Literature Scan: Mental Health Centers & Behavior Specialists in Schools
Prepared by the Department of Research & Performance Management

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Key Findings

- Universal programs and selective/indicated inventions paired together to create a whole-school multi-tiered framework is recommended
- Universal screenings can help pinpoint students that need more resources and more intentional mental health services
- While training teachers about trauma is vital, specialized personnel with formal training need to be in schools, helping both students and teachers navigate trauma and social emotional learning

Strategies for Implementing School-Based Mental Health Centers

- Universal intervention[1,2,3,4,5,6,7,8]
- Indicated/selective intervention[7, 8, 9, 10, 11, 12]
- Multi-tiered intervention framework[6, 8, 13]
- Mental health screenings[9, 11, 14, 15, 16, 17, 18, 19]
- Training/Professional Development (PD) for teachers[3, 6, 20, 21]
- Behavior specialists/trained, specialized personnel[9, 10, 11, 13]

Universal (Preventative) Intervention

The main goal of universal intervention is to broaden all students' social emotional wellness by using a curriculum or framework throughout the entire school. A good rule of thumb is that if 15-20 percent of the population of a given setting (school, district, etc.) has certain behavior issues that are wanting to be addressed (e.g. exclusionary disciplinary actions), resources are better served providing universal services rather than individualized, direct services.[1] Looking at only high schools in the 2019-20 school year, the suspension rate for the District overall was 13.9 percent. This rate was higher for Black students and for students with disabilities (SWD) (16.3 and 20.7 percent, respectively). Districtwide in 2019-20, over all grade bands the suspension rate was 9.2 percent with the SWD rate at 14.7 percent and the Black student rate at 11.2 percent[†] (See Figure 1 and 2 in the Appendix for a look at the dashboard). Universal intervention is preventative intervention; this framework looks to teach students about coping mechanisms and social emotional well-being before any symptoms or behavior issues occur.

- Examples of successful models/studies of universal intervention:
  - A meta-analysis of seventy-three school-based universal programs showed that "the overall random effects mean was 0.21 ($p < .001$)," which indicates that students had significantly lower aggressive and disruptive behavior after participating in these interventions than the control group of students who did not participate. These programs tended to be more effective with lower socioeconomic status students and when the frequency of sessions was higher.[2, 7]
  - School-Wide Positive Behavior Interventions and Supports (SW-PBIS) is a universal program meant to lower school behavior problems and promote positive student outcomes. Over 200,000 schools in the United States have used this model since its inception in 2000. SW-PBIS is not a curriculum but a framework and set of strategies to create a nurturing school culture. In this model, school staff develop clear behavior

expectations that they model, teach, and practice. School staff is expected to give students higher rates of positive attention over negative attention. Data are collected surrounding behavior issues, including location, time, type, etc. School leaders use these data to assess if this system is working and to find areas of improvement. "If a high number of infractions occurs on the playground, the team would decide how to reduce the problem perhaps by reteaching expectations, increasing adult supervision, and/or increasing positive attention rates."[1] Studies of SW-PBIS have found reduced problem behaviors, and two randomized trials found that SW-PBIS is associated with improvements in "school safety, academic achievement, positive student behaviors, and school climate compared to control schools."

Indicated/Selective Interventions

This type of intervention is meant for specific students. Indicated interventions are for students who have shown problem behaviors. Selective interventions are for students who have not exhibited behavior problems but are assessed to possibly benefit from the program (anxious students).

- Examples of successful models/studies of indicated/selective interventions:
  - In the same meta-analysis mentioned above, forty-seven selective and indicated interventions were assessed and the overall effect size was similar at 0.26, which was significant. Interventions were found to be "more effective with regular education students than special-education students," and programs implemented by teachers or researchers were more effective than programs implemented by graduate students.[2, 7]
  - One study observed statistically significant changes on social and behavioral scales in at-risk middle school students after completing Solution-Focused Brief Therapy (SFBT). The school provided SFBT group treatment to 26 students during school hours with four trained adults: two masters in social work interns, the school social worker, and the researcher who has a PhD in social work. These four each led a small group of students in SFBT for eight weeks. The students showed positive changes in their social skills at the posttest and maintained these gains at the follow up at six weeks. This group also improved their overall classroom behavior post treatment. This finding was supported by teacher feedback. Parents were also surveyed and reported fewer homework completion issues.[12]

Multi-tiered Intervention Framework

- A multi-tiered intervention framework uses a whole-school approach to support the success of students with trauma.[9] In this framework there are three tiers; the first two have been discussed previously. Tier 1 is universal supports, Tier 2 involves more specific supports for at-risk students or students with behavior issues, and Tier 3 is more intensive interventions for students suffering from trauma.[6, 8, 13]
  - In one specific example, the San Francisco Unified School District (SFUSD) implemented a multi-tiered framework entitled Healthy Environments and Response to Trauma in Schools (HEARTS) in 2009-10 to combat the school to prison pipeline.[6] Each of the tiers include intervention or training for students, staff and caregivers, and for the entire system. In Tier 1 students received training on how to deal with

stress, school staff received training on trauma and secondary trauma, and social emotional learning curricula was put in place in all schools. In Tier 3, students affected by trauma had individualized services and teachers were given support and referrals for more intensive care (see Figure 3 in the Appendix for the entire diagram). The evaluation of the program found significant changes in knowledge about trauma, sensitive practices. Student engagement significantly increased. There was a significant decrease in behavioral incidents after one year; after five years there was an 87 percent decrease in total incidents. Out-of-school suspensions decreased by 95 percent after five years of HEARTS implementation.

- Another study followed the development of mental health centers in three different schools over five years.[13] The study saw the continuation of the programs and the expansion of SEL to all students as success and did not detail the schools' data. Each school used local university graduate students to help implement their programs and used a tiered system. School B and C were able to continue and expand their programs, while School A did not continue after Year 5 due changes in school leadership.

Mental Health Screening

- There are two main types of mental health screenings: Universal screening and screeners for specific mental illnesses.
  - First, the universal screener is given to all students of the school to parse out whether students need mental health services.[9, 11, 14, 15, 16, 17, 18, 19] Screening all students ensure that services are not only given when there are disciplinary issues, as not all students will cause classroom issues when they are in need of mental health services.[4] One study emphasizes this need by saying, "The movement from a reactionary to a preventive and comprehensive method of student identification and support provides an avenue for more complete and efficient use of the skills of the school psychologist."[15]
  - The second type of screener is for any specific mental illness (ex. PTSD[18], Anxiety[17], Depression, etc.[11]) These could help point a school counselor/behavior specialist in the right direction. Some schools have used these as their main screener, but this could be limiting students' diagnoses.
- Some studies recommend screening parents or students at school entry.[11] "Early screening and detection can significantly support efforts to minimize risk for future emotional, academic, and social difficulties."[16] School entry screening can also provide a framework for expanding targeted intervention programs.[9]

Training/Professional Development (PD)

- A study done in 2017 found that almost 50 percent of teachers surveyed felt they did not have suitable mental health training, and 85 percent expressed a desire to receive more training on the subject. Only 19 percent believed that their school had adequate mental health resources, while 22 percent believed their school had a clear plan to address students' mental health needs.[3]
- Trauma-informed training can reduce 'behavior issues' and exclusionary disciplinary actions in the classroom, which more often are given to Black students than to white students.[6, 20,

[22] This kind of trauma training can include information like, what is trauma, how it impacts children's behavior, establishing common language around trauma, and how to deal with burnout and secondary trauma.[3, 6, 20, 21]

Behavior Specialists/School Counselors

- It is vital to have specialized personnel in the school building. There is a need for more of these professionals to be in the classroom and school setting to be able to meet the mental health needs of students.[11]
- These specialized personnel can get to know the students and their unique needs. The student can engage with a trusted adult and the school counselor or similarly trained professional is able to bring their knowledge of the child's history into their work.[13]
- Many of the studies mentioned having outside, community-based partnerships to help create wraparound services for families.[10, 11, 13, 23] Often times schools find their trained personnel through this kind of partnership. Schools may not be ready to have indicated/selective interventions, but community-based programs may be able to help. This can also help entire families, rather than just students; a family is more likely to get help if they are given resources and the parents are already familiar with the community-based partner's work.[10, 13, 14, 23]
- There are different options in the research of what this person's title and training could be: examples in the literature show effective programs with a school social worker, a school psychologist, a school counselor, a community psychiatrist, a graduate or doctoral student from a local university in social work or psychology, a researcher with a PhD in those fields, etc. The most important aspect of this role is that the person has had formal training to interact with students with trauma and mental health issues.[11] While a meta-analysis found that programs led by graduate students were seen as less effective than programs done by teachers or researchers, this could be a more cost-effective way to boost the number of mental health workers in a school setting (as well as being a symbiotic relationship with local universities).[2, 7, 10, 12, 13, 14, 15]

Return on Investment

- Setting realistic goals and timelines for measuring program effectiveness
    - It is important to remember that change in the social emotional learning of a child will take time. It is recommended that the Cabinet and Board allocate funds for these programs even if they have not shown immediate success in the upcoming years. Investing in the social emotional needs of our children is one of the best things we can do for their overall outcomes in the future, as shown in the research below of untreated Adverse Childhood Experience (ACEs) and mental illnesses (see Background section). As one researcher notes, however, society often looks at children as though they will one day be adults, rather than viewing them as human beings right now that deserve the best social emotional care that we can provide to them.[24] Funding is often based on the evaluation of the program. One researcher warns, that school-based interventions are "often evaluated immediately or shortly after the intervention. However, there is increasing evidence that some long-term effects are emerging and that although effects gradually decrease over time they can remain substantial."[4] It may feel as though funding SEL or school-based mental

health centers is a waste of resources, but in reality, these programs could be having substantial effects on students and should be given time to develop before being discontinued or seen as a failure.[13]
    - Evaluations should begin after at least two years so that the program has a chance to gain structure, and school staff and teachers get more time to learn best practices.
- Screening data can help schools/the District understand the scope/volume of student needs and resources can be adequately allocated.
    - More individualized screenings can show which students would benefit from intervention, but they can be costly in terms of both time and labor force.[11]
    - "With these assessment data in hand [from screening at school entry], school districts are more able to advocate for additional funding to provide smaller classes, higher teacher-to-child ratios, and the hiring of mental health specialists."[11]
- Spending: Invest first in universal/preventative interventions, as this type of program is likely to reduce behavior issues and help students' self-esteem and social emotional health overall[1, 2, 5, 6, 15]

Background

- Around 20 percent of children and adolescents suffer from a mental illness[25] and around 60 percent of adults have said they experienced at least one ACE.[26] "The number of ACEs in childhood demonstrate a strong association with the likelihood of developing posttraumatic stress disorder (PTSD) and/or other negative mental health outcomes in adolescence."[16] One study has found that PTSD in children is underdiagnosed.[18]
- Children that experience ACEs or adolescents with depression are more likely to engage in risky behavior, such as alcohol and nicotine abuse or dependence, suicidal tendencies, school failure, aggressive behavior, etc. later in life.[27, 28]
- Oftentimes without school-based programs, youth do not get the mental health services they should.[29, 30] One study found that Black and white youth were equally likely to have a mental illness, but Black youth were half as likely as white youth to get help from specialty mental health services.[29] The same study found that school services, however, showed little ethnic disparity. Another study found that three barriers are common for children getting the mental health help they need: "(1) Lack of knowledge about child mental health and help-seeking pathways, (2) Stigmatization and parent blame (3) Challenges of multiagency collaboration."[31]
- Secondary Traumatic Stress (STS) in an educational setting can be described as when an educator learns about a primary victim's (often a student) traumatic experience and then experiences vicarious trauma. Symptoms of STS can be burnout, compassion fatigue, PTSD, etc.[10] "Untreated STS may be among the hidden causes of undesirable workforce turnover for principals and teachers, particularly when STS and children's trauma are clustered in high-poverty schools."[10]

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Appendix

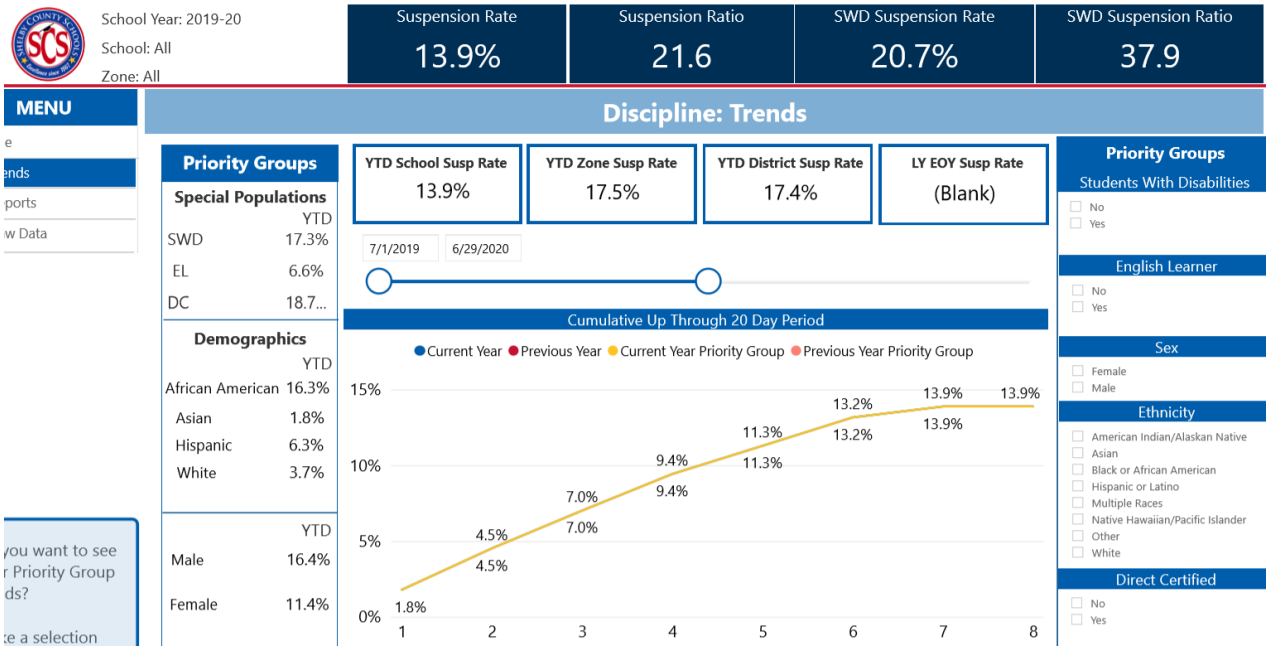

Figure 1: Power Bi Dashboard: Student Profile (ILD): Districtwide high school discipline rates for 2019-20

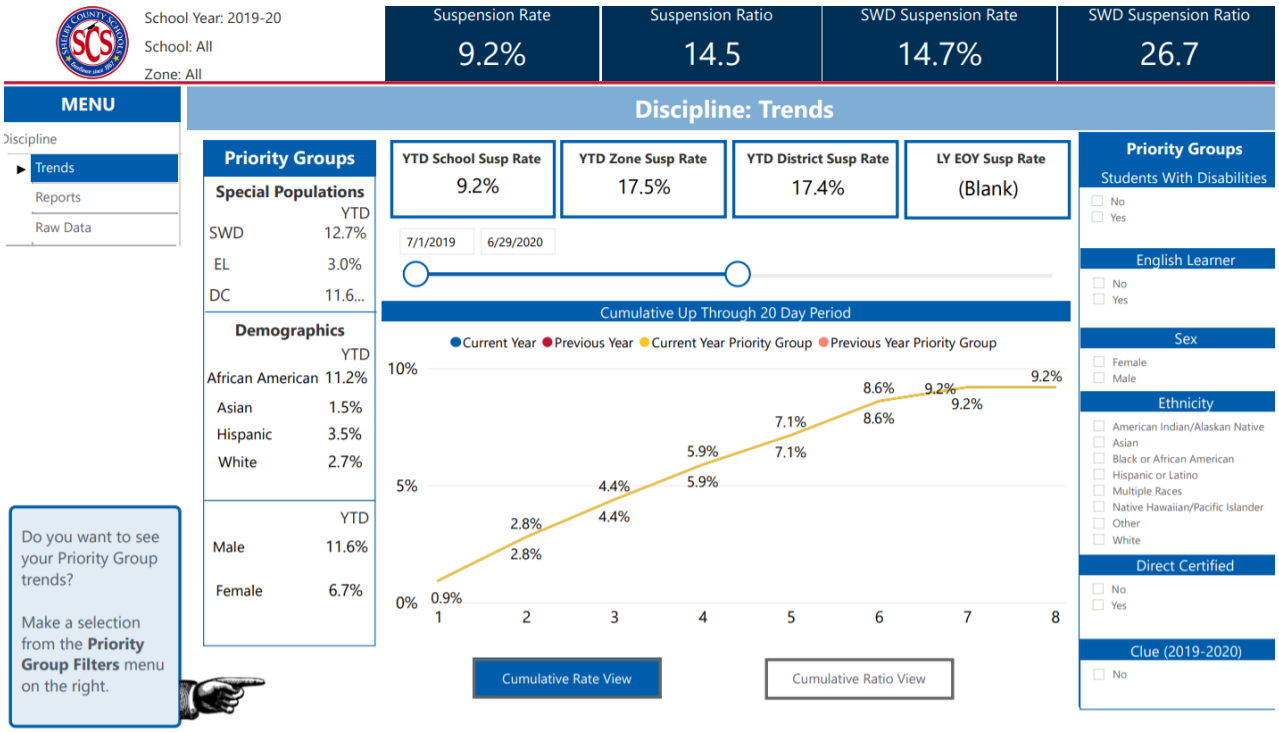

Figure 2: Power Bi Dashboard: Student Profile (ILD) Districtwide all grade bands discipline rates for 2019-20

LEVEL	TIER 3: Targeted/Intensive Supports (Tertiary Intervention)
Students	School-based, trauma-specific individual, group, and family therapy services for students with trauma-related mental health difficulties; includes intensive collateral work with students' teachers, as well as consultation around Individualized Education Program (IEP) assessment and plans when IEP is warranted
Adults (staff and caregivers)	Brief crisis support for trauma-impacted school staff, and referral for more intensive services if needed
	Engaging and supporting parents/caregivers as part of their children's psychotherapy
System	Consultation around central district office personnel efforts to improve the district-wide Educationally Related Mental Health Services (ERMHS) process
	TIER 2: Selected Supports (Secondary Intervention)
Students	Psychoeducational skill-building interventions for at-risk students
Adults (staff and caregivers)	Wellness (non-treatment) support for school staff that addresses stress, burnout, and secondary trauma (e.g., teacher wellness groups)
	Participating in Coordinated Care Team meetings that address the needs of at-risk students and coordinate integrated responses, as well as; respond to school-wide concerns
System	Consultation to school or district efforts to re-examine and revise discipline policies and procedures, and alternatives to suspension
	TIER 1: Universal Supports (Primary Prevention)
Students	Classroom training for students on coping with stress
Adults (staff and caregivers)	Training and consultation for all school staff (e.g., teachers, administrators, support staff, paraprofessionals, and school medical and mental health staff) around (a) trauma-sensitive practices, and (b) addressing stress, burnout, and secondary trauma
	Psychoeducation and skill-building workshops for parents/caregivers on coping with stress
System	Providing a trauma-informed lens to school staff in their implementation of school-wide supports and interventions (e.g., Positive Behavioral Interventions and Supports, Restorative Justice/Practices, social emotional learning curricula)

Fig. 1 Examples of HEARTS tiered supports at three levels of intervention

Figure 3: The HEARTS Tiered supports from Dorado et al., 2016.[6]