Mental Health Services as Student Support

Module 25

Thomas Monaghan, MS Ed

Old Dominion University

Series Editors

Irene Walker-Bolton
Virginia Department of Education
Richmond, VA

Robert A. Gable
Old Dominion University
Norfolk, VA

Stephen W. Tonelson
Old Dominion University
Norfolk, VA

Pat Woolard
Old Dominion University
Norfolk, VA

Virginia Department of Education Division of Special Education and Student Services
Web site: www.doe.virginia.gov/special_ed

Mrs. Martin noticed a recent significant decline in Martha's overall academic performance, having dropped by two letter grades over the past month. When Martha returned from winter break, she was considerably more withdrawn and disinterested in class activities. After discussion with her parents, Martha's change in behavior was evident at home, as well. Martha's mother expressed concern at her daughter's lack of enthusiasm and feared Martha was overwhelmed and frustrated by her academic decline. Both agreed that Martha's grades were of significant concern and may be a contributing factor to her withdrawal and depression. However, Martha's mother confided she had no idea why. She also divulged that she was uninsured and could not afford a psychological evaluation for Martha. Mrs. Martin assured her there were options available. With her consent, Martha could be referred to the school mental health program for evaluation in order to receive the help she needs.

Description of the Procedure

Many students with emotional disabilities evidence psychological problems that distinguish them from students with other disabilities. Manifestations of emotional distress can vary widely from withdrawn or depression (internalized) behavior to disruptive or acting out (externalized) behavior (Yell, Meadows, Drasgow, & Shriner, 2009). Students may pose unique complications that distress parents and stretch the capabilities and resources of special educators and school counselors. With the ever-increasing number of school-age children diagnosed with emotional disabilities, in-school mental health services have become the primary source of psychological care for many of these students (Elias, Zins, Graczyk, & Weissberg, 2003).

To meet the needs of students with psychological concerns, some schools are establishing counseling practices and mental health services to provide necessary treatment and supports. In light of an increasing demand for in-school mental health services, "expanded school mental health" programs need to reach students in need by providing comprehensive psychological care programs. These programs may include effective assessment, case management, preventive care, and therapy delivered through cooperative partnerships between schools and community mental health agencies (Weist & Albus, 2004).

The first step to providing appropriate mental health services for students is effective screening. Teachers play a key role in this process. Aside from the students' parents, teachers have the most contact with school-aged children. Considering their importance within the lives of their students, teachers must often don multiple hats throughout the school day, including surrogate parents, role models, confidants, and counselors. Classroom student performance typically is the first indicator of emotional, behavioral, and/or mental problems. Teachers should be able to recognize the warning signs of students in potential need of mental health services (mood swings, hyperactivity, frequent absences, aggressive behaviors, complaints of neglect or abuse, etc.) and be aware of the available options to pursue screening and treatment (Cohen & Angeles, 2006; DeSocio & Hootman, 2004).

It is especially critical for teachers to be mindful of students who experience feelings of anxiety, depression, hopelessness, withdrawal and avoidance, hyper-vigilance, separation anxiety, sleep disorders, recurring nightmares, heightened aggression, increased drug and substance abuse, or other deviant behaviors and physical symptoms. These students are particularly vulnerable to thoughts of suicide as a "way out." This is no surprise given the statistics. The suicide rate for 15- to 19-year-olds has tripled between 1960 and 1990, while the suicide rate for 10- to 14-year-olds has increased 120% between 1980 and 1998. Accordingly, schools must be prepared to help at-risk children (Kalafat, 2003).

The next step toward establishing an effective mental health program is to structure the program around existing school resources. This can be accomplished by augmenting the responsibilities of school counselors, nurses, social workers, and special education teachers. A coordinated effort by all school personnel serves as the basis for a successful mental health program.

The Health Resources and Services Administration (HRSA) provides an overview for establishing and maintaining an effective in-school mental health program. Schools must be ready to identify at-risk students, refer them for assessment, provide interventions, and monitor their progress as part of a school-wide program to ensure their psychological well-being. Schools must also be able to identify school and community-based resources for students in need of long-term mental health care. Partnering with community-based services can provide students with long-term care options that normally would not be available to them during breaks and vacations. Additionally, school mental health programs must coordinate effectively between the parents and community-based agencies while maintaining a staff of qualified school-based personnel including counselors, psychologists, social workers, nurses and nurse-practitioners, and other professionals trained to assist children with emotional, behavioral, and mental health conditions (HRSA, 2010).

When to Consider Mental Health Services

Recent research has shown that mental health disorders among children is more prevalent than previously believed. Up to 20% of the youth population experience mental disorders while 10% of these children experience mental conditions that are significantly detrimental to daily functioning. Many students with emotional problems are provided these services through the

mandates of IDEA (Yell et al., 2009). However, only half of all students who qualify receive services (Wagner et al., 2006). Additionally, students who have a disability other than an emotional disability are not provided mental health services through IDEA. These children may have to rely upon legal channels to seek the assistance they require. A more troubling statistic is that half of all children experiencing mental disorders do not receive any mental health care (Yell et al., 2009). Of those that do, upward of 80% receive services for their condition only at school (Gonzalez, Nelson, Gutkin, & Shwery, 2004). These findings underscore a growing need for in-school mental health screening, services, and mental health personnel.

Guidelines for Implementation of Mental Health Services

The Developmental Pathways Screening Program provides five key components to successful screening:

1. Universal screening for all students, not only for those "at risk."
2. Accommodations for students with special needs.
3. Questionnaires that probe for both internalized and externalized manifestations of emotional problems.
4 Follow-up clinical consultations for students who exhibit signs of emotional distress through the screening process.
5 Integration and collaboration among academic, social, and psychological resources and supports (Vander Stoep et al., 2005).

The 'Our Kids' program is one model for in-school mental health services linked to academic outcomes. The Our Kids program is a multidisciplinary, multi-agency approach to mental health care that integrates the activities of teachers, school social workers, principals, case managers, mental health clinicians, and county child-serving agencies. The program provides a continuum of preventative services, including consultation and support to teachers on effective classroom management, and community organizing linking families with local health care resources and services. Early-after-onset interventions provide for screening, resource coordination, crisis debriefing, individual or group behavioral interventions; while services for severe/chronic problems include referrals to clinical mental health specialists, grief and anger management group support, and coordinated services between multiple agencies and programs. The referral, screening, and treatment process involves:

1. Initial referral by the teacher, principal, social worker, or other responsible school professional.
2. The case manager conducts an initial assessment across multiple domains then develops an intervention plan.
3. Students who show signs of an emotional disorder are referred to a licensed mental health specialist or organization for further evaluation and treatment.
4. The mental health specialist's recommendations and treatment plan is closely coordinated with the case management team.
5. If necessary, the case manager may initiate crisis response procedures in urgent risk situations.

6. Case managers conduct individual meetings with students and parents, family meetings, crisis intervention, coordinate interaction with other agencies and organizations to broker needed services (Cohen & Angeles, 2006).

For students with more severe emotional problems, the Intensive Mental Health Program (IMHP) model may prove more successful, especially for children whose academic performance and/or behaviors have been significantly impacted by their condition. IMHP is a highly structured program that utilizes behavior management methods and positive reinforcement contingent upon appropriate behaviors across school and home settings. Students enrolled in the program attend school during half the day with the intent to return to full-time attendance. IMHP provides continuous, cooperative consultation and treatment delivery between parents, child, and care providers while offering an array of evidence-based interventions tailored to the student's specific needs and abilities.

A major concern of in-school mental health providers is student suicide prevention. Some students must regularly contend with instability within the family, substance abuse, cyber-bullying, violence, and risky sexual behaviors. Students from minority backgrounds face ridicule, stereotyping, and social rejection. Children who do not "fit in" are especially prone to depression, anxiety, and low self-worth. These are vulnerable children who may find no other recourse than the services available at school.

Despite financial complications that decrease access, training, and staffing to in-school mental health services, resources exist to aid schools and students in need of services. These outlets include Medicaid and the State Children's Health Insurance Program which provide financial assistance for low-income families of children with certain types of disabilities. The Substance Abuse and Mental Health Services Administration as well as The Children's Mental Health Services Program provide funding to states and local communities to implement services for school-age children with mental, emotional, and substance-abuse disorders. Finally, the Department of Education's Office of Special Education and Rehabilitative Services under IDEA provides for mental health services to students who qualify for in-school assistance.

Despite an academic infrastructure conducive to providing mental health services to students with emotional problems, a relatively low percentage of these students are provided services. Similarly, only half of students with emotional problems receive behavioral support plans despite them being an IDEA mandate. Mental health services not only serve the students, but also provide a support network for these overwhelmed teachers. Just as troubling is the low percentage of family support services provided across all grade levels. These services empower families to become more involved in the mental health treatment of their children, and also contribute to improved academic performance (Wagner et al., 2006).

Some emotional and mental disorders may be long-term or permanent, requiring consistent, year-round care which most schools are unable to provide due to the unavailability of personnel and services during extended breaks (Hoagwood et al., 2007). One final complication to in-school mental health services involves limited access and diminished quality of care due to funding issues. Coordinated and collaborative training, screening, and service delivery among health care professionals and teachers requires funds from a continually shrinking school budget; services that are often sacrificed at the expense of student health and welfare (Maag & Katsiyannis, 2010).

Despite efforts to improve student access to in-school mental health services, four challenges remain:

1. Reduction in the stigma attached to receiving mental health services.
2. The formation of interagency partnerships.
3. Securing parental consent and privacy measures.
4. Achieving mental health service capacity (Weist & Paternite, 2006).

References

Cohen, E., & Angeles, J. (2006). School-based prevalence assessment of the need for mental health services: Survey development and pilot study. *Research on Social Work Practice*, *16*(2), 200-210.

DeSocio, J., & Hootman, J. (2004). Children's Mental Health and School Success. *The Journal of School Nursing*, *20*(4), 189-196.

Elias, M. J., Zins, J. E., Graczyk, P. A., & Weissberg, R. P. (2003). Implementation, sustainability, and scaling up of social-emotional and academic interventions in public schools. *School Psychology Review*, *32*, 303–319.

Gonzalez, J. E., Nelson, J. R., Gutkin, T. B., & Shwery, C. S. (2004). Teacher resistance to school-based consultation with school psychologists: A survey of teacher perceptions. *Journal of Emotional and Behavioral Disorders*, *12*(1), 30-37.

Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. (2010). *Health, mental health and safety guidelines for schools: Health and mental health services*. Retrieved July 30, 2011, from http://www.nationalguidelines.org

Hoagwood, K. E., Olin, S. S., Kerker, B. D., Kratochwill, T. R., Crowe, M., & Saka, N. (2007). Empirically based school interventions targeted at academic and mental health functioning. *Journal of Emotional and Behavioral Disorders*, *15*(2), 66-92.

Kalafat, J. (2003). School approaches to youth suicide prevention. *American Behavioral Scientist*, *46*(9), 1211-1223.

Maag, J. W., & Katsiyannis, A. (2010). School-based mental health services: Funding options and issues. *Journal of Disability Policy Studies*, *21*(3), 173-180.

Vander Stoep, A., Mccauley, E., Thompson, K. A., Herting, J. R., Kuo, E. S., Stewart, D. G., Anderson, C. A., & Kushner, S. (2005). Universal emotional health screening at the middle school transition. *Journal of Emotional and Behavioral Disorders*, *13*(4), 213-223.

Wagner, M., Friend, M., Bursuck, W. D., Kutash, K., Duchnowski, A. J., Sumi, W. C., & Epstein, M. H. (2006). Educating students with emotional disturbances: A national

perspective on school programs and services. *Journal of Emotional and Behavioral Disorders, 14*(1), 12-30.

Weist, M. D., & Albus, K. E. (2004). Expanded school mental health: Exploring program details and developing the research base. *Behavior Modification, 28*(4), 463-471.

Weist, M. D., & Paternite, C. E. (2006). Building an interconnected policy-training-practice-research agenda to advance school mental health. *Education and Treatment of Children, 29*, 173–196.

Yell, M. L., Meadows, N. B., Drasgow, E., & Shriner, J. G. (2009). *Evidence-based practices for educating students with emotional and behavioral disorders*. Upper Saddle River, NJ: Pearson.