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Mental Health in Schools-Legislators 2020

I am Kathy Mosher, Executive Director of Central Kansas Mental Health Center (CKMHC), a community mental health center (CMHC) dedicated to being a leader in mental health treatment for 5 rural and frontier counties: Saline, Lincoln, Dickinson, Ellsworth, and Ottawa Counties. I am here to talk about the mental health in schools initiative.

CKMHC was chosen to be in the original school mental health pilot. We were the only pilot site to take on 4 different school districts, all rural and uniquely different- Solomon, Herington, Chapman, and Abilene. We were tasked to develop a model that works for rural communities and can be replicated.

Through this partnership with schools:

1. **We Increased access to services**. We placed trauma trained therapists in schools. 30% more at-risk youth received services compared to the previous year. An excellent return on your investment.
    - System barriers such as transportation were removed.
    - Students missed significantly less class time.
    - Services were more convenient for parents who work.
    - It was easier for schools to make referrals.
    - Less youth fell through the cracks from lack of follow through because of warm hand-offs from school staff to mental health staff.
2. **We achieved excellent outcomes.** Of the schools who collected data for us last year, we got results:
    - **Attendance increased 65%.**
    - **Academic Performance increased 48%.**
    - **Behavior improved (using a standardized tool) 77%.**

    These outcomes will also led to higher graduation rates, long term employability, better health, and will save money in many other budget areas of the state.
3. **We saved lives and reduced youth suicide.** Unexpectedly, we found that many of the students in the pilot reported contemplating suicide upon starting treatment. As a CMHC, we were able to wrap intensive supports around each student far beyond therapy (e.g. In home family services, 24/7 crisis intervention, Mental Health First Aid (MHFA) training for staff/parents/students, trauma programs, skill building groups, parent support, medication management, vaping cessation, and our 72 hour youth crisis house). This carries benefit far beyond a therapy session.
    - One example is a school principal who said he now handles things differently and cited a student he found in the bathroom in which he normally would have sternly hurried him to class. Instead, he talked with him and realized he was having a mental health crisis so he got immediate help and with tears in his eye, the principal stated, “I know I saved a life that day. I think differently now.”
4. **We cut cost by utilizing private insurance when available and we work with all ages, mental health conditions, and behaviors.** Youth are identified and served sooner which research confirms reduces the length of treatment needed, and therefore conserves resources, important during a workforce shortage.

5. **Stigma is almost gone in these schools.** Students are talking about mental health in the halls and recommending it to each other. Teachers are more open about discussing mental health issues in conferences and meetings. Staff are interacting in new ways with kids and often walk them to the mental health staff to make introductions and start a relationship.
6. **We filled gaps in the existing system**. The mental health system did not have enough funding to have a physical office in every small town in Kansas. By partnering with schools, they gave us an office and internet and we doubled the number of towns we had offices in. By the end of last year, every school district saw the importance of providing us the school office space to continue to provide services over the summer.

The legislature set the foundation for a robust mental health system in schools without the cost of duplicating a second mental health system. When we start, we partner with the schools to find out what is working well, where the needs are and we only fill those gaps. If a school has staff with specialized training such as trauma or they already meet with youth one-on-one, then we may focus on depression groups or after school programs. Some of our most requested services:

- On-site therapy clearly helped with access.
- Social emotional skill building groups *(e.g. success story)*
- Teen depression group-addressing high student suicide rate
- Staff training- Building resiliency, trauma intervention, Conscious Discipline, MHFA, ASIST (suicide intervention training for communities)
- Assist teachers by removing student barriers to learning
- Youth 72 hour crisis house
- CKMHC's Suspension Program
- Therapeutic preschool aimed at kindergarten readiness

This school year (2019-2020) several more school districts wanted us on board. Salina, Southeast of Saline, Bennington/Tescott, and Minneapolis schools started in August. We just received the results for their very first semester:

- **Attendance improved by 88%.**
- **Academic performance improved by 84%.**
- **Behavior improved by 83%.**
- **Internalizing behavior improved by 81%.**

We now have on-site therapists in 23 schools (8 school districts in 3 counties).

We also provided social emotional skill building groups in 17 schools which significantly reduced behavioral referrals, and now schools are asking for specialized therapy groups to address community needs such as suicide prevention, anxiety/depression, resilience training, etc.

We not only built a school mental health system but this allowed CKMHC to expand to 10 new communities. We doubled the amount of towns with our offices for a fraction of the cost. One public mental health system and no duplication of systems=low cost and excellent ROI.

As a CMHC and the local Mental Health Authority, our staff have to keep up on best practices that get the best results. We don't just offer a service. We provide individualized support, education, and services proven to get results and we aren't limited to the school. We provide crisis response 365 days a year. It is all carefully designed to get the best outcomes.

1. **We don't stop services when school is out** nor do we go home at 3:30**.** We continue to offer treatment over the summer, during spring break and winter break if needed.
2. **CKMHC's relationship with schools resulted in new programs:**

- **72 hour youth crisis house** - designed to prevent youth from being sent out of their community to inpatient hospitalization.
- **Suspension program** - Youth can come to our program during their normal school day and we work on resolving the behaviors that led to suspension and keep them up to date on school work.
- **K-PREP** - a therapeutic preschool to provide intensive trauma treatment and kindergarten readiness skills to 3-4 year olds who have been kicked out of multiple daycares or out of preschool/Head Start. (example: Instead of being completely unprepared for Kindergarten emotionally, behaviorally, and academically, we have had kids progress so quickly they return to preschool and graduate successfully or they start Kindergarten with emotional self-regulation skills necessary to be able to focus on learning.)

3. **We help train teachers in trauma, suicide prevention, Jason Flatt Act, Mental Health First Aid training, vaping cessation, cyberbullying, etc. based on what they need.** Through our partnership, one school even got our Mental Health First Aid training approved for graduate college credit through Baker University. Teachers filled the classes to earn their graduate hours toward their pay tier.
4. **We are all talking the same language from home to school to MH treatment.** That is a huge gain for continuity of care and outcomes.

Did you know? As of today there are 14 CMHCs and 32 school districts in Kansas where the pilot is happening.

Recommendations:

1. **Keep the School Mental Health partnership going with CMHCs**.
   - **The partnership between CMHCs and schools gets excellent results for students which will reduce cost in several state budget areas.** We have already seen truancy decrease, graduation forecasts increase, suicides prevented, and youth are turning to mental health instead of drugs and alcohol. In a few years I believe we will see a big impact. We have seen a 15% decrease in youth needing our crisis house this year.
   - **No need to duplicate a second mental health system** – It is cost effective to avoid overhead and just cover the gaps. This gives a great return on investment by developing school mental health programs. **But in addition, it has also added many new CMHC office locations in many more communities for very low cost.** These school-CMHC partnerships are now evolving and will have far reaching benefits now and in the future.
   - **CMHCs in schools are getting great outcomes.** It is our therapy services along with our crisis services day and night. It is treating the whole person and family even when school is not in session, and it is our training resources like suicide prevention, vaping cessation, and Mental Health First Aid which in turn gets community members and school staff doing much of the mental health intervention at no extra cost to the state.
2. **Raise the Medicaid rates for mental health which have not been raised in over 11 years.** We can't attract a workforce without being able to offer fair wages and we can't offer fair wages when Medicaid rates for behavioral health don't cover costs. An example: The cost of a psychiatrist has nearly tripled over the last decade. Without rate adjustments, we now lose a half million a year on Psychiatry/Medication Management. We do as much as we can because primary care won't take complex cases and some mental health conditions require medication to achieve good outcomes.
3. **Expand Medicaid to reduce access barriers**. This would reduce the self-pay issue in schools and build healthier communities while being cost effective.

Our Motto: Better Access, Better Quality, Better Patient Satisfaction (We aim to be the best!)