School Mental Health in Rural Communities
Getting to Wide Scale Adoption of Comprehensive School Mental Health

Addressing the Challenges and Opportunities within Rural Schools and Communities
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Disclaimer

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Addressing the Challenges and Opportunities within Rural Schools and Communities

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Project Aware Coordinator
McDowell County, West Virginia
Images of Welch, West Virginia
McDowell County, West Virginia

- Population: 18,456: Welch: 2,406 in Welch
- Of which 525 of the 2,406 living in Welch are employed, the remainder are either disabled or unemployed. (drug addiction is the biggest barrier to employment).
- Rural district amid the hills of central Appalachia
- Poorest county in WV & the eighth poorest in the country with a poverty rate of 35.4%
- Median Household Income: $27,115
- More than half of McDowell County students do not live with their biological parents because of circumstances such as incarceration or hospitalization
- In addition to poverty, opioid crisis is another dire issue affecting entire state, particularly McDowell
McDowell is one of Project AWARE’s three demonstration local education agencies

11 schools: 6 Primary, 1 Middle, 2 High Schools, and 1 Career Technical Center serving 3,011 students

100% of students receiving free breakfast and lunch program

Two School Based Health Center (SBHC) located in 2 High Schools provide physical and limited mental health services.
History of our school mental health services

- School mental health services across the continuum were scarce prior to WVDE’s award of SAMHSA’s Now Is The Time Project AWARE in 2014
- AWARE afforded opportunities of increased collaboration and partnerships between school and child serving systems
- Limited mental health services provided in schools and community at large due to limited providers in county
Our school mental health model

Key partners:
- Mental health providers, SBHCs, Reconnecting McDowell Initiative, Drug Court, regional suicide prevention, regional youth service center, Family Resource Networks, WVDHHR
- County leadership team, school counselors,
- Community stakeholder meetings: progress of services, services and resources, feedback and communication/information sharing

Services:
- Enhancing multi-tiered system of support across all 3 tiers: 5 schools implementing PBIS (elementary, middle and high school), building trauma-informed schools, Too Good for Drugs/Violence, Kognito, Coping Cats, Promoting Alternative Thinking Strategies (elementary). Three community mental health providers/two SBHCs providing Tier 3 services.
- Two Schools fully implementing Community Schools,
- Four schools in the initial implementation of Communities in Schools

Student identification/referral
- Student Assistance Teams, IEPs, Bright Bytes (early warning system), Suicide Assessment Tools.

Family Engagement
- Family services and supports - home visitation program, Family Advisory Council, Second Time Around Club for Grandparents, yearly county Early Childhood Fair, open houses at schools, parent nights (supported by Title I funding)
Our funding model

• Medicaid is a primary funding stream through fee for service, Chips and private insurances

• Mental health providers have committed time and resources in non-billable services activities such as planning, training and prevention activities at no cost

• Exploring county school funding streams (Title Funds/ESSA) for provision of services and professional learning
Our greatest school mental health successes

• Expanded support of county administrators for mental health services and awareness.

• School and community partnerships with increased knowledge and availability of resources, services, and supports

• Increased services within a MTSS (Kognito, PBIS, Too Good For Drugs, Coping Cats, PATHS, creating trauma-informed services).

• Increased Tier 3 services and Tele-health services provided in SBHC through WVU grant, and Tele-health through KVC Community Mental Health Provider services.

• Increased workforce development opportunities resulting in more comprehensive understanding of link between social and emotional well-being and academic success and impact of traumatic experiences on child development and behavior

• Enhanced student assistance team and referral process.
Our biggest school mental health challenges

Workforce
• Lack of credentialed mental health providers
• Significant turnover, recruitment and retention issues in all child-serving systems creating challenges with continuity of care, ability to provide needed training/professional development

Opioid Crisis

Access ability and availability of mental health providers
Despite our challenges, we keep doing school mental health because...

• School mental health services, interventions and supports for ALL students are essential to ensure our children, youth, and families are happy, healthy, and successful members of their communities.

• Unless the current supports are sustained and increased, students will not be able to overcome the struggles faced from the opioid crisis and trauma exposures they face daily.

• BETTER OUTCOMES FOR MCDOWELL STUDENTS
What questions do you have/what are you hoping to learn today to better advance rural school mental health?

- Strategies and funding streams utilized by states/districts
- Strategies/supports to increase tele-medicine services
- How other states are utilizing ESSA to support increased mental health services without reducing other needed services with current funding
- What tools/data other states are utilizing to determine TIER III service needs
- Opportunities to have a Tele-health center that all providers could work through
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Addressing the Challenges and Opportunities within Rural Schools and Communities

Allison Anderson Harder
Executive Director of Special Services
Emporia, KS
Please Describe Your Rural Community

- Emporia is in central Kansas
- Population – 24,916 (Caucasian, Hispanic and African American)
- Primarily blue collar, 25.9% lived in poverty; 85.7% who are 25 and older with high school degree; 26.1% have a bachelor’s degree and above (2017 Census Reporter)
- 1 Preschool (serves 300 students)
- 6 Elementary Schools (280 – 420 students)
- 1 Middle School (750 students)
- 1 High School (1200 students)
History of our school mental health services

• Ongoing partnership with local mental health agency since early 1990’s – rotating informal PD on different topics – quality waned around 2005 for a variety of reasons

• CoIIN Grant in 2015
  – PASS Program
  – School-based mental health services increased
Our school mental health model

- Key partners: CrossWinds
- How many schools: 9 (Pre-K – High School)
- Services provided – Case management, therapy, intakes
- The high school has a therapist full-time with case managers who work with students who are clients, preschool, elementary schools and middle schools have school-based mental health with therapists and case managers who are on site on specific days
Tiers 1, 2 and 3:

We are working on implementing a screener and have been developing Tiers 1, 2 and 3 over the last several years. It is currently more successful by individual buildings than a district-wide model, although this is a goal.

- Pre-K and elementary have regular guidance lessons taught by Student Support Specialists (counselors/social workers), all buildings provide school counseling as needed
- How are students identified for services? Office referrals, teachers, student intervention meetings

How do community partners engage with school-employed staff:

Case-by-case

How are families engaged in the program?

Case-by-case and the extent to which families are willing to meet with a multidisciplinary team, we obtain release of information forms to ensure transparency
Our funding model

– Who pays for the service provision –
  • 4 Full-time CrossWinds employees
    – (2) Preschool and Elementary Case Managers – para reimbursement + client billing + at-risk funds
    – (1) Day school for students with SED Case Manager – para reimbursement + client billing + special education funding
    – (1) High school Therapist – client billing + school support staff building fund
    – CrossWinds Therapeutic Preschool – in process of partnering with school district

– Budget amount and allocations
  • This has been a challenge and we have been working through funding sources

– Percentage of revenue generated by fee-for-service
  • Inconsistent at this time – working for consistency

– How services are sustained
  • Regular meetings with CrossWinds and schools
  • Social Emotional Success – Kansans Can pillar established by State Commissioner of Education
Our greatest school mental health successes

• Increased services with intake process more accessible to parents
• Increased partnership at day school
• Therapeutic preschool
• Increased understanding and promotion of need
  – Community group and BOE study session
  – Suicide prevention training to high school students
  – Radio talk to share information and promote
  – State level presentation for administrators (USA Kansas)
  – National presentations at Mental Health Conferences (PASS, Preschool program, community partnership)
Our biggest school mental health challenges

• Screener – access, need, response, liability
• Collaborative work across the district
  – competition
  – territorialism
  – lack of trust
• State funding for more school counselors and school psychologists
• Availability of licensed school counselors and school psychologists
Despite our challenges, we keep doing school mental health because...

- We need to address the needs of our students for their benefit as well as their ability to focus on and be receptive to academic instruction.
- It benefits our community as a whole because often families need the services and if we can help one child, their family may be more willing to explore/accept services.
What questions do you have/what are you hoping to learn today to better advance rural school mental health?

- What are innovative approaches schools have increased school-based mental health services?
- What screening tool is being used? What are the pros/cons and how are needs supported?
- What grants are available to address mental health needs of students?
  - “Whole Child”
Contact Information

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Addressing the Challenges and Opportunities within Rural Schools and Communities

Crystal Holmes
Student Services Grant Coordinator
Adams-Friendship Area School District
Friendship, Wisconsin

Greta Blancarte
District Wellness Coordinator
School District of Ashland, Ashland, WI

Rockville, MD
May 17, 2018
Friendship, Wisconsin
County/District Demographics

- 3 Elems, 1 Middle School & 1 High School (550 square miles)
- 71% free and reduced (state 36%)
- Ranked 70th out of 72 counties in overall health
- 50% of families use food stamps (state 30%)
- Mental Health Providers 2,890:1 (state 623:1)
City of Ashland, Bad River Reservation, Rural Ashland
School District of Ashland - Demographics

- City of Ashland, Bad River Band of Lake Superior Chippewa, nine rural townships in two counties
- Total Population: 12,503
  - City of Ashland: 7000, Bad River Reservation: 1500
- 345 sq miles
- Four distinct cultural groups
- 3 elementary schools, 1 MS, 1 HS, 1 alternative
- 59% free and reduced
History of our school mental health services: Adams Friendship School District

- Data collection began with when Adams Friendship was awarded funds from Promise Neighborhood Grant in 2013
- Project AWARE encouraged the incorporation of integrated behavioral health providers
- YTD we have 5 agencies with signed MOU’s and 10 psychotherapist providing services in 6 different buildings
History of our school mental health services:
Ashland School District

- First provider partner started in 2013
- Prior to SY 16/17 – 4 providers totaling 1.3 FTE
- Since hiring of Wellness Coordinator in Sept 2016 with Project AWARE funding, program has grown to 6 providers and 2.6 FTE in addition to an elementary day treatment program partnership with our local critical access hospital.
- SY 18/19 agreements with two additional providers totaling 1.2 FTE
Our school mental health model

- **Key partners:** Adams County Health and Human Services, Central Wisconsin Counseling, Compass Counseling, Pine Valley Integrated Services and a private licensed psychotherapist.

- **6 buildings in our district including;** 3 elementary, 1 middle School, 1 high school and one location for two alternative education programs
  - **HS and Alternative:** 2 ½ days per week
  - **MS:** 4 days per week
  - **Elementary:** 4 days per week
Services provided: individual counseling, family counseling, group therapy sessions, psychoeducation and AODA services.

Tier 1: universal services received by all students  (Positive Action, SOS)

Tier 2: selected by our building assistance teams  (CICO, Purpose of Life Group)

Tier 3: Individualized services selected by pupil service team, parent and/or case manager when appropriate

Provider/District communication: Quarterly meetings, phone conferencing, IEP meetings and PD days.

Families are first engaged through district staff including home visits and school visits. They are then scheduled to meet with the therapist and student at the district office.
Our school mental health model: Ashland

- Key Partners: Memorial Medical Center, Northlakes Clinic, SOAR Services, Bad River Health and Wellness Center, Katy Gorman-private practice, Ashland County HHS
- Tier 1: SOS, Responsive Classrooms, Developmental Designs
- Tier 2: CICO, social skills groups (partners and pupil services)
- Tier 3: individual psychotherapy (all grade levels), therapy groups (middle school), elementary day treatment (grades 1-5).
- Partners participate in IEP, team meetings: school and county CST-based), inservices, staff meetings
- Families engaged through initial exploration of services with Wellness Coordinator, warm hand-offs to providers, continual follow-up with WC and guidance staff.
Funding Model

• Treatment services all billed through third party insurance whenever available
• Uninsured or underinsured students are connected to community mental health providers who have a satellite clinic within our schools. Services are provided on a sliding fee scale pro-bono with participating partner clinics/providers
• Exceptions to third party billing include:
  • reimburses for mileage and hourly consultation fees
  • social skills groups run by our county contracted mental health therapist.
Our greatest school mental health successes

• Community Partnerships has encouraged a community approach to mental health services in Adams Friendship. We are no longer afraid to have the conversation.

• Ashland: Wellness Coordinator position/online referral pathway system leading to high % of successful services connections. Community commitment to student mental health: day treatment program and MH spaces in schools through community referendum
Our biggest school mental health challenges

• Remote Rural
  – lack of community resources
  – reliance on school staff

• Access - limited providers for the demonstrated need and catchment area of our local resources.

• Cultural diversity of community and cultural differences in beliefs about mental health supports
Despite our challenges, we keep doing school mental health because...

• *Educating the whole child is necessary. This means educating their mental health as well.*
What questions do you have/what are you hoping to learn today to better advance rural school mental health?

• Wisconsin has started to look at other funding streams as a state. What can we do to further support and encourage these efforts when we know this work is so crucial for our students and families?
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Addressing the Challenges and Opportunities within Rural Schools and Communities

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Rockville, MD
May 17, 2018
Rural Upstate New York
Rural Upstate New York

- Central Upstate New York State
- Otsego County = 62,000
- Rural, agrarian and with wooded hills and almost no public transportation; economically depressed for decades
- Eleven schools in Otsego County
- School-Based Health Program in 15 school districts in four counties
- Very limited MH services otherwise
Upstate New York
School-Based Health Centers have been part of our health care of children and adolescents for over 20 years. We provide dental, somatic and mental health. We use NPs, PAs, L CSW-Rs and RDHs as well as physicians and a dentist.

- We see about 7,500 students for about 33,000 visits per year
- About 30% of our visits are for mental health
Our school mental health model

- Students are referred by: NPs or PAs, physicians, parents, teachers, administrators or they self-refer
- 20 schools, 15 different school districts
- Screenings, short and long term therapy, prescriptions
- ADHD and adjustment disorders → to anxiety, depression and suicide prevention
- County Mental Health is very understaffed; private practitioners are not readily available; we do refer to some substance abuse services
- Depending on the age and needs of the students, families are usually very involved both at a distance and sometimes in therapy
Our funding model

• For mental health purposes, we see only SBHC enrolled students
• We get insurance information each year
• We bill for all services but do not balance bill
• For those without insurance, we promote CHIP
• Almost no insurance covers the costs for mental health services
• We write grants as often as we can
Our greatest school mental health successes

- Kids graduating from HS
- The ‘Columbine’ that didn’t happen.
- The ‘girl who didn’t.’
- Telepsychiatry
Upstate New York
Our biggest school mental health challenges

- Funding
- Staffing
- Funding
- Reimbursement
- Funding
- Long-term Placement
Despite our challenges, we keep doing school mental health because...

- We can make a difference in the lives of many children and their families.
- Schools want mental health services more than somatic health services.
- The alternative to NOT doing mental health services is too painful to consider.
What questions do you have/what are you hoping to learn today to better advance rural school mental health?

• How can we remain financial viable in the health care industry’s current form?
• How can we bend the hearts of those who hold the purse strings?
Upstate, New York
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