

Behavioral Health Goes to School:

*An Analysis of School-Based
Behavioral Health Services
in Philadelphia*



About PCCY

Public Citizens for Children and Youth (PCCY) serves as the leading child advocacy organization working to improve the lives and life chances of children in the region.

Through thoughtful and informed advocacy, community education, targeted service projects and budget analysis, PCCY watches out and speaks out for children and families. PCCY undertakes specific and focused projects in areas affecting the healthy growth and development of children, including child care, public education, child health, juvenile justice and child welfare.

Founded in 1980 as Philadelphia Citizens for Children and Youth, our name was changed in 2007 to better reflect our expanded work in the counties surrounding Philadelphia. PCCY remains a committed advocate and an independent watchdog for the well-being of all our children.

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Executive Summary

Executive Summary

All children should have the opportunity to be happy, healthy and successful. While they strive for this goal, they must learn to effectively cope with life stressors, setbacks and hurts. Many children need help to build this capacity called resilience, a protective process that enables us to cope effectively when we are faced with significant adversities. Among the factors enhancing a child's resilience are: positive relationships with caregivers and peers; internal strengths such as problem-solving skills, determination and hope; and environmental factors such as effective schools and communities.¹

Unfortunately, some children face serious hardships. Some encounter external challenges – unexpected loss, indifference, poverty, and a myriad of community problems while other children's struggles are caused by internal or organic psychological difficulties. Some kids experience both kinds of predicaments. Regardless of the source, these challenges can cause children to experience difficulty coping, learning, engaging, socializing and adjusting at home, in school and in other settings. They need extra supports to build and maintain their health, well-being and resiliency. One key kind of support for these children is behavioral health services.

Most children who receive mental or behavioral health services secure them in a therapist's office in the community. Some children benefit from obtaining services in school. The movement to place services in schools has grown in the last decade. Wanting to know more about the services and how well they worked, PCCY began to explore them in Philadelphia schools. Some people reported children were being well-served and others expressed concern and criticism. We began believing that locating services in schools seemed to make a lot of sense; bringing services to children removed access barriers. But we did not know: which children were getting the services, what services they were getting, how the children were doing and what were some of the strengths and shortcomings of the services and their delivery systems. We set out to explore those questions; our findings are contained in this report.

What did we learn about school-based behavioral health services? Many things. Co-locating services is difficult. The two main systems responsible for delivering this care, the School District of Philadelphia and Community Behavioral Health, are big, complicated and have different missions, mandates and procedures. Our exploration took place at a particularly challenging time for the District; significant budget reductions were causing extensive change throughout the District including school closures, staff lay-offs and consolidation of resources.

Nonetheless, both the District and Community Behavioral Health (CBH) are charged with working to improve child well-being. From the school's perspective the goal of the services is for children to function better in the classroom; the children who are disruptive or unengaged are most likely to be referred for care. From the behavioral health system, the perspective is not only looking for children to do better in school but to help them adjust to life and function better in their home and their community. Actualizing these similar yet different goals and aspirations poses many challenges. Broader avenues of collaboration and trust between these systems must be created. Strengthening and prioritizing communication and relationship building and holding each system accountable to the other as well as to the child must become priorities.

We found that data about these children were difficult to obtain. The School District of Philadelphia did not know how many children were receiving these services and did not keep aggregate data on these students. CBH staff reported that they maintained data on an individual child level but did not routinely track aggregate data on this population. They have agreed to compile and analyze this data in the future.

Although both the District and CBH have staff and departments charged with managing school-based behavioral health services, the difficulties we experienced finding information about these children underscores the need for increased cross systems collaboration. Children and systems are disadvantaged by a lack of communication and mismatched expectations.

To begin our report on school-based behavioral health services in Philadelphia we note that:

- There are about 154,000 Philadelphia children who attend public schools; 104,803 children attend kindergarten through 8th grade and 44,773 youth are currently enrolled in high school.
- Every child must have a diagnosed behavioral health issue to secure school-based behavioral health services.
- Every child must have Medicaid health insurance to secure school-based behavioral health services.
- Community Behavioral Health is the city agency that manages behavioral health care services for Medicaid recipients; CBH is the only insurer that pays for school-based services.

Executive Summary

- In fiscal year 2010, 27,653 Philadelphia children with Medicaid coverage received outpatient behavioral health care; about 5,000 (18 percent) received these services in school.
- There are three, main school-based services in the Philadelphia public schools funded by Community Behavioral Health (CBH): Wraparound (closely associated with TSS workers or Therapeutic Staff Support), School Therapeutic Services and CARE classrooms (Children Achieving Through Re-Education)
- Most children receive one-on-one behavior management support from a trained behavioral health worker in their classroom for as much as 30 hours a week, weekly group therapy with their peers and a divided hour of weekly therapy/therapeutic intervention with a therapist. Most children do not receive an hour of uninterrupted therapy which is typical in traditional outpatient care in a therapist's office.
- All three services focus on children in kindergarten through 8th grades. There are no CBH-supported school services for high school students (except an outpatient clinic at Frankford High School).
- Most students receiving services are in 3rd and 4th grade – grades during which students typically transition from more informal to formal classroom environments and teaching approaches – including the introduction of standardized testing.
- Some students are referred by their existing therapist while others are referred by a teacher or school counselor through the Comprehensive Student Assistance Process (CSAP).
- A disproportionate number of students receiving services are African American (about 78 percent) though they comprise 58 percent of the overall District population.
- A disproportionate number of students are male, about 73 percent.
- The most prevalent diagnosis assigned to these children is ADHD – Attention Deficit and Hyperactivity Disorder.
- Provider agencies collect and submit data to CBH on a child's status, but there have been problems with transmitting the data. Consequently,

there is no available aggregate data to track the outcome or impact of these services. A lack of outcome data is a common phenomenon among many large school districts we researched.

- Schools do not routinely connect the impact of the services on children's academic performance and attendance, or the contribution a school-based program may make on overall school climate and/or on overall school achievement. This lack of group or relational outcome data may contribute to the uneven acceptance or mixed success at integrating behavioral health services in schools.
- The behavioral health system and the school system are imperfectly aligned with each other, contributing to uneven communication and differing expectations.

Recommendations

Basing behavioral health services in schools seems to make sense, but the challenges are many. We commend the work so far, but urge that we become better at informing, collaborating, being accountable and keeping the promise to all children to help them become resilient and realize their full potential.

In order to support a more holistic, integrated approach to providing services to children in schools, both systems and individuals have to work more closely together.

Together we must:

I. Track Students in School-Based Programs and Measure Student Outcomes

Count the Students Served

Count students who are recommended for and receive in-school services every year to monitor changes in the number of children who are getting services and who they are (age, grade, gender, race/ethnicity, diagnoses, etc.) in order to identify trends, monitor utilization, improve services and plan for the future.

Measure Student Behavioral and Academic Outcomes

We should work together to obtain agreement about the desired/expected outcomes of school-based behavioral health services (e.g. students are able to continue to attend school, perform well in school, learn to cope better in life and schools gain improved climates). In order to know whether children were faring better and whether the schools

they attended were improving as a result of on-site behavioral health services, we must develop indicators to measure these expected outcomes while preserving individual children's confidentiality and privacy. Evidence that the programs work and kids were doing and feeling better will encourage community and school leadership to invest in the programs.

II. Improve Communication and Strengthen Collaboration Among Major Stakeholders

Strengthen Bridges Between the District, CBH and Provider Agencies

Together we must facilitate more and better communication and training among key school personnel and behavioral health agency staff to establish clearer expectations, policies and procedures such as how providers and schools can best function together and what services providers can and cannot provide to which students. Further, we must strengthen and build a liaison/mediator function between the schools and CBH dedicated to building relationships between the two entities.

Create New Bridges

Additionally, we must create a position/function at the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), the office that oversees CBH, to develop policy and serve as a connector and mediator between CBH and behavioral health agencies.

We should start a School-Based Behavioral Health Services Advisory Team comprised of a cross-section of stakeholders to monitor and review program outcome data and collaboratively make decisions about the type and amount of services needed. Members might include representatives from: DBHIDS, CBH, District's Office of Behavioral Health, principals (schools), behavioral health agencies, the student body, parents and advocates.

III. Improve Parents' Access to School-Based Care for Their Children

We must increase awareness of existing school-based programs and assist parents in accessing them as well as community-based behavioral health services.

Behavioral Health Goes To School

I. Introduction

The 2001 US Surgeon General's report on children's mental health estimates that approximately 21 percent of U.S. children have a diagnosable mental health problem leading to at least mild impairment and about 11 percent of children and adolescents suffer significant impairment from an emotional or behavioral problem.² With about 264,000 school-age children in Philadelphia, there are an estimated 55,500 children ages five to 18 in the city who have a diagnosable behavioral health condition; over 29,000 of these children are significantly impacted by a behavioral health problem.

There was a time when some of these children would not have attended public school. Public schools were not mandated to serve some of these children, and the schools were not fortified with necessary resources and expertise to effectively meet the needs of children with significant behavioral health issues. Currently, the School District of Philadelphia has mechanisms in place to help identify students who may be experiencing barriers to learning because of behavioral health issues and provides a spectrum of services in many of the schools to help students overcome or manage these issues. Some of these services focus on groups of children; Positive Behavior and Intervention Supports (PBIS), violence prevention curricula, anti-bullying programs and other school-community programs are examples of this group approach.

This report focuses on the school-based behavioral health services that Philadelphia's Medicaid behavioral health insurance organization, Community Behavioral Health (CBH), supports.³ These are School Therapeutic Services (STS), Children Achieving through Re-education (CARE) and Therapeutic Staff Support

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(TSS). These services are primarily based in elementary and middle schools and are part of a continuum of services designed to help students adjust to school and life. For some students, participating in these services is necessary to enable them to attend school.

Traditionally, the school counselor has been the staff person most associated with helping students with any behavioral health difficulties they might face. But as more students are coming to school with behavioral health issues and the job description and workload of the counselor has changed, the school counselor is now one person among teachers, Resource Specialists and school-based behavioral health providers responsible for students' behavioral health. During the 2010-11 school year, there were about 20 agencies delivering school-based behavioral health services in Philadelphia schools.

There are advantages and drawbacks to delivering behavioral health services to students in school. Several school-based behavioral health providers we interviewed for this report noted that bringing the services to school makes sense and improves the “show rate” or percentage of children who keep their appointments. Co-location requires less parental or caregiver presence; with traditional outpatient services, parents must find time to take their children to a mental health agency.⁴

A disadvantage to basing the services in schools is that securing school-based services can take longer than pursuing services outside the school. Co-location requires that processes and procedures need to be aligned and well understood by each partner system. For example, teachers may refer a child hoping for immediate treatment when the child has not been registered to the provider or may not be eligible for the service. The evaluation process to determine whether the student is eligible for school-based services can, depending on the provider, take an average of three different sessions, which contributes to a common two-month wait.

Working within two different systems takes time; if a caregiver, on the other hand, wants to pursue outpatient services for a youth, he or she just has to contact an outpatient behavioral health agency and as long as the student has insurance the agency accepts, that student might be seen in a week or two.

Maintaining continuity of care for some students has been difficult and may pose more of a challenge in the future because of extensive change taking place throughout the District including school closures, traditional public schools being transformed into independent charter schools, staff lay-offs and a general consolidation of resources.



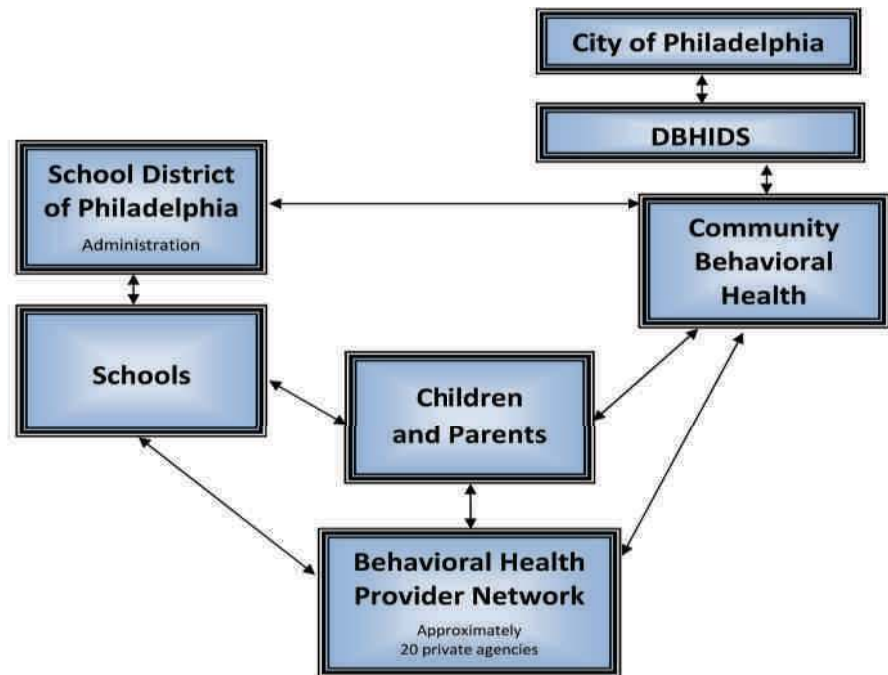
Public Citizens for Children and Youth explored the benefits and burdens of providing behavioral health services in schools and collected other information in this report by speaking with many individuals and with an advisory board we formed with staff from Community Behavioral Health, the School District of Philadelphia, school-based behavioral health agencies and other community advocates. We also gained helpful insights from focus groups we conducted with parents/caregivers, high school students and school counselors. Community Behavioral Health and the School District of Philadelphia provided the report’s quantitative data.

This report answers some questions and raises others; we ask you to join us in further pursuing improved behavioral health care for the City’s children.

II. Systems Involved In School-Based Behavioral Health

Four major systems are involved in delivering school-based behavioral health services:

- The School District of Philadelphia (SDP);
- Community Behavioral Health (CBH), the non-profit corporation created by the City of Philadelphia to provide mental health and substance abuse services to Medicaid recipients;
- the network of Behavioral Health Providers, and
- parents, children and families.



The School District of Philadelphia

Philadelphia’s public school system is the eighth largest school district in the nation with 154,482 students in over 250 schools. School-based behavioral health programs are coordinated through the District’s Office of Counseling and Promotion Standards. The school system supports the behavioral health programs in their buildings in a variety of ways, including operating a referral program, the Comprehensive Student Assistance Process or CSAP, which helps identify children with potential and actual behavioral health issues and connects them to appropriate services. The schools provide space, furniture and sometimes computers for the agencies; staff in the schools and in the District office work with CBH and the provider agencies to help support the school-based programs.

Community Behavioral Health (CBH)

CBH is the insurer and authorizes, manages and financially supports mental health and substance abuse services for the 420,000 Medicaid recipients in Philadelphia, among whom approximately 262,000 are children. In fiscal year 2010, CBH reported that a total of 31,479 children received behavioral health care and 27,653 of them obtained the care in an outpatient setting at an agency, at school or in their home. CBH is housed within Philadelphia’s Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) which provides mental health, addiction and mental retardation services.

CBH develops and administers the school-based programs, tracks needs, determines where school services should be located and chooses, through a competitive bidding process, the mental health agencies that provide the services. When we describe CBH-funded school programs, we are referring to services for elementary and middle school students; there are very few CBH-funded services for high school age students.

Behavioral Health Provider Network

There are approximately 60 mental health agencies in the city that provide services to children insured through Medical Assistance; 20 provide services in the schools. In addition to the school-based services, many of these agencies also provide individual counseling, psychiatry, home-based services and drug and alcohol counseling outside the school setting.

Some agencies provide more specialized services, such as trauma treatment in the areas of abuse, violence, homicide or traumatic grief. Many of these agencies have been providing services to children in the community for decades.

Parents, Children and Families

The children receiving services and their parents and families may not typically be thought of as a system among the others, yet we believe they are the most important part of the picture. It is critical that parents and children are included and actively engaged in shaping and directing their care and that services are developmentally appropriate and consider the whole child and family, focusing on both struggles and strengths.



III. How Students Are Referred To School-Based Behavioral Health Services

Comprehensive Student Assistance Process (CSAP)

If a child already receives behavioral health services at an agency, the child's therapist can recommend and refer him for school-based services. When teachers, counselors, nurses or other school staff identify a student with a potential behavioral health problem, they refer him to the school's Comprehensive Student Assistance Process (CSAP).

The goal of CSAP is to help students overcome barriers to learning – be they behavioral, social or academic in nature. Students with eight or more unexcused absences, three or more suspensions, or students who are failing in core subjects such as reading or math are required to be referred to CSAP. Each school has a CSAP team generally coordinated by a school counselor and further comprised of key school staff involved with the particular student as well as the student's parents/caregivers.

CSAP Tier I: Group Intervention

CSAP is organized into three levels of interventions. At Tier I, students participate in a group intervention which is typically coordinated by a designated teacher. For example, teachers with children struggling with reading across a school's third grade classrooms identify and implement practices to assist them. The Tier I Coordinator will ensure the teachers continue to address the issue and track and measure students' progress over an initial 30-day period.

CSAP At A Glance

Comprehensive Student Assistance Process or CSAP, is the school structure which connects students with the supports they need to learn.

When we asked parents, teachers, school counselors and school-based behavioral health providers how it was working, time and again we were told that its effectiveness depends heavily on the leadership in an individual school.

CSAP Tier II: Individual Attention

At Tier II, interventions focus on individual students. Students either move up to Tier II if Tier I interventions have not been successful or students automatically start at Tier II if they have eight or more unexcused absences, are failing reading or math or have three or more suspensions. A school counselor typically coordinates the CSAP Tier II team comprised of the student's parent or guardian, primary teacher and other staff relevant to that child and his/her barrier.

If the student's barrier to learning involves behavioral health difficulties and if his school has a school-based behavioral health program, he might qualify for school-based treatment if: a) he has a mental health diagnosis;

b) he is prescribed school-based services, and c) he is insured by Medicaid. Tier II interventions are implemented for at least 60 days, after which services can be continued, ended or the student can be referred to Tier III.

CSAP Tier III: Out of School Placement or Special Education

CSAP Tier III interventions are more serious with students being sent to out of school placements or entering the special education system. A student does not have to have received Tier I or II services to be referred to Tier III; if a student is experiencing significant barriers to learning, his parent or guardian can request an evaluation for Tier III services. The school psychologist evaluates the student and at this level can recommend him for special education and initiate an Individualized Education Plan (IEP). If the child is in 2nd through 7th grade, the psychologist may also recommend a more intensive behavioral health program, such as CARE (Children Achieving through Re-Education), which is a partial hospitalization program located in separate classrooms in a school.⁵

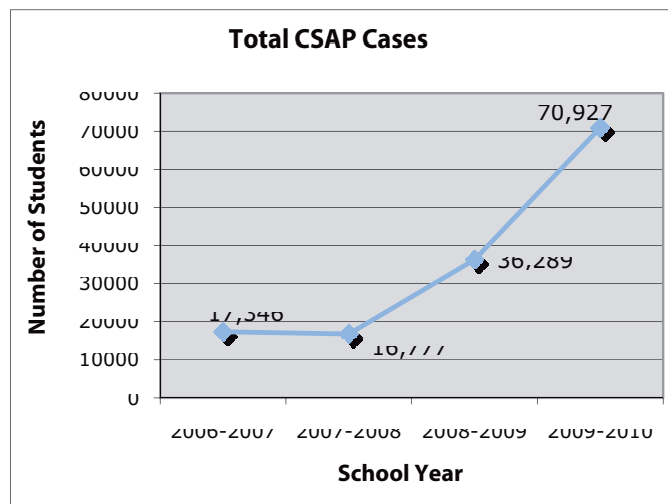
Perspectives on CSAP's Effectiveness

CSAP is the school structure which connects students with the supports they need to learn. When we asked parents, teachers, school counselors and school-based behavioral health providers how it was working, time and again we were told that its effectiveness depends heavily on the leadership in an individual school; in some schools it works very well and in others it practically doesn't exist. In some schools, the CSAP coordinators are efficient and thorough in keeping track of referrals generated inside the school or outside by a student's outpatient therapist.

They monitor most students' progress in each tier. At other schools, staff find it extremely difficult to make time to meet as a team, and they are frustrated by a lack of resources with which to connect students.

Many people we interviewed told us that the schools simply do not have the capacity to assist the high number of students referred. Over the last two years, the number of students referred to CSAP has significantly increased. During the 2008-09 school year, the number of students in CSAP more than doubled from 16,777 to 36,289 and in 2009-10 the number almost doubled again to 70,927 (see the chart below). This exponential rise has been attributed largely to increased monitoring of CSAP and the broad inclusion of negative student behaviors (such as truancy and lateness) as required referral reasons.

The District reported that in 2008-09, the Superintendent required principals to report their CSAP activities/efforts on the School Annual Report Card which records an individual school's progress towards meeting specific benchmarks. If a school reported that 200 students were persistently truant, for example, it was now expected that these students would enter into and be counted by CSAP. Their progress would be noted on the Annual Report Card.



How Students Are Referred To School-Based Behavioral Health Services

In spite of the increased responsibility to serve these students, capacity was not enlarged until this 2010-11 school year when there was some added capacity.

The District submits CSAP data to the Pennsylvania Department of Education including the number of students referred by age, grade and race/ethnicity, the person who made the referral, reason for the referral, type of intervention or service recommended and whether the student received the service, and if not, why not.

The State and the School District have not been able to successfully agree on common data points as yet but are working toward a resolution of this problem. Thus it is currently not possible to report accurately on the efficacy of the program.

An accurate account of why students enter CSAP and whether they receive the recommended services is critical to measuring student and program progress. Problems cannot be adequately resolved if we don't know their breadth and depth. Strengthening the exchange between the District and the State Department of Education will contribute to a more precise picture of issues, conditions and recommendations for students who are experiencing problems in meeting school expectations.

The District reported it pilot tested a new electronic CSAP database last year and its implementation across the District is slated for September 2011. This new database has been designed for use by a variety of school staff to serve several functions. For example, teachers and counselors will not only record a student's status in the system but will also obtain assistance in designing specific academic or behavioral interventions. Absences and suspensions will also be recorded in the database; principals and other administrators will be able to access students' information. We look forward to reporting on the progress of this initiative.

1,200 Students from One School in CSAP

A school counselor told us that just before Thanksgiving 300 students had been referred to CSAP Tier I because of truancy in the first school quarter. The number swelled again in the first marking period right after Thanksgiving with students who had at least two 'Fs' on their report card. The counselor said that it is common for 1,200 students to be referred to CSAP by the end of a school year based on school absenteeism alone.

Overall, many questions remain. How can we best serve students who are struggling with behavioral health issues? How can we best identify children with actual issues and connect them to services? Should we be combining students with primarily behavior-related barriers to learning with students

with primarily attendance-related barriers? Is the net too broad or right-sized?

Given that there is no reliable quantitative data to determine whether CSAP works or not and with mounting anecdotal data that it is failing too many students, will re-designing CSAP or a similar referral process strictly for students with behavioral health issues better ensure that we meet their needs?

IV. Children Participating In School-Based Behavioral Health Services

In this report, we have focused primarily on services CBH financially supported during the 2010-11 school year for students with a mental health diagnosis. Those services are Therapeutic Staff Support (TSS), School Therapeutic Services (STS) and Children Achieving through Re-Education (CARE).

Approximately 5,000 children received these school-based services last year. Some of these children were dealing with more than one issue and received more than one diagnosis. CBH reports on a child's primary diagnosis; these are the data we present here. Primary diagnoses are largely a reflection of a child's observable behaviors and generally do not identify the underlying cause(s) of a child's behavior.

For example, a child diagnosed with ADHD who is observed as talkative, disruptive and having difficulty focusing may actually be depressed related to a traumatic event he experienced or observed. Consequently, the primary diagnosis data

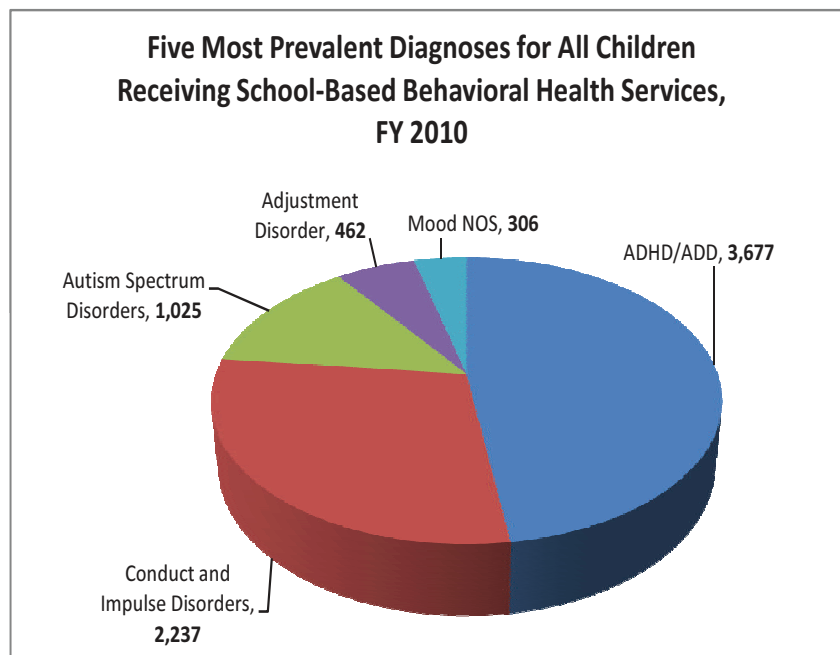
5,000

The approximate number of children who received school-based behavioral health services last year.

may not be the most accurate description of the causes of the child's problem. Treatment recommendations may well turn on the availability of treatment rather than causality.

Data from the most recent available school year show the five most prevalent diagnoses in descending order were: Attention Deficit Hyperactivity Disorder combined with Attention

Deficit Disorder; Conduct and Impulse Disorders; Autism Spectrum Disorders; Adjustment Disorders and Mood NOS.⁶



Children Participating In School-Based Behavioral Health Services

Five Most Prevalant Diagnoses for All Children Receiving School-Based Behavioral Health Services Fiscal Year 2010 ^ *						
		ADHD/ADD	Conduct and Impulse Disorders	Austim Spectrum Disorder	Adjustment Disorder	Mood NOS
Total		3677	2237	1025	462	306
Gender	Male	2954 (80%)	1593 (71%)	857 (84%)	280 (61%)	185 (60%)
	Female	723 (20%)	644 (29%)	168 (16%)	182 (40%)	121 (40%)
Race/Ethnicity	African-American	2506 (69%)	1788 (80%)	494 (48%)	327 (71%)	209 (68%)
	Hispanic	732 (20%)	272 (12%)	115 (11%)	73 (16%)	61 (20%)
	Caucasian	332 (9%)	129 (6%)	294 (29%)	55 (12%)	26 (8%)
	Asian	8 (<1%)	5 (<1%)	38 (4%)	1 (<1%)	4 (1%)
	Native American Indian/ Alaskan Native	0	2 (<1%)	1 (<1%)	0	0
	Other	95 (3%)	41 (2%)	83 (8%)	6 (1%)	6 (2%)

^ The data in this table describes children receiving school-based services and home-based services. CBH reported that this was the only available data.

* The data is for the first three quarters of fiscal year 2010-11.

Boys outnumber girls in all five diagnostic categories (range of 60-84 percent). (See the chart above). Compared to the overall composition of African-American students in the District (58 percent), African-American children are over represented within four of the top five diagnoses (range of 68-80 percent), with the exception of Autism Spectrum Disorder. (See the chart on page 19). Caucasians with Autism Spectrum Disorder are over represented (29 percent diagnosed compared to 12 percent population presence District-wide).

The percentage of Hispanic students with diagnoses compared to Hispanic students District-wide is similar for ADHD/

ADD and Mood NOS (around 18 percent). We identified fewer children of Hispanic origin with Conduct and Impulse Disorders, Autism Spectrum Disorder and Adjustment Disorder. Asian and Native American Indian/Alaskan Native children were under represented in all diagnostic categories.

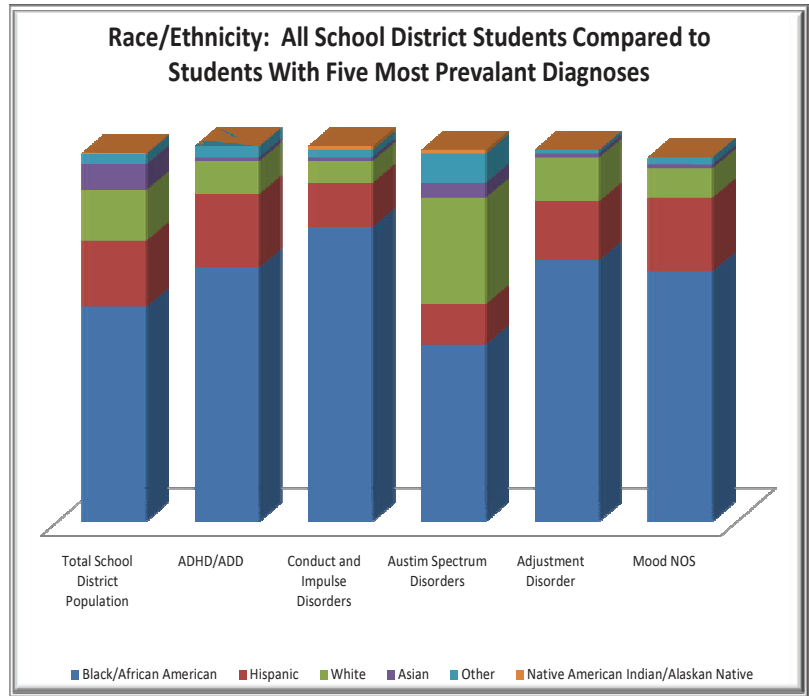


Although children and youth in grades kindergarten through 8th grade are eligible for school-based services, CBH reported that most students receiving care were in the 3rd and 4th grades. In Pennsylvania, standardized testing begins in 3rd grade and there is heightened pressure in schools and on students for good academic

results. Schools begin to measure individual students against their peers in these grades; this testing and measuring could stimulate a number of results.

Low test scores flag students who need additional academic supports – and possibly behavioral health supports if behavioral health issues appear to be barriers to learning. Third and 4th grade also represent transition years between primary and intermediate grades when classrooms often shift from a more informal environment encouraging children to interact and work together into a more structured learning format with children sitting behind desks listening to teachers lecture; some children may experience difficulty making these adjustments.

Overall, the data show that a disproportionate number of children receiving school-based behavioral health services are African American boys in 3rd and 4th grades diagnosed with ADHD/ADD. The over representation of African American boys is very troubling; some parents, behavioral health providers and school staff we spoke with raised questions about the role race and gender play in identifying and treating children for behavioral health issues.



Historically and currently, many parents, community leaders and educators have been concerned about the possible over-use of medication and labeling of African-American students. We believe that further examination of race, school conduct and school expectations is warranted; we intend to continue to pursue these issues.

V. Overview of School-Based Behavioral Health Services

Description of Types of School-Based Services:

The three major CBH-funded school-based behavioral health services available in the 2010-11 academic year were Therapeutic Staff Sup-

port (TSS), School Therapeutic Services (STS) and Children Achieving through Re-Education (CARE). A brief description of each service is below.

Current CBH-Funded School-Based Behavioral Health Services			
Service	Description	Target Grades	Number of Schools with the Service
Therapeutic Staff Support (TSS)	One-to-one behavioral support provided by a Therapeutic Support person for students diagnosed with Autism Spectrum Disorder and students who qualify for STS (see below) but there is no STS program in their school.	Kindergarten – 8th Grade	Information not available
School Therapeutic Services (STS)	Therapeutic intervention provided by a clinical team. These students receive services from a Lead Clinician (masters-prepared therapist); most receive group therapy and some receive therapeutic intervention provided by a Behavioral Health Worker in a ratio of one worker to three students.	Kindergarten – 7th Grade	96
Children Achieving through Re-Education (CARE) Classrooms	An alternative to partial hospitalization, students leave their regular classroom and go to a specialized classroom that may or may not be located in their school. The classroom has a teacher and at least one therapist.	2nd – 7th Grade	8 schools with two CARE classrooms – one for younger and one for older students



Trends in Utilization: The number of children receiving school-based services has been growing (see charts below). Data from the last four years show an increase from 3,881 to 4,995 students (a 29 percent increase).

Last year most children received School Therapeutic Services/STS (3,481) followed by Therapeutic Staff Support/TSS (1,651) and Children Achieving Through Re-Education/CARE (241).

Number of Children Receiving School-Based Behavioral Health Services in Selected Fiscal Years							
	STS	TSS	CARE	TESC~	SBBH*	Nuture#	Total Children Served ^
2007-2008	453	1950	418	86	1035	223	3881
2008-2009	570	2069	397	81	1169	219	4180
2009-2010	1906	1641	353	64	1135	176	4797
2010-2011 ⁺	3481	1651	241	71	0	0	4995

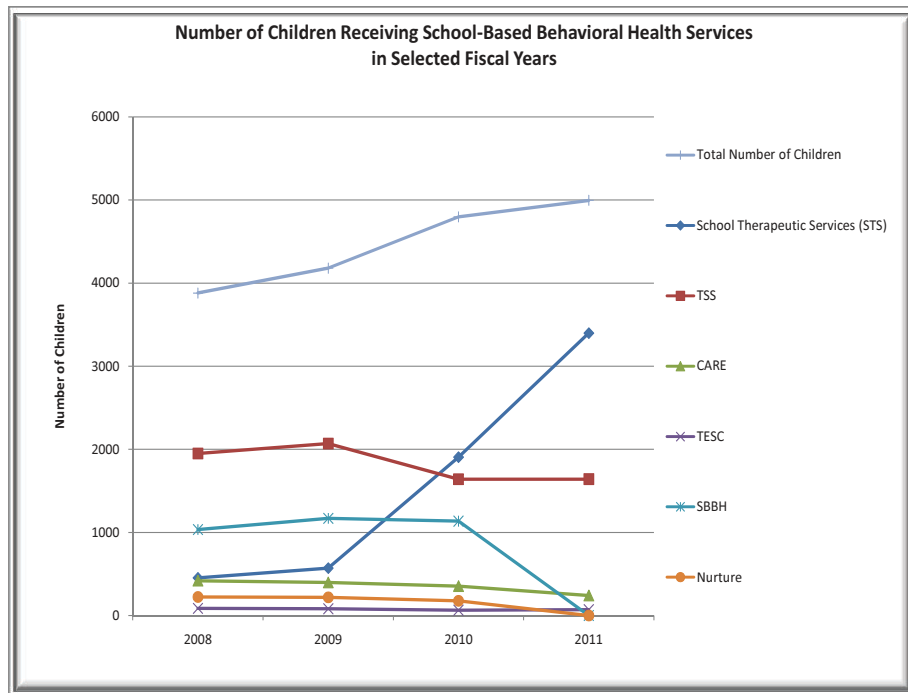
~TESC refers to Therapeutic Emotional Support Classrooms which are CBH-funded, but unlike STS, TSS and CARE, all participating students must be enrolled in special education. This report does not specifically examine behavioral health-related services for children in special education, yet we believe further exploration of these services for this population is warranted.

*SBBH, or School-Based Behavioral Health, was the pre-cursor to STS and ended in academic year 2009-10.

#Nuture provided services similar to SBBH and ended in academic year 2009-10 when CBH expanded STS.

+The data for 2010-11 is for the first three quarters of the fiscal year.

^Total children served in a given year cannot be calculated by adding across all columns/service categories because the service categories are not mutually exclusive; individual children can appear in more than one service category by year and can also be counted in more than one age group.



VI. Analysis of the Individual School-Based Behavioral Health Services

Therapeutic Staff Support (TSS) – Part of Wraparound/Behavioral Health Rehabilitation Services

Therapeutic Staff Support is one of three services that comprise Behavioral Health Rehabilitation Services (BHRS) commonly referred to as “Wraparound.” Wraparound was designed to surround a child with whatever behavioral health supports he or she needed wherever they were needed - at home, in school or at a child care program. Wraparound came to Philadelphia as an evidenced-based model of care with demonstrated good outcomes for children in other parts of the country. In Philadelphia, Wraparound is fairly synonymous with one service: Therapeutic Staff Support or TSS.

The TSS component can be provided in a home or school setting; it involves one-to-one support for a student up to an entire school day, five days a week. The staff providing TSS are college graduates who receive specialized training by their employer/provider agency. (The other two services a child may receive under BHRS are provided by a Behavior Specialist Consultant who works with the family to develop the child’s



Children Receiving TSS - Who Are They?

Most of the children receiving TSS, and most of the students receiving school-based behavioral health services, are African American boys.

treatment plan and a Mobile Therapist who provides therapy to the child and his/her family).

From its inception in Philadelphia, Wraparound quickly grew as an alternative to more restrictive care for a number of reasons: it was one of the most accessible services; it offered higher, more reasonable reimbursement rates in comparison to other outpatient services; it was easier to start up and sustain, and many parents and teachers welcomed the service because it provided immediate, concrete help to children.

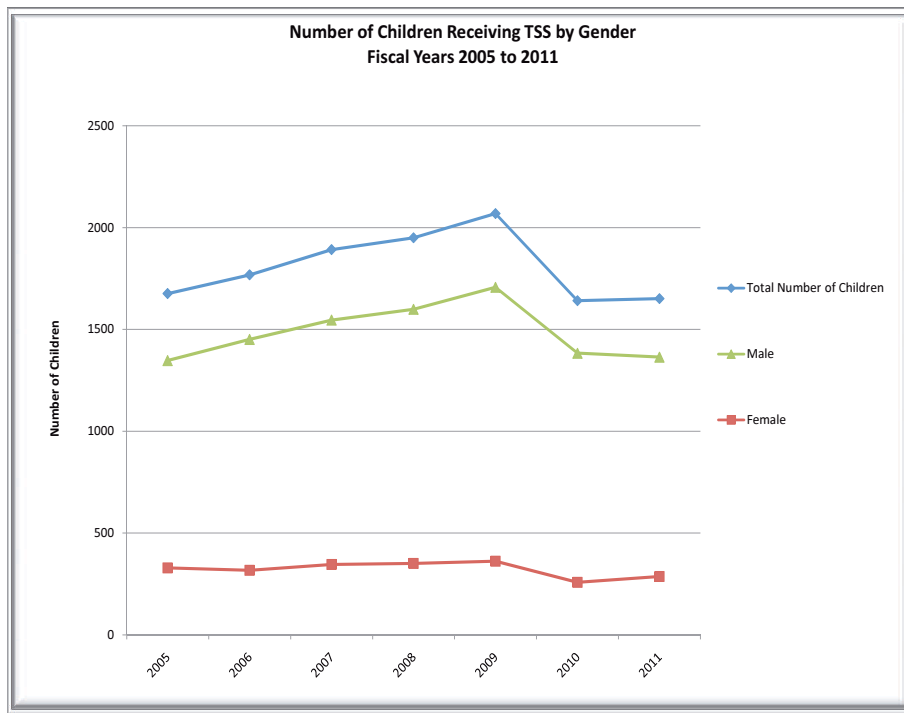
Over time Wraparound was prescribed for an increasing number of students; demand outstripped supply and students authorized for services began to have to wait for longer periods of time to start care. Concerns surfaced about the rising cost of TSS services, the many different providers with different approaches to training and oversight in classrooms and the quality of care.

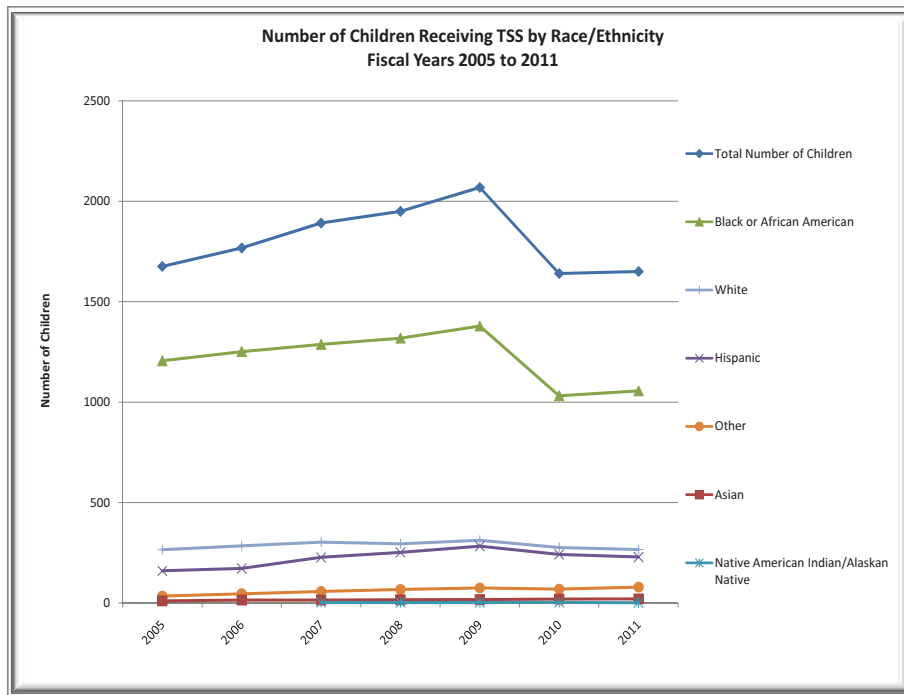
To begin to address the perceived and actual shortcomings of TSS, CBH created a new program that assigned one provider agency to a school to simplify coordination between the

school and service providers and to create more uniformity in training workers and delivering care. The new program also increased the number of students assigned to each worker – from one child to one worker to up to three children for one worker. This new program is currently called School Therapeutic Services (STS).⁷ This is a good example of all of the systems, the school district, CBH, behavioral health agencies and families, responding to a variety of challenges and working together to resolve them.

The older program, TSS, still exists, but its utilization has been sharply narrowed. TSS currently serves children with Autism Spectrum Disorder and children who need some kind of wraparound services but whose school does not have School Therapeutic Services (STS).

The number of children receiving TSS climbed from 1,676 students in 2005 to 2,069 students in 2009, an increase of 23 percent (see the chart below).⁸ The number of students in TSS eventually started to decline as other services grew. In this last school year, 1,651 students received TSS. Most of the children receiving TSS, as are most of the students receiving school-based behavioral health services, are African American boys.





Good Outcomes for Children When Schools and Agencies Work Together

A behavioral health provider was working with a child in an elementary school classroom. The teacher identified another student in the class struggling with a similar behavioral health issue and asked the provider for assistance with this second student. The provider partnered with the teacher, the parent and the school and helped initiate a behavioral health evaluation for this child. During the evaluation process, the provider started a behavior modification program with the student that involved establishing positive behavioral expectations and acknowledging the child every time he met those expectations.

The child responded positively to the interim behavior modification strategy which helped to immediately improve the relationship between the student and the teacher and improve the learning climate in the classroom. The child was eventually identified as having a serious behavioral health issue, and CBH approved him for School Therapeutic Services.

This is a good example of all the stakeholders involved in school-based behavioral health care – children and parents, agencies, schools and CBH – possessing a good understanding of each other's roles and expectations and acting on that knowledge to work collaboratively to successfully support the child, first and foremost, and all others involved.

School Therapeutic Services (STS)

STS is comprised of three distinct yet interconnected components all delivered in a school. First, a Lead Clinician is assigned to every student; this clinician is a licensed mental health provider. The Lead Clinician provides three hours of assistance a week divided between one-to-one time with the child and time engaged in care and resource coordination with the other STS staff, the child's parents, teachers and other critical stakeholders. How much time the Lead Clinician spends with a child is dependent upon the child's level of need.

We understand that Lead Clinicians do not typically spend a continuous hour with a child in school which is the general practice in traditional outpatient therapy. Lead Clinicians may spend shorter amounts of time with a child spread over several days.



The second component is Group Mobile Therapy which is facilitated by a clinician. The groups are broken down by age groups for one hour a week delivered all at one time or broken into two sessions depending on the needs of the students and what the school schedule can accommodate. Generally the only students who do not get Group Mobile Therapy are the few who have difficulty functioning in a group.

The third component most students receive is support from a Behavioral Health Worker for either 15 or 30 hours a week depending on a child's needs. One Behavioral Health Worker can work with up to three students, and similar to TSS, is in the classroom with the students assisting them with managing their behavior.

STS was introduced in the 2007-08 school year in a small number of schools and was designed as an alternative service to TSS. STS programs went from being in about 60 schools in 2009-10 to being in about one hundred schools last year with 1,587 additional

students enrolled, an increase of 83 percent (see the charts on the next page).

Again, males have been disproportionately represented in STS (78 percent) as have African American students (73 percent in care compared to 58 percent in the District); Caucasian students

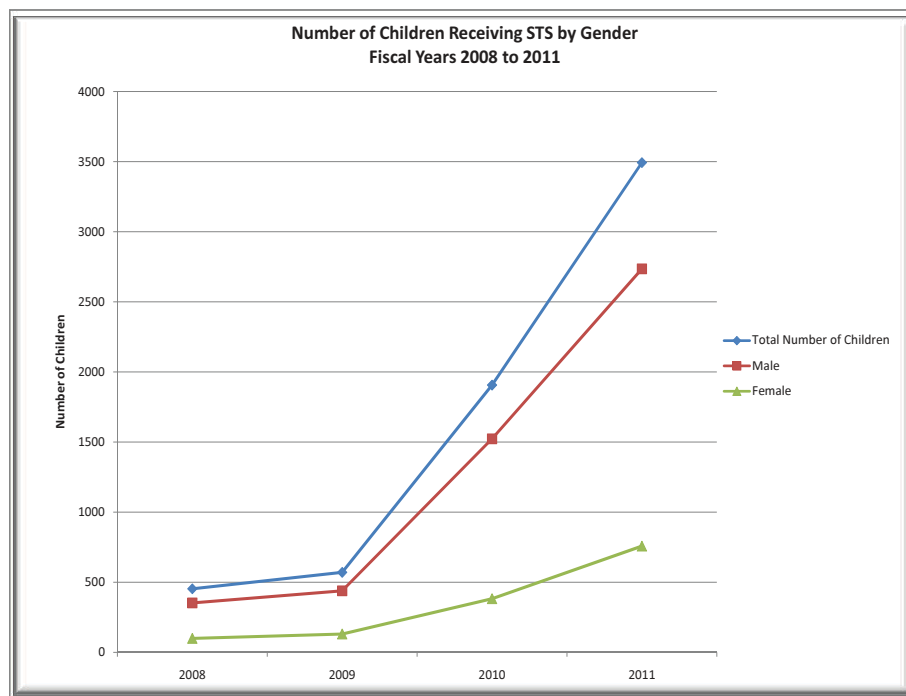
are under-represented (7 percent compared to 14 percent).

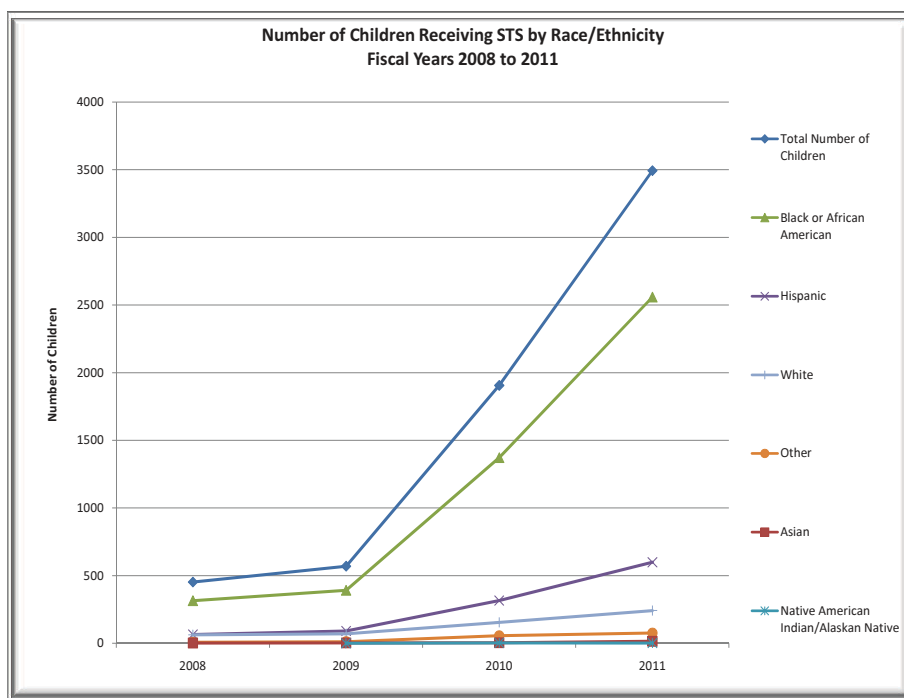


Analysis of the Individual School-Based Behavioral Health Services

Number of Children Receiving School Therapeutic Services (STS) Fiscal Years 2008 - 2011					
		2008	2009	2010	2011*
Total Number of Children		453	570	1906	3493
Gender	Male	353 (78%)	439 (77%)	1523 (80%)	2735 (78%)
	Female	100 (22%)	131 (23%)	383 (20%)	758 (22%)
Race/Ethnicity	African-American	315 (70%)	392 (69%)	1372 (72%)	2559 (73%)
	Caucasian	63 (14%)	71 (12%)	155 (8%)	242 (7%)
	Hispanic	65 (14%)	91 (16%)	316 (17%)	599 (17%)
	Asian	2 (<1%)	3 (<1%)	4 (<1%)	15 (<1%)
	Native American Indian / Alaskan Native	0	1 (<1%)	4 (<1%)	2 (<1%)
	Other	8 (2%)	12 (2%)	56 (3%)	76 (2%)

*The data for 2010-11 is for the first three quarters of the fiscal year.





Among other things, STS was designed to increase capacity for school-based care and reduce the time students waited to have care initiated. We found that care has been initiated far more quickly under STS; CBH reports that there is no waiting time for STS. Many provider agencies report that children are getting into care more quickly. Several providers told us that there is no waiting time for children in their schools. When new children are authorized for services, the agencies quickly add children to the existing STS team in the school. Since the Behavioral Health Workers can assist up to three children at a time, they can accommodate new students or add the staff they need to meet the demand.

STS was also designed to decrease the number of therapeutic staff in a classroom – partially because of concerns that having many adults in one classroom was a distraction to learning. One Behavioral Health Worker in STS works with up to three students, while one TSS worker works with one student. It can also be

less stigmatizing for children to work with a Behavioral Health Worker instead of being paired up with one TSS worker all day.

Because they are all connected to one agency, Behavioral Health Workers can also fill in for each other in a school if one of them is absent. Some providers told us that if the one-to-one TSS worker is absent leaving a student without support, some schools ask parents to take the child back home because the school/teacher cannot adequately manage the child's behavior; this practice disrupts the child's learning and potentially the parent's job. Thus, STS has seemed to solve many problems cited by providers, parents and school staff.

One concern expressed to us about STS is that most students do not receive a weekly, uninterrupted hour of counseling with the Lead Clinician (therapist). Should this be the goal? We were told the Lead Clinician spends an hour with a child but it is typically broken into smaller periods of time over the week due

Analysis of the Individual School-Based Behavioral Health Services

to increasing academic demands on students resulting in difficulty finding a continuous hour for students to be out of class. In the New York City School District, students in their school-based program receive a weekly, continuous 50 minute counseling session. The hour is generally scheduled during a class in which the students are performing well or the counseling session period rotates so a student doesn't keep missing the same class.⁹ Some Philadelphia providers

reported to us that there is no clear cut answer regarding whether children should or should not receive a weekly, continuous hour of counseling. One provider stated that his agency devotes a lot of thought concerning the best way to provide good therapy in a school setting and still help the child return to class after the session. This consideration would not be experienced in an out of school setting.

Commitment As One Step Toward Increased Collaboration

Flexibility and commitment are key to maximizing collaboration between two huge systems like the School District of Philadelphia and Community Behavioral Health to meet children's behavioral health needs. One example highlighting this involves three girls, all about age 13, who were transferred to the same school after having been expelled from other schools. The principal of the receiving school was determined to make sure that the school was the final stop in these girls' circuit among schools that could not handle them. She reached out to the school-based behavioral health provider to work with school staff and provide the necessary support to the girls. Because the principal took a personal interest in trying to keep the girls in her school, the behavioral health provider was not only supporting the girls' needs but also the principal's.

From the time the girls came to the school, the school worked to address their academic needs; the school counselor, for example, connected each student to an individual tutor. When a school addresses students' academic needs, the school-based behavioral health provider can be more effective in working with students' behavioral health needs. If a student is anxious and acting out because she cannot read at grade level, once that student is helped through that reading issue, the school-based behavioral health provider can better focus on a student's more emotionally-rooted behavioral issues. In addition to flexibility between systems leading to good outcomes for children, this example also illustrates a commitment from and a synergy between all involved systems.

**Children Achieving through Re-Education:
CARE Classrooms**

The Philadelphia School District’s CARE program is based on a national model and serves as a partial hospitalization program, but instead of being based in a hospital or agency setting, it is based in a school. CARE is designed for students who according to a CBH provider bulletin, “have an extensive history of inability to function successfully in their current educational placement due to behavioral health challenges and who have been unsuccessfully treated in lower levels of behavioral health treatment”. Without the CARE program, many of the students enrolled in the program would be unable to continue to attend school for at least some period of time.

Last year CARE programs were located in eight schools covering the major regions of the city; most students have to leave their home school to attend CARE. A specified group of 20-30 schools “feed” into each of the eight

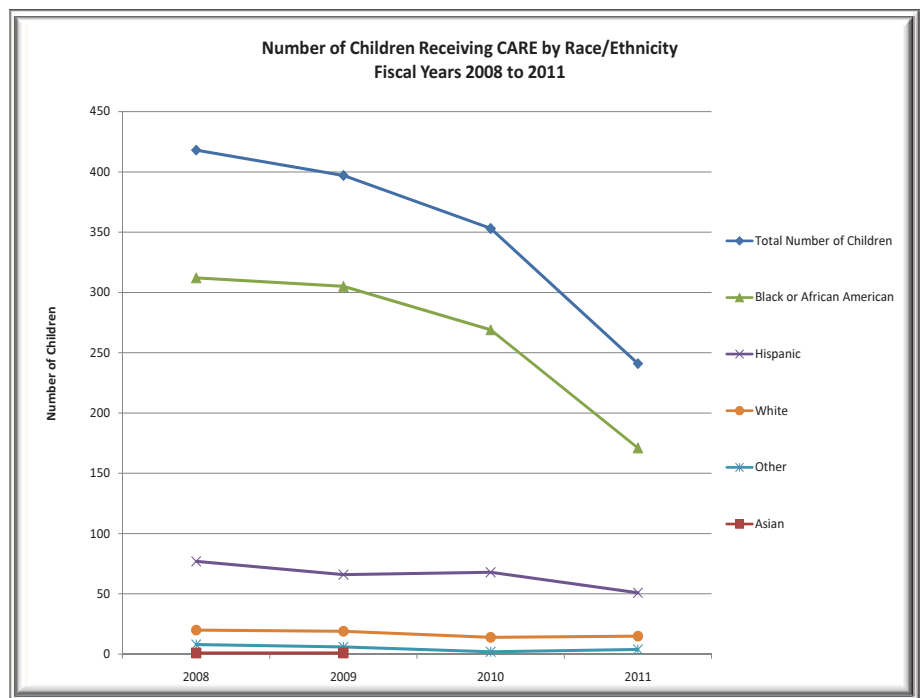
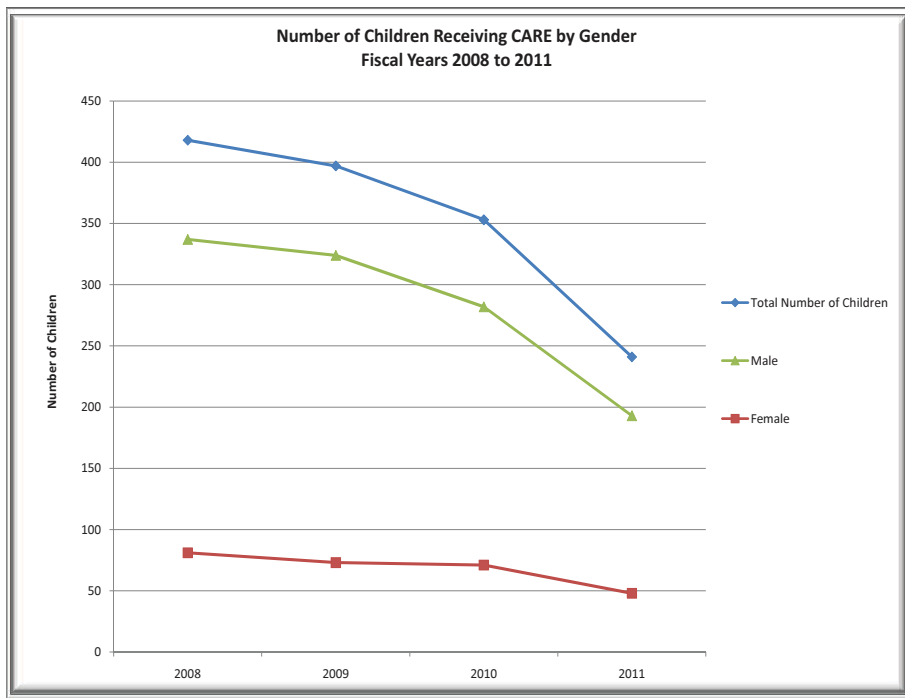
schools. CARE is designed for students in 2nd through 7th grades, and each of the participating schools has two CARE classrooms, one for younger students and one for older students. Each program is staffed with at least one special education teacher, and each classroom is staffed by a teacher and at least one therapist from a behavioral health agency. To assist students to eventually make a successful transition out of a CARE classroom, teachers in the child’s home or receiving school are expected to obtain training on how to best support them. CBH reported that students spend an average of 15-18 months or one and a half to two school years in a CARE classroom.

Again, male students have been disproportionately represented in CARE (80 percent in 2010-11) as have African American students (71 percent). The number of students in CARE has declined over the last few years with 418 enrolled students in 2008-09 and 241 students in 2010-11, a 42 percent drop.

Number of Children Receiving CARE Services (Children Achieving through Re-Education)					
Fiscal Years 2008 - 2011					
		2008	2009	2010	2011*
Total Number of Children		418	397	353	241
Gender	Male	337 (81%)	324 (82%)	282 (80%)	193 (80%)
	Female	81 (19%)	73 (18%)	71 (20%)	48 (20%)
Race/Ethnicity	African-American	312 (75%)	305 (69%)	269 (76%)	171 (71%)
	Caucasian	20 (5%)	19 (5%)	14 (4%)	15 (6%)
	Hispanic	77 (18%)	66 (17%)	68 (19%)	51 (21%)
	Asian	1 (<1%)	1 (<1%)	0	0
	Native American Indian / Alaskan Native	0	0	0	0
	Other	8 (2%)	6 (2%)	2 (1%)	4 (2%)

*The data for 2010-11 is for the first three quarters of the fiscal year.

Analysis of the Individual School-Based Behavioral Health Services



CARE In-Depth

To further understand the current state of the demand for CARE, we conducted phone interviews with school personnel, mostly school counselors, responsible for helping to submit CARE referrals to CBH. We wanted to get a sense of how many students they were referring

and how many were approved and denied. We spoke with over 50 school staff from two groups of schools that feed into two CARE programs.

What did we find? Overall most staff in both feeder school groups were not referring many students to CARE. Among school staff who recalled referring at least one child this year,

most reported CBH approving them for CARE. Several staff stated that they were still waiting for CBH to make a determination for some students and a few reported that they unknowingly referred children who were too young (below second grade). Some school staff reported CBH denying CARE, but we don't have details about these instances.

School staff reported some sort of barrier related to referring students to CARE. A number of school staff reported that they stopped referring students to CARE because: a) they perceive the referral process to be too lengthy and cumbersome; b) in past years students waited a long time for approval for CARE and/or to start CARE after approval; c) they did not understand the purpose of CARE and which students would benefit; d) other programs exist in their school that they believe are similar, better or easier to obtain; e) and finally, students often returned from CARE classrooms to new schools leaving the sending school staff unaware of the program's impact on the child.

Some staff reported that parents are part of the hesitancy in referring children to CARE stating that some parents: a) believe that CARE is for "bad" children and their child is not bad; b) believe that being in CARE stigmatizes their children; c) do not understand what CARE is and, therefore, do not see the need to follow through with the referral, and d) are afraid or uncomfortable with their child leaving their home school to attend a new school in a different neighborhood.

We appreciate the significance and difficulty of a child being removed from his home school to participate in CARE – particularly if the child has other siblings in his home school and if

the child has to travel far to the new school. Parents would have to make changes and devote more time and attention to managing new transportation schedules and relationships with staff at multiple schools.

Overall, we listened to school staff describe a wide range of steps they believed to be involved in the referral process and a wide variety of people necessary to facilitate it – some accurate and some not - leaving us with the impression that many school staff in the position of assisting with CARE referrals do not fully understand the process themselves and may not be referring correctly.

We subsequently spoke with the director of the School District office in charge of behavioral health services who acknowledged that there was room to improve the CARE program. He was anxious to positively modify it and felt it was a necessary program for a group of students who seemingly had no alternative options.

He recognized that some children had unnecessarily long bus commutes to their CARE classroom, that some classrooms were not properly equipped with educational materials, that some school counselors did not understand which students were appropriate for CARE services or how to shepherd students through the referral process. He stated that the District was actively working to make the necessary changes to strengthen CARE so that all students would receive the education and behavioral health supports they required. We look forward to working with him to effect improvement.

Choosing Appropriate Treatment for Students in CARE and in All School-Based Programs

Some school staff told us they believed that CBH denied CARE for their students because the students had not yet been treated in a lower or less restrictive level of behavioral health care – that the student had not yet participated in STS which is considered a sort of step-down from CARE. CBH referral criteria for CARE explicitly states that students must “have an extensive history of inability to function successfully in their current educational placement due to behavioral health challenges” and must “have been unsuccessfully treated in lower levels of behavioral health treatment.”

While we were researching this report, representatives from several behavioral health agencies reported that they refer some children for a particular treatment, but CBH denies the requests because the child must “fail first” a lower level of care before entering a higher one. Providers argue that based on some children’s problems, the lower level treatments such as traditional once a week outpatient therapy visits would not adequately meet a child’s current needs. The overall philosophy of CBH and DBHIDS is a strength-based approach - that treatment that produces the best results must be the least restrictive, most inclusive and focused on a child’s assets instead of risk factors.

But would more collaboration between CBH and agencies about best treatment choices be an appropriate goal?

VII. Do The Services Work and How Are Children Faring?

We heard loud and clear from many people representing all of the systems involved in school-based behavioral health care that measuring how well the services work and whether children feel and act ‘better’ as a result was complicated and difficult. Measuring progress and outcomes in the field of mental and behavioral health overall is challenging.

In physical health care, one can more readily use quantitative measures to gauge if people are healthier – measures such as the presence or absence of a rash, blood sugar levels for diabetes and an improvement in vision with new glasses. Measuring changes in mood, in relating to peers and adults and in being better able to concentrate, for example, don’t lend themselves as easily to hard and fast measures. And then there is the question of how much of a change, in what amount, constitutes a child doing ‘better’?

Currently, CBH requires school-based providers to administer an evaluation tool called the Achenbach Scale of Empirically Based Assessment or ASEBA. The ASEBA has two separate surveys - one for the parent to complete and the other for a child’s teacher. They are to be completed when a child is first referred to care and again three to five months later.¹⁰

CBH reported that there have been technical difficulties with the software behavioral health agencies use to record and transmit the ASEBA data. Consequently, CBH does not have aggregate data to report on children receiving school-based services, so to date, we do not know how they are doing and if the services appear to be working.

How Do We Measure Progress?

Measuring changes in mood, relating to peers and adults and being better able to concentrate, for example, don’t lend themselves as easily to hard and fast measures. And then there is the question of how much of a change, in what amount, constitutes a child doing ‘better’?

We understand that CBH has been working with agencies to correct these problems, and CBH hopes to soon have some level of ASEBA outcome data to share from this last school year.

Not having outcome data and knowing how kids are doing and if the services appear to be working is not only a challenge for Philadelphia. We looked for outcome data for several other large school districts across the country including New York City, Baltimore and Los Angeles, and there was little to no data on how their students in school-based services were faring.

Of note, we were surprised to learn that the ASEBA did not include an assessment by a child’s therapist; someone who we believed would have a solid grasp on the child’s issues and progress. Therapists do report a child’s status to CBH at different points during treatment, but it is reported outside the ASEBA.

Do The Services Work and How Are Children Faring?

Concern about a therapist's objectivity is one argument against their inclusion. There are other assessment tools that include therapist input.

Would we better assist children in school-based services if therapists participated in the evaluation process or not?

Together both systems and communities must develop and use an assessment tool that can guide the work to provide care to children who need it. Difficulties with some assessment

tools should not hinder utilization of assessments and evaluation overall. For this and many other reasons, we believe perfecting and using the ASEBA and other tools to measure child outcomes is warranted. Additionally, we believe that further exploration is needed to determine how to directly measure if the school service models, TSS, STS and CARE, work well and what other quality measures are in place or need to be in place.



VIII. Additional School-Based Behavioral Health Services

There are several other school-based services that CBH does not financially support which address the behavioral health needs of all District students – not just students with diagnosed behavioral health problems as does TSS, STS and CARE. These services and staff include School Counselors, CSAP/Behavioral Health Liaisons, Social Service Liaisons and School-Based Social Services. All are coordinated by the District’s Office of Counseling and Promo-

tion Standards. (The office also oversees the CBH-funded programs). (See the chart below). Because the School-Based Social Services program assists students in all grades including high school, whereas TSS, STS and CARE assist only children in elementary and middle school, and because some outcome data is available about the program’s impact, we provide more information about this program below.

Additional School District of Philadelphia Behavioral Health-Related Staff and/or Programs as of Academic Year 2010 - 2011		
	Function	Number of Staff
School Counselors	Support students’ academic and behavioral health needs – primarily by supporting teachers who are addressing students’ barriers to learning through the CSAP process.	Approximately 400
CSAP / Behavioral Health Liaisons	Support CSAP operations and help maintain functionality and adherence to state and federal CSAP mandates; facilitate relationship between schools and school-based behavioral health agencies; support school counselors by convening monthly counselor meetings, conducting trainings and assisting with students experiencing behavioral health crises.	11
Social Service Liaisons	Play a similar role as the CSAP/Behavioral Health Liaisons but they specifically work in the District’s 23 chronically failing Empowerment schools undergoing drastic reform.	16
School-Based Social Services (delivered by Resource Specialists)	Provide case management, brief counseling and service coordination to students experiencing barrier(s) to learning; they serve on the school’s CSAP team.	111

School-Based Social Services

The School-Based Social Services (SBSS) program primarily provides case management, service coordination and brief counseling to students experiencing any type of barrier to learn-

ing, including behavioral health concerns. The substance of the program has existed for the last 20 years under various names, the last being the Consultation and Education program. Students are referred to SBSS through CSAP; services are delivered by 111 Resource Specialists.

Additional School Behavioral Health Services

It is important to note that the main CBH-funded behavioral health programs discussed in this report focus on students in elementary and middle school – not high school-age students. School Based Social Services, however, does begin to address the behavioral health needs of high school students.

Every neighborhood high school in the District has a full-time Resource Specialist; most of these professionals have Master's degrees. These Resource Specialists can conduct brief counseling sessions with students, if necessary, particularly as students wait to start behavioral health services at a community-based agency. Part-time Resource Specialists with Bachelor's and Master's degrees work in the middle and elementary schools.

Some process and outcome data are available about the SBSS program and its students. In six months, from January to June 2010 Resource Specialists:

- Served 3,141 students, two thirds in kindergarten through eighth grade and the remaining one third in high school. Sixty seven percent were African American, 18 percent Hispanic, 11 percent Caucasian, two percent Asian American and two percent of some other origin. Almost 60 percent were male.

- Made 660 referrals to outpatient behavioral health services; initial appointments were scheduled within 30 days for 84 percent of these students.
- Provided 306 behavioral health crisis consultations which they believe contributed to 185 students being diverted from the city's children's mental health emergency room (the Crisis Response Center).

Furthermore, compared to all students in the District, a smaller proportion of students receiving SBSS were referred for more intensive interventions, such as special education or placement in a disciplinary school. SBSS may be helping to prevent an escalation of student's issues.

SBSS also conducted satisfaction surveys with principals, parents and 11th grade students. Ninety six percent of the principals reported being satisfied with the program; the main criticism they reported was a lack of communication with them. Ninety eight percent of students were satisfied with the services and 96 percent of parents as well, with many parents stating that because of SBSS, their child was now amenable to attend counseling.



IX. Do The Systems Encourage Collaboration? How Does It All Seem To Work?

Overall, there was agreement from representatives of every system involved in school-based behavioral health care that there was on-going need for these services. The question remains, given the many parts and perspectives on school-based services, how does it all seem to work? How does each system seem to function alone and how do they function together? We talked with many people from various groups to assess school-based services. Not surprisingly, both contradictory and common themes and concerns cut across all of the groups.

We talked with some parents, high school students, school staff (mostly school counselors, CSAP/Behavioral Health Liaisons and leadership in the Office of Counseling and Promotion Standards), providers from agencies delivering school-based services, and CBH staff in charge of school-based services. Some of the prominent themes we identified were:

Need for and availability of services: Schools reported that more and more students were troubled and displayed poor conduct at young ages. CSAP teams in many schools were overwhelmed with the number of children referred for assistance. Some high school students we spoke with did not know what services were available in their school and others thought enough services existed but were simply poorly advertised. Some parents said that there were more school police than counselors in schools, implying that there was more attention to punitive responses than to therapeutic ones.

Stigma: Some school staff reported that some parents did not follow through with referrals because they thought the programs were for “bad” kids and their child was not bad. Some high school students said that when they were younger they were embarrassed by being identified as troubled, but with maturity now say they know they need help and they are benefitting from the help. One student stated that her school debates a “topic of the week” and suggested that making mental illness the issue one week would lower some stigma concerns.

Eligibility for and purpose of school-based programs: Some parents, students and schools did not know about and/or have an accurate understanding of what the programs were and which children qualified for them.

Process of referring students into school-based care: Many school counselors reported the process of referring students was complicated and had actual experience with or perceived that the process took a long time. In some cases they felt discouraged from pursuing the services.

Approval and denial of care: Some behavioral health providers and school counselors reported a lack of collaboration concerning the most appropriate care for children. Some providers and school counselors expressed frustration when CBH denied a treatment request for a child and seemingly dismissed their judgment.

Do The Systems Encourage Collaboration? How Does It All Seem To Work?

Parent involvement: Some parents reported feeling left out and wanted to be involved. One caregiver mentioned that she felt “victimized” by the system and believed there was a “divide and conquer” approach taken between caregivers and children. Some parents reported that some providers and school staff made incorrect assumptions about a family’s values which ultimately undermined a child’s treatment.

Expectations/role of provider agencies: Some parents and school staff wanted providers to tell them about how students were doing, and many providers believed they were providing parents and schools with adequate information. Many schools also wanted or expected providers to help students apply for Medicaid in order to qualify for their services and assist any student in a crisis situation, even if the student was not enrolled in one of their programs. Some providers saw this as their role and others did not.

Integration of services within schools and school culture: Many providers wanted help figuring out how to work in a school setting, desiring more collaboration with an individual school, and said they tried unsuccessfully to obtain help from the school, the District and CBH. Many schools, the District and CBH had this same desire for more collaboration. Schools

were particularly interested in agencies training teachers and other school staff to support and manage students with behavioral health problems.

Problem resolution and accountability: Some agencies said there was no one for them to regularly consult to resolve disagreements with CBH and establish clear policy regarding administration of services CBH financially supports.

Communication and collaboration across systems: Among all stakeholder groups, there was general agreement that each group could benefit from creating more opportunities to work together. Some providers said they would like regular dialogue with CBH to assist in designing and evaluating services given their experience implementing them. Some parents said that schools did not listen to them about their concerns for their children until their child’s behavior erupted at school. Some school staff reported they needed to work more closely with CBH and/or agencies to better understand the programs in their schools and how to refer students.

X. What Does It All Mean?

When it comes to children's behavioral health, Philadelphia has a lot going for it. In this report we have identified a number of assets upon which to build. Namely, access barriers have been removed for many children who can obtain services where they are - in school. For many of the children who need help, Medicaid funding continues to be available to pay for the school-based services and Philadelphia is in a unique position in having the city manage Medicaid behavioral health care. An extensive network of long-standing mental health agencies exists to deliver the care. Parents and children are experts on their experiences and many of them meaningfully contribute towards improving their health and making systems work better.

We believe we can, however, make even better use of these assets. While we strive to build resilience among Philadelphia school children, we can strive to build more resilience in the systems and partners that support them – the School District, CBH, behavioral health agencies and families. We can use these assets, for example, to build more bridges between these mammoth systems and recognize the challenge that educating and providing behavioral health care to children presents.

For many students, there is no clear line between when they act out in expected, developmentally appropriate ways and when they act out because they are struggling with a behavioral health issue. The only clear line is the one we must learn to accurately identify when children need more support and offer all children the best chance for a good future.

As our public schools receive children with many different life experiences, school staff must be vested with the know-how and support to help prepare all of them for adulthood.

Through this work, we identified a number of potential ways to make improvements, and we identified a number of important but as yet unanswered questions. Before turning to the recommendations we want to pose these questions, some of which we raised in the report and others we did not address. We look to the community's help to begin to answer them.

- Are these the right services? Are the existing services appropriate and in the right amounts? Together we must ask, how are the programs working?
- How are the programs designed? How good are the models upon which they are based? Are we making the best use of the expertise that exists in the city to help develop them?
- How does the cost of care figure into the design and implementation of these services?
- What is the implication of over-representation of some groups of children in school-based services?
- School services do not typically include a traditional individual, uninterrupted 50 minute therapy session. Why not? Should they?

What Does It All Mean?

- Why are there practically no services in the high schools? Do teenagers experience similar difficulties as younger children accessing traditional outpatient care? There is a behavioral health clinic at Frankford High School. How are the students there doing? What about replicating this model?
- Currently school-based behavioral health services are available only to low income children with Medicaid health insurance; will children at higher income levels and other insurance programs be eligible when the health care reform law is implemented?
- Can public behavioral health services in tandem with public schools successfully knock down the barriers to learning that some youth experience?
- Are children, their families and their schools doing better? To measure the fullest impact of these services, when behavioral health outcome data is finally available on each child, should we match this data with report card/school performance data? Would this demonstrate the impact on a child's academics? Should we relate it to the school as a whole?
- What quality measures are in place to evaluate the agencies and providers delivering school-based behavioral health services?
- How do we resolve differences between behavioral health agencies and CBH? – particularly regarding disagreements in the selection of the appropriate service for some children?
- How do we better maintain continuity of care for students when they change schools?
- What types of school-based behavioral health services are available to students outside the traditional public schools such as the alternative and disciplinary schools and the Renaissance charter schools?
- How are we responding to the behavioral health needs of some children in special populations such as children in special education or children who are homeless or children involved with child protective services? Would some of these children benefit from school-based services – and are some of these children currently receiving them?
- In some other cities, colleges and universities play a significant role in the development, delivery and evaluation of school-based behavioral health services. Is there a larger role for higher education institutions in Philadelphia to contribute? Where are the opportunities for more collaboration?

Basing behavioral health services in schools seems to make sense, but the challenges are many. We commend the work so far, but urge that we become better at informing, collaborating, being accountable and keeping the promise to all children to help them become resilient and realize their full potential.



Recommendations

XI. Recommendations

As a community, we must come together and assure that we:

I. Track Students in School-Based Programs and Measure and Report Student Outcomes

1) Count Students

a. We should count students every year to monitor changes in the number of children in care and who they are (i.e. age, grade, gender, race/ethnicity, diagnoses, etc.) in order to identify trends, monitor utilization, better target services, and better plan for the future.

2) Measure and Report Students' Behavioral Outcomes and Connect Them with Academic Outcomes

a. We should ensure that each child's behavioral health status is evaluated on a regular basis.

b. We should work together to obtain agreement about the desired/expected outcomes of school-based behavioral health services (e.g. students are able to continue to attend school, perform well in school, learn to cope better in life and schools gain improved climates). In order to know whether children were faring better and whether the schools they attended were improving as a result of on-site behavioral health services, we must develop indicators to measure these expected outcomes while preserving individual children's confidentiality and privacy.

II. Improve Communication and Strengthen Collaboration Among Major Stakeholders/ Systems

1) Strengthen Communication and Cross-Training Between the District, Individual Schools, CBH, Behavioral Health Agencies and Parents

a. We should create more and better communication and training between key personnel in the schools and at the central District office and behavioral health agency staff to establish clear expectations, policies and procedures concerning how providers and schools can best function together and what services providers can and cannot provide to students.

b. We should strengthen existing or create a new liaison position or function between the schools and CBH dedicated to building relationships between the two entities.

2) Create New Bridges

a. We should create a position/function at DBHIDS to make policy and serve as a mediator between CBH and behavioral health agencies.

b. We should develop a School-Based Behavioral Health Services Advisory Team comprised of a cross-section of stakeholders to monitor and review program outcome data and collaboratively make decisions about the type and amount of services that should be offered. Members could include representatives from: DBHIDS, CBH, District's Office of Behavioral Health, principals (schools), behavioral health agencies, the student body, parents and advocates.

III. Improve Parents' Access to and Involvement in School-Based Care for Their Children

1) Increase Parental/Public Awareness of Services

a. We should increase parental/public awareness of existing school-based programs and assist parents in accessing them. We also must seek to improve families' knowledge about and access to community-based behavioral health services at agencies' offices and services available in the home.

2) Improve Parental Involvement in Children's Care

a. We must make it easier for more parents to participate in their children's care; scheduling care coordination meetings at mutually convenient times, involving parents in making decisions about the type of care their child needs and keeping parents abreast of their child's progress will in the end improve care and education.

Footnotes

¹ Abrahams, I.A. et al (2011). Philadelphia Behavioral Health Services Transformation Practice Guidelines for Recovery and Resilience Oriented Treatment, Version 1.0, A-7.

² US Public Health Service. (2000). Report of the Surgeon General's Conference on Children's Mental Health: A national action agenda. Washington, DC: US Department of Health and Human Services.

³ The CBH supported behavioral health services are located in non-charter public schools. This report focuses on services in the non-charter public schools.

⁴ Although the parental involvement requirement seems to be less, basing a youth's behavioral health services in school still requires caregiver involvement, which if lacking can either prevent a student from receiving the services or create a disruption in services.

⁵ Although not a treatment, students in middle and high school may also be transferred to a disciplinary school when they exhibit some negative behaviors that may be related to their behavioral health. A deeper examination of the efficacy of this process is warranted yet outside the scope of this paper.

⁶ ADHD/ADD is characterized by inattention, hyperactivity and impulsivity and is the most commonly diagnosed behavior disorder in young people. Conduct and Impulse Disorders involve long-term behavior problems such as defiance, impulsivity, lack of concern for other people's feelings, drug use and breaking social rules/criminal activity. Autism Spectrum Disorders (ASD) are complex developmental disorders of brain functioning categorized within five different levels of severity. They are defined by social deficits, communication problems and repetitive or restricted behaviors. Adjustment Disorders are emotional and behavioral reactions that develop within three months of a life stressor (i.e. family conflict, school problems) and which are stronger than what would be expected for the type of event that occurred. Mood NOS (Not Otherwise Specified) implies there is a disturbance of mood/ emotion as the underlying feature of the diagnoses but not enough clarity to meet criteria for Major Depression or Bi-Polar Disorder. Behavioral health providers often use Mood Disorder NOS as a provisional diagnosis while assessing over time if a child's behaviors or mood change.

⁷ The pre-cursor to the School Therapeutic Services program was School-Based Behavioral Health (SBBH). SBBH was implemented from the 2006-07 school year until the end of 2009-2010 when it was ended and STS was expanded.

⁸ The TSS data presented in this report does not include children with Autism Spectrum Disorders.

⁹ Scott Bloom, personal communication, March 28, 2011, Director of School Mental Health Services, New York City public schools.

¹⁰ Achenbach, T. (2001). Child behavior check list for ages 6-18. In ASEBA: Achenbach Scale of Empirically Based Assessment. From: www.aseba.org.

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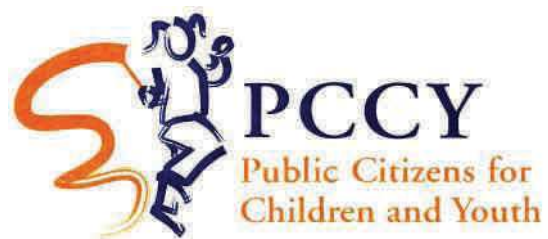
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