Children's Behavioral Health Highlights

Strengthening the children's crisis system of care through school-based health centers

Issue #4

Introduction

Through the Children's Behavioral Health Initiative (CBHI), Massachusetts has developed a robust, statewide crisis system of care for children that has reduced use of emergency departments and decreased the need for inpatient psychiatric treatment. There are 21 Mobile Crisis Intervention (MCI) teams across the Commonwealth providing community-based interventions and brief treatment that collectively delivered 37,024 episodes of care in 2015. Schools initiated 20% (7,413) of these MCI service requests and the intervention was provided in a school 8% (2,983) of the time.[1] These are impressive statistics, but only one part of the story in understanding the scope and scale of any community's crisis need and assuring commensurate, effective response.

Those 21 MCI teams serve a state that has 404 public school districts representing 1854 schools[2] and hundreds of other private schools. On any given day, most if not all of the schools are likely watching for, supporting, or actively engaging students experiencing mental health crises without calling a MCI team.

Present in 33 schools across the Commonwealth, the School-Based Health Center (SBHC) Program, administered by the Department of Public Health (DPH) since 1989, has become an integral part of the health care delivery system for children in Massachusetts. The Centers play a critical role in efforts to reduce disparities in health care access and child health status by providing a consistent source of primary health care in the most accessible environment. School-based health center care has been shown to be an important option for reducing both financial and non-financial barriers to health care, such as lack of insurance, lack of confidentiality, inconvenient office hours and locations, inability of working parents to leave their jobs to get children to care, lack of transportation, and apprehension and discomfort discussing personal problems affecting health.

Viewing the traditional crisis system from the lens of the school, it is easy to see that MCI teams and the community mental health system are on their own insufficient in serving the mental health needs of students in any particular school. The school population includes students unknown to treatment services; those who carry varying insurance (or no insurance); and students unlikely to participate in formal treatment services. In each school and on any given day, some students, (reported by the SBHC teams to be in the range of 30-200 depending on the school) are swirling around in some type of crisis, often taking the time and attention of several student support staff. SBHC teams also spend considerable scheduled and unscheduled time each week addressing these crises.

Each MCI team serves multiple school districts and dozens or even hundreds of different schools depending on the region. Even when a MCI team provides an extended service, it is point-in-time care. SBHC teams are there before, during and after a crisis episode and thus are better positioned to do prevention and aftercare work than a MCI team.

[1] Source: MBHP. CY 15 (Jan15-Dec15), MCI 0-20, All Payers

[2] https://ballotpedia.org/Public_education_in_Massachusetts

This brief provides an overview of a training and coaching initiative offered to behavioral health clinicians working in five SBHCs located in a city in northeastern Massachusetts. It describes the scope of the training and coaching activities, the results it had on the SBHC team member's comfort in addressing crises, and overall impressions regarding the role of a SBHC in the larger "crisis system of care."

Training and coaching support

The DPH School Based Health Center Program in collaboration with the CBH Knowledge Center and MassHealth, implemented a training and coaching initiative with five SBHC programs. Project objectives were to:

1. Increase SBHC team comfort and competence in crisis planning, support and intervention with students and their parents/guardians
2. Brainstorm how a SBHC can function at its best in supporting schools and students when there is a mental health crisis.
3. Increase SBHC efficacy in partnering with MCI teams and other community providers to support youth in crisis.

Participating teams received two full days of training in student/family-centered and resolution-focused crisis planning, support and intervention. This was followed by two, on-site coaching sessions that were team-specific. Coaching sessions are a chance to transfer and apply classroom knowledge to the everyday complexity of working with specific students in crisis and their parents; within the context of the SBHC, host school, and broader crisis system of care.

Teams from the five pilot sites also received crisis and safety planning tools they can continue to use that are designed to realign care in ways that are student/family-centered and resolution focused.

The Children's Behavioral Health Knowledge Center, located at the Massachusetts Department of Mental Health, was established in Chapter 321 of the Acts of 2008: An Act Relative to Children's Mental Health. The Center's mission is to ensure that: the workforce of clinicians and direct care staff providing children's behavioral health services are highly skilled and well trained; the services provided to children in the Commonwealth are cost-effective and evidence-based; and the Commonwealth continues to develop and evaluate new models of service delivery. The Knowledge Center fills a gap in the children's behavioral health system by serving as an information hub, through its Annual Symposium, website, workshops, and webinars.

Results

In each site there were evident and verbalized positive shifts in the team's view of students in crisis or their parents; a renewed sense of efficacy, and formulation of new strategies for crisis planning, support and intervention with the student or parent. In two sites, there was an effective shift in thinking about collaborating with the local MCI team. And in one site, there was new understanding of the school's administrative approach to managing behavioral health crises and strategies formed for strengthening the relationship and flow of

referrals.

A survey was administered pre and post-intervention and significant positive changes were noted. For example, on a 5 part scale ranging from *Agree* to *Disagree*, the percent of participants who AGREE they have…

- …clear permission to carry out crisis planning and intervention for students and their families increased from 42% to 70%.
- …the skills, and feel comfortable engaging students in crisis planning increased from 58% to 80%.
- …The skills, and feel comfortable involving parents/guardians in crisis planning with students increased from 42% to 80%.

Conclusion

DPH was interested in SBHC knowledge acquisition but also what insights could be gleaned in doing this project with school-based teams. Here are some of those thoughts:

Schools are quite consumed and preoccupied by the business of educating hundreds and hundreds of students. And while the schools are certainly doing it, attending to mental health crises does not easily or naturally fit into the day—it is disruptive to both student and school. (*As a consultant who has largely viewed crisis systems through a mental health system lens, it was compelling to think about crisis systems from the lens of a school. I was jolted by the machine of the school—the tight timetables each day; the pace and movement of students and staff; and the need to mark educational progress each day, with few spare moments between bus drop off and pick up.*)

The potential value of an SBHC as an ally in sorting out and addressing health and mental health issues facing kids and families is clear, but not a given. SBHCs are guests in a school and as with any embedded team or program, they must be mindful of the idiosyncrasies of the school and work in a fashion that benefits students and families, while also being experienced as a net benefit for the schools. From a school perspective this might mean minimizing time out of essential classes, ensuring treatment goals have a link to school success and working in step with school protocol.

Uniquely, SBHCs can address crisis prevention and intervention across the acuity scale (not requiring a crisis to rise to a certain level of risk prior to intervention), and can do so within the cultural context of a student's home, school and community. This broad approach aligns with public health principles suggesting that care should focus on: "a) reducing mental health problems among children for whom a problem has been identified and b) helping all children optimize their mental health. Doing so can improve children's overall health, competence, and later functioning and life satisfaction."[3] Through SBHC sites, crisis support and intervention can be carried out not just when a child is in acute crisis, but also when a child's distress is expressed in a tummy ache or need for a hug. In these instances the SBHCs identified a health-promoting role in naming and strengthening a student's instinct for knowing they are in distress and taking a positive action to find soothing.

Effective crisis planning, support and intervention with children and families is necessarily (but not naturally) systemic. Effective crisis systems must be deliberately built and continuously attended

[3] Miles, J., Espiritu, R.C., Horen, ., Sebian, J., Waetizig, E. (2010). A Public Health Approach to Children's Mental Health: A Conceptual Framework. Washington, DC: Georgetown University Center for Child and Human development, National Technical Assistance Center for Children's Mental Health.

to remain robust. Building crisis competencies within other levels of care and other youth-serving systems improves essential skills in crisis planning support and intervention. But it also increases expectancy of and exerts influence on the traditional providers of crisis service.

Crisis capability and competency within each school varies considerably, as does overall school culture and climate. In the absence of an established relationship, a crisis team may be reluctant to engage a school or encourage a parent to share information with the school (not knowing if it will ultimately help or harm a student). Of course it is part of the job of MCI teams to provide ongoing outreach to youth-serving systems, including schools. But to ensure the best crisis treatment of youth and support of their families, the responsibility is mutual. SBHCs are positioned to have more intimate knowledge of the struggles of the students in their schools and neighborhoods, of cultural considerations, and of the crisis support approaches most likely to be sustainable within a given school. But the SBHC teams need strong working relationships with MCI teams in order to impart the knowledge.

Effective crisis systems of care (and all systems of care) feed on multi-directional tension—each part pushing the other to be the best it can be, teasing out the idiosyncrasies of each relationship, figuring out the best way to facilitate the movement of people and data, and accomplishing all of this in a way that maximizes the health benefit and minimizes the iatrogenic risk to student and family that is inherent in the work. It is systems work at its finest.

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