Implementing A Statewide Framework For Trauma-Informed School Mental Health In Connecticut

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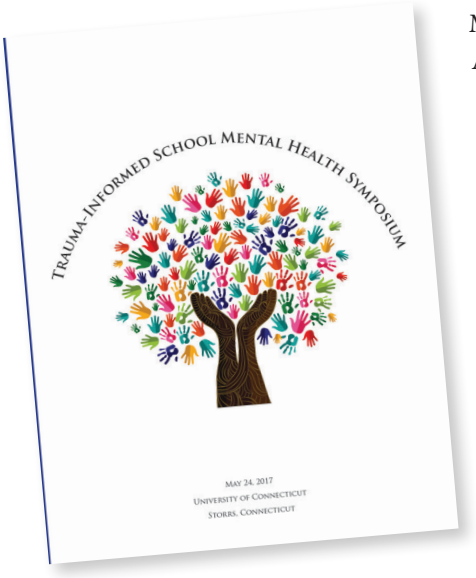
Next Steps For Implementing A Statewide Framework For Trauma-Informed School Mental Health In Connecticut



On May 24, 2017, the "Symposium on Trauma-Informed School Mental Health: Broadening and Aligning the Conversation Towards Action" brought together approximately 100 leaders from across the state representing schools and educators, mental health providers, state agencies, higher education, and other community partners to discuss strategies for addressing childhood trauma with a focus on school settings.

The goals of this interactive symposium were to raise awareness around school-based mental health services and comprehensive trauma-informed approaches to care, to begin development of a coordinated framework and infrastructure supports for addressing childhood trauma in school-based settings, and to build a coalition of leaders committed to moving the work forward. This approach to address both systems-level infrastructure development and enhancement of trauma-specific treatments acknowledges that a system-wide culture of awareness and response to trauma and its effects is necessary to create a safe and supportive learning environment for all students, as well as school and classroom level trauma-based supports so that those students who require individual intervention have access to appropriate evidence-based care.

When asked about the value of hosting this type of event, Dr. Sandra Chafouleas, Board of Trustees Distinguished Professor in the Neag School and Co-Director of the UConn Collaboratory on School and Child Health, indicated that "The event provided a critical space to bring great minds together to collaborate about what it means to adopt a trauma-informed lens in supporting student success."

The event, held at the Neag School of Education on the Storrs Campus of the University of Connecticut was sponsored through a collaborative effort of the Capitol Region Education Council (CREC), the state Department of Education (CSDE), the University of Connecticut Collaboratory on School and Child Health and Neag School of Education (CSCH), the Ana Grace Project, Clifford Beers Clinic, and the Child Health and Development Institute (CHDI). The event began with introductory remarks by the Connecticut State Department of Education Commissioner Dianna Wentzell and discussion of guiding principles by Dr. Jeff Vanderploeg of the Child Health and Development Institute and Dr. Alice Forrester of the Clifford Beers Clinic.

Dr. Forrester encouraged participants to think differently and work to break down existing siloes between child-serving systems and funding streams to ultimately improve outcomes for students, stating:

> "We can use dollars wisely. We can make policy changes for the better of our kids and families. We can address all the issues related to trauma and mental health within the school day, and it will help our kids. They will attend more school, have less suspensions, better grades, and most importantly—they will feel better. They will feel optimistic."

Breakout sessions were then offered to participants to discuss 1) what is currently working well in relation to trauma-informed school-based mental health; 2) existing barriers or challenges; and 3) recommendations or strategies for improvements, discussed across four breakout session topics:

- Preparing and Building our Workforce's Capacity to Provide Trauma Informed Education and Care
- Financing School Mental Health and Accountability Systems
- Prevention and Early Identification: The Interface of Social Emotional Development, Mental Health, and Behavior Prevention Programming in Schools, and
- Interventions that Bridge Schools, Families, and Communities.

The planning team reconvened following the breakout sessions to summarize major themes and has provided the following summary of the symposium proceedings to guide next steps in developing and implementing a statewide framework for trauma-informed school mental health in Connecticut. A summary of cross-session themes are presented below, followed by outlines of each of the four co-facilitated breakout sessions.

> "The [Symposium] provided a critical space to bring great minds together to collaborate about what it means to adopt a trauma-informed lens in supporting student success."

Summary Of Major Themes From Symposium

Several common themes emerged across breakout sessions, indicating a need for further work in the following areas:

• Consistent language: terms such as Social Emotional Learning (SEL), trauma-informed, and school mental health need to be defined and distinguished to guide the state in developing a common framework for advancing this work across systems and disciplines

• Comprehensive framework: development of a comprehensive, evidence-based, tiered approach to structuring, implementing, and evaluating trauma-informed school mental health services and supports is required to disseminate a statewide model

• Professional/personal development and support: additional training, coaching, and on-going support for school staff and administration, teacher training faculty, behavioral health providers, and families are necessary to build awareness, knowledge, and skills in trauma-informed practice and self-care

• Leadership support and buy-in: leadership across all levels of school administration and support from community partners, legislators, and funders are necessary for developing, financing, and sustaining a common framework for trauma-informed school mental health

• School climate and culture: universal supports for promoting positive school climate and culture must be expanded and attention to reducing racial and ethnic disparities among students are key factors in supporting school mental health

• Collaboration/School-Family-Community Engagement: strong partnerships at the local and state level are critical to providing an integrated and shared responsibility for improving student health and academic outcomes

• Financing and sustainability: currently several sources of funds contribute to support school mental health services and staffing; however stronger integration of funds and sustainable infrastructure supports are needed to advance a statewide system.

Next Steps

1. Integrate symposium planning team with School Mental Health workgroup of the Connecticut Behavioral Health Plan Implementation Advisory/Connecticut Network of Care Transformation CONNECT Initiative (http://www.plan4children.org/) to create the School Mental Health Task Force. This group will meet on a monthly basis to continue to move this work forward on a statewide systems level.
   a. Next steps of this Task Force include:
      i. Develop the statewide vision statement, goals, logic model, and theory of change for an integrated framework for trauma-informed school mental health
      ii. Develop inventory of activities related to school mental health and trauma-informed practices happening across the state
      iii. Promote district participation in the School Health Assessment and Performance Evaluation System (SHAPE, www.theshapesystem.com) to advance quality and sustainability assessment goals regarding school mental health practices, as supported by a Technical Assistance grant from the University of Maryland Center for School Mental Health.
      iv. Review, edit, and disseminate CHDI IMPACT report on comprehensive systems for trauma-informed school mental health to serve as a guiding document for a comprehensive statewide framework for implementing best practices.
      v. Develop listserve communication tool and strategy for information sharing among symposium participants and other interested collaborators.
2. Support and disseminate information about fall 2017 screenings of the film "Resilience" sponsored by the Connecticut Association of Schools (CAS) and Clifford Beers Clinic to promote awareness about the effects of trauma on youth and strategies for strengthening resilience to all school personnel.

3. Plan and convene a statewide conference in 2018 on best practices in trauma-informed school mental health.

For more information about the statewide School Mental Health Task Force, contact Jeana Bracey, CHDI, bracey@uchc.edu or Heather Tartaglia, CREC, htartaglia@crec.org

Breakout Session Summaries

Preparing and Building Our Workforce's Capacity to Provide Trauma-Informed Education and Care

Noel Casiano, PsyD, LMFT (The Ana Grace Project)
Cecilia F. Singh, Ph.D. (Yale University Child Study Center/CHDI)

1. Developing a consistent definition of trauma and applying it appropriately. Educators are also in need of strategies when working with traumatized children. Developing a toolkit for teachers on strategies that change the climate and culture within their classroom, which are more trauma-informed.

2. Changing structure of traditional professional development, focusing on personal development. Discussing the impacts of secondary trauma for educators, all school staff (including custodial & lunchroom/dietary staff) and school/community clinicians. Supervision of school staff and clinicians is needed for ongoing support and professional development and growth.

3. Promoting self-care and avoiding compassion fatigue. Providing school staff with a toolkit on how they can continue to practice positive self-care techniques day to day. Establishing a support network for teachers and clinicians to be able to get together to discuss and process working with traumatized children and the impact it has on them as teachers and clinicians. School administrators should understand that self-care for teachers and school staff is a high priority.

4. Authentically embedding trauma work into the school culture. Trauma informed school curriculum that is embedded into the year round school curriculum should be considered. Integrate social-emotional learning (SEL) curricula in schools so that traumatized children can feel more comfortable in learning and addressing their mental health needs. Teaching core values of kindness, respect and responsibility.

5. Developing strong leadership, having a mental health professional at an administrative level and at the Board Level to support sustained mental health practices in schools. Make trauma-informed practices and professional development a financial priority.

6. Continuing successful partnerships between schools and community agencies.

Financing School Mental Health And Accountability Systems

Charlene Russell-Tucker (CSDE)
Alice Forrester, Ph.D (Clifford Beers Clinic)
Jeffrey Vanderploeg, Ph.D. (CHDI)

Participants generally agreed that there is enough money being spent, it's just a matter of using those funds to create a predictable and efficient system.

School Mental Health is currently funded in a variety of ways:
1. School District funds: Provide support for school psychologists, social workers, guidance counselors. Special education funds provide support for services as well.

2. State grant dollars

a. DCF funding for school-based initiatives: CBITS, New Haven Trauma Coalition
b. DCF funding for school-linked initiatives (services delivered outside the school building to which schools frequently refer students): EMPS, outpatient treatment, outpatient evidence based practices like TFCBT and MATCH, intensive in-home models like IICAPS, Multisystemic Therapy, Functional Family Therapy, and others.
c. DPH funds School Based Health Centers, who then bill Medicaid (for eligible youth).
d. SDE: Alliance District initiative provides funds for social work staff
e. SBDI integrates funds from DCF, DMHAS, SDE, and CSSD, to reduce arrests and also increase student access to mental health supports such as EMPS
f. Providing state dollars directly to schools has been problematic in the past due to lack of accountability for how those funds were spent.

3. Federal funds: Provide support to some communities through the Safe Schools Healthy Students initiative, SERVE grants, 21st Century Community Learning Centers, and other mechanisms. These are often time-limited and not scaled statewide.

4. Medicaid: The Medicaid Clinic Option allows schools to establish clinics, or allow for community providers to establish clinics within a school. There are certain limitations with this model (e.g., all services require psychiatric sign-off).

5. Private Philanthropy: Some foundations (e.g., CT Health Foundation) have supported discrete school mental health initiatives in the past (e.g., iCARE in Middletown) and others have supported outpatient clinics to which schools refer youth (e.g., United Way).

Vision for Financing School Mental Health

1. Promote a full integration of state agency dollars
   a. State agencies place too much consideration on their mandates, and not enough consideration to a shared purpose and vision, which would facilitate the breaking down of silos that currently limit the efficient use of available funds.
   b. Each state agency is putting dollars into administrative costs, which is inefficient.
   c. Leadership and collaboration will be required to break down these silos

2. Move toward the Medicaid Rehabilitation Option
   a. This would allow more flexibility in setting of service delivery and flexibility in some of the regulations that currently limit service delivery. There are many that believe this would be a cost neutral proposal.

3. Address the needs of commercially insured youth, and engage commercial insurance providers
   a. Right now, youth with mental health needs who are commercially insured and who have mental health needs of equal severity to youth on Medicaid cannot access services because of high deductible plans.
   b. Collect data to convince commercial insurers that investing in an integrated model of school mental health will save them money in the long-run.
   c. Address needs of commercially insured kids with the same intensity of need who can't access services due to high deductible plans.

4. Ensure grant funds are available to support activities not easily funded in a fee-for-service model
   a. Staff training and public education
   b. Incorporate care coordination and flexible funding into any model that seeks to address mental health needs, either through direct Medicaid reimbursement, or state general fund dollars.

5. Work with schools and communities to identify new ways of allocating special education funds
   a. Identify ways to reallocate special education funds to include promotion, prevention, and intervention supports.
   b. Schools need to re-think the overall cost of educating a child on a per pupil basis, to include funding for mental health. Embrace the notion that addressing trauma and mental health is part of the cost of properly educating a child.
   c. Consider regionalizing special education dollars across multiple districts, which would allow those dollars to go further
   d. Refocus use of EAP dollars to train teachers and provide support for their own trauma
   e. Consider return on investment as part of any financing model
      i. What are the cost savings in delivering school mental health?
      ii. Can they be leveraged in a Pay for Success model?

6. Tie financing to outcomes and other value-based reimbursement models
   a. Identify cost savings associated with school mental health (e.g., absences, graduation rates, arrests, JJ/criminal justice contact, emergency department visits, out-placement in therapeutic schools)
   b. Invest in data systems that will allow for examination of cost savings
   c. Support the delivery of evidence-based practices
   d. Promote systems that pay for outcomes rather than units of service
   e. Consider Social Impact Bond/Pay for Success models
   f. Ensure community accountability, not just fiscal accountability
   g. Report outcomes using a Results-Based Accountability (RBA) framework

7. Other
   a. Consider the change process.
   b. Embed school mental health into how education is approached (i.e., consider the cost of health and mental health as critical to the education of youth)
   c. Promote joint school-community planning, with family involvement, as a requirement for accessing mental health dollars funds
   d. Increase predictability in funding for schools and school-community linked systems

Prevention And Early Identification: The Interface Of Social Emotional Development, Mental Health, And Behavior Prevention Programming In Schools

Heather Tartaglia (CREC)
Sandra M. Chafouleas, Ph.D. (UConn CSCH)

1. Social, emotional, and behavioral (SEB) screening in schools and early care settings provides opportunity for full engagement and communication with families and communities and schools.
   a. Some examples of screening being used:
      i. BASC-2 used in district following Sandy Hook-grades 3-11 as universal screener
      ii. Use of Protective Factors Index in Middletown as universal screener
      iii. Signs of Suicide Training and screening universally
      iv. Screening of high risk kids (suspensions, expulsions for substance use, and adverse childhood experiences (ACEs)
      v. Massachusetts conducts universal screening of high school students for substance abuse with referral/consultation with pediatricians for kids that are screening positive

2. Positive benefits to screening but current state is described as "baby steps" – particularly for universal (all students) - what should we be measuring and can we agree on indicators for schools which can be faced with privacy/consent issues versus community settings?
   a. Example given of identifying appropriate measures for screening that can be used consistently within the state to aid common language to get around privacy and consent issues.

3. Terminology used- think carefully - about connecting appropriately to different contexts.
   a. There is danger of potential silo in using term "trauma lens" - need to figure out how it fits within the larger picture of child well-being (health and learning).
      i. Addressing intergenerational trauma in ways that are distinct from acute traumas and equipping districts/agencies to do this.

4. Equitable access to community resources need sustainable partnerships for districts.
   a. Examples provided:
      i. Collaboration exist between Hartford and the Village - however, this is school/program specific and does not impact the whole district
      ii. Collaborations are viewed as more difficult to garner, and perceived as less necessary, in higher socioeconomic suburbs-however, the need is significant in these communities
      iii. Use of school-based health centers within school and ensuring collaboration between the school and the school-based health center so no one is operating in a "vacuum."

5. Social, emotional, and behavioral (SEB) data systems need to move to informing decisions in prevention, not just reactionary (e.g. discipline referrals).

6. Racial/ethnic disparities and social determinants need to be central in the discussion of any assessment system as there can be missed opportunities and unintended consequences.
   a. For example - Over identification of student of color for special education due to lack of understanding

7. Prevention/early intervention extends beyond the individual student to focus on families,

educators, school leaders, and peers.

a. Examples of success in UConn's Early Childhood Education program

8. Identify critical components or a framework- not just "programs" that are embedded into daily practice for all (teachers, admins, special services) that place an emphasis on family conversations.

a. Examples in need:
   i. Further development of Tier 2/3 interventions in schools.
   ii. Embedding social emotional learning for significantly in the curriculum and across school staff.

9. Preservice and in-service space is very important for all to gain understanding of important skills.

a. Some example comments:
   i. Farmington has seen success with use of district wide teacher and social worker to train teams on how to deal with children, particularly young students, with challenging behaviors
   ii. At times, staff become de-sensitized to community violence and the potential traumas they may have, which can be a barrier to ensure students received needed intervention.

Interventions That Bridge Schools, Families, And Communities

Jeana R. Bracey, Ph.D. (CHDI)
Kim Jewers-Dailley, M.A., RDT (Clifford Beers Clinic)

1. There is a statewide need for consensus on a common set of terms to distinguish and operationalize social-emotional learning (SEL) and trauma-informed programming to move towards a common language to identify various efforts working to address mental health and trauma in schools.

a. Common terminology will help to identify core components that are working well and prioritize strengthening those to address gaps.

2. A comprehensive multi-tiered model of supports to address mental health and trauma is needed that engages schools, families, and communities at all levels. This framework must incorporate professional development and ongoing support through training, practice workgroups, and ongoing coaching and supervision for school staff. Students, families, and their natural supports must be engaged as full partners in decision-making about their care. The model must apply across currently siloed systems to engage community-based providers and state agencies.

a. Known CT models with positive outcomes: PBIS, New Haven Trauma Coalition, SBDI, ARC, Social Emotional Learning/RULER, ECTC, TARGET, general school climate and culture, restorative practices
b. Other models of interest: Compassionate Schools—the Heart of Learning and Teaching approach out of Washington State, Collaborative and Proactive Solutions approach (Ross Greene)

3. There is acknowledgement that several programs and settings across the state are working to shift their thinking about education to include a focus on mental/emotional/behavioral health prevention and intervention through a trauma-informed lens. Successful trauma-informed

programs may be doing different things, but have common practices of addressing trauma as prevention and working to shift their program's paradigm of thinking about education to include mental/emotional/ behavioral health. What is lacking is a clear, consistent approach to identify effective components of those models and a process for generating buy-in to support successful models.

4. Enhanced transparency and accountability are needed with respect to data collection and monitoring regarding education and demographics sharing the message with communities/families and tracking data on prevalence, outcomes, disparities, and funding.

5. We need to think about the educators and school staff who are working with kids who have experienced trauma and support them in a comprehensive, ongoing manner.

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