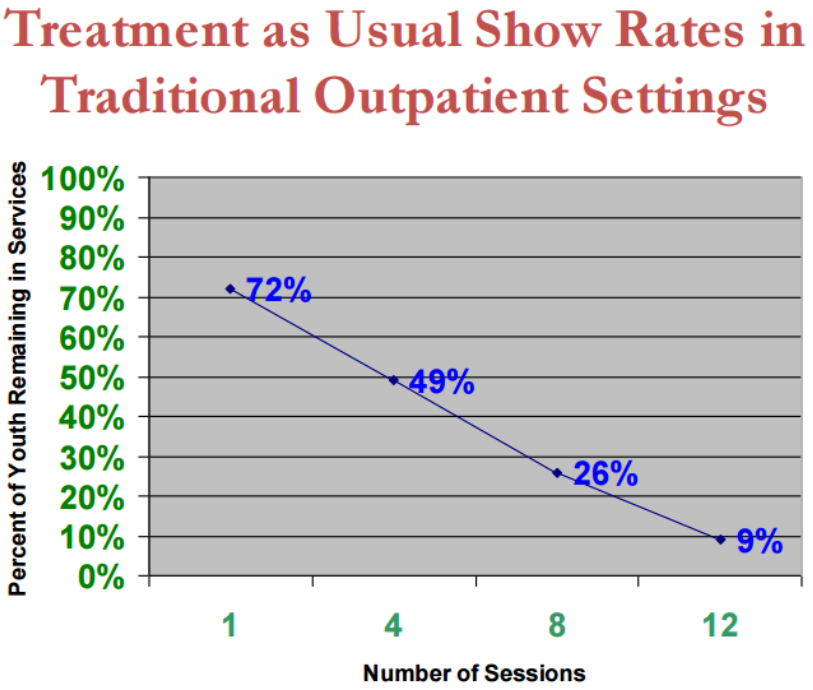
Due to many barriers to receiving quality community-based care, public schools are often the safety net for students with mental health and medical disorders



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.

18-19 Accountability Report

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)

Activity #1: Turn & Talk

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

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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

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Priority Population

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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

BRYT Network Statistics (2017)

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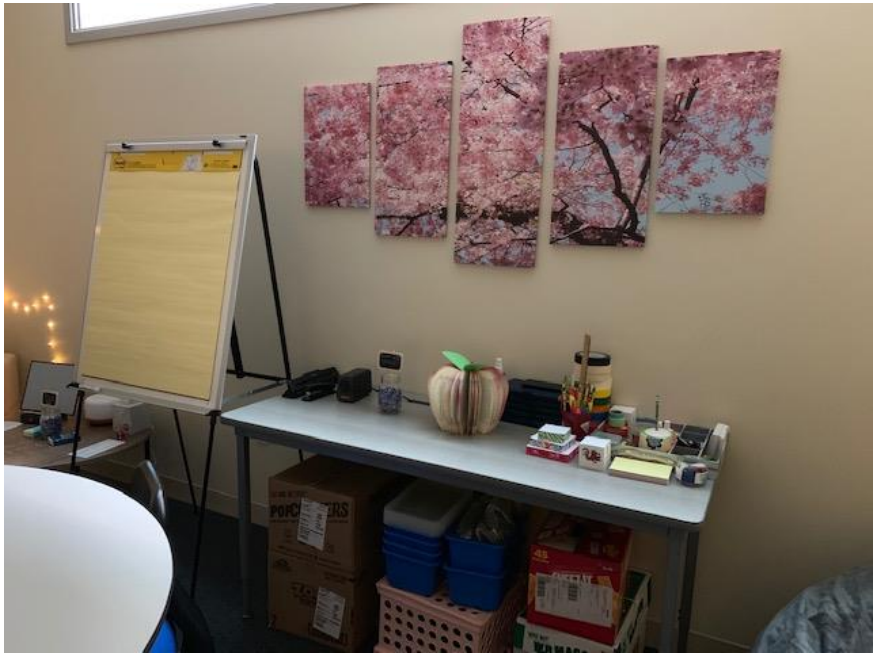
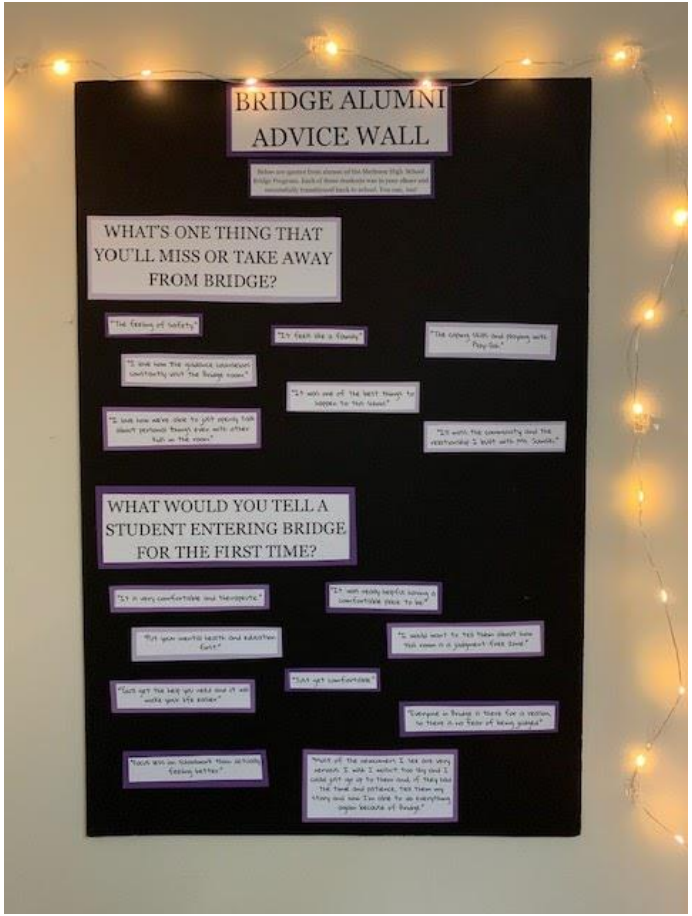
COUNTING ON CARE	
85%	85% of participants graduate or are on track to graduate by the end of the year.
8%	BRYT participation reduces the dropout rate for students with serious mental health issues from 50% to 8%.
113,300	Across Massachusetts, 102 BRYT Network schools create a mental health safety net for more than 113,300 students.

The Brookline Center for Community Mental Health (2019)

Bridge Room at MHS

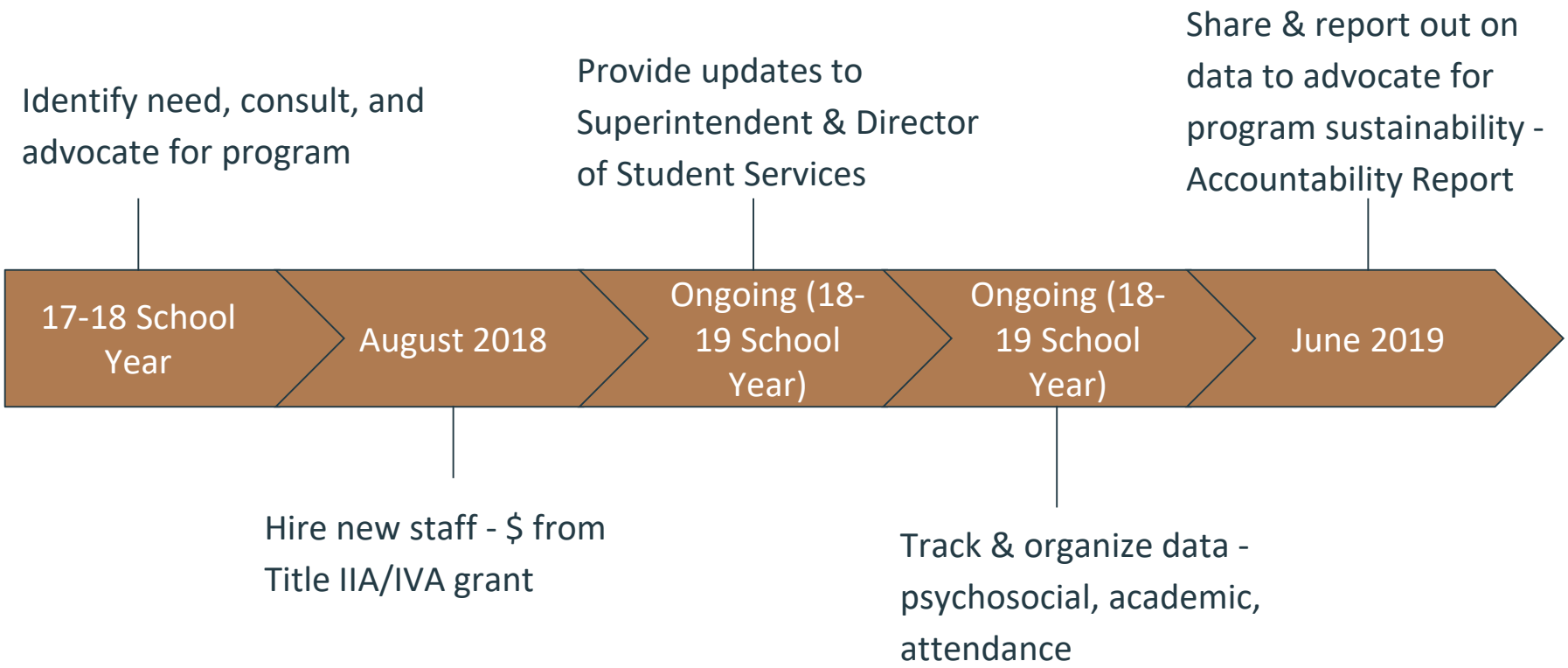



BRIDGE ALUMNI
ADVICE WALL
WHAT'S ONE THING THAT YOU'LL MISS OR TAKE AWAY FROM BRIDGE?
WHAT WOULD YOU TELL A STUDENT ENTERING BRIDGE FOR THE FIRST TIME?

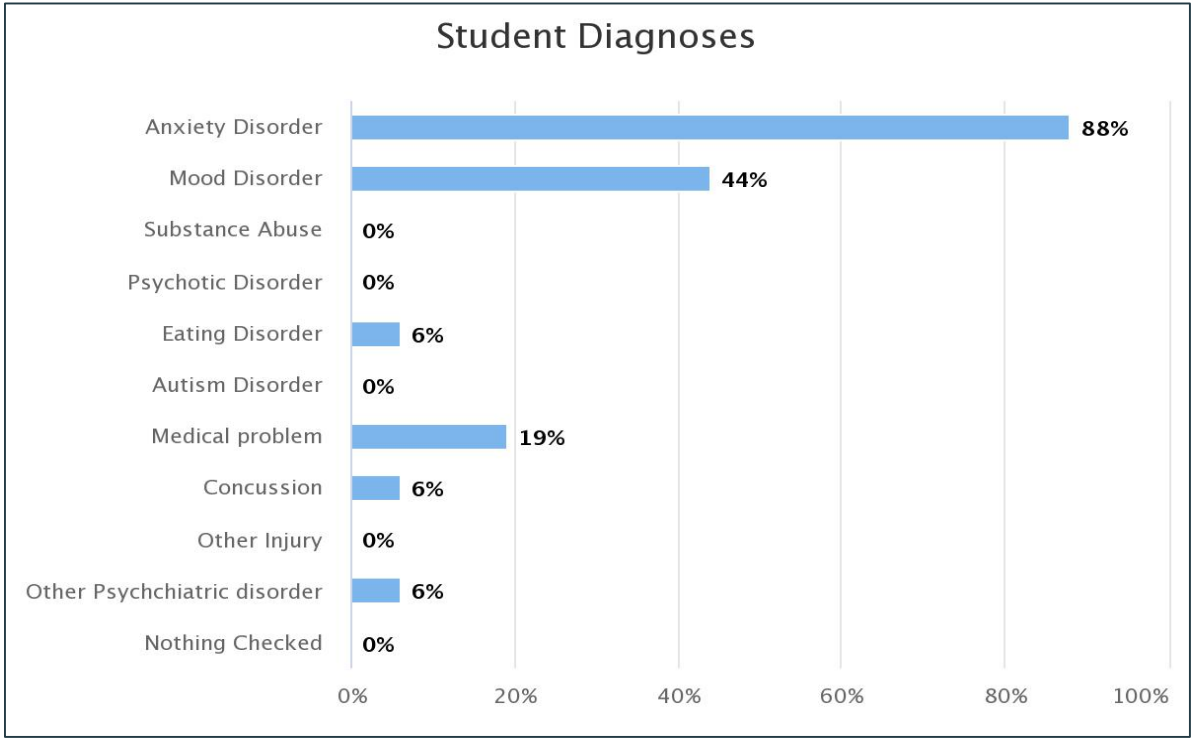

TAKE A SWEET &
GET BACK ON YOUR FEET!
Be KIND
(to yourself + others)

Implementation & Sustainability

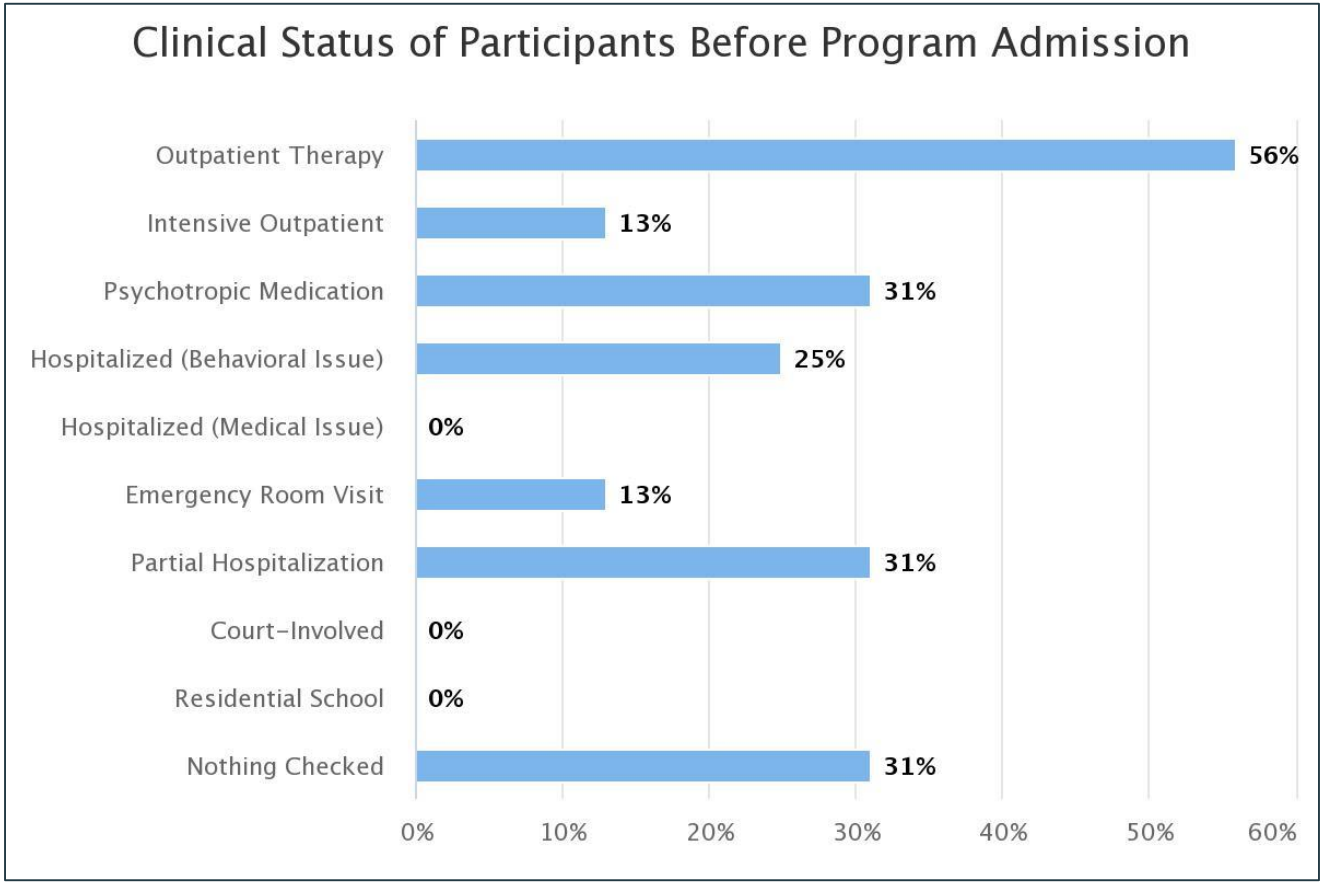
Our Implementation Timeline



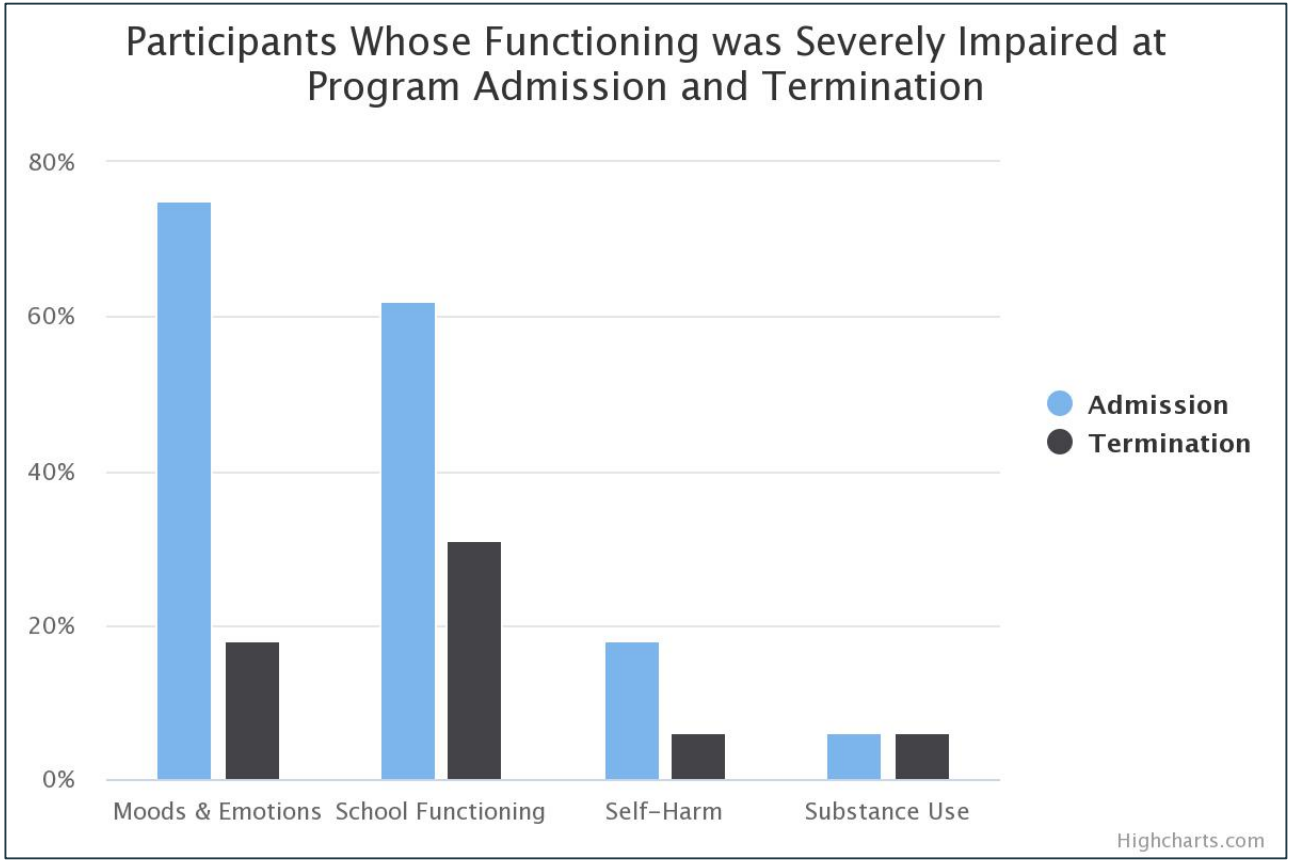
Our data related to advocacy, implementation, & sustainability 2018-19



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.



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).

Hodges, K. (1999). *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

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

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

Grohol, J.M. (2018)

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?*

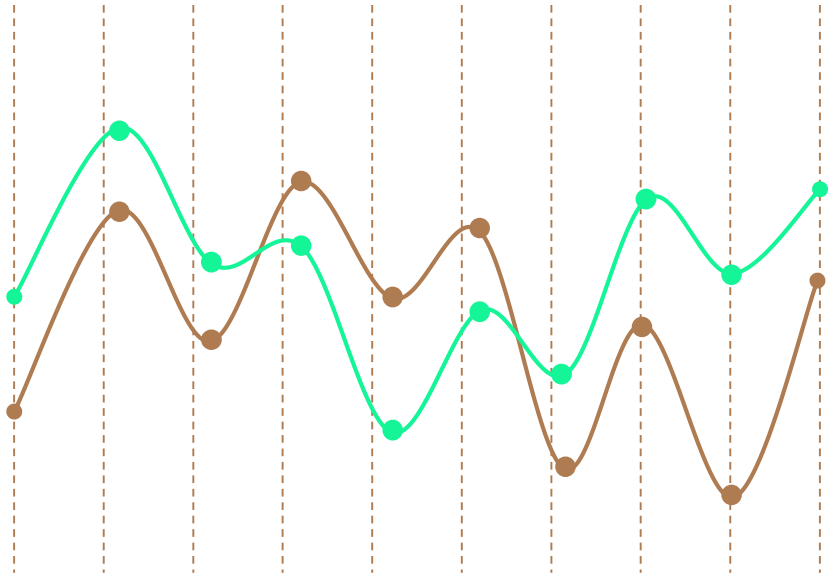
Student engagement - is student engaged in school & feel ready to transition back to full schedule? Has this engagement increased from time of entry to graduation?

- 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

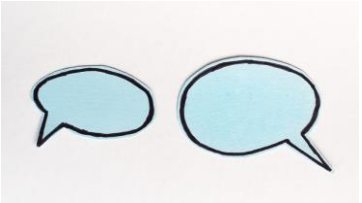
								AC	AR	WS	SI	
20. I did things to cut myself off from other people.	○	○	○	○	○	○	○				_	R
21. I took time off of work/school/chores/responsibilities simply because I was too tired or didn't feel like going in.	○	○	○	○	○	○	○			_		R
22. My work/schoolwork/chores/responsibilities suffered because I was not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

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

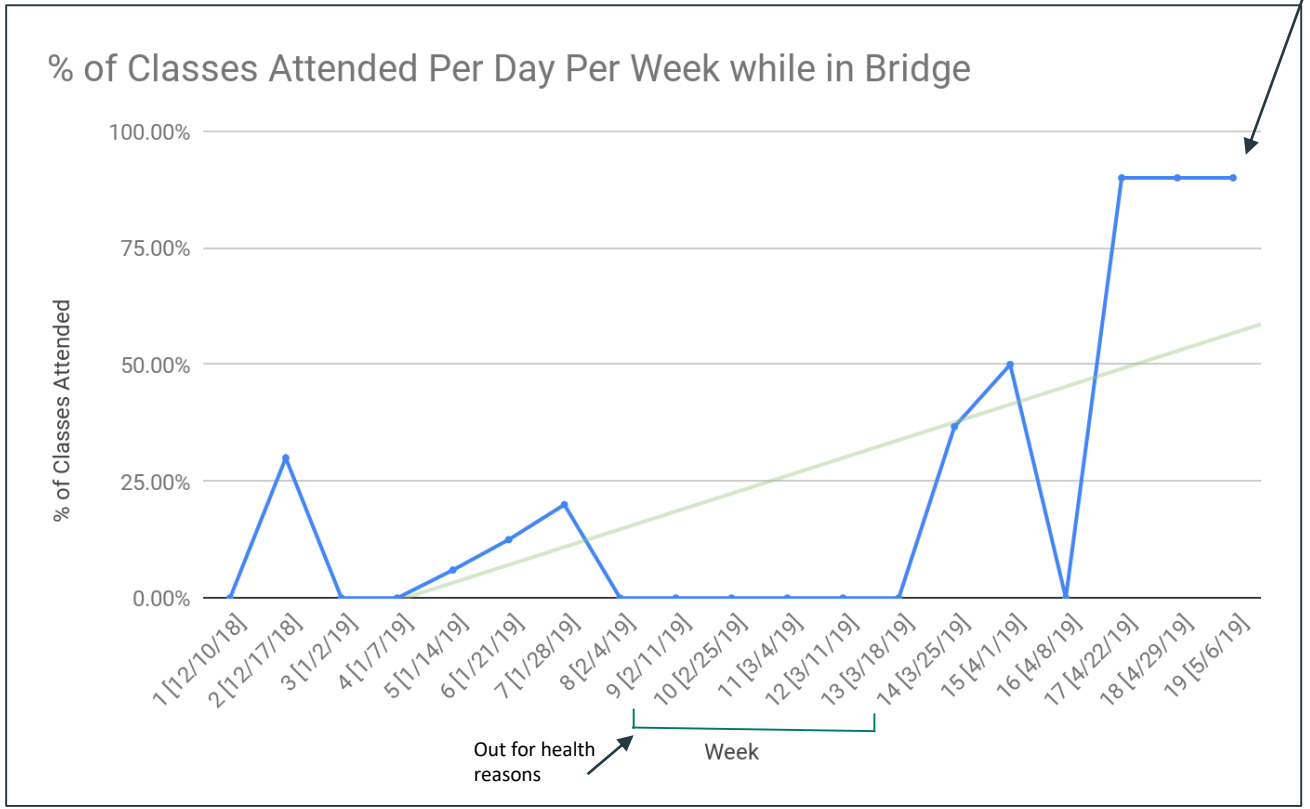


- Student presenting with depressive symptoms related to recent breakup, declining grades, self-image issues, and overall feeling of lack of purpose/direction (September 2018)
- Referral for psych evaluation due to suicidal ideation (October 2018)
- Student receiving individual therapy with school counselor & 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

Attendance

Results:

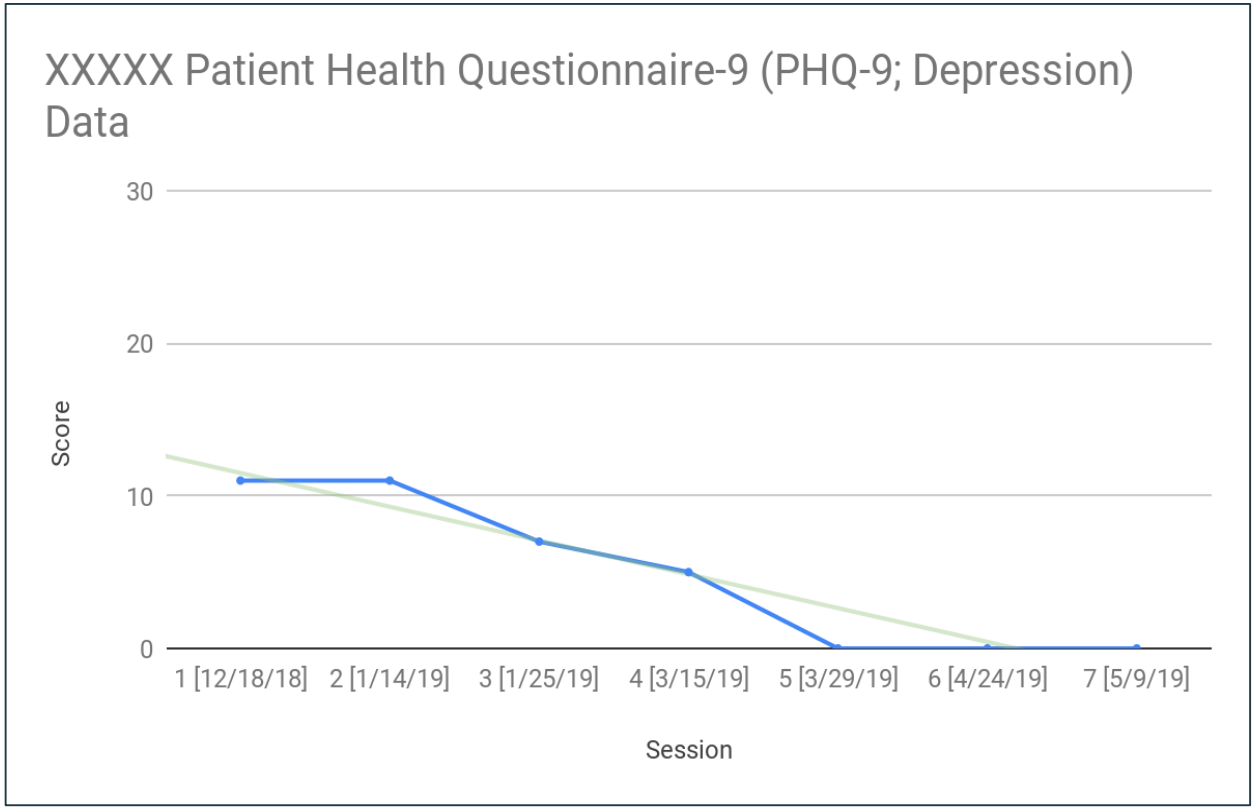
Student entered Bridge after attending *0%* of classes. Slight increases over time, with a few decreases due to absences. Upon time of Bridge graduation, student maintained *90% class attendance* per day per week over a 3-week period



Psychosocial Data

Results:

100% decrease in depressive symptom presentation over 12 weeks, moving from *Moderate* to *None-Minimal* range (PHQ-9)



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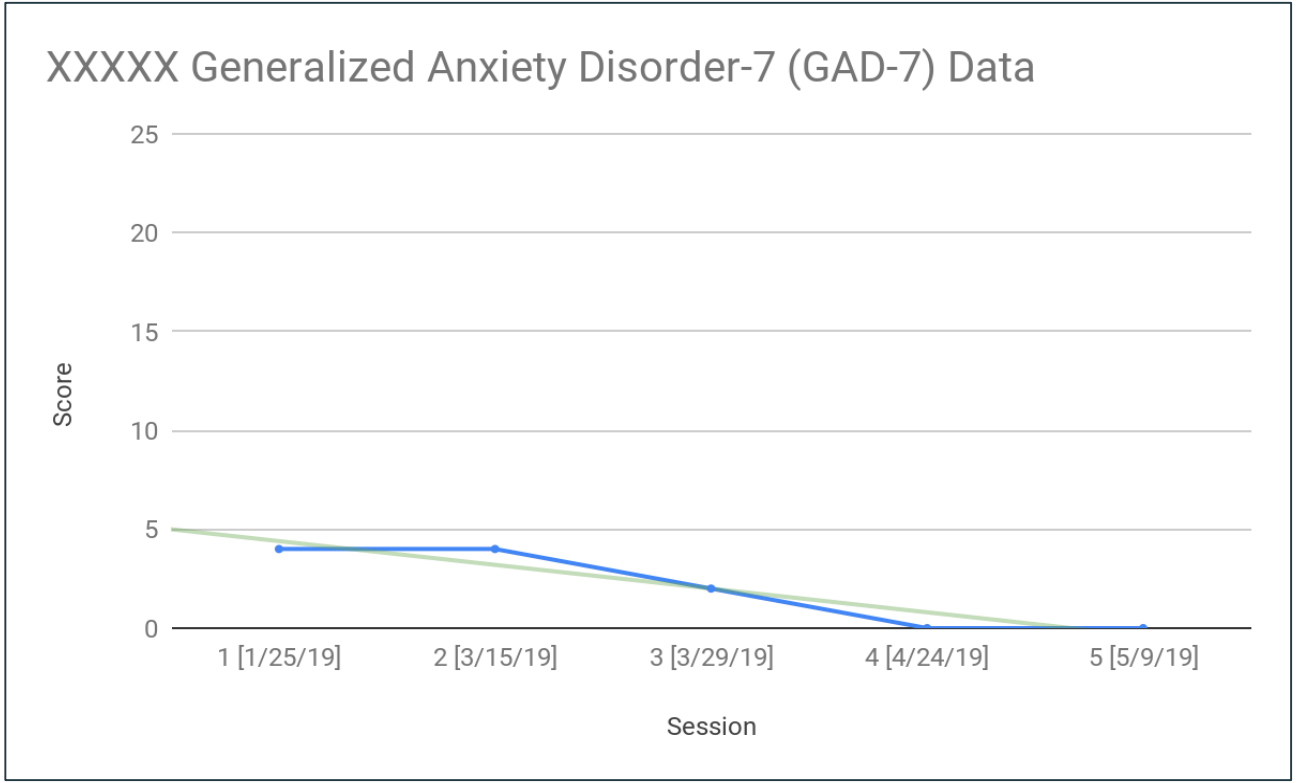


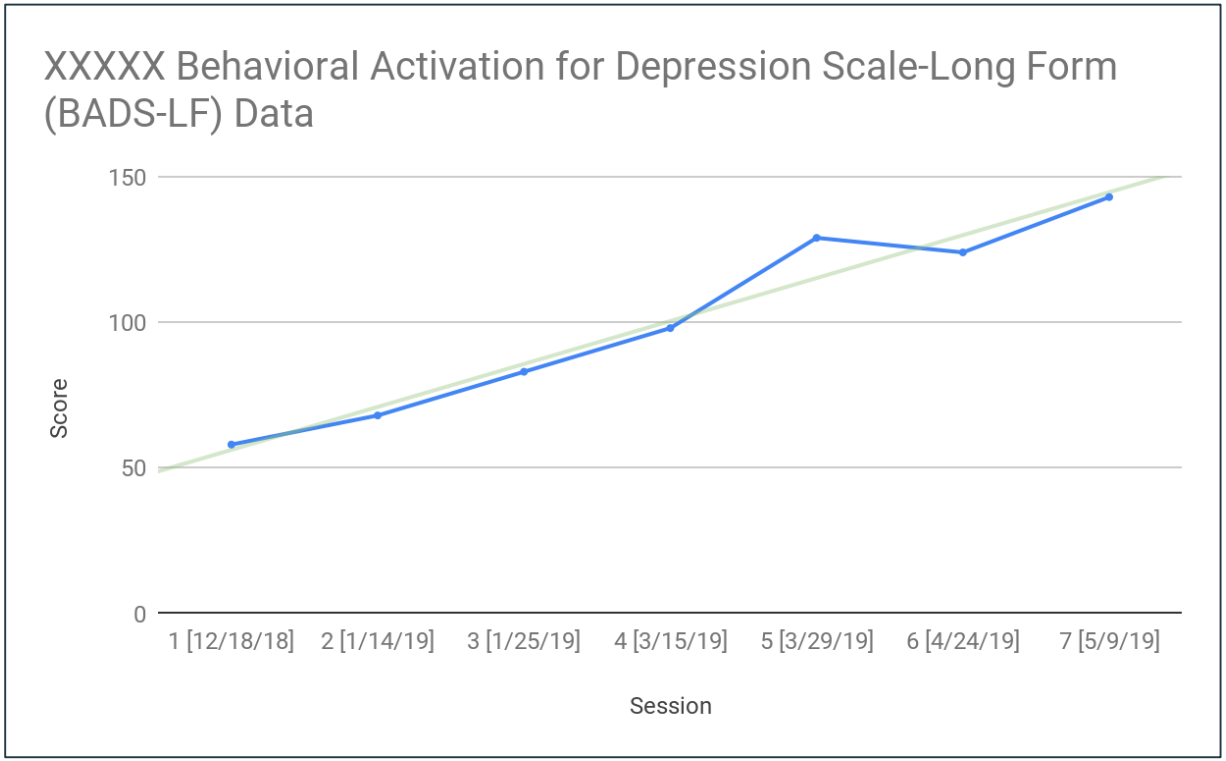
Results:

100% decrease in anxiety symptom presentation over 8 weeks, maintaining *None* range (GAD-7)

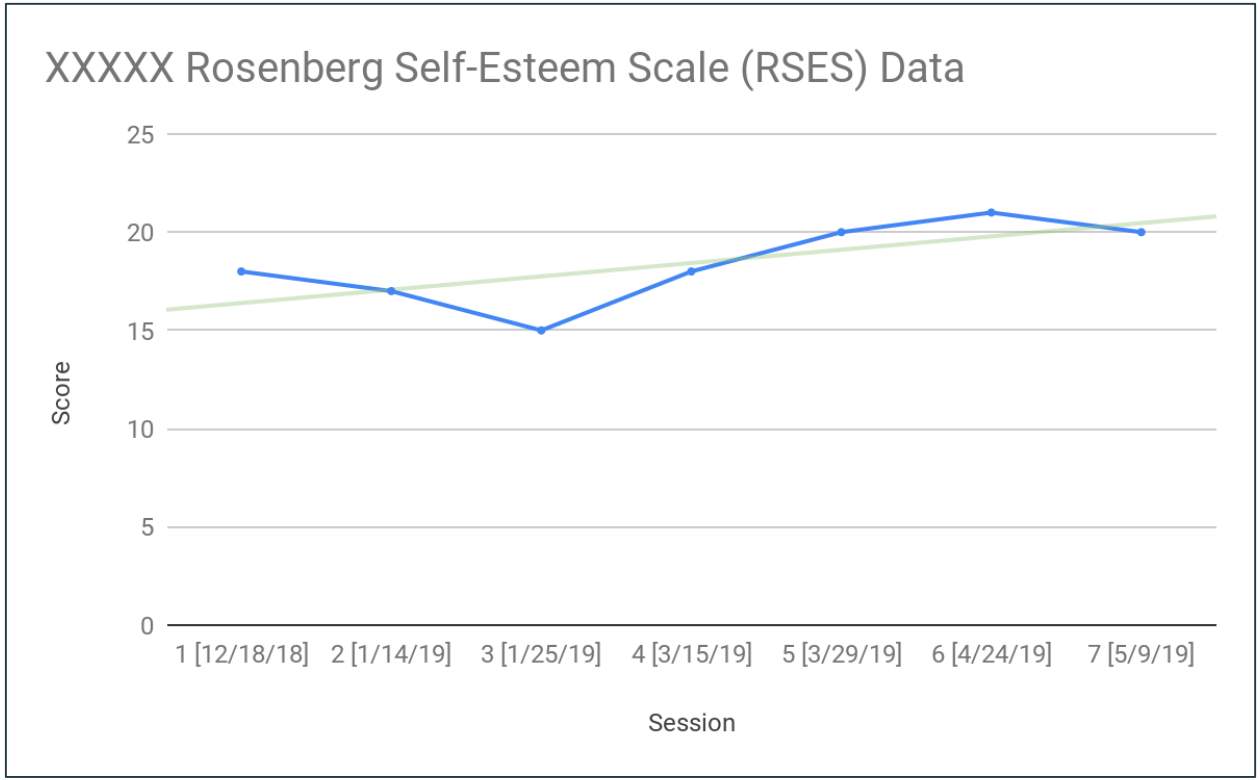
Psychosocial Data (cont.)

Results:

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



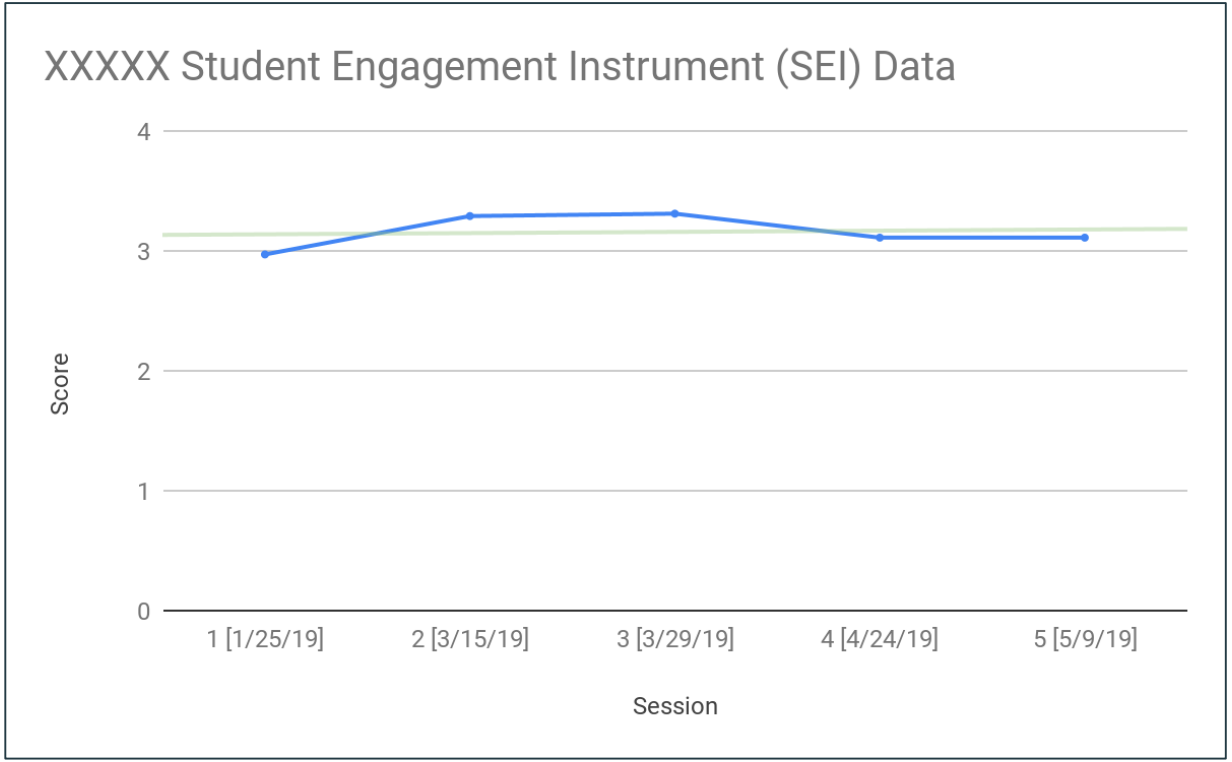
Psychosocial Data (cont.)



Results:

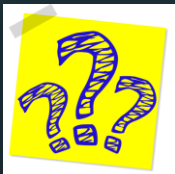
11.1% increase in self-esteem over 12 weeks, maintaining in the *Normal* range (RSES)

Psychosocial Data (cont.)



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

Adkins, M. A., Birmin, D., Sample, B. (2016). Cultural adjustment, mental health, and ESL: The Refugee experience, the role of the teacher, and ESL activities. *Spring Institute for International Studies.* Retrieved September 12, 2019.

The Brookline Center for Community Mental Health (2018). BRYT notes: Changing school culture to support mental health. Retrieved September 10, 2019.

The Brookline Center for Community Mental Health (2019). How BRYT works. Retrieved September 10, 2019.

Crocker, J. (2019). Methuen comprehensive school mental health system (CSMHS) 18-19 accountability report.

Grohol, J.M. (2018). What's the difference between CBT and DBT? PsychCentral. Retrieved May 2, 2019.

Hodges, K. (1999). Child and Adolescent Functional Assessment Scale (CAFAS). In M. E. Maruish (Ed.), The use of psychological testing for treatment planning and outcomes assessment (p.. 631-64). Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers.

Kanter, J. W., Mulick, P. Busch, A. M., Berlin, K. S., & Martell, C. R. (2007). The behavioral activation for depression scale (BADS): Psychometric properties and factor structure. *Journal of Psychopathology and Behavioral Assessment, 29,* 191-202.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62,* 593– 602.

Massachusetts Department of Children & Families (2017). Annual progress and services report (APSR) federal FY2018. Retrieved September 12, 2019.

McGill University (2012). How a parent's education can affect the mental health of their offspring. *ScienceDaily*. Retrieved September 12, 2019

References (cont.)

McLaughlin, K. A., Costello, E. J., Leblanc, W., Sampson, N. A., & Kessler, R. C. (2012). Socioeconomic status and adolescent mental disorders. *American Journal of Public Health*, *102*(9), 1742–1750.

National Alliance on Mental Illness (2019). Mental health by the numbers. Retrieved September 10, 2019.

National Institute of Mental Health (2019). Mental illness. Retrieved September 10, 2019.

NIDA. (2017). Health consequences of drug misuse. Retrieved September 12, 2019.

Teich, J.L., Robinson, G., Weist, M.D. (2011) What Kinds of Mental Health Services do Public Schools in the United States Provide? Advances in School Mental Health Promotion, 1:sup1, 13-22.

White, H., LaFleur, J., Houle, K., Hyry-Dermith, P., Blake, S.M. Evaluation of a school-based transition program designed to facilitate school reentry following a mental health crisis or psychiatric hospitalization. *Psychol Schs*. 2017; 54: 868– 882.