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Optimizing the Effectiveness of Mental Health Support Staff in Your District

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Mental Health Statistics

Approximately 20% of children and adolescents have a mental health disorder. 5% are seriously emotionally disturbed.

Availability of Treatment

At most, half of them receive some mental health treatment, with the most common type being medication management by primary care physicians.

The majority of interaction between children and adolescents and mental health providers takes place in the school setting.

School District Response to the Covid-19 Crisis

The Covid 19 pandemic has added a whole new dimension of challenges in addressing students' mental health needs. Many students who previously had no mental health difficulties are now dealing with Covid 19 adjustment related problems, and students who had previously struggled with mental health disorders are now dealing with the additional stresses that COVID-19 brings.

In light of COVID-19, there needs to be expansion of tier 1 services for students and staff including a focus on lifestyle, self-mastery, mindfulness, and the cultivation of resilience. Tier 2 and 3 services need to be optimized, given the expected increase of mental health problems stemming from COVID-19. Mental health support staff play a crucial role in all three tiers.

Expansion of Tier 1 Services

Lifestyle Interventions

Behavioral patterns are the largest contributor to health and disease. They have a health contribution of 40%, followed by genetic disposition (30%), social circumstances (15%), healthcare (10%) and environmental exposure (5%).

Lifestyle behavioral patterns include diet, exercise, adequate sleep, use of tobacco, alcohol or other intoxicants and social connectedness.

Improving students' lifestyles results and improvements in health and mental health.

Learning the Skills of Self Mastery

Children and adolescents have a remarkable ability to self regulate their bodies and minds. They can learn to control their autonomic nervous systems (Dikel, W. and Olness, K., "Self-Hypnosis, Biofeedback, and Voluntary Peripheral Temperature Control in Children" Pediatrics 1980 66(3): 335-340). They can learn techniques that result in self-relaxation, increased focus and concentration, improved productivity and overall increases in well-being.

Schools are increasingly recognizing the benefits of teaching mindfulness techniques to students and educators. Mindfulness is defined as "increased, purposeful, nonjudgmental attention to the present moment."

Studies find that youth benefit from learning mindfulness in terms of improved cognitive outcomes, improved attention and focus, social-emotional skills, behavior in school, empathy and well-being. Teachers who learned mindfulness experienced reduced stress and burnout, greater efficacy in doing their jobs, more emotionally supportive classrooms and better classroom organization.

Cultivating Resilience

A key aspect of student's well-being is the self-esteem that results in mastering one's response to life stressors. This results from learning resilience. Schools can build effective partnerships with students' parents to help foster the development of these crucial life skills.

The Roles of Mental Health Support Staff

Mental health support staff (school counselors, social workers, psychologists and nurses) play a key role in assisting students who have emotional and/or behavioral problems. Frequently, they report being "spread too thin", trying to provide mental health support services.

There is a wide variation in mental health backgrounds of mental health support staff. For example, some school districts employ deans rather than social workers, and many of the deans have very limited mental health training.

On the other end of the mental health background spectrum are licensed school psychologists and social workers who could “hang up a shingle” or be employed at a mental health clinic to provide mental health diagnosis and treatment.

Mental Health Counseling vs. Treatment

In general, mental health support staff in schools provide counseling and not mental health treatment.

Counseling refers to the provision of support, guidance, problem-solving and other activities focused on assisting students to succeed in school.

Therapy refers to the actual treatment of mental health disorders. An example of this would be the treatment of a suicidal student who has depression and posttraumatic stress disorder secondary to having been molested. Therapy may include the use of psychiatric medication.

School Districts and Mental Health Treatment

School districts could employ mental health professionals to provide diagnostic and treatment services to students, but this approach has significant associated potential problems.

All diagnostic and treatment notes become part of the educational record. Schools cannot obtain malpractice insurance if they are sued for poor supervision of mental health professionals, and their Errors and Omissions insurance clauses may not provide adequate protection. School professionals would need to provide evening, weekend and vacation coverage in the case of crises. Schools are unlikely to bill private insurance for mental health treatment.

Benefits of the Co-located Model of Treatment

The provision of mental health on-site services provided by clinicians working for a community mental health clinic can provide bridges to mental health services while maintaining adequate financial and legal firewall protection to the district.

Needs Assessment

Given the great need for mental health services, it is essential to conduct a needs assessment and an assessment of available resources in order to optimize mental health support services in a school district.

Many school districts provide a wide variety of mental health support services. These are usually provided for students in tiers 1 and 2.

The Pyramid Model

The pyramid model (e.g. the Multi-Tiered System of Support (MTSS) model) identifies approximately 80% of students requiring tier 1 services, 15% requiring tier 2 services and 5% requiring tier 3 services.

Tier 1 refers to universal services provided all students, visualized as the bottom of a pyramid. Tier 2 refers to services provided to at risk students, often in the form of groups. Tier 3 refers to students who are identified as needing more intensive individual assessment and interventions.

Many districts do an excellent job of providing mental health support services to a wide variety of students. However, an analysis of outcomes indicates very serious ongoing problems for many of the most severely disturbed students.

Widespread Severity Reflected in the Minnesota Student Survey

Although numerous mental health supports are provided by school social workers, school counselors and school psychologists, the results of the Minnesota Student Survey continue to reflect significant evidence of mental health disorders in students.

For example, one relatively affluent district's students reported on the Minnesota Student Survey:

As high as 42% of 11th grade females and 26% of 11th grade males reported that they had long-term mental health behavioral or emotional problems lasting six months or more.

Seriously considering attempting suicide within the last year ranged from 5% of 8th grade males to 17% of 11th grade females. "More than a year ago" ranged from 5% for 8th grade males to 20% of 11th grade females.

Among those who missed part or all of a full day of school due to feeling very sad, hopeless, anxious, stressed or angry ranged from 3% of 5th grade males to 31% of 11th grade females.

As many as 37% of 11th grade females reported feeling down, depressed or hopeless several days in the last two weeks.

Feeling nervous, anxious or on edge nearly every day was reported by 22% of 11th grade females.

These numbers suggest that there is a population of students who demonstrate significant evidence of ongoing mental health disorders.

Drilling Down for Mental Health Data

Mental health data from the Minnesota Student Survey can be analyzed by your district to hone in on the identification of students who are particularly at risk for mental health disorders. For example, in the last district where I consulted, if an 11th grade female reported receiving mostly C grades, she had a 44% chance of having ongoing suicidal ideation. Data analysis can shed light on the most effective use of interventions for vulnerable, at risk students.

Roles and Responsibilities

Identifying and establishing clearly defined roles and responsibilities for mental health support staff is the first step in ensuring optimization of mental health support services

Supervisory Challenges

Directors of student support services including special education services may find themselves being criticized by mental health support staff for having a limited background in mental health. In some situations, the directors may feel that they do not have the expertise to supervise mental health support activities, and this may result in self-supervision of the mental health staff.

This situation runs the risk of working without an overall district mental health plan that is data driven, that stresses accountability and that is outcome oriented.

Skill Sets

An analysis of roles and responsibilities begins with the understanding of skill sets of mental health support staff. Interestingly, the websites for American Associations of school social workers, school counselors and school psychologists describe many similar mental health support activities for their practitioners. School nurses also play a major role in providing mental health support services, given their frequency of dispensing psychotropic medications and seeing students who have underlying mental health problems.

Flexibility of Providers' Roles

The process of assigning specific activities for various mental health support staff does not have to be a rigid one. What works at one school site may not work at another. Flexibility is possible as long as the overall goals of providing appropriate services to the right students in the right way are accomplished.

Adequacy of Mental Health Support Services

District staff may have a misperception about the adequacy of mental health support staff services. Data analysis can clarify whether a district falls within the normal range of support staff versus being an outlier with inadequate services available.

Prioritizing Services

In many districts, services are provided that may have been essential at one point but are no longer necessary. Providing group counseling on an ongoing basis to a small number of students who demonstrate mild impairment may not be the best use of time. Given complaints of being stretched too thin and requests for hiring additional staff, it is worthwhile to prioritize present day activities to assure that they are essential. This is especially important, given the high degree of very serious pathology indicated by the Minnesota Student Survey and other sources.

Overlap of Services

In order to assign appropriate activities for different groups of support staff, skill sets need to be clarified for each group. Some activities can be accomplished by a variety of groups. For example, skills training can be done by most psychologists, counselors, social workers and many teachers. Other activities require specific expertise. For example, only nursing staff can disperse medication and only school psychologists can do psychometric testing.

What are People Doing?

It is not unusual in my consulting practice to work with school districts in which the director of student support services does not have a clear idea of the nature and extent of various mental health support services provided in their district. In that situation, I recommend an anonymous survey to be filled out by school social workers, school psychologists, school counselors and school nurses that identifies the number of approximate hours per week spent on various interventions. The results of this activity analysis can be truly surprising, with huge discrepancies in the amount of time that various interventions are provided. This is the first step in assuring that activities reflect student needs.

After skill sets are established, specific interventions are identified and prioritized. The provision of interventions needs to be accompanied by continual analysis of progress and outcome. For example, if a student is to be seen for individual counseling, there needs to be a process of identifying the nature of the problem, the need for services, evidence of progress being made, and identification of factors that would indicate that counseling is no longer necessary.

Efficiency of Service Provision

An analysis of mental health support services may indicate that some interventions are not necessary. Mental health staff spend a great deal of time involved in case management, some of which could be done by a county case manager instead. Similarly, crisis management from county or county contracted services may be underutilized. For example, school professionals may be doing suicide assessments or other interventions that the county crisis team could be doing. Time spent doing special education assessments can be freed up in some cases when innovative tier 2 services are used to

prevent the need for a special education assessment. Districts can help parents understand that special education social work related services may no longer be necessary, and that there is no clear advantage of continuing them "just in case". Prioritization of student support activities may indicate that some are not necessary

Unfortunately, in many districts, mental health support services are provided in a certain way because "that's how we have always done it". Establishing clearly defined roles and responsibilities is akin to the process of removing cars from the parking lot, painting new parking spaces according to prioritized responsibilities, and assuring that cars are parked in a planful manner.

Addressing Mental Health Disorders

The significant evidence of serious and widespread student psychopathology including depression, anxiety and suicidal thoughts or acts raises important concerns about how this problem can be better addressed. The numbers indicate that the pyramid model used by interventions such as the Multi-Tiered System of Support is not reflective of the high percentage (much higher than 5%) of students requiring individualized attention due to evidence of mental health disorders. This is partially due to the fact that pyramid models are designed for interventions for students who are demonstrating school problems. Thus, students who are getting average grades or better and who are not demonstrating aberrant behavior could be easily missed in this model.

It is not surprising that students who have significant mental health disorders demonstrate a limited response to tier 1 and tier 2 activities. Many mental health disorders have a biological basis and require clinical interventions. They include many anxiety disorders, mood disorders, psychotic disorders, etc. Just as a student at risk for diabetes may develop that disorder even though he or she has a healthy lifestyle as a result of counseling, a student may develop major depression, bipolar disorder, panic disorder, obsessive compulsive disorder, etc. despite receiving excellent tier 1 and tier 2 services.

Special Education Database

Students being evaluated for EBD services are screened for evidence of mental health difficulties. In fact, the vast majority of them have either already been diagnosed with mental health disorders or demonstrate evidence of having them. Districts can create a database that can identify students' educational and mental health issues in such a way as to optimize the process of identification and servicing of students who have mental health disorders.

Mental Health Training

In order for mental health support staff to be optimally effective, they require adequate mental health training that includes the nature of mental health disorders, their manifestation in the classroom, and effective classroom interventions that take these disorders into account. Training needs to be provided to teachers as well.

Co-located, On-site Community Mental Health Treatment

If in fact, many of school districts' most severely disabled students have a limited response to interventions provided by mental health support staff, consideration should be made for expanding contractual relationships to community mental health clinics that provide diagnostic and treatment services.

Although mental health services are provided in the community, many families have great difficulty utilizing these services for a variety of reasons. These include disruption of the parent's workday and difficulty with co-pays and deductibles.

Many school districts use the model of co-located, on-site community mental health treatment providers in the schools. They can bill Medicaid and private insurance and may receive funding from grants and the school district to cover ancillary, unbillable services. Costs to cover ancillary services would generally not exceed $40,000 a year per full-time equivalent clinician. Much of these funds can come from non-school sources.

The issue of expanding co-located services requires clinical, educational and financial consideration. For example, if a district is deciding on whether to hire a school social worker, or to provide financial assistance to a community mental health clinic to expand co-located services, it is necessary to analyze the unmet need for tier 3 services and the staffing patterns that would be necessary to have them provided at an adequate level. I would argue that if there is an abundance of tier 1 and tier 2 services with ongoing evidence of a need for tier 3 diagnostic and treatment services, the school district should seriously consider increasing co-located services rather than tier 1 and 2 services.

This issue is certainly controversial. School mental health support staff may feel threatened regarding job security if additional co-located clinical services are added to the district.

District administrators may be concerned about payor of last resort issues. Mental health school law mandates mental health diagnostic and treatment related services for a small proportion of special education students who, but for the treatment, would be unable to benefit from educational programming. In general, co-located services should be conceptualized as a method to increase access and availability to community mental health services, rather than being a school-provided educational service.

Ultimately, addressing student mental health disorders is a societal responsibility in which schools play only a partial role. True collaboration between multiple child serving systems is necessary in order to effectively address these complex issues. Mental health support staff provide essential services to school districts. In order to optimize their effectiveness, it is necessary to take a "big picture approach" that assures that all students have available services that meet their needs.

Addendum:

A School District Mental Health Plan

School districts have health plans outlining activities necessary when dealing with medical disorders such as asthma or diabetes. They generally do not have mental health plans. For planning to be most effective regarding mental health support staff activities, their services should be part of an overall mental health plan for the district.

School District Mental Health Plan:

1.) Roles and Responsibilities

2.) Supervision

3.) Pre-referral Interventions

4.) Educational planning

5.) Methods of Conducting Educational Evaluations of Students who have Mental Health Disorders

6.) Clarification of Behavioral vs. Clinical Contributors to the Student's School Difficulties

7.) Designing Accommodations and Modifications Based on the Symptoms of a Student's Mental Health Disability

8.) Crisis Intervention

9.) Mental Health Data Practices

10.) Gathering and Analysis of Individual and Group Mental Health Data

11.) Documentation of Activities

12.) Protocols and Checklists

13.) Symptom Monitoring and Communication of Behavioral Observations to Parents and Medical/Mental Health Providers

14.) Provision of Direct Services to Students

15.) Adopting Evidence-Based Teaching Methods for Students who have Emotional/Behavioral Problems

16.) Creating Partnerships with Community Providers, Including the Establishment of Co-located Mental Health Services

17.) Maximizing Reimbursement to Assure Program Sustainability

18.) Coordinating with County Resources

19.) Mental Health Training

20.) Consultation as Needed

21.) Outcome Assessment