APPENDIX A

Adapted from the *Final Report On School-Based Mental Health*
Conducted by The University of Kansas, School of Social Welfare, Center for Children and Families[1]

Statewide Survey Data: Key Findings

Online surveys were disseminated statewide to educators, community mental health providers, and parents. A summary of each survey follows.

Educator Survey Results

Sample

A total of 777 educators and school staff completed a one-time, online survey. The sample was 81% female, 92% White, non-Hispanic; the average age was 45.5 years (*SD* = 11.1). Approximately 76% of respondents reported having a master's degree and had been at their current school an average of 18 years (*SD* = 10.8). The majority of the respondents were school staff: 226 counselors/mental health providers (29%), 139 teachers (18%), 124 administrators (superintendent or principal; 16%), and 73 special education teachers (9%). Over 55% were elementary school staff, and 30% and 31% were employed at a middle or high school, respectively. Forty-six percent of respondents characterized their school as serving a rural area with 23% reporting serving a suburban locale and 21% urban.

Results

Although 74% of respondents reported being aware of resources in their school to assist students with mental health needs, 65% felt these resources were inadequate and over 84% felt there needed to be greater access to school mental health services. Most educators (66%) reported being moderately confident about recognizing mental health issues among students; however, 84% agreed or strongly agreed that further professional development training is needed, including training on mental health disorders (58%), training on behavioral management techniques (57%), specialized skill training (e.g., social skills, anger management skills (52%), positive behavioral supports (50%), and information on understanding trauma (45%). Major themes of current successes in and barriers to school-

based mental health (SBMH) are outlined in Tables 1 and 2.

Table 1
Educator Survey Results: Major Qualitative Themes for Successful Collaboration

Identification & Referral	"Being able to identify serious issues and refer to local mental health center [is important]."
Relationship Building	"At this time teachers, administrators or school counselors that reach out and purposely develop relationships with students and family are our best means of support and aid to students."
Services & Supports at School	"Having [CMHC staff] located in schools fosters better understanding and trust among school staff and mental health staff."
District-Employed Mental Health Staff	"Our district has recently added full-time social work services in several elementary schools in our district. The schools with full-time services are now better equipped to identify and assist in helping those students and their families access mental health services. These social workers also provide mental health training for teachers and other staff members which helps in the identification and referral for mental health services."
Team Approach	"Working together as a team with parents, school psychologists, teachers and outside agencies works the best …"
Collaboration & Communication	"Collaboration between staff and mental health professionals in schools to try and help families get the proper mental health referrals needed and communication with parents to either share concerns or to discuss issues a student is having [is key]."
Prevention Programming	"Proactive, preventive mental health care with the counseling curriculum taught in the classrooms" and "school wide positive behavior support, education or proactive approach to behaviors" [are needed].

Table 2 ***Educator Survey Results: Major Qualitative Themes for Current Barriers***	
Lack or Resources/ Funding	"The continuous issue of funding for implementing services in the most comprehensive way – more staff, more time. Juggling academic issues and mental health concerns requires numerous individuals and the need to keep consistency in how services are provided."
Parent Engagement	"Takes a long time to convince the family to take the child to a mental health agency, then childcare and transportation, getting time off work are barriers for families."
Lack of Training & Knowledge among School Staff	"The general education support staff has little training in the area of mental health. There should be more professional development days geared toward addressing student mental health."
Collaboration with CMHCs	"Our community mental health providers are underfunded leading to a lack of adequate services for our students;""Not enough qualified counselors and psychologists in our community;""There is too much confusion between the school and community on the roles each have."
Stigma	"Stigma. No one wants to admit they have a mental health issue. Only once they become severe are issues dealt with;""Overall social stigma is still pervasive in our small community."

Community Mental Health Center (CMHC) Staff Survey Results

Sample

A total of 71 community mental health providers responded to the survey (78% female, 87% white, non-Hispanic; average age was 39 years old, *SD* = 12.0). Most respondents had at least a four-year college degree (31.4%) or master's degree (41%) with 45% holding a professional license (e.g., LMSW, LSCSW, LMFT, LPC). Participants reported they had been in the mental health field for an average of 11 years (*SD* = 8.6). Approximately 20% described the geographic region served by their CMHC as urban, whereas 11% said semi-urban, 28% suburban, 59% rural, and 7% frontier. A range of job titles were reported, including attendant care worker (*n* = 3), case manager (*n* = 11), therapist (*n* = 7), program director/manager (*n* = 6), CBS director (*n* = 9), wraparound/parent support facilitator (*n* = 2), CPST (*n* = 5), and CEO (*n* = 1), with 27 respondents not reporting their job title.

Results

Most participants reported favorable working relationships with local schools, with 32% agreeing and 57% strongly agreeing with the statement that their CMHC had a positive working relationship with local schools. Most participants (79%) reported that their job included working with school staff to address students' mental health concerns. Approximately 46% noted that they found schools to be reluctant to work with CMHCs to address students' mental health concerns. Of note, 90% reported that children and adolescents need greater access to mental health services at school.

Participants listed a number of ways in which collaboration between schools and CMHCs were working well, including:

1. Similar **goals** for behavior modification in the classroom and in other settings
2. **Providing** services in the school
3. Collaboration specifically between **school-based mental health professionals**, like counselors and school social workers
4. **Monthly meetings** with schools to discuss students already in services
5. Ongoing and open **communication** with special education teachers, counselors, and school administrators
6. IEP and wraparound **planning meetings** with school staff
7. **Including** school staff in treatment planning meetings
8. Actively **introducing** CMHC staff to staff at the local schools
9. **Sharing information** between schools and CMHCs to coordinate care
10. Providing **prevention** programming (e.g., suicide, bullying) in schools

However, participants also reported that they had experienced a range of barriers when collaborating with schools. Table 3 lists these barriers and the percentage of participants who endorsed them.

Table 3
Barriers to Collaboration Endorsed by Participants

Barrier	Endorsement
Lack of Knowledge About Mental Health Issue Among School Staff	62%
Different Priorities Between CMHC and School System	59%
Difficulty Coordinating Meeting Times With School Staff	45%
Negative or Stigmatizing Attitudes Among School Staff	44%
Limited Time to Collaborate Due to Limited Funding or Capacity to Bill for Services	42%
Unclear Boundaries and Roles Between CMHC and School Staff	39%
Lack of Administrative Support for Collaboration at the School of District Level	31%
Lack of Interest in Mental Health Issues Among School Staff	30%
Amount of Time Required to Coordinate With School Staff	28%
Confidentiality Restrictions in CMHC	22%
Lack of Structure or Mechanism for Collaborating	17%
Lack of Administrative Support for Collaboration at the CMHC Level	16%
Confidentiality Restrictions in Schools	10%
Staff Turnover in Schools	10%

Parent Survey Results

Sample

A total of 18 parents responded to the survey. Despite continued efforts to collect additional parent surveys, the response rate among parents was low. Thus, all parent results must be interpreted with caution. Of these 18 respondents, 78% were female, and 67% identified as White, non-Hispanic. The average age was 47 years old (*SD* = 9.6). All reported having some college education (21%), with 28% reporting a college degree and 50% reporting a master's degree. On average, the child receiving mental health services was 12 years old (*SD* = 4.9) and 58% were male. Range of diagnoses was reported, including ADHD, ODD, CD, Anxiety, ASD, FASD, Bipolar, RAD, and PTSD. Nine parents did not report a specific diagnosis. Only 30% indicated that their child received mental health services at school. However, 54% indicated their child receives special education services.

Results

In terms of how well school staff and CMHCs collaborate to meet their child's mental health needs, 44% of parents reported that the collaborative process worked well, but only 33% reported that there was clear communication between the school and CMHC to coordinate care. Relatedly, only 33% felt their child received adequate support at school for his or her mental health needs with less than 20% reporting that adequate resources were in place at their child's school to support mental health issues. Only 22% felt confident in school staff's ability to address their child's mental health needs.

Parents did indicate that several aspects of collaboration between schools and CMHCs were working well. These included consistency in care, particularly among the mental health staff (e.g., same worker for years); consistency in special education staff that understand child's needs well; flow of communication once appropriate releases are in place; and open communication between therapists/case managers and school staff. However, parents also reported several barriers, the most common being a lack of mental health knowledge among school staff, negative or stigmatizing attitudes among school staff, and differences in job responsibilities and roles in schools and CMHCs (e.g., differences in attendant care workers at CMHCs and paraprofessionals at schools).

Summary of Survey Results

Consistent themes were seen across the educator, CHMC, and parent surveys, including the following:

1. **Resources** to address students' mental health needs at school are currently **inadequate.**
2. **Lack of knowledge**/need for further **professional development** exists among school staff.
3. Greater **flexibility in funding** is needed to better meet the needs of students.
4. **Ongoing communication** is key to successful collaboration and coordination of care.
5. Consistent **planning meetings** between families, school staff, and CMHCs strengthen the provision of services through greater role clarity and coordination of care.
6. **Providing services in schools** (e.g., CMHC staff providing services in schools; having school-based mental health staff in place) is an important way to meet students' needs and address key barriers, such as stigma, transportation, etc.

Recommendations

System-Level Infrastructure

1. Provide training statewide to educators on recognizing and appropriately responding to mental health issues among students.
    a. Continue to offer Youth Mental Health First Aid (YMHFA) to educators around the state for *free* and allow for continuing education hours for licensure.
    b. Strongly encourage participation via supportive leaders in the field (e.g., Kansas State Department of Education [KSDE] Commissioner, School Board Association, Professional Associations such as the Kansas School Counselor Association or Kansas Association of American Educators).
2. Provide training to educators on social and emotional learning (SEL) to assist with the integration of SEL skills into the classroom.
    a. Conduct statewide training on the newly adopted Social, Emotional, and Character Development (SECD) Standards.
    b. Support the implementation of SEL programs in schools (e.g., *Second Step*) via targeted funding.

3. Create flexible funding mechanisms.
    a. Consider joint applications for funding by the Kansas Department of Aging and Disability Services (KDADS) and KSDE.
    b. Jointly fund initiatives by combining existing KDADS and KSDE revenue streams.
4. Provide cross-system training opportunities.
    a. Invite CMHC staff to participate in existing statewide trainings hosted by KSDE (e.g., Safe and Supportive Schools Conference).
    b. Invite school staff to participate in existing statewide/community level trainings supported by KDADS.
5. Examine the impact of current models of SBMH on student outcomes and establish a set of best practices for Kansas schools.
    a. Identify current models of SBMH in the state and assess the impact on students' mental health, academic success, and social-emotional learning.
    b. Evaluate a model for providing SBMH services based on key findings described in this report from FY2015 Task 9 and assess the impact on students' mental health, academic success, and social-emotional learning.
6. Identify additional partners at the state and local levels from the Juvenile Justice, Child Welfare, and Health sectors.
    a. Explore the successes and challenges for students with mental health needs who are also involved in other child-serving systems, like Juvenile Justice, Child Welfare, and Public Health.
    b. Identify opportunities for collaboration to improve service delivery across all child-serving systems, including schools, CMHCS, Juvenile Justice, Child Welfare, and Public Health.

Practices Within Schools and CMHCs

1. Adopt a community-level response to students' mental health and the provision of services.
    a. Explore successes and challenges unique to each community and identify solutions that fit with the population served by the community.
    b. Create a community-level planning council to assist with community-wide ownership/investment in students' mental health.
    c. Provide community-level workshops to educate community members on mental health issues and to reduce stigma.

2. Implement emerging best practices in expanded school-based mental health (ESMH).
   a. Adopt a team approach by creating an ongoing treatment planning meeting (e.g., wraparound care meetings).
   b. Establish communication between schools and CMHCs (e.g., offer presentations by CMHC staff to schools to identify available services and referral procedures; provide presentations to CMHC staff by educators on opportunities and constraints of providing services in schools).
   c. Develop protocols for the identification of mental health needs and referral procedures in local schools.
   d. Provide space in schools to provide services, when possible.
   e. Consider ways to jointly fund mental health professionals (e.g., funded by school districts and local community mental health agencies).
   f. Assess the impact of services on children's developmental outcomes, such as their mental health, academic success, and social-emotional learning.

References

1 Williford, A., Mendenhall, A., Moon, J., DePaolis K. J., and Lassman, H. (2015, September 15*). Healthy children, healthy schools, healthy communities. Final report on school-based mental health*. Lawrence, KS: University of Kansas, School of Social Welfare Center for Children & Families.

Resources

- **University of Kansas: Center for Children & Families**
  http://childrenandfamilies.ku.edu/