NASP 2014-15 Priorities & Features

Mental Health Matters

Stephen E. Brock, PhD, NCSP, LEP
NASP President, 2014-15

Our Vision and Mission

- **Vision:** All children and youth thrive in school, at home, and throughout life.
- **Mission:** NASP empowers school psychologists by advancing effective practices to improve students' learning, behavior, and mental health.

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Boiled Down….

- What NASP does for members ultimately benefits children
- We want the organization, our members, and the children we serve to:

THRIVE

Helping children thrive. In school. At home. In life.

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NASP

NATIONAL ASSOCIATION OF
School Psychologists

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Redesigning Our Website

Current Site
- Hard to find stuff
- Fairly static layout
- Too many clicks to get where you are going

New Site (in progress)
- Streamlined look
- More user friendly navigation
- Better search
- Improved functionality

NASP Periodicals: Research to Practice

Access complete issues online at
http://www.nasponline.org/publications/periodicals.aspx

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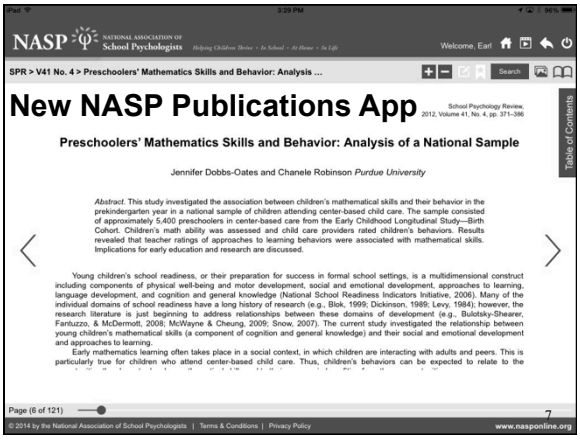
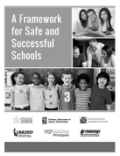


New Best Practices Series

- Available for pre-order starting August 1, 2014 (shipped by September 2)
- Sold as a set or individually in print
- Organized around 4 major areas of NASP Practice Model

Policy Priorities 2014-2015

- **Comprehensive School Safety**
  Focus on mental health; role of school-employed MH professionals; collaboration with allied groups; links to MTSS; training/PREPaRE
  - http://www.nasponline.org/resources/BP-armed-assailant-drills.aspx
- **Affordable Care Act**
  Focus on ensuring that SPs are included as approved providers for reimbursement at state level
- **NASP Practice Model**
  Focus on providing guidance and resources for school psychologists to enhance their role at the local level; release of the *Implementation Guidebook*



Enhancing Student Success:

Promoting Mental Health

Stephen E. Brock, PhD, NCSP, LEP
NASP President, 2014-15

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Mental Health Matters:
Key Points

1. **individual, schools, and society**
2. **School psychologists are perfectly positioned to promote mental wellness and qualified to address the challenges of mental illness**
3. **There are well established and effective school-based approaches to addressing mental health**

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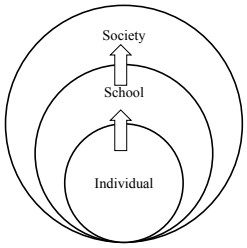
The Burden of Mental Illness



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The Burden of Mental Illness

Individual

1. 13 to 20% of children
2. 1994-2011 surveillance suggests increasing prevalence
3. 24% increase in inpatient admissions 2007-2010
   - Mood disorders a common primary diagnosis
   - 80% increase in rate of rate of hospitalizations of children with depression

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Merikangas et al. (2010); Health Care Cost Institute (2012); Perou et al. (2013); Pfuntner et al. (2013)

The Burden of Mental Illness

Individual

- 65% of boys and 75% of girls in juvenile detention facilities have at least one mental illness
  - *We are incarcerating youth living with mental illness, some as young as eight years old, rather than identifying their conditions early and intervening with appropriate treatment* (NAMI, 2010, ¶ 9).

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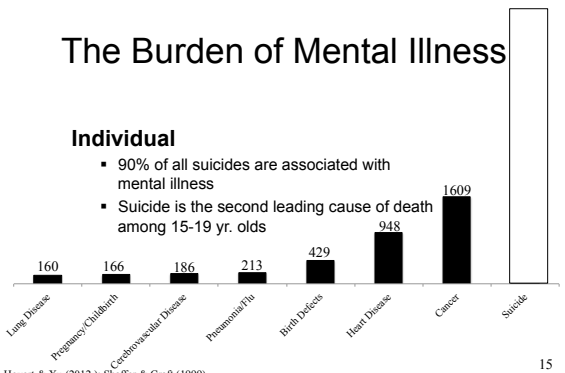
Teplin et al. (2002)

The Burden of Mental Illness

Individual

- 90% of all suicides are associated with mental illness
- Suicide is the second leading cause of death among 15-19 yr. olds



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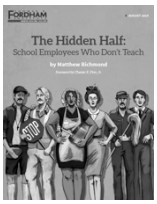
Hoyert & Xu (2012); Shaffer & Craft (1999)

The Burden of Mental Illness

Individual

- Apparently alleviation of the pain of the mentally ill student is insufficient for some
- Not everyone thinks that school psychologists matter when it comes to success in school



Richmond (2014)

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The Burden of Mental Illness

School

1. Mental illness is associated with poor academic achievement, academic decline, and poor attendance
2. Mental wellness (e.g., healthy self-regulation, emotional competence, and positive relationships) is associated with school success and achievement

Boyce et al. (2002); Roderick et al. (1997); DeSocio & Hootman, (2004); U.S. Department of Health and Human Services1(999)

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The Burden of Mental Illness

School

- Over 10% of high school dropouts are attributed to mental illness
- Approximately half of students 14 years and older with a mental illness dropout of high school
  - The highest dropout rate of any disability group

Breslau et al. (2008); U.S. Department of Education (2001)

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The Burden of Mental Illness

School

- May play a role in the so called "achievement gap"
  - While the overall PTSD rate among high school aged youth is 5%, the prevalence of PTSD among some urban populations can be as high as 30%

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Berton & Stabb (1996); Buka et al. (2001); Saigh et al. (1997); Seedat et al. (2004); Lipschitz et al. (2000)

The Burden of Mental Illness

Society

- Mental disorders are among the most costly conditions to treat in children
  1. In the US, the annual cost of mental disorders among persons under age 24 years was estimated at almost $2.5 billion
  2. Mental disorders in childhood is associated with mental disorders in adulthood, which is in turn associated with decreased productivity, and increased substance use and injury

Soni (2009); Eisenberg & Neighbors (2007); National Research Council (2007); Perou et al. (2013); Reeves et al. (2011); Smit et al. (2006)

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Mental Health Matters:
Key Points

1. **Mental illness places a significant burden on the individual, schools, and society**
2. **School psychologists are perfectly positioned to promote mental wellness and qualified to address the challenges of mental illness**
3. **There are well established and effective school-based approaches to addressing mental health**

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School Psychologists:
Well Positioned to Address Mental Health

1. Only 20 percent of children with mental disorders receive mental health services
2. However, of those who do receive care 70 to 80% receive this care in a school setting
3. Not surprisingly, given these statistics, the most common entry point to mental health services is the school

U.S. Public Health Service (2000); Rones & Hoagwood (2000)

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School Psychologists:
Well Positioned to Address Mental Health

Mental Health Service Entry Point	*N*	%
Education	531	60.1
Specialty mental health	258	27.3
General medicine	141	12.9
Child welfare	52	6.5
Juvenile justice	30	2.5

Farmer et al. (2003)

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School Psychologists:
Well Positioned to Address Mental Health

Further supporting this assertion, are the facts that

1. 88.7% of our nation's youth attend a public school.
2. Youth are 21 times more likely to visit a school-based health clinic for their mental health care than they are a community based clinic
3. Half of all life time cases of mental illness have their onset by age 14 years

Kessler et al. (2005); Juszczak, Melinkovich, & Kaplan (2003); U.S. Department of Education (2009)

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School Psychologists:
Well Positioned to Address Mental Health

Disorder	Age of Onset
Any mental disorder	**50% by age 14**
Any anxiety disorder	50% by age 11
Any mood disorder	25% by age 18
Any impulse control disorder	90% by age 18
Any substance use disorder	25% by age 18

Kessler et al. (2005)

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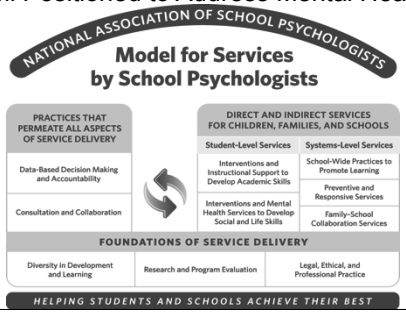
School Psychologists:
Well Positioned to Address Mental Health



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School Psychologists:
Qualified to Address Mental Health

NASP's Standards for the Graduate Preparation of School Psychologists

- Address both promotion of wellness and response to illness
  - 2.4: Interventions and Mental Health Services to Develop Social and Life Skills
  - 2.6: Preventive and Responsive Services

NASP (2010)

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School Psychologists: Qualified to Address Mental Health

- While 90% of school psychologists report having counseling training, over 40% report not providing counseling services
- Common reasons
  - Services provided by other personnel
  - Lack of time during school day
  - No expectation in district to provide services
    - *School psychologists cannot afford to relinquish a role that they have been trained to undertake, or to refrain from providing a vital service to students as a response to the perceptions or lack of expectations of others.* (p. 667)

Hanchon & Fernald (2013)

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School Psychologists: Qualified to Address Mental Health

- What school mental health services do you provide?
  1. What do you do at the **universal** primary preventative intervention level?
  2. What do you do at the **targeted** secondary preventative intervention level?
  3. What do you do at the **individual** tertiary preventative intervention level?

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Mental Health Matters: Key Points

1. **Mental illness places a significant burden on the individual, schools, and society**
2. **School psychologists are perfectly positioned to promote mental wellness and qualified to address the challenges of mental illness**
3. **There are well established and effective school-based approaches to addressing mental health**

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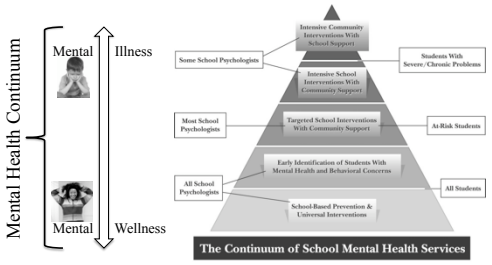
Promoting Mental Wellness & Addressing Mental Illness



Cowan (2006); Rossen & Cowan (2014); Center for Mental Health in Schools at UCLA (n.d.)

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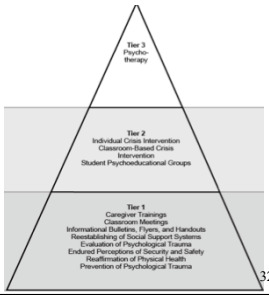
Promoting Mental Wellness & Addressing Mental Illness



Brock (2011)

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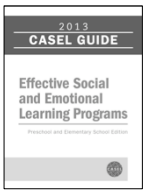
Promoting Mental Wellness

Universal Wellness promotion

- Positive Behavioral Supports
- Social and Emotional Learning
  - Improves social relationships
  - Increases attachment to school and motivation to learn
  - Reduces anti-social, violent, and drug-using behaviors



Horner et al. (2002); CASEL (n.d.); CASEL (2012)

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Promoting Mental Wellness

P	**P**revent and **P**repare for psychological trauma
R	**R**eaffirm physical health and perceptions of security and safety
E	**E**valuate psychological trauma risk
P **a** **R**	**P**rovide interventions **a**nd **R**espond to psychological needs
E	**E**xamine the effectiveness of crisis prevention and intervention

Brock et al. (2009)

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Promoting Mental Wellness

Prevent Crises:

Ensure physical safety

a. Crime prevention through environmental design
   i. Natural surveillance
   ii. Natural access control
   iii. Territoriality
b. Vulnerability assessment

P R E PaR E
Prevent Reaffirm Evaluate Provide and Respond Examine

Reeves, Nickerson, & Jimerson (2006)

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Promoting Mental Wellness

Prevent Crises:

Ensure psychological safety

a. School-wide positive behavioral supports
b. Universal, targeted, and intensive academic and social–emotional interventions and supports
c. Identification and monitoring of self- and other-directed violence threats
d. Student guidance services

P R E PaR E
Prevent Reaffirm Evaluate Provide and Respond Examine

Reeves et al. (2011)

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Promoting Mental Wellness

Prevent Traumatization:

Foster Internal Student Resiliency

- Promote active (or approach-oriented) coping styles.
- Promote student mental health.
- Teach students how to better regulate their emotions.
- Develop problem-solving skills.
- Promote self-confidence and self-esteem.
- Promote internal locus of control.
- Validate the importance of faith and belief systems.
- Nurture positive emotions.
- Foster academic self-determination and feelings of competence.

Brock (2011) 37

Promoting Mental Wellness

Prevent Traumatization:

Foster External Student Resiliency

- Support families.
- Facilitate peer relationships.
- Provide access to positive adult role models.
- Ensure connections with prosocial institutions.
- Provide a caring, supportive learning environment.
- Encourage volunteerism.
- Teach peace-building skills.

Brock (2011) 38

Promoting Mental Wellness

Prevent Trauma Exposure:

Keep Students Safe

- Remove students from dangerous or harmful situations
- Implement crisis response procedures (e.g., evacuations, lockdowns)
  - "The immediate response following a crisis is to ensure safety by removing children and families from continued threat of danger." (Joshi & Lewin, 2004, p. 715)
  - "To begin the healing process, discontinuation of existing stressors is of immediate importance." (Baroppaum et al., 2004, p. 48)

Brock (2011) 39

Promoting Mental Wellness

Prevent Trauma Exposure:
Avoid Crisis Scenes and Images

- Direct ambulatory students away from the crisis site
  - Do not allow students to view medical triage
- Restrict and/or monitor media exposure
  - Avoid excessive viewing of crisis images on television or Internet

Brock (2011) 40

Promoting Mental Wellness

Prepare for Crisis Intervention

- Develop immediate crisis intervention resources
- Identify longer-term psychotherapeutic resources

Brock (2011) 41

Promoting Mental Wellness

Reaffirm <u>Physical</u> Health & Safety

1. General and special needs students
2. Responding to acute needs
3. Ensuring physical comfort
4. Providing accurate reassurances

Brock (2011) 42

Promoting Mental Wellness

Reaffirm <u>Psychological</u> Health & Safety

1. Recognizing the importance of adult reactions and behaviors
2. Minimizing crisis exposure
3. Reuniting/locating caregivers and significant others
4. Providing facts and adaptive interpretations
5. Returning students to a safe school environment
6. Providing opportunities to take action

Brock (2011)

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Addressing Mental Illness

Universal Screening

- School-based mental health screening needs to be as institutionalized as is school-based vision and hearing screening.
  - *The key step in reform is to move school-based psychological services from the back of the service delivery system, in which only students at the highest level of risk receive services, to the front of service delivery through the use of universal, proactive screening.* (p. 174)

Dowdy (2010)

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Addressing Mental Illness

Targeted Prevention and Intervention

- Screening results suggesting mental health problems in 1st grade predict poor academic achievement 3 years later.
- Students with mental health risk have lower achievement when compared to students without such risk.
  - *Unlike poverty, parental education and preexisting academic ability—the other major predictors of academic success in this study—mental health is a risk factor that may yield to intervention* (p. 409).

See Kamphaus et al. (2014) for a current discussion of behavioral and emotional risk screening
Guzman et al. (2011)

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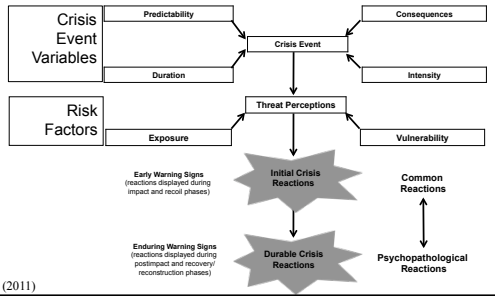
Addressing Mental Illness

Evaluate Psychological Trauma



Brock (2011)

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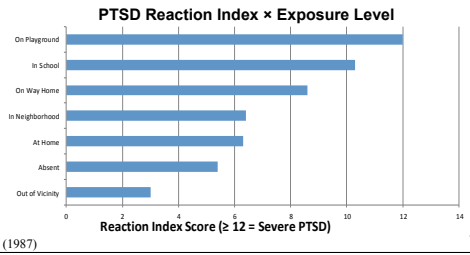
Addressing Mental Illness

Evaluate Psychological Trauma:
Crisis Exposure Physical Proximity Risk Factor



Pynoos et al. (1987)

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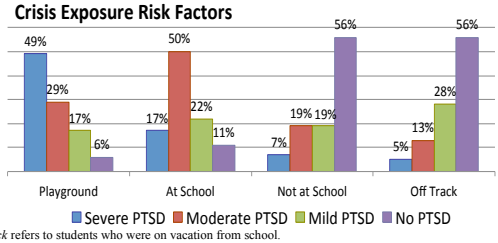
Addressing Mental Illness

Evaluate Psychological Trauma:
Crisis Exposure Risk Factors



Off track refers to students who were on vacation from school.
Pynoos et al. (1987)

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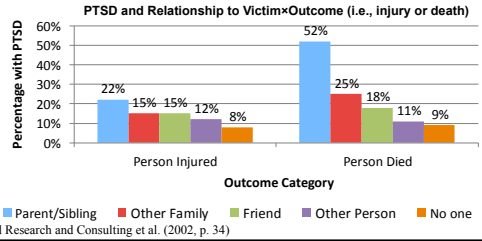
Addressing Mental Illness

Evaluate Psychological Trauma:
Crisis Exposure Emotional Proximity Risk Factor



Applied Research and Consulting et al. (2002, p. 34)

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Addressing Mental Illness

Evaluating Psychological Trauma:
Internal Vulnerability Risk Factors

i. Avoidance coping style
ii. Pre-crisis psychiatric challenges
iii. Poor ability to regulate emotions
iv. Low developmental level and poor problem solving
v. History of prior psychological trauma

Brock (2011)

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Addressing Mental Illness

Evaluating Psychological Trauma:
External Vulnerability Risk Factors

i. Family resources
   1. Not living with a nuclear family member
   2. Family dysfunction (e.g., alcoholism, violence, child maltreatment, mental illness)
   3. Parental PTSD/maladaptive coping with the stressor
   4. Ineffective and uncaring parenting
   5. Poverty or financial stress

ii. Extra-familial social resources
   1. Social isolation
   2. Lack of perceived social support

Brock (2011)

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Addressing Mental Illness

Evaluating Psychological Trauma:
Threat Perception Risk Factor*

a. Subjective impressions can be more important than actual crisis exposure.
b. Adult reactions are important influences on student threat perceptions.

*Risk factors increase the probability of psychological trauma and, as such, should result in increased vigilance for symptoms of traumatic stress (or warning signs).

Brock (2011) 52

Addressing Mental Illness

Evaluating Psychological Trauma:
Crisis Reaction Warning Signs*

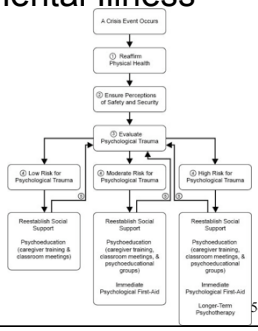
a. Early warning signs
b. Enduring warning signs
c. Developmental variations
d. Cultural variations

*Warning signs are symptoms of traumatic stress.

Brock (2011) 53

Addressing Mental Illness

1. Reaffirm physical health.
2. Ensure perceptions of safety.
3. Evaluate psychological trauma.
4. Make initial crisis intervention treatment decisions.
5. Reevaluate degree of psychological injury and make more informed crisis intervention treatment decisions.



Brock (2011) 54

P R E PaR E
Prevent Reaffirm Evaluate Provide and Respond Examine

Reestablish Social Support Systems

1. Reunite students with primary caregivers.
2. Reunite students with peers and teachers.
3. Return students to familiar environments and routines.
4. Facilitate community connections.
5. Empower caregivers with crisis recovery information.

Brock & Jimerson (2004)

55

P R E PaR E
Prevent Reaffirm Evaluate Provide and Respond Examine

Limitations of Social Support

1. Caregivers can be significantly affected by the crisis.
2. Not sufficient following extremely violent and life-threatening crises (e.g., mass violence), chronic crisis exposure, or when psychopathology is present.
3. Support is sometimes not perceived as helpful.

Brock & Jimerson (2004)

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P R E PaR E
Prevent Reaffirm Evaluate Provide and Respond Examine

Psychoeduction Strategies

1. Informational documents
2. Caregiver trainings
3. Classroom meetings
4. Student psychoeducational groups

Brock et al. (2009); Reeves, Kanan, & Plog (2010)

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P Prevent | R Reaffirm | E Evaluate | PaR Provide and Respond | E Examine

Psychoeducation:
Caregiver Training Elements

1. **Introduce** caregivers to the training (5 min)
2. **Provide** crisis facts (10 min)
3. **Prepare** caregivers for the reactions that may follow crisis exposure (15 min)
4. **Review** techniques for responding to children's crisis reactions (15 min)

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P Prevent | R Reaffirm | E Evaluate | PaR Provide and Respond | E Examine

Psychoeducation:
Classroom Meeting Elements

1. **Introduce** the meeting (5 min).
2. **Provide** crisis facts (5 min).
3. **Answer** student questions (5 min).
4. **Refer** to techniques for responding to children's crisis reactions.

Adapted from Reeves et al. (2010)

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P Prevent | R Reaffirm | E Evaluate | PaR Provide and Respond | E Examine

Psychoeducation:
Student Psychoeducational Group Elements

1. **Introduce** students to the lesson (5 min)
2. **Answer** questions and dispel rumors (20 min)
3. **Prepare** students for the reactions that may follow crisis exposure (15 min)
4. **Teach** students how to manage crisis reactions (15 min)
5. **Close** the lesson by making sure students have a crisis reaction management plan (5 min)

Brock et al. (2009)

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P R E PaR E
Prevent Reaffirm Evaluate Provide and Respond Examine

Limitations of Psychoeducation

1. Not sufficient for the more severely traumatized
2. Must be paired with other psychological interventions and professional mental health treatment
3. Limited research

Amstadter, McCart, & Ruggiero (2007); Howard & Goelitz (2004); Lukens & McFarlane (2004); Oflaz, Hatipoğlu, & Aydin (2008)

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P R E PaR E
Prevent Reaffirm Evaluate Provide and Respond Examine

Psychological Intervention Strategies

1. Immediate classroom-based (or group) crisis intervention
2. Immediate individual crisis intervention
3. Long-term psychotherapeutic treatment interventions

Brock et al. (2009)

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P R E PaR E
Prevent Reaffirm Evaluate Provide and Respond Examine

Psychological Interventions:
Classroom-Based Crisis Intervention

1. **Introduce** session (10–15 min)
2. **Provide** crisis facts and dispel rumors (30 min)
3. **Share** crisis stories (30–60 min)
4. **Identify** crisis reactions (30 min)
5. **Empower** students (60 min)
6. **Close** (30 min)

Brock et al. (2009)

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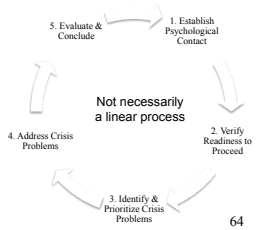
P R E PaR E
Prevent Reaffirm Evaluate Provide and Respond Examine

Psychological Interventions:
Individual Crisis Intervention Elements

1. Establish contact
2. Verify readiness
3. Identify and prioritize problems
4. Address crisis problems
5. Evaluate and conclude



Brock et al. (2009)

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P R E PaR E
Prevent Reaffirm Evaluate Provide and Respond Examine

Psychological Interventions:
Psychotherapeutic Treatments
Trauma-Focused Therapies

Trauma-focused psychotherapies should be considered first-line treatments for children and adolescents with PTSD. These therapies should

1. Directly address children's traumatic experiences
2. Include parents in treatment in some manner as important agents of change
3. Focus not only on symptoms improvement but also on enhancing functioning, resiliency, and/or developmental trajectory.

Cohen et al. (2010, pp. 421–422)

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P R E PaR E
Prevent Reaffirm Evaluate Provide and Respond Examine

Psychological Interventions:
Psychotherapeutic Treatments
Cognitive–Behavioral Therapies

1. Imaginal and in vivo exposure
2. Eye-movement desensitization and reprocessing (EMDR)
3. Anxiety management training
4. Cognitive–behavioral intervention for trauma in schools (CBITS; group delivered)
5. Parent training

Brock et al. (2009); Cohen et al. (2010)

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P R E PaR E
Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Psychological Interventions:
Psychotherapeutic Treatment Interventions

"Overall, there is growing evidence that a variety of CBT programs are effective in treating youth with PTSD . . . Practically, this suggests that psychologists treating children with PTSD can use cognitive–behavioral interventions and be on solid ground in using these approaches."

"In sum, cognitive behavioral approaches to the treatment of PTSD, anxiety, depression, and other trauma-related symptoms have been quite efficacious with children exposed to various forms of trauma."

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Feeny et al. (2004, p. 473); Brown & Bobrow (2004, p. 216)

Addressing Mental Illness

Individual Intervention

- ED identification and special education eligibility determinations, but …
  - 13 to 20% of youth experience a mental disorder
  - 0.56 to 0.73% of students are identified ED (1994-2010)
  - 4,000,000 youth suffer from a serious mental disorder
  - 700,000 students are identified ED under IDEA (2013)

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Perou et al. (2013); U.S. Department of Education (2013); U.S. Department of Health and Human Services (1999)

Addressing Mental Illness

Individual Intervention

- *Overall, the meta-analyses reviewed here have demonstrated that an array of treatments for a variety of psychological concerns are beneficial for children and adolescents.* (p. 1095)
- *As all children are required to attend school, and are consequently provided adequate transportation, the school building becomes an ideal environment for the assessment and provision of therapeutic services, often eliminating the transportation, insurance, and social stigma barriers. Although the demands on professionals within the school system are extraordinary … , time spent providing psychotherapy to students would be well spent.* (p. 1095)

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Zerkelback & Reese (2010)

Stephen E. Brock, Ph.D., NCSP, LEP
NASP President (2014-15)

Please feel free to contact me
brock@csus.edu

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