Mental Health Education and Training (MHET) Initiative
Final Report

I. Introduction and Background

In studies of school-based health center (SBHC) service utilization, mental health counseling is repeatedly identified as the leading reason for visits by students, representing approximately one third to one half of all visits. Despite these figures, a national survey of SBHC health and mental health providers conducted by the National Assembly on School-Based Health Care (NASBHC, 2002) indicated that not only are a variety of mental health services being delivered in SBHCs without the presence of an on-site mental health provider, but that both mental health and other health providers feel that they need further mental health training to effectively manage student's mental health needs. In particular, respondents of NASBHC's survey indicated a desire for training in effective mental health assessment techniques, guidelines for mental health practice and school-based implementation, and short-term interventions in the areas of anxiety, depression, disruptive behaviors, and substance abuse. NASBHC responded to this need, with the development of a collaborative training partnership between the national organization and school-based health centers on effective mental health service delivery, the Mental Health Education and Training (MHET) initiative.

The MHET initiative was developed in partnership with the University of Maryland School of Medicine Center for School Mental Health, a national leader in technical assistance, training and research on implementing evidence-based practices in schools. The purpose of MHET was to increase knowledge and implementation of mental health screening, diagnosis, referral, coding, and empirically-supported short-term interventions among SBHC primary care and mental health providers. This interdisciplinary initiative reached 19 SBHCs in six states between 2004-2006 and was designed based on a four- pronged approached to evidenced-based practice in school mental health: 1) decrease stress/risk factors; 2) increase protective factors; 3) increase knowledge in core mental health skills, and 4) implement evidence-based manualized interventions. This report presents the methodology, results and lessons learned from the two-year MHET initiative, and provides direction for future initiatives designed to enhance school-based primary care and mental health providers' mental health service quality.

II. Methodology

NASBHC Quality Improvement Collaborative Process

Participants in the current initiative took part in a 15-month quality improvement process focused on advancing mental health competencies among both primary care and mental health providers in school-based health centers. The Mental Health Education and Training (MHET) initiative is one of several quality improvement collaboratives implemented by the National Assembly on School-Based Health Care (NASBHC), and based on nationally recognized rapid quality improvement concepts and learning techniques. Similar to other NASBHC quality improvement collaboratives, core elements of the MHET initiative included: a competitive Request for Proposals for site selection; partnership between NASBHC and school-based health center sites to advance quality; intensive training and ongoing technical assistance; workplan development and accountability mechanisms; and, data collection to evaluate efforts and inform quality improvement activities.

Participants

Participating school-based health center (SBHC) sites successfully applied to a Request for Proposals, with the following eligibility requirements:

- SBHCs had to be in middle and/or high school settings.
- Applicants could apply as one SBHC or as two SBHCs that share a geographic area.
- States that had already participated in a NASBHC training collaborative were not eligible to participate.
- Participating SBHC(s) were asked to identify a lead agency and lead staff person willing to provide coordination.
- Participating SBHCs had to have at least one full-time (during school year) mental health staff person whose time was 100% assigned to the SBHC and one full-time (during school year) medical/nursing staff person whose time was 100% assigned to the SBHC.
- Partcipating SBHCs must have been established for at least 2 years.
- At least three staff members from each SBHC (including one mental health provider and one medical/nursing provider) had to be available to participate in all learning sessions.

A copy of the MHET Request for Proposals is included in Appendix A.

MHET participants included teams from 19 School-Based Health Centers (SBHCs) in six states: Colorado, Louisiana, Michigan, New Jersey, North Carolina, and West Virginia. Team members reflected a variety of disciplines including: social workers, counselors, nurses, nurse practitioners, physicians, physician assistants, administrative assistants, and other school-based health center staff.

Process

Participants engaged in a series of four intensive learning sessions, work-plan development, monthly technical assistance from MHET faculty, and a final review and celebration of progress. (Note: MHET faculty included several national experts in mental health and primary care, and in the implementation of effective mental health service

delivery in school-based settings.) Learning sessions occurred at the start of the initiative and then approximately every four months thereafter. During the learning sessions, participants received intensive training in:

- Mental health screening and assessment, including training in the use of the computerized version of the Diagnostic Predictive Scales (DPS) from Columbia University
- Mental health diagnosis
- Referral and follow-up
- Diagnostic and procedural coding
- Risk and Protective Factors
- Core Skills (Evidence-based practice skills for Depression, Anxiety, Disruptive Behavior Disorders and Substance Abuse)
- Selected Manualized Intervention (Note: Participants were trained on one of three manualized interventions: Friends For Youth by Paula Barnet (group intervention for anxiety and depression); Skills Streaming by Arnold Goldstein (group intervention designed to enhance youths' social skills); and Cognitive Behavioral Intervention for Trauma in Schools (group intervention for trauma-exposed youth) by Lisa Jaycox

Within each learning session, participants developed work plans with specific action steps corresponding to the following eight MHET objectives:

1) To increase SBHC primary care and mental health professionals' knowledge about risk and protective factors associated with youth mental health, and to increase interventions aimed to decrease risk factors and increase protective factors.
2) To facilitate appropriate referral and follow-up for mental health services
3) To improve diagnostic and procedural coding for mental health screening, assessment and referral
4) To increase integration and collaboration among primary care and mental health care providers
5) To increase providers' knowledge of mental health diagnoses and common symptoms
6) To increase providers' knowledge and use of mental health screening and assessment
7) To increase SBHC primary care and mental health professionals' knowledge about skills related to youth mental health, and to anxiety, depression, substance use/abuse, and disruptive behaviors, more specifically, and to increase interventions aimed to train youth in these skills
8) To increase SBHC primary care and mental health professional's knowledge about evidence-based menualized interventions for anxiety, depression, substance use/abuse, and disruptive behaviors, and to implement at least one of the selected or targeted evidence-based manualized interventions for referred students.

Sites provided completed work-plans to NASBHC based on the above objectives on a monthly basis, and provided quarterly progress reports describing progress, identifying any obstacles to progress, and requesting technical assistance, as needed. See Appendix B for Work Plan and Quarterly Progress Report templates. In addition to learning sessions, participants received on-going phone support from MHET faculty and NASBHC staff, including monthly site calls to review work plan progress and to address any obstacles. In addition, as chart audit data was collected from sites, NASBHC reported findings back to the participants in order to inform

quality improvement activities. All participating sites were invited to present their progress at the NASBHC annual convention at the culmination of the collaborative process.

Assessments and Chart Audits

Pre- and post-assessments of providers' knowledge and perceived quality of mental health service delivery were collected from MHET participants at each learning session. Each assessment tool is described below:

The Mental Health Services Self-Evaluation was administered at Learning Session One (pre-assessment) and Learning Session Four (post-assessment), and asked participants to rate their School-Based Health Center on a 4-point Likert Scale (1 = Very Poor; 4 = Very Good) on a variety of dimensions of mental health service delivery including: screening, assessment, diagnosis, referral, referral follow-up, procedural and diagnostic coding, use of evidence-based/empirically-supported interventions, and primary care-mental health integration and collaboration.

Participants completed a Diagnostic Assessment prior to their training on mental health diagnosis (pre-assessment) and at Learning Session Four (post-assessment) to assess their knowledge of mental health diagnosis for four disorder areas: Anxiety, Depression, Disruptive Behavior Disorders and Substance Abuse/Dependence. The measure consists of 36 items, with a combination of multiple choice, true/false, and open-ended response formats. The items were summed to achieve a total score.

The Diagnostic and Procedural Coding Assessment was completed by participants prior to their training on Mental Health Coding (pre-assessment), and again at Learning Session Four (post-assessment). The assessment asks participants to rate their familiarity with mental health diagnostic codes (ICD-9/DSM-IV codes) and procedural codes (CPT codes) on a 4-point Likert Scale (1 = Not at all; 4 = Very Familiar) and to rate their frequency of documentation of diagnostic and procedural codes, also on a 4-point Likert Scale (1 = Never; 4 = Very Frequently). Participants were also asked to report where they document diagnostic and procedural codes following the delivery of a mental health service.

The Core Skills Assessment was administered to participants prior to their training on cognitive behavioral skills for Anxiety, Depression, Disruptive Behavior Disorders and Substance Abuse/Dependence, and again at Learning session four (post-assessment). The 10 items assess participants' knowledge of specific techniques and appropriate use for skills such as cognitive restructuring, parent training, exposure, relaxation, and activity scheduling.

Participants completed the Risk and Protective Factors Assessment prior to their training on mental health risk and protective factors (pre-assessment), and again at Learning Session Four (post-assessment). The measure consists of open-ended questions, requesting that respondents define both "Protective Factors" and "Stress/Risk Factors", and also name three protective and stress/risk factors in each of the following categories: Individual, Family, Community and School.

The Mental Health Planning and Evaluation Template (MHPET) was completed only by participants in the second year of the MHET initiative. (The MHPET had not been finalized prior to the start of the first MHET cycle.) Participants in Year 2 completed the MHPET at Learning Session One (pre-assessment) and Learning Session Four (post-assessment).
NASBHC developed the Mental Health Planning and Evaluation Template (MHPET) in partnership with the Center for School Mental Health (CSMH) to systematically assess and improve the quality of mental health services delivered within school-based settings. At the time of administration, the MHPET was a 30-indicator measure designed to assess areas of strength and improvement in school-based mental health quality. (Note: Since the MHET Initiative, the MHPET has been revised, and includes an additional 4 items. Please see www.nasbhc.org for the most recent version of the measure.) The MHPET is organized into eight dimensions:

- operations
- stakeholder involvement
- staff and training
- identification, referral, and assessment
- service delivery
- school coordination and collaboration
- community coordination and collaboration
- quality assessment and improvement

Participants were asked to rate their degree of implementation of quality indicators within each of these dimensions on a 6-point Likert Scale (1 = Not at all in place; 6 = Fully in place).

Chart Audits - Three chart audits were conducted by SBHC providers over the course of the MHET process. Chart audits included 30 randomly selected charts from each SBHC; Only charts with at least 3 visits to the SBHC were selected for audit. Chart audits assessed indicators of mental health service quality, including the use of mental health assessment and screening, referral and follow-up, identification of mental health symptoms, and the use of evidence-based treatments. Ten of the nineteen sites provided complete chart audit data, providing data for 30 charts per chart audit. Four of the nineteen sites provided enough data to be included in the analyses (86 of 90 charts from two sites, and 87 of 90 charts from one site, and 89 of 90 charts from one site). The remaining 5 site were not included in analyses because they either a) did not provide data for at least one time interval (N=2 sites), or b) provided data on a limited and variable number of charts across time intervals (N=3 sites). Those sites with incomplete data typically cited lack of resource capacity to conduct the chart audits as the reason for not submitting the information.

Follow-up Site Leader Interviews

Following the implementation of both years of the MHET collaborative, site leaders were asked to participate in a follow-up interview to discuss their experiences of participating in MHET. Follow-up interviews were conducted with ten of the 19 participating SBHC sites. Reasons for not participating in the follow-up interviews included: SBHC closure, staff turnover and inability to schedule interviews.

Site leaders were asked open-ended questions about their successes and challenges during their MHET participation. In addition, the interviewers reviewed their site-specific assessment and

chart audit data with the site leaders, and inquired about reasons for change or no change on each MHET objective. For objectives that had shown improvement over the course of the MHET process, site leaders were asked whether the change was sustained or not.

Copies of all assessment instruments are included in Appendix C.

III. Results

Data Analysis
Statistical analyses were performed using the Statistical Package for the Social Sciences Version 16 (SPSS). For all measures using a pre- to post-intervention design, a series of paried comparison *t* tests was conducted to determine whether significant changes occurred in each of the domains of interests from pre- to post-intervention. Statistical significance was set at $\alpha = .05$. Frequency analyses were conducted for chart audit data to reveal differences in frequency of targeted outcome across the three chart audit time intervals. Chart audit analyses were conducted on 1249 charts from the 14 sites that provided complete, or near complete, chart audit data.

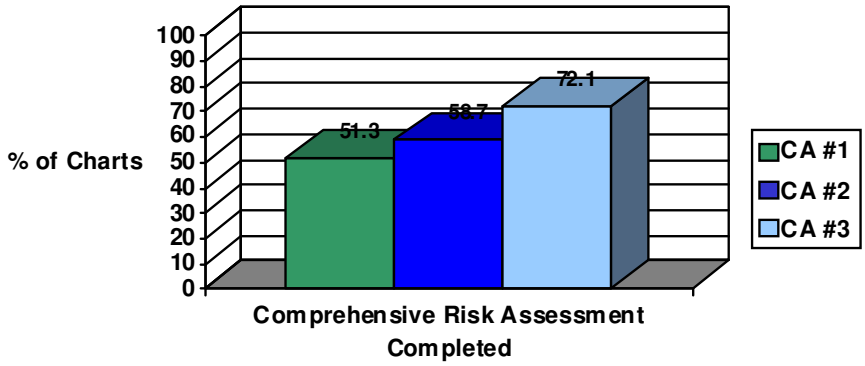
Results Overview
Overall, chart audits demonstrate significant improvement in the mental health screening and risk assessment process, mental health diagnosis and referral processes, diagnostic and procedural coding, and the use of evidence-based practice for mental health problems (Anxiety, Depression, Disruptive Behavior Problems, Substance Use/Abuse). Providers' self-reports support chart audit findings and reflect perceived improvements in all measured components of mental health service delivery, including primary care and mental health integration and collaboration.

Results are described below within MHET Objective domains, in the following order: chart audit data, if available, pre- and post-assessment data, if available, and follow-up interview data. Follow-up interview data, obtained between one and two years post-intervention include information about reasons for change/no change within domains, as well as the sustainability of change following the intervention.

Risk Assessment and Screening

Results indicate that the majority of the sites showed improvement in the completion of comprehensive risk assessments and in the use of screenings for Depression, Suicide, Disruptive Behavior Disorders, and Substance Use/Abuse. In addition, results showed an increase in the identification of mental health symptoms and subsequent follow-up assessments.

Chart Audits
Chart audits revealed an increase in charts with comprehensive risk assessments from 51.3% to 72.1%.



Furthermore, the audits demonstrated an increase in screenings for Depression, Suicide, Anxiety, Disruptive Behavior Disorders, and Substance Use/Abuse.

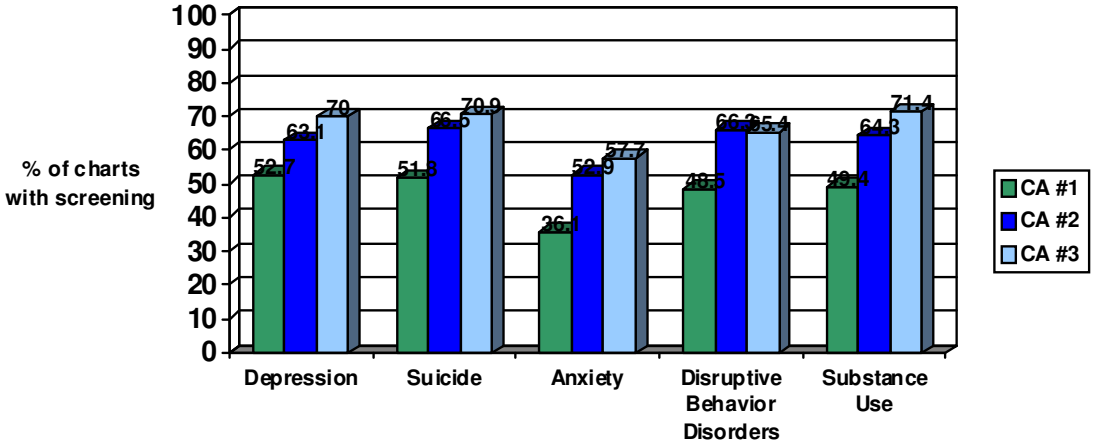
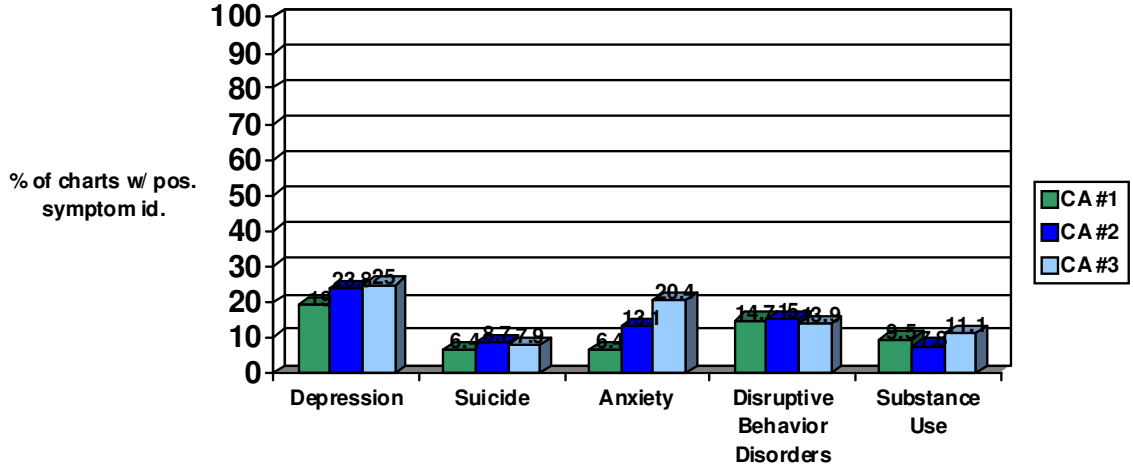
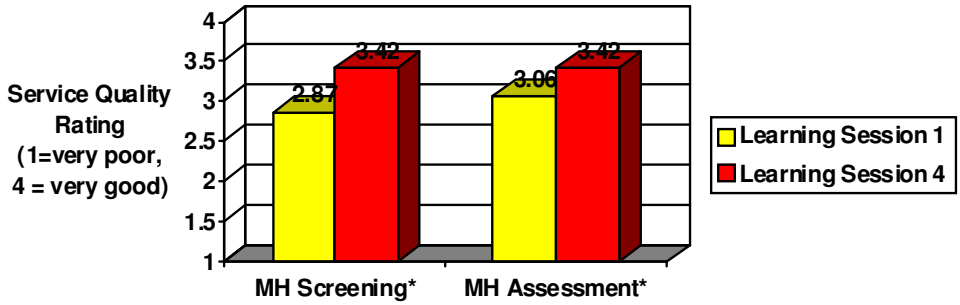


Chart audits show that positive identification of symptoms for Depression, Anxiety, and Substance Use/Abuse increased, but not for Disruptive Behavior Disorders nor Suicidality.



Pre- and Post-assessments

Participant ratings of their SBHC's screening and assessment quality significantly increased from 2.87 to 3.42 (p=.000) and 3.06 to 3.42 (p=.001), respectively (1 = very poor, 4 = very good).



Follow-up interviews

Many of the sites reported that changes were made to previous assessment and screening procedures and that acquiring an appropriate tool assisted in the improvement of care. One of the sites mentioned that it revised its anxiety screening tool because it discovered that the necessary questions were not being asked. Of the few sites that demonstrated no change or a decrease in completion of risk assessments and use of screenings for Depression, Suicide, Disruptive Behavior Disorders, and Substance Use/Abuse, it was stated that the chart audits did not accurately reflect their use of mental health assessment and screening, and that the audits were primarily from "well child visits."

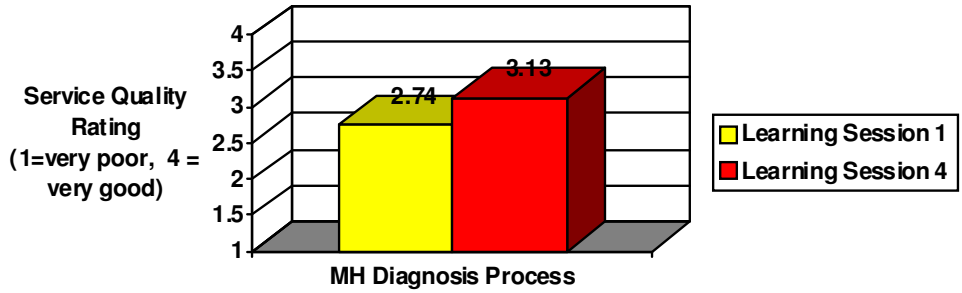
All of the interviewed sites with documented improvements in screening and assessment reported that these improvements had been sustained since the end of the MHET initiative.

Mental Health Diagnosis

Overall, sites reported improved knowledge in the area of mental health diagnosis. The diagnostic assessment concurred with these perceived improvements, indicating an overall increase in the knowledge of specific mental health diagnostic information.

Pre- and post-assessments

Participant ratings of the mental health diagnosis process in their SBHC significantly increased (p=.001) from 2.74 to 3.13 (1 = very poor, 4 = very good).



Follow-up interviews

Results indicate that more than half of the sites interviewed showed improvement in providers' knowledge of diagnostic information. Sites reported that having diagnostic aids available, increasing their use of the Diagnostic and Statistical Manual -IV, knowing the standards of mental health, and putting more information into the charts contributed to these improvements. Of those sites reporting either no change in providers' knowledge of diagnostic information or a decrease in knowledge, site leaders reported that changes in staff attendance at the learning sessions may have contributed to these findings.

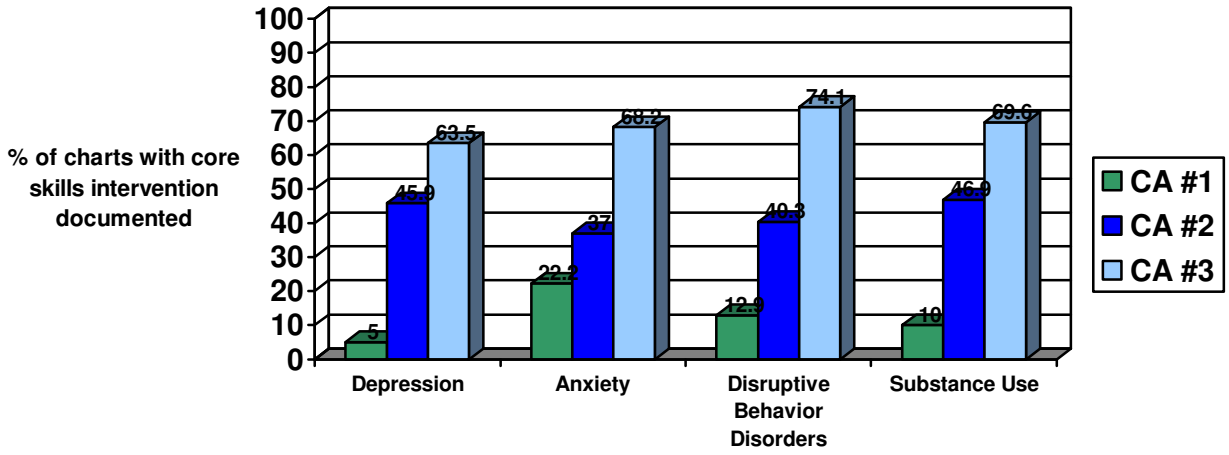
Eight sites reported that the improvements have been sustained since the end of the MHET initiative. One site indicated that the improvements have not been sustained while another site did not provide a response.

Use of Evidence-Based Skills

Overall, results showed improvement in the knowledge and use of evidence-based skills for students with mental health problems, as demonstrated via providers' perception of increased knowledge and use of skills and chart documentation of the use of these skills.

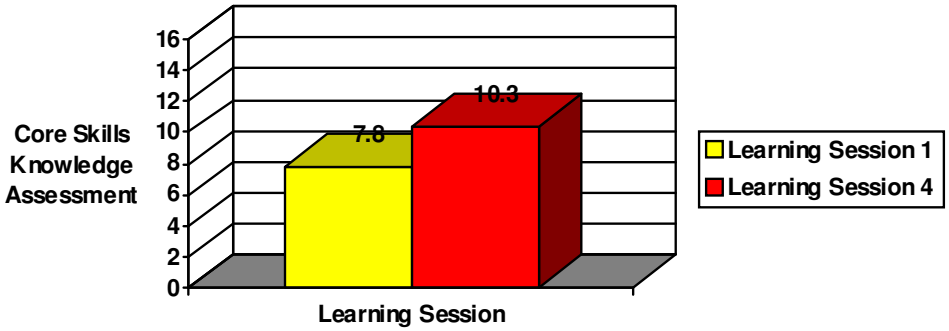
Chart Audits

The chart audits revealed an increase in the documented use of evidence-based skills (e.g., cognitive behavioral skills, behavior management training) for students with identified symptoms of Depression, Anxiety, Disruptive behavior Disorders or Substance Use/Abuse.

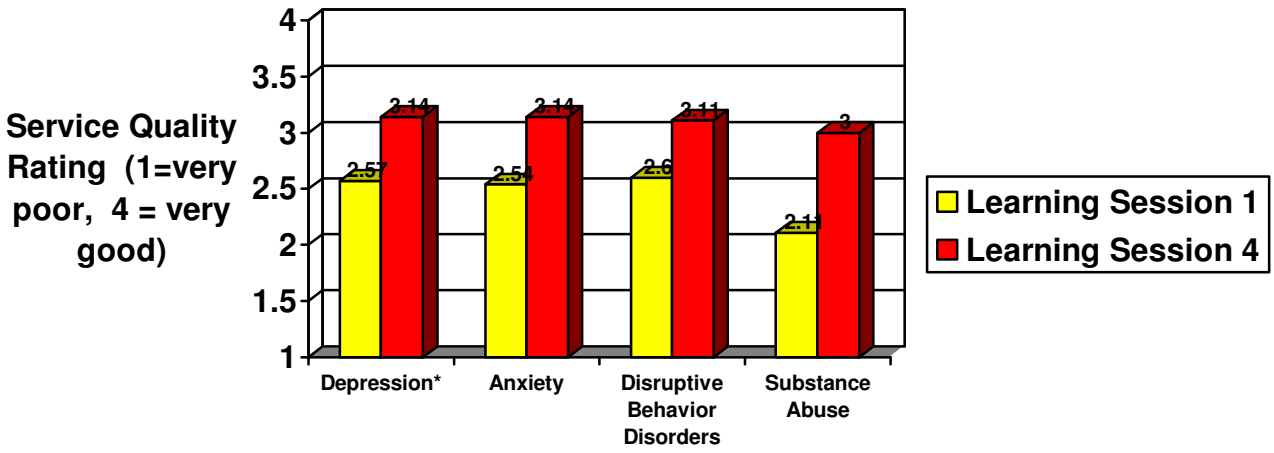


Pre- and post-assessments

As measured on the Core Skills assessment, providers' knowledge of core skills to treat mental health problems improved significantly (p=.000) from pre- to post-assessment. Specifically, participants' average score on the assessment increased from an average of 7.8 to 10.3 (out of a possible 16) following participation in learning sessions.



Providers reported that their SBHC's use of evidence-based mental health practices improved significantly for Depression (p=.000), Anxiety (p=.000), Disruptive Behavior Disorders (p=.001), and Substance Abuse (p=.000) following participation in the learning sessions (1 = very poor, 4 = very good).



Follow-up interviews

The majority of interviewed sites showed improvement in the use of evidence-based skills for mental health problems. Site leaders reported that they referred to their training and appropriate manuals when needed, could easily recognize when evidence-based interventions should be used, and incorporated cognitive-behavioral techniques into practice when necessary. Several of the sites mentioned that they have since started to use the new skills acquired through the MHET initiative.

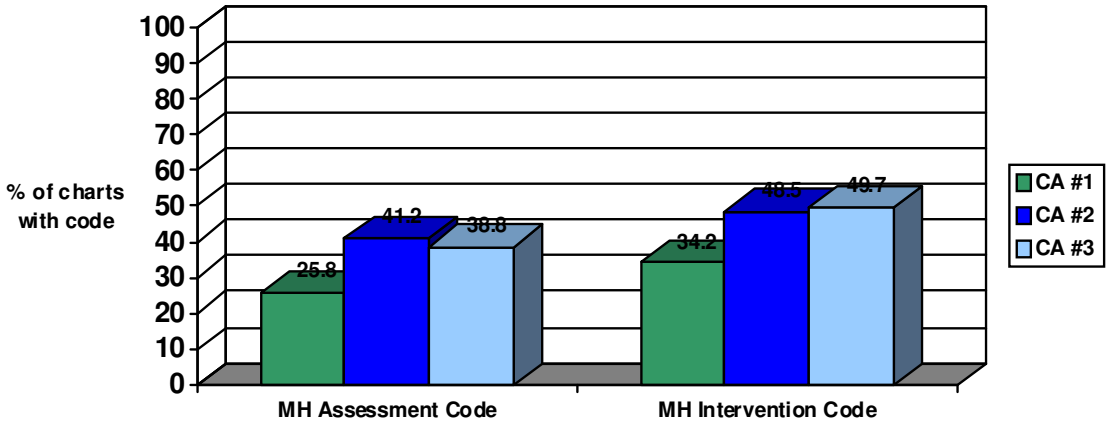
Four sites reported that these improvements had been sustained since the end of the MHET initiative. One indicated that the improvements have not been sustained whereas the remaining five did not provide a response.

The sites that showed no change or a decrease in evidence-based skills claimed that they were not mental health providers or that they "screen but don't treat."

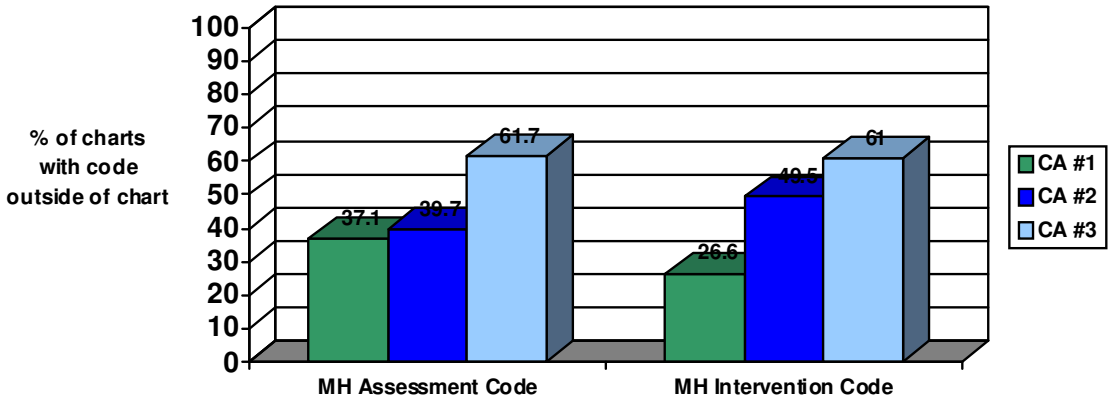
Coding

Chart Audits

The chart audits showed an increase in documentation of procedural codes for mental health assessments and interventions. As reflected in the table below, providers increased their use of mental health assessment codes in charts from 25.8% of charts to 38.8% of charts, and their mental health intervention codes in charts from 18.8% of charts to 46.9% of charts.



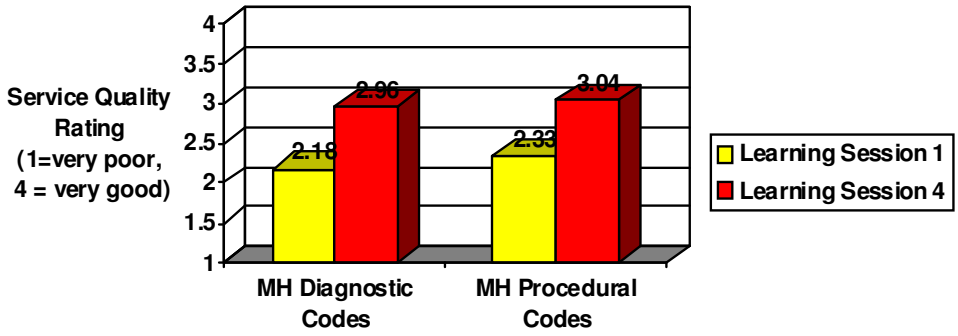
Importantly, chart audits also demonstrated an increase in the documentation of codes *outside of charts (e.g., electronic database/MIS, encounter form),* such that *when codes were not documented in charts* there was an increase in the documentation of mental health assessment codes in other places from 37.1% to 61.7%, and in the documentation of mental health intervention codes from 26.6% to 61%. When taken together, information from the above chart and the chart below suggest that providers dramatically increased their use of mental health procedural codes via a combination of documenting in the actual medical records or another site (database, encounter form, etc.).



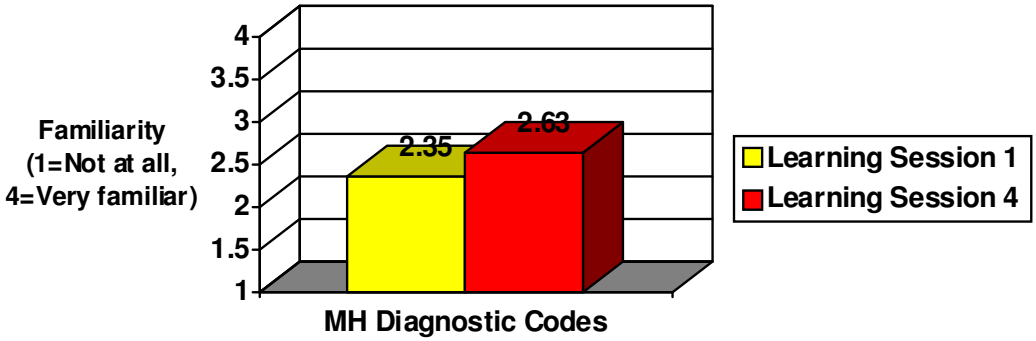
Pre- and post-assessments

Participant ratings of the use of mental health diagnostic and procedural codes by their SBHC increased significantly from 2.18 to 2.96 (p=.000) and 2.33 to 3.04 (p=.000), respectively (1 =

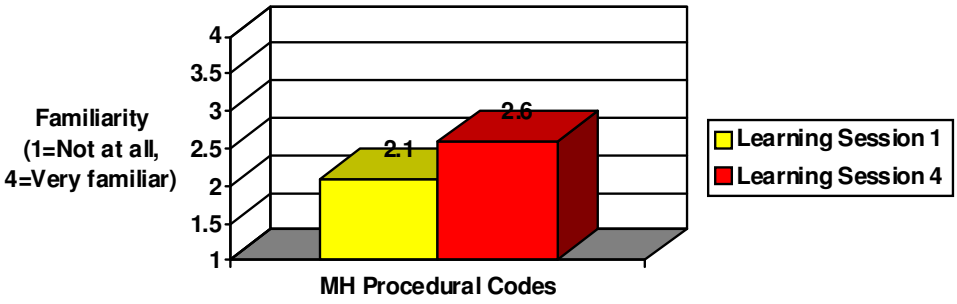
very poor, 4 = very good).



Participant ratings of their own familiarity with mental health diagnostic codes did not change significantly (p=.155) from pre- to post-intervention (1 = Not at all, 4 = Very Familiar, for each of four disorders).

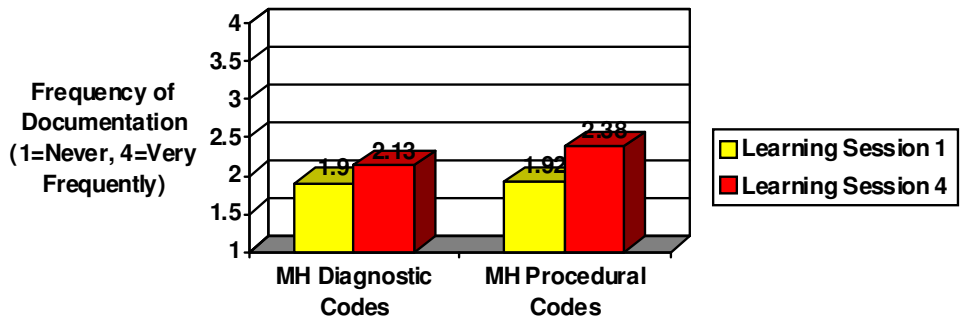


Participant ratings of their familiarity with mental health procedural codes increased significantly (p=.017) from pre- to post-intervention (1 = Not at all, 4 = Very Familiar, for Evaluation and Management codes and MH Procedural Codes).



Finally, participants rated themselves on their frequency of documenting mental health diagnostic and procedural codes. Participants reported a significant increase (p = .028) in their

documentation of mental health procedural codes, but no significant change (p=.139) in their documentation of mental health diagnostic codes.



Follow-up interviews

The majority of interviewed sites showed increases in the documentation of mental health problem codes, assessment codes, and intervention codes. Sites reported that the ability to receive training, discuss with consultants, and identify resources (e.g., supervisors or manuals) facilitated the coding process.

Five sites reported that these improvements had been sustained since the end of the MHET initiative. Two sites indicated that the improvements have not been sustained and three sites did not provide a response.

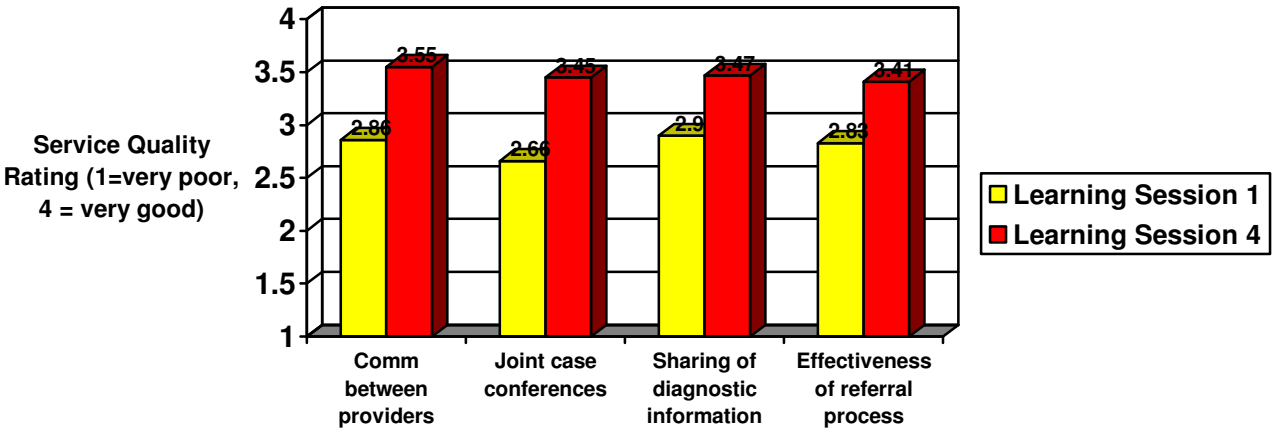
A limited number of sites reported either no perceived change in the familiarity of the codes or demonstrated no improvement in documentation of coding. Sites pointed to some lack in understanding of which codes to use for specific procedures as well as the inability to bill for services as contributing to lack of progress in this domain.

Primary Care Integration

Overall, sites reported perceived improvement in primary care and mental health integration in their SBHCs, describing the implementation of several strategies to advance this objective.

Pre- and post-assessments

Providers reported a perceived improvement in collaborative care between mental health and primary care providers, reflected by significant improvements in communication between providers (p=.001), joint case conferencing (p=.000), sharing of diagnostic information (p=.002) and effectiveness of referral process (p=.001) (1 = very poor, 4 = very good).



Follow-up interviews

The majority of interviewed sites showed improvement in collaboration and communication between providers, joint case conferencing and referrals, and sharing of information. Sites reported that they added new intake processes, allowed for more supervision and family engagement, included more mental health information in the primary care charts, and continued daily team meetings (sometimes referred to as "huddles"). One site reported that they now understood that sharing of information is not a breach of confidentiality and this contributed to their improved functioning.

Five sites reported that these improvements have been sustained since the end of the MHET initiative. Two indicated that the improvements have not been sustained and three sites did not respond.

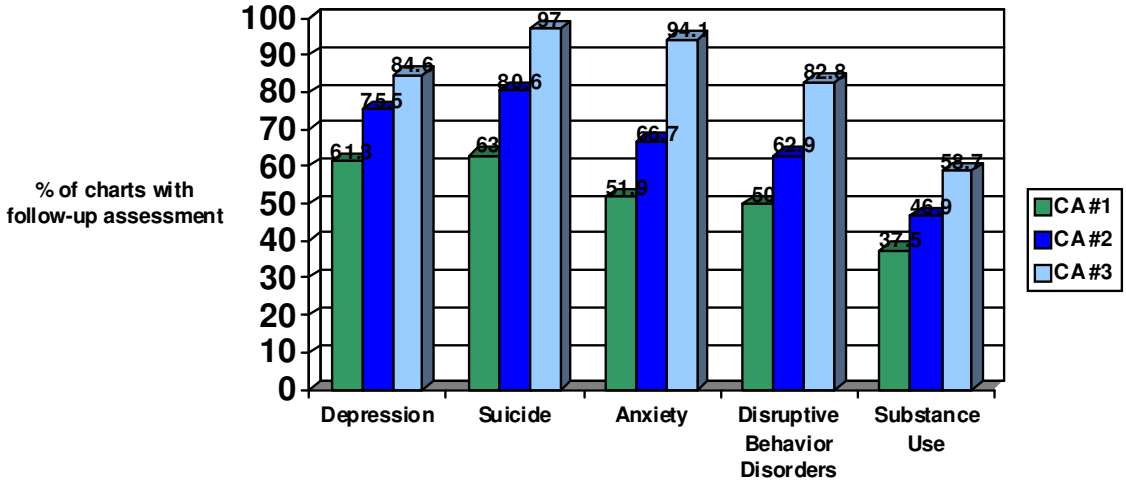
A decrease in communication between providers was reported by a small number of the sites, and was explained by a lack of formal staffing and minimal support from supervisors.

Follow-Up and Referral

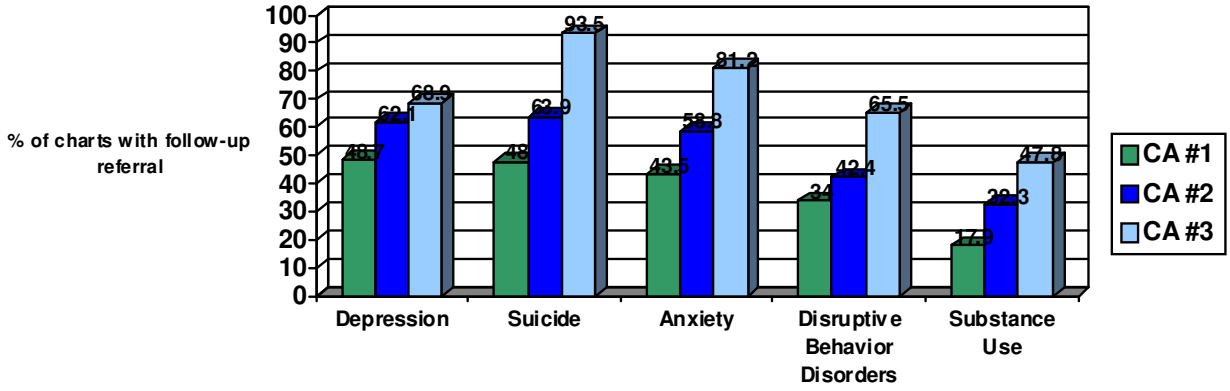
Chart Audits

Chart audits showed that, following the positive identification of symptoms, follow-up mental health assessments increased for Depression, Suicide, Anxiety, Disruptive Behavior Disorders,

and Substance Use/Abuse.



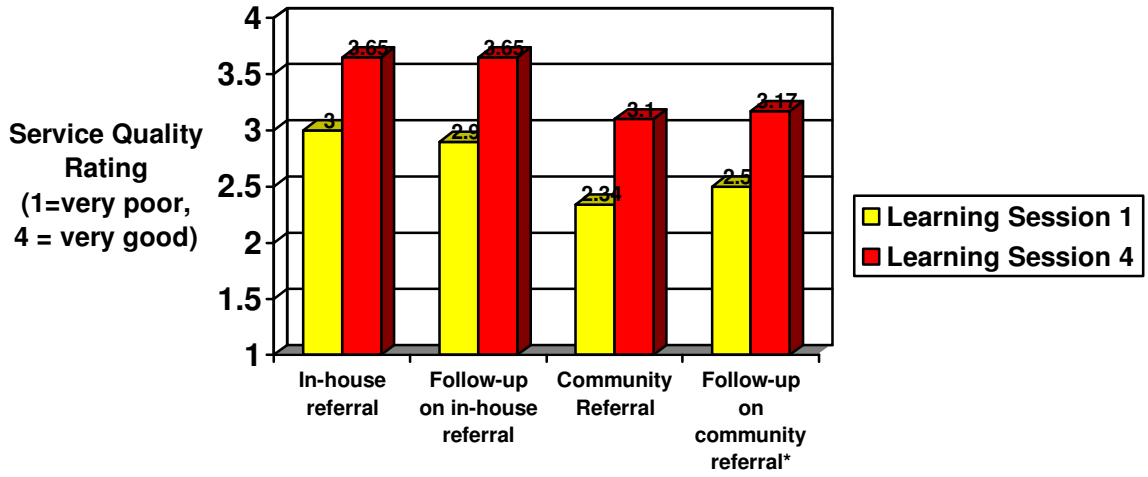
Additionally, chart audits demonstrated increased follow-up referrals for students with identified mental health symptoms.



Pre- and post-assessments

According to providers' self-reports, the mental health referral process had improved in reference to In-House Referral (p=.000), Follow-up on In-House Referral (p=.000), Community Referral (p=.000), and Follow-up on Community Referral (p=.000) (1 = very poor, 4 = very

good).



Follow-up interviews

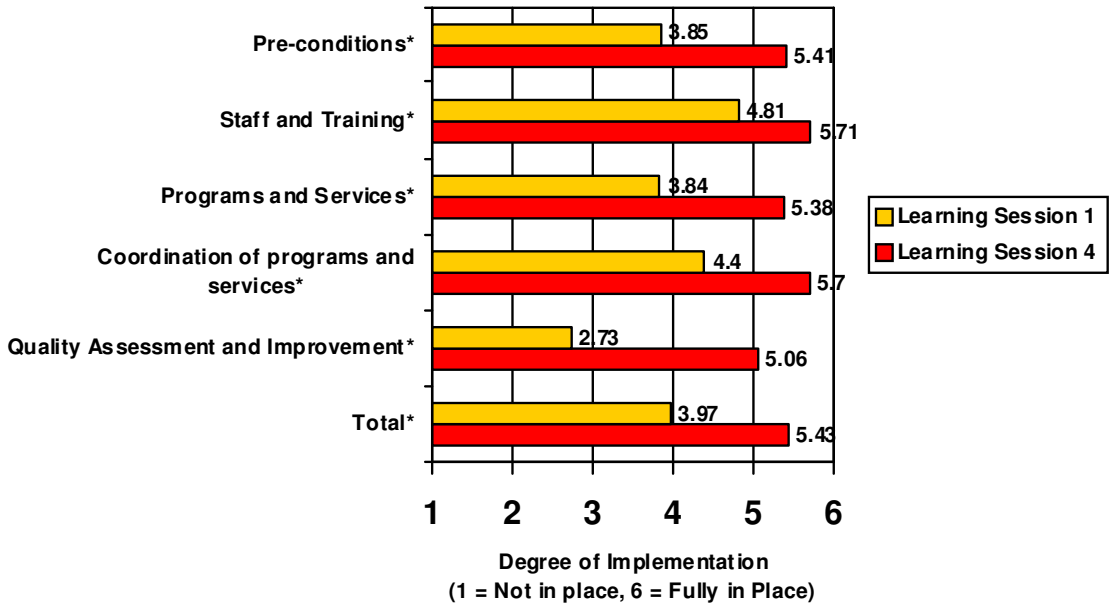
All of the interviewed sites showed improvement in in-house referrals, follow-up on in-house referrals, community referrals, and follow-up on community referrals. In addition, the majority of the sites demonstrated improvement in referrals when symptoms of Depression, Suiciduality, Anxiety, Disruptive Behaviors, or Substance Use/Abuse were identified. Sites attributed these improvements to developing a more detailed referral process, increasing participation in clinical supervision, increasing discussions about referral, improving workload management, and developing working relationships with guidance counselors and school nurses.

Nine of the sites reported that these improvements have been sustained since the end of the MHET initiative. One site reported that the improvements have not been sustained.

Overall Mental Health Service Delivery

In the second cycle of the MHET initiative, participants rated themselves on overall mental health service delivery at Learning Sessions one and four using the *Mental Health Planning and Evaluation Template (MHPET)*. Results showed a significant improvement from pre- to post-assessment in overall best practices in mental health services across all responding sites. Specifically, sites reported significant improvements in Pre-conditions for a successful program, Staff and Training, Programs and Services, Coordination of Programs and Services, and Quality

Assessment and Improvement.



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Summary

Results from this two-year, multi-state training collaborative suggest that the applied framework for mental health quality assessment and improvement in school-based health centers led to increases and provider knowledge and provider behavior change consistent with best practices in mental health service delivery to children and adolescents. Overall, both mental health and primary care providers reported improvements in most targeted areas of mental health practice including screening and assessment, diagnosis, referral, coding, intervention skills and collaborative/integrated care.

IV. Lessons Learned

Based on the experiences of the MHET faculty as well as qualitative data gained through participant follow-up interviews, some key lessons learned included:

- ✓ **Greater staff buy-in leads to greater success –** As noted in the Executive Summary of NASBHC's Quality Improvement Collaborative Series, "As every member of the team has an impact on quality of care, every member of the team – from administrator to frontline staff – has to be on board and open to new ways of doing business" (p.2). It was evident that those programs whose administrators had achieved buy-in from *all* staff prior to the initiation of the MHET initiative were more ready and motivated to make changes in their mental health service delivery.

- ✓ **Site leadership is critical** – In addition to staff buy-in, it was critical to success for sites to have an established, motivated leader willing to spearhead the initiative. Several participants noted that their investment in the initiative was driven by the commitment of their site's leader. In addition, leaders played a crucial role in coordinating activities, collecting data, communicating with MHET faculty and creating buy-in.

- ✓ **Conduct needs assessments and meet sites where they are** – Sites participating in the MHET initiative began the process at very different levels of implementation on each of the targeted objectives. For example, some sites had been using shared (primary care and mental health) medical records for years, while others had completely separate charting systems and significant reluctance to merge records. Similarly, some sites had well-established in-house and community referral systems, while some had no written referral policies and very limited processes with respect to referring students with mental health needs. In order to tailor the MHET collaborative to sites' needs, it was extremely important to gain a clear understanding of the readiness and status of sites related to each targeted objective; This was achieved via review of the competitive proposals, interviews with site leaders prior to the initial training, and pre-assessments of providers at the first learning session. Activities were also tailored to meet the individual site needs by allowing participants to develop customized work plans at each learning session.

- ✓ **Employ creative learning techniques** – As highlighted in the NASBHC's Quality Improvement Collaborative Series Executive Summary, the learning techniques employed across all of the NASBHC Quality Improvement Collaboratives, including behavioral rehearsal and storyboarding were especially effective in enhancing providers' knowledge and skills.

- ✓ **Collect data and provide ongoing progress reports to sites** – A critical component of the MHET initiative was the utilization of assessment and chart audit data. As noted in this report, providers were asked to provide a significant amount of data via pre- and post-assessments at learning sessions, and also via a comprehensive chart

review process which collected information about provider behavior from 30 charts at three different intervals throughout the collaborative process. This information was not only helpful in allowing the MHET faculty to gauge sites' progress, it proved to be a valuable mechanism of providing feedback to sites about their own gains and areas in need of improvement. Collected data was analyzed on an ongoing basis and reported back to sites via user-friendly PowerPoint materials that could be shared with all staff. In addition, site summaries were provided to all sites at the conclusion of the initiative and were used by many sites to share their efforts with critical stakeholders (e.g., school board, funders).

V. Recommendations

It is evident that the implementation of an effective quality assessment and improvement (QAI) initiative can lead to significant positive changes in the delivery of quality mental health services in a school-based health center. Based on the findings of the Mental Health Education and Training (MHET) initiative, and also upon the ongoing mental health work at the National Assembly on School-Based Health Care, the following recommendations and resources are offered to sites considering their own mental health QAI process:

1) Needs Assessment: Prior to the initiation of a mental health QAI process, it is highly recommended that a needs assessment at the state or site level of mental health resources, capacity and needs be conducted. There are several tools that have been identified to assist in the planning and needs assessment phase of developing an effective school mental health delivery system. It is recommended that states and sites refer to the following document when considering tools for conducting this process: *Assessment Tools for School Mental Health Capacity Building* located at www.nasbhc.org in the Mental Health section, under School Mental Health Capacity Building Partnership.

2) Mental Health Planning and Evaluation Template: It is recommended that SBHC sites consider using the Mental Health Planning and Evaluation Template (MHPET) in structuring a QAI process. Since the implementation of the MHET initiative, significant revisions and enhancements have been made to the MHPET, and the instrument has been developed into an online tool for assessing and improving mental health service quality. In addition to the evaluative value of the tool, the MHPET is now accompanied by a wealth of resources aimed to assist in a QAI process. The MHPET may be accessed at www.nasbhc.org. Below is a description of the MHPET:

NASBHC developed the Mental Health Planning and Evaluation Template (MHPET) in partnership with the Center for School Mental Health (CSMH) to systematically assess and improve the quality of mental health services delivered within school-based settings. Originally conceived as a tool to be applied in school-based health centers (SBHCs), the MHPET can also be used in evaluating activities and services across the field of school-based mental health. The MHPET can also be equally utilized for new or established school mental health programs.

The MHPET is a 34 indicator measure that operates as an assessment tool to target areas of strength and improvement in school-based mental health quality. The MHPET is organized into eight dimensions:

- operations
- stakeholder involvement
- staff and training
- identification, referral, and assessment
- service delivery
- school coordination and collaboration
- community coordination and collaboration
- quality assessment and improvement

In considering whether to use the MHPET, please note the following three assumptions:

1. The activities and services to be evaluated have the support of the sponsoring organization and the school and community being served.
2. It is not the sole responsibility of mental health service providers to achieve the indicators. Rather, it is a shared responsibility of the providers, sponsoring organization, school, family, community, and youth partners.
3. If evaluating the mental health services within a school-based health center (SBHC), it is assumed that the SBHC has adopted the NASBHC Principles and Goals of School-Based Health Care.

3) NASBHC's State-National Training and Technical Assistance Partnership: Also since the implementation of the MHET initiative, NASBHC launched its newest training and technical assistance initiative, the state-national training and technical assistance partnership, referred to as *the Partnership*. The Partnership created a venue for NASBHC to assist state SBHC associations and other state organization partners to establish an infrastructure for providing ongoing state-based training and technical assistance to organizations and individuals interested in establishing school-based health centers and to sponsoring organizations, clinical staff, and administrators that are already working in SBHCs The state-based infrastructure consists of organizational capacity building of a lead state association/organization and its partners coupled with skill building of multi-disciplinary training teams using a training of trainer model. Through this approach, NASBHC transfers its training and technical assistance tools, resources, and expertise to each state partnership and each state partnership becomes a repository of SBHC training and technical assistance expertise.

To date, eight states have participated in the Partnership:

- California School Health Centers Association,
- Illinois Coalition for School Based Health Care,
- Louisiana Assembly on School Based Health Care,
- School Based Health Alliance of Michigan,
- New Mexico Alliance for School Based Health Care,
- North Carolina School-Community Health Alliance,
- Ohio School Based Health Care Association, and

- Texas Association of School-Based Health Centers

Examples of state organizations represented in the eight states' partnerships include:
- state SBHC association,
- state primary care association,
- state health department,
- state departments of education,
- state office of mental health,
- state medical societies/associations,
- state school nursing association,
- state universities,
- state offices of juvenile justice, and
- state coalitions on special issues.

Each state makes a two year commitment to the Partnership. By the end of their second year, each state gains
- a statewide SBHC partnership lead by the state SBHC association,
- A statewide training and technical assistance needs assessment,
- An infrastructure needs assessment and SWOT analysis,
- A trainer needs assessment and analysis,
- A three year training and technical assistance g improvement plan,
- An multidisciplinary team of four trainers equipped with SBHC specific content and expertise, and
- Four of more state, regional, and web-based workshops and trainings supported by NASBHC.

Other outcomes reported by states include hiring a training director for their state SBHC association, collaborating with Partnership trainers from other states on joint state and national trainings, and creation of state-based collaboratives in PMI.

A core training component of the Partnership is Mental Health, with several trainings related to improving mental health service delivery being offered, including one on Motivational Interviewing to Promote Behavior Change and one on Primary Care-Mental Health Integration. For additional information about the Partnership and its training and resources in the area of mental health, please contact:

Laura Brey…

APPENDIX A. MENTAL HEALTH EDUCATION AND TRAINING COMPETETIVE REQUEST FOR PROPOSALS

National Assembly on School-Based Health Care

Mental Health Education and Training Initiative

School-Based Health Center Collaborative

Application Guidance

NASBHC invites school-based health centers (SBHCs) to participate in a fifteen-month quality assurance collaborative with the mission to increase knowledge and implementation of mental health screening, diagnosis, referral, coding, and evidence-based short-term mental health interventions among SBHC primary care and mental health providers. Since 2002, NASBHC has been working collaboratively with the University of Maryland, School of Medicine, Center for School Mental Health Assistance (CSMHA) to develop the Mental Health Education and Training (MHET) Initiative for school-based primary care and mental health providers. MHET initiative is funded by HRSA's Maternal Child Health Bureau and the Bureau of Primary Health Care. Successful applicants will engage in a mental health quality improvement model that incorporates evidence-based practice supported through technical assistance provided by MHET experts and staff.

What is a collaborative?

Participating school-based health centers from across the country will form a collaborative – an interdisciplinary and geographically diverse group of school-based health care professionals working toward a common goal: the implementation of effective mental health practice, specifically in the areas of depression, anxiety, disruptive behavior, and substance abuse.

Who is eligible to participate in the collaborative?

- SBHCs in middle and/ or high school settings. Applicants may apply as one SBHC or as two SBHCs that share a geographic area. NASBHC will select six SBHCs from **three** - **four** geographic areas to participate in this initiative**. Preference will be given to sites that have not previously participated in one of the National Assembly's collaboratives.** Participating SBHC(s) must have an **identified lead agency** and **lead staff person** willing to provide coordination.
- Participating SBHCs must have at least one full-time (during school year) **mental health staff person** whose time is 100% assigned to the SBHC **AND** one full-time (during school year) **medical/nursing staff person** whose time is 100% assigned to the SBHC.
- Participating SBHCs must have been established for **at least 2 years**.

- At least three staff members from each SBHC (including one mental health provider, one medical/nursing provider, and one other provider) must be available to participate in the first 2-day training session**.**
- Selection priority will be given to SBHCs who are members of NASBHC.

What program outcomes are expected under MHET?

Participating SBHCs should expect to:

- increase providers' knowledge and use of mental health screening and assessment.
- increase integration and collaboration among primary care and mental health care providers.
- facilitate appropriate referral and follow-up for mental health services.
- increase providers' use of evidence-based practice in the following areas:
    - assessment of and interventions to reduce risk factors
    - assessment and development of protective factors
    - implementation of core skills training (e.g., relaxation training, problem-solving skills, resistance skills)
    - implementation of manualized evidence-based interventions
- increase implementation of effective services for anxiety, depression, disruptive behavior disorders, and substance abuse.
- Improve diagnostic and procedural coding system for mental health screening, assessment, referral, and intervention

What types of technical support and information are available through MHET?

Participating collaborative members will receive the following technical support over the course of the fifteen-month initiative:

- 2-day introductory learning session for participating SBHC staff covering:
    - collaborative introduction
    - integration of mental health in risk assessment
    - intensive training in Diagnostic Predictive Scales (DPS) by Columbia University
    - training in diagnosis and coding
    - development of workplan for screening/assessment/referral, including resource map and role assignment
- 1-day on-site learning session for each site covering:
    - overview of four-pronged approach to evidence-based practice
    - Intensive training on risk/protective factors for depression, anxiety, disruptive behavior disorders, and substance abuse
    - development of workplan for risk/protective factors
- 1-day on-site learning session for each site covering:
    - intensive training in core skills training for depression, anxiety, disruptive behavior disorders, and substance abuse
    - overview of manualized, evidence-based intervention
- 1-day learning session for each site covering:
    - intensive training in one manualized, evidence-based intervention

- on-going phone support from MHET experts, staff and collaborative members.
- Learning session at 2005 NASBHC annual convention
    - lessons learned, storyboards

What is expected of the collaborative participants?

Collaborative members, which include the entire SBHC team, are expected to:

- Participate in project data collection on-site and in training sessions, which includes information about health care services and policies and practices related to mental health practice. **Participating SBHC providers will be asked to consent to having their data used for research purposes. Note: Student data will NOT be collected. Only provider data will be collected.**
- Show visual representation of progress throughout project with storyboards
- Have access to email
- Commit adequate time devoted to team improvement activities
- Share experiences and data openly so that knowledge and learning can be summarized
- Implement effective mental health practice (screening, assessment, diagnosis, referral and follow-up, coding, evidence-based interventions) as outlined in the collaborative objectives
- Implement one formal, manualized, evidence-based intervention for depression, anxiety, disruptive behavior disorders, OR substance abuse

What can participating collaborative members expect from NASBHC?

- Coverage for expenses related to all learning sessions
- Curriculum and faculty for all learning sessions
- Ongoing technical assistance, coaching and feedback
- Nominal stipend for resource and materials costs

How will participating collaborative members be selected?

MHET technical experts and staff will review all applications. SBHCs will be selected on merit of application. The National Assembly will select up to **six** SBHCs that represent geographically diverse areas. Priority for SBHC selection will be given to applicants who document:

- Commitment of each site to the collaborative mission
- Capacity of each SBHC to adopt collaborative goals
- Capacity of lead staff person to provide support and liaison with MHET staff
- Well defined relationship between lead staff person and participating SBHC(s)
- Demonstrated need for technical assistance

Mental Health Education and Training Initiative
SBHC APPLICATION

Review Criteria	Application (100 points)
The capacity and commitment of the lead staff person to coordinate the initiative at the site level. (15 pts)	**Lead staff person** 1. Provide a one-page letter of intent from lead staff person describing: • commitment to project goals, • experience in school-based health centers, • capacity to achieve project goals, and • relationship to applying SBHC(s) Provide resume for lead staff person
The commitment of the SBHC(s)' lead agency to the project goals and the leader's participation. (10 pts)	**Lead Agency** 1. Provide one-page letter from lead agency describing commitment to project goals and support of lead staff person to assist in the coordination of site activities. 2. Letter of support from sponsoring agency (if not the lead agency noted above)
The commitment of the SBHC team and sponsoring agency to project goals. The capacity of SBHCs team implement this project. The demonstrated need for technical assistance (70 points)	**SBHC Participants (up to 2 SBHCs per application)** 1. Each SBHC applying to participate in the initiative shall provide a brief description of (**no more than two pages, single spaced**): • the capacity of the health care team to implement this project (adequate staff, including mental health staff, and ability to schedule team meeting times). Include a description of current mental health staffing (FTE mental health staff) and service delivery (estimated mental health provider caseload, type of services), as well as a description of current medical/nursing staffing and service delivery. Also include any information about the SBHC(s) involvement in other projects or initiatives (10 pts) • the commitment of the SBHC participants as shown through letters of support or endorsement from SBHC providers and other team members from each participating SBHC. Include acknowledgement that participants will be asked to provide data about provider services (NOT student data) for research purposes. (15 pts) • the MIS capability to implement project. (10 pts) • the community/population it serves and history of SBHC. Please include SBHC enrollment rates. (10 pts) • the commitment to mental health services. (10 pts) • the commitment of sponsoring agency to mental health services if not the lead agency described above. (5 pts) • a demonstrated need for technical assistance. (State goals for your participation in the project). (10 pts)

LETTER OF INTENT DUE: March 12, 2004
APPLICATION DEADLINE: March 29, 2004

ALL APPLICATIONS AND QUESTIONS MUST BE SENT VIA EMAIL TO: lbrey@nasbhc.org
(Responses to questions will be sent via email to all applicants who submit a letter of intent).

ALL LETTERS OF SUPPORT MUST BE SENT VIA FAX TO Laura Brey at: 919-866-0930

NOTIFICATION OF ACCEPTANCE WILL BE BY PHONE IN APRIL 2004.

APPENDIX B. WORKPLAN AND QUARTERLY PROGRESS REPORT TEMPLATES

State:
School-Based Health Center Name:

Mental Health Education Training Initiative Work plan

Measurable Objective: OBJECTIVE 7: To increase SBHC primary care and mental health professionals' knowledge about skills related to youth mental health, and to anxiety, depression, substance use/abuse, and disruptive behaviors, more specifically, and to increase interventions aimed to train youth in these skills.

Each objective is accomplished by having a work plan in place that identifies action steps to accomplish the objective. Additionally, both the person responsible and the time frame in which the action steps must be done are important components of an effective work plan. Action steps should be indicated in time order.

Action Step	By Whom	Projected Completion Date

MHET Site Monthly Progress Report

Name of Site Leader
School-Based Health Center:
Date:

Objective from work plan	Progress	Obstacles	Strategies tried	Technical assistance requested Yes/No
Objective 1				
Objective 2				
Objective 3				
Objective 4				
Objective 5	1.			
Objective 6				

The below information is to be completed by NASBHC
Technical assistance provided for all areas requested Yes/No_____, if no why:
Description of technical assistance:

APPENDIX C. MEASURES

MENTAL HEALTH EDUCATION AND TRAINING INITIATIVE

Mental Health Services Self-Evaluation

How would you rate your SBHC in the following areas?	Very Poor	Poor	Good	Very Good
Mental Health Screening Process	1	2	3	4
Mental Health Assessment Process	1	2	3	4
Mental Health Diagnosis Process	1	2	3	4
"In-house" Referral Process for Mental Health Concerns	1	2	3	4
Follow-up on "In-house" Referrals for Mental Health Concerns	1	2	3	4
Community Referral Process for Mental Health Concerns	1	2	3	4
Follow-up on Community Referrals for Mental Health Concerns	1	2	3	4
Use of Evidence-based/Empirically-supported Mental Health Interventions for:				
Depression	1	2	3	4
Anxiety	1	2	3	4
Disruptive Behavior Disorders	1	2	3	4
Substance Abuse	1	2	3	4
Procedural Coding for Mental Health Problems (screening, assessment, intervention)	1	2	3	4
Diagnostic Coding for Mental Health Problems	1	2	3	4
Integration/Collaboration				
Communication between mental health and primary care providers chart sharing/documentation	1	2	3	4
Case conferences involving both mental health and primary care providers	1	2	3	4
Sharing of diagnostic information between mental health and primary care providers	1	2	3	4
Effectiveness of referral process (speed, reliability, ease, etc.)	1	2	3	4
Overall Integration/Collaboration between SBHC Primary Care Providers and Mental Health Providers	1	2	3	4

MENTAL HEALTH EDUCATION AND TRAINING INITIATIVE

Diagnostic Assessment

1. DSM-IV-TR stands for:

	a. Developmental Standards of Measurement – Fourth Edition – Text Revision
	b. Diagnostic Standards of Mental Health – Fourth Edition – Transcription Revision
	c. Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition – Text Revised
	d. Diagnostic Standards of Measurements – Fourth Edition – Text Revised

2. There are 13 symptom criteria for a Panic Attack. List as many symptoms of a Panic Attack as you know.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.

3. A Panic Attack usually peaks at one hour. ___T ___F

4. Persistent and excessive worry about losing, or about possible harm befalling major attachment figures is a symptom of:

	a. Obsessive Compulsive Disorder
	b. Panic Disorder
	c. Depression
	d. Separation Anxiety Disorder

5. Excessive anxiety and worry, occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance) is a criterion for which disorder:

	a. Specific Phobia
	b. Generalized Anxiety Disorder
	c. Posttraumatic Stress Disorder
	d. Depression

6. Someone with a Specific Phobia will become immediately anxious when exposed to the phobic stimulus. ___T ___F

7. The most common childhood phobia is:

	a. Airplanes
	b. Animals
	c. Heights
	d. Death

8. Which of the following is <u>not</u> a diagnostic criteria option for Separation Anxiety Disorder?

	a. Persistent and excessive worry about losing, or about possible harm befalling, major attachment figures.
	b. Recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated.
	c. Noticeable increase in aggression or behavioral problems due to separation.
	d. Persistent reluctance or refusal to go to school or elsewhere because of fear of separation.

9. Someone with Separation Anxiety may experience recurrent nightmares about the theme of separation. ___T ___F

10. Suicide is the eighth leading cause of death in adolescents. ___T ___F

11. An overarching feeling of depression most of the day, more days than not, that does <u>not</u> meet criteria for a Major Depressive Episode is called:

	a. Seasonal Affective Disorder
	b. Adjustment Disorder with Depressed Mood
	c. Dysthymia
	d. Agoraphobia

12. Which is not an inattention symptom of ADHD?

	a. Blurts out answers
	b. Poor organization
	c. Loses objects
	d. Forgetful in daily activities

13. Learning Disabilities are frequently seen in children with ADHD. ___T ___F

14. Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD) fall under what general category of diagnoses?

	a. Disruptive Behavior Disorders
	b. Personality Disorders
	c. Anxiety Disorders
	d. Depressive Disorders

15. Alcohol use may cause alterations in adolescents' brain chemistry. ___T ___F

16. There are six symptom criteria for Generalize Anxiety Disorder (GAD). Please list as many as you know:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

17. The diagnostic criteria of Generalize Anxiety Disorder for children is more stringent than for adults. ___T ___F

18. In order for GAD to be diagnosed, excessive anxiety and worry must be present for at least how long?

	a. 2 weeks
	b. 6 weeks
	c. 2 months
	d. 6 months

19. DSM-IV-TR criteria for all disorders is based largely upon evidence based research. ___T ___F

20. Obsessive Compulsive Disorder is a type of:

	a. Childhood disorder
	b. Disruptive behavior disorder
	c. Anxiety Disorder
	d. None of the above

21. Which of the following is NOT true about Specific Phobias?

	a. Most cannot be treated in children
	b. In children, anxiety may be expressed as crying, tantrums, freezing, or clinging.
	c. Adults recognize that their fear is excessive.
	d. Children may not recognize that their fear is excessive

22. One third to one half of all adult OCD patients report onset in childhood or adolescence. ___T ___F

23. Compulsions, a component of Obsessive Compulsive Disorder, refer to what?

	a. Repetitive thought patterns
	b. Excessive physiological arousal
	c. Persistent behaviors
	d. Uncontrollable emotions

24. Which of the following is <u>unnecessary</u> for the diagnosis of Post Traumatic Stress Disorder to be given?

	a. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

	b. The person's response involved intense fear, helplessness, or horror.
	c. The person experienced rapid mood changes directly after the event occurred.
	d. None of the above.

25. Inability to recall an important aspect of the traumatic event can be a symptom of PTSD. ___T ___F

26. More adolescent males experience depression than adolescent females. ___T ___F

27. There are nine symptom criteria for Major Depressive Episode. Name as many as you know:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

28. In order for a diagnosis of Major Depressive Disorder to be made, symptoms must be present for at least:

	a. 1 week
	b. 2 weeks
	c. 4 weeks
	d. 6 weeks

29. Children and adolescents may express a depressed mood in the form of irritability. ___T ___F

30. Which of the following is true of suicide?

	a. Males make more suicide attempts than females
	b. Females complete more suicide attempts than males
	c. Most completed suicides are by means of substance abuse
	d. Suicide is most associated with depressive disorders

31. Research has shown what to be the best predictor of a suicide attempts?

	a. Presence of an axis I disorder
	b. Having made a previous attempt
	c. Feelings of isolation
	d. Social incompetence

32. Attention deficit disorder can occur with and without hyperactivity. ___T ___F

33. There are eight symptom criteria for Oppositional Defiant Disorder. Please list as many as you know:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

34. Which of the following is true of Oppositional Defiant Disorder?

	a. Females are more commonly diagnosed than males
	b. It is an anxiety disorder
	c. It often occurs with ADHD, depression, or anxiety

35. Which of the following is not a diagnostic symptom of conduct disorder?

	a. Hurting oneself
	b. Aggression toward animals or people
	c. Destruction of property
	d. Deceitfulness

36. Tolerance and Withdrawal are criteria for:

	a. Substance Abuse
	b. Substance Dependence

MENTAL HEALTH EDUCATION AND TRAINING INITIATIVE

Diagnostic and Procedural Codes Assessment

How **familiar** are you with the following types of codes?	Not at all			Very Familiar
Diagnostic (ICD-9/DSM) Codes:				
Diagnostic Codes for Anxiety Disorders	1	2	3	4
Diagnostic Codes for Depressive Disorders	1	2	3	4
Diagnostic Codes for Disruptive Behavior Disorders	1	2	3	4
Diagnostic Codes for Substance Use Disorders	1	2	3	4
Procedural (CPT) Codes:	1	2	3	4
Evaluation and Management Codes	1	2	3	4
Mental Health Procedural Codes (e.g., Diagnostic Interview, Individual Psychotherapy)	1	2	3	4

How frequently do you **document** the following types of codes?	Never			Very Frequently
Diagnostic (ICD-9/DSM) Codes:				
Diagnostic Codes for Anxiety Disorders	1	2	3	4
Diagnostic Codes for Depressive Disorders	1	2	3	4
Diagnostic Codes for Disruptive Behavior Disorders	1	2	3	4
Diagnostic Codes for Substance Use Disorders	1	2	3	4
Procedural (CPT) Codes:	1	2	3	4
Evaluation and Management Codes	1	2	3	4
Mental Health Procedural Codes (e.g., Diagnostic Interview, Individual Psychotherapy)	1	2	3	4

If you provide a mental health service, where do you document the PROCEDURAL (CPT) CODE (check all that apply):

___ I do not document procedural codes
___ Mental Health chart
___ Medical Record
___ Log Sheet
___ Database
___ Encounter Form

If you provide a mental health service, where do you document the DIAGNOSTIC (ICD-9/DSM) CODE (check all that apply):

___ I do not document procedural codes
___ Mental Health chart
___ Medical Record
___ Log Sheet
___ Database
___ Encounter Form

MENTAL HEALTH EDUCATION AND TRAINING INITIATIVE

Core Skills Assessment

1. Cognitive Restructuring is a skill that is helpful to people coping with:
    a. Depression
    b. Anxiety
    c. Both Depression and Anxiety
    d. None of the above

2. To practice deep breathing effectively, students should:
    a. Hold their breath for as long as they can, and then breathe out slowly
    b. Breathe only through their mouth
    c. Breathe through their nose, focusing on the rising and falling of their stomach
    d. Try to think of other tings than their breathing

3. Progressive Muscle Relaxation involves:
    a. Tensing and releasing all muscles of the body at one time
    b. Tensing and releasing muscles one muscle group at a time
    c. Tensing muscles until they are exhausted so that your body will become relaxed
    d. Getting a massage to relax different muscle groups progressively

4. Name three type of cognitive distortions often used by anxious or depressed students:

_____

_____

_____

5. Training in Systematic Desensitization is best explained as:
    a. Creating a fear hierarchy and exposing the student to different feared objects/situations while they practice relaxation techniques
    b. Systematically relaxing different muscle groups
    c. Immediate exposure to the most feared object/situation of an anxious student
    d. Walking a student through imagined fearful situations

6. Activity Scheduling is a skill most often used with students who suffer from:
    a. Posttraumatic Stress Disorder
    b. Substance Abuse
    c. Depression
    d. ADHD

7. The process of interrupting disturbing or unwanted thoughts by shouting "stop" or by snapping a rubber band on one's wrist is referred to as:
    a. Thought Elimination
    b. Thought Stopping
    c. Thought Blocking
    d. Thought Interrupting

8. The most effective cognitive behavioral interventions for Disruptive Behavior Disorders involve:
    a. Self-monitoring
    b. Teacher and Parent management
    c. Cognitive Restructuring
    d. Refusal Skills

9. Name three skills that are helpful for students with anxiety:

_____

_____

_____

10. Name three components of parent training for students with disruptive behavior disorders:

_____

_____

_____

MENTAL HEALTH EDUCATION AND TRAINING INITIATIVE

Risk and Protective Factors Assessment

1. **Define:**

Protective Factor:

_____
_____
_____

Risk/Stress Factor:

_____
_____
_____

2. **List 3 individual-level protective factors for children/adolescents:**

_____
_____
_____

3. **List 3 family-level protective factors for children/adolescents:**

_____
_____
_____

4. **List 3 community-level protective factors for children/adolescents:**

_____
_____
_____

5. **List 3 school-level protective factors for children/adolescents:**

_____
_____
_____

6. **List 3 individual-level risk factors for children/adolescents:**

_____
_____
_____

7. **List 3 family-level risk factors for children/adolescents:**

_____
_____
_____

8. **List 3 community-level risk factors for children/adolescents:**

_____
_____
_____

9. **List 3 school-level risk factors for children/adolescents:**

_____
_____
_____

MENTAL HEALTH EDUCATION AND TRAINING INITIATIVE

Mental Health Planning and Evaluation Template

Dimension 1: Pre-conditions for a successful program	Not at all in place					Fully in place	N/A	Targeted Indicator
1) The mental health program has been developed with input from students, school leaders, school staff, families and other community members.	1	2	3	4	5	6	N/A	
2) The program and school have adopted a shared protocol that clearly defines when and how to refer students.	1	2	3	4	5	6	N/A	
3) Mental health staff work in a confidential space and have access to dedicated phone lines and file cabinets that can be locked to ensure privacy of records.	1	2	3	4	5	6	N/A	
4) Support staff are assisting mental health staff in administrative functions such as: client scheduling, data management, and documentation.	1	2	3	4	5	6	N/A	
5) Mental health staff develop and maintain relationships and participate in training and meetings with educators and school-employed mental health staff.	1	2	3	4	5	6	N/A	
Dimension 2: Staff and training								
6) Mental health staff have completed accredited graduate training programs.	1	2	3	4	5	6	N/A	
7) Mental health staff are licensed in a mental health profession or are actively pursuing licensure and receiving required supervision toward licensure.	1	2	3	4	5	6	N/A	
8) Mental health staff receive training and ongoing support and supervision in implementing evidence-based prevention and intervention in schools.	1	2	3	4	5	6	N/A	
9) Mental health staff receive training, support and supervision in providing strengths-based and developmentally and culturally competent services.	1	2	3	4	5	6	N/A	
Dimension 3: Programs and services								
10) A range of services, including school-wide mental health promotion, prevention, early intervention and treatment services are provided for youth in general and special education.	1	2	3	4	5	6	N/A	
11) Mental health staff respond as rapidly as possible to referrals and inform school staff, health staff and/or family members on the status of referrals.	1	2	3	4	5	6	N/A	
12) Mental health prevention and intervention services provided in the school are informed by evidence-based practice.	1	2	3	4	5	6	N/A	
13) A theme of partnership with families in developing and implementing mental health services is emphasized.	1	2	3	4	5	6	N/A	
14) The SBHC works with the school to effectively identify youth who present or are at risk for presenting emotional/behavioral difficulties.	1	2	3	4	5	6	N/A	
15) The mental health intake approach is comprehensive and accurate while minimizing barriers to service for young people and their families.	1	2	3	4	5	6	N/A	
16) Mental health staff use brief, validated measures of youth strengths and psychosocial functioning to enhance initial, ongoing, and outcome evaluations.	1	2	3	4	5	6	N/A	
17) Psychiatry consultation is available to clinicians to assist in the assessment and treatment of youth with serious and/or complex mental health issues.	1	2	3	4	5	6	N/A	
18) Treatment plans are uniformly completed and accurately match program services to the presenting needs of students and their families.	1	2	3	4	5	6	N/A	
19) Through peer and case consultation and other mechanisms, treatment plans and implemented strategies are frequently reviewed and adjusted to ensure that services are being delivered to address the most important problems/issues.	1	2	3	4	5	6	N/A	

Dimension 3: Programs and services (continued)	Not at all in place					Fully in place	N/A	Targeted Indicator
20) Following legal and professional guidelines, appropriate case records are developed and maintained, with methods to ensure privacy and confidentiality								
21) There are clear protocols and supervision for handling severe problems and crises (e.g., suicidal ideation, psychosis, abuse/neglect) presented by students.								
Dimension 4: Coordination of programs and services								
22) The SBHC maintains a regularly updated directory to assist students and families in connecting to relevant health, mental health, educational and other programs and resources in the school and the surrounding community.	1	2	3	4	5	6	N/A	
23) SBHC mental health staff coordinate efforts with SBHC health providers and school-employed mental health and health professionals to ensure that youth who need services receive them and to avoid service duplication.	1	2	3	4	5	6	N/A	
24) The SBHC coordinates services with community-based mental health organizations to enhance resources and to serve students whose needs extend beyond the scope or capacity of the SBHC.	1	2	3	4	5	6	N/A	
25) Mental health services adhere to clear policies and procedures to share information appropriately within and outside of the school and to protect student and family confidentiality.	1	2	3	4	5	6	N/A	
26) Interdisciplinary meetings and training are regularly held within the SBHC with all health and mental health staff of the SBHC participating in them.	1	2	3	4	5	6	N/A	
27) Health and mental health staff provide mutual support and cross referrals (i.e., health staff screen students for mental health issues and refer them to mental health staff and vice versa).	1	2	3	4	5	6	N/A	
Dimension 5: Quality assessment and improvement								
28) The SBHC receives ongoing guidance on mental health programming from stakeholders including youth, families, school staff, and community leaders who are diverse in terms of race/ethnicity and personal/cultural background.	1	2	3	4	5	6	N/A	
29) The SBHC is actively implementing a mental health quality assessment and improvement (QAI) plan that is supported by and guided by stakeholders as above, and includes appropriate tools for developing QAI strategies and measuring progress.	1	2	3	4	5	6	N/A	
30) A plan for evaluating mental health services is developed and implemented with active and ongoing guidance from stakeholders (as above). The plan enables qualitative assessment (e.g., satisfaction ratings), measures the impact of services on school-related outcomes (e.g., attendance, school behavior, school performance), and uses findings to continuously improve services.	1	2	3	4	5	6	N/A	

MENTAL HEALTH EDUCATION AND TRAINING INITIATIVE
Chart Review Guide

Chart Selection

- RANDOMLY select 30 charts of students who have visited your SBHC during the implementation cycle (after August 2004). (e.g., Select every fifth chart in an alphabetical listing of students).

**** Please note that you should not leave any cell blank, we have added an option for Not Applicable.**

**** Please pay close attention to the "If positive identification" questions. Mark down 2 for "Not Applicable" if it does not apply to you.**

Risk Assessment

- For this question, it is NOT necessary that the risk assessment include all of the areas in the next few questions. We want you to document whether you did ANY risk assessment on the student.

Comprehensive Risk Assessment Indicators

- Indicate if the risk assessment includes information on each of the areas specified on the review form.

Our goal for risk assessments is that they will include the components of a "Comprehensive Risk Assessment" as outlined in the power point presentation in Learning Session One:

"Must be developmentally appropriate and is expected to cover: injury, safety, violence, diet and exercise, dental, substance use and passive exposure, abuse, family relationships, school, friends, mood and emotional health, and sexuality"

Specific Mental Health Problems

The next set of questions asks you to document the presence of screening for each of the four areas of mental health problems, as well as suicidality. Screening refers to any questions addressing the symptoms associated with the disorder. For example:

Screening for depression

- "Screening" for depression refers to any questions addressing depressive symptoms (e.g., "Are you or have you ever been depressed?"; "Have you been feeling sad or blue?")

  In the case of suicidality, screening refers to any questions addressing suicidal thoughts or behaviors.

Next, indicate if the chart contains a positive identification of symptoms in each of the areas.

- For those charts with positively identified symptoms in an area, indicate if the chart contains a follow-up assessment (i.e., a more thorough formal assessment of the identified mental health concern) and/or a follow-up referral (i.e., referral for mental health services either with a provider in the SBHC or to an outside source).

Do charts with identified mental health concerns include:

- "*Documentation* of a mental health screening or assessment, intervention, or diagnosis/problem?" refers to any documentation in the chart of these procedures or problem identification. For example, a depression assessment included in the chart would represent documentation of a mental health assessment. If a progress note indicated that a provider delivered psychotherapy for anxiety, that would represent documentation of a mental health intervention. Finally, if a provider notes that a student is presenting with disruptive behavior problems, that would represent diagnosis/problem identification.

- *"Documented code* for a mental health assessment, intervention, or diagnosis/problem?" refers to the documentation of a Procedural Code (CPT Code) for an assessment or intervention and a Diagnostic Code (ICD-9 or DSM-IV Code) for a diagnosis/problem.

- *IF YOUR SBHC DOES NOT DOCUMENT CODES IN THE CHART, BUT DOES DOCUMENT CODES ELSEWHERE (e.g., encounter form, MIS) PLEASE ANSWER YES TO THIS QUESTION*

Interventions

- *"Assessment of protective factors"* refers to any assessment in the chart of these factors.
- ***Protective factor:*** A condition that inhibits, reduces, or buffers the probability of a disorder (e.g., parental monitoring, problem-solving skills, school connectedness).

MENTAL HEALTH EDUCATION AND TRAINING INITIATIVE
Chart Review Form

Reviewer:_____ **Name of SBHC:**_____

(2= Not Applicable 1= Yes 0 = No)

	ID:	ID:
A. Risk assessment		
B. Is risk assessment signed and dated by provider?		
Comprehensive Risk Assessment indicators: IF yes to A. indicate all that apply:		
Injury		
Safety		
Violence		
Diet and Exercise		
Dental		
Substance Use and Passive Exposure		
Abuse		
Family Relationships		
School		
Friends		
Mood and emotional health		
Sexuality		
INDICATE IF CHART INCLUDES:		
Depression		
Screening for depression symptoms		
Positive identification of one or more depression symptoms		
If positive identification, is there documentation of a follow-up assessment for depression?		
If positive identification, is there documentation of a follow-up mental health referral?		
If positive identification, were any of the following strategies used (Cognitive Restructuring, Thought Stopping, Activity Scheduling, Problem Solving, Relaxation Training)		
Suicide		
Screening for suicide symptoms		
Positive identification of one or more indicators of suicidality?		
If positive identification, is there documentation of a follow-up assessment for suicidality?		
If positive identification, is there documentation of a follow-up mental health referral?		
Anxiety		
Screening for anxiety symptoms		
Positive identification of one or more anxiety symptoms		
If positive identification, is there documentation of a follow-up assessment for anxiety?		
If positive identification,is there documentation of a follow-up mental health referral?		
If positive identification, were any of the following strategies used (Deep Breathing, Progressive Muscle Relaxation, Mental Imagery/Visualization, Cognitive Restructuring, Systematic Desensitization, General Stress Busters)		
Disruptive behavior		
Screening for disruptive behavior symptoms		
Positive identification of one or more disruptive behavior symptoms		
If positive identification, is there documentation of a follow-up assessment for disruptive behavior?		
If positive identification, is there documentation of a follow-up mental health referral?		
If positive identification, were any of the following strategies used (parenting training, school interventions, and child-focused treatments)		
Substance use		

Screening for substance use symptoms		
Positive identification of one or more substance use symptoms		
If positive identification, is there documentation of a follow-up assessment for substance use?		
If positive identification, is there documentation of a follow-up mental health referral?		
If positive identification, were any of the following strategies used (Family-based and Classroom-based intervention, Refusal Skills, Self-esteem, Education, Motivational Interviewing)		
General Mental Health		
Documentation of a mental health assessment (e.g., note)		
Documented code(s) for mental health assessment (Procedure/CPT code)		
If no to above question are procedural codes documented in other places(eg MIS, Encounter form)		
Documentation of a mental health intervention (e.g., note)		
Documented code(s) for mental health intervention (Procedure code/CPT code)		
If no to above question are procedural codes documented in other places(eg MIS, Encounter form)		
Documentation of a mental health diagnosis/problem (e.g., note)		
Documented code(s) for mental health diagnosis/problem(Diagnostic/Problem code)		
If no to above question are diagnostic/problem codes documented in other places(eg MIS,Encounters)		
Interventions		
Assessment of protective factors		
Documentation of interventions aimed to decrease risk factors and/or increase protective factors		

MENTAL HEALTH EDUCATION AND TRAINING INITIATIVE

Site Leader Interview Guide

School-Based Health Center: _____
State: _____
Name of Site Leader: _____
Contact Information for Site Leader:
Address:

Phone(s):
Fax:

Questions

1. At the time MHET began, what disciplines (e.g., pediatrician, social worker) FTEs (part-time, full-time) were working in your SBHC?

2. We want to ask you a few questions about your school when MHET was being conducted.

    a. Was the school elementary, middle or high?
    b. Was the school in a rural, suburban or urban setting?
    c. Approximately how many students were enrolled in the school?
    d. What was the racial/ethnic profile of the school?
    e. What was the percentage of students receiving free/reduced-lunch?
    f. What were the primary mental health problems of students in the school?

3. What did you see as the ultimate goal of the MHET initiative?

4. Why did you want to be a part of this process? Did you see room for improvement in mental health services in your SBHC?

5. What did you find the most helpful from participating in the MHET initiative?

6. What was the least helpful from participating in the MHET initiative?

7. What were the greatest successes from participating in MHET initiative?

8. What were the greatest challenges to participating in MHET initiative?

Now I would like to ask you about your SBHC's progress in each of the objective areas in the MHET initiative. I would like to know what changes you made in each area as a result of the MHET initiative, and which you have been able to sustain.

9. The first objective area is DIAGNOSIS –
According to your SBHC's pre- and post-assessments, there was perceived **XX**
in the area of Mental Health Diagnosis.

THE DIAGNOSTIC ASSESEMENT ALSO SHOWED XX IN PROVIDERS' KNOWLEDGE OF DIAGNOSTIC INFORMATION FROM LEARNING SESSION 2 TO LEARNING SESSION 4.

In your opinion, what may have contributed to these findings?

c. Has this improvement been sustained since the end of the MHET initiative?
__ *Yes*
__ *No*

Notes:

10. The next objective area is SCREENING AND ASSESSMENT –

According to your SBHC's pre- and post-assessments, there was **XX in the area of assessment and XX in the area of assessment.**

Your Chart Audits show a **XX in the completion of comprehensive risk assessments and XX in the use of screenings for depression, suicide, disruptive behavior disorders and substance use.**

What do you think might account for this discrepancy between the providers' perception of change and the chart audit reports?

In your opinion, what may have contributed to these findings?

Has this improvement been sustained since the end of the MHET initiative?
__ *Yes*
__ *No*

Notes:

11. The next objective area REFERRAL AND FOLLOW-UP –

According to your SBHC's pre- and post-assessments, there was perceived **XX** in the area of Referral and Follow-up. Providers reported XX in in-house referrals, follow-up on in-house referrals, community referrals, and follow-up on community referrals.

Chart Audits \suggest **XX** in the area of referrals, particularly for XX

What do you think might account for this discrepancy between the providers' perception of change and the chart audit reports?

In your opinion, what may have contributed to these findings?

Has this improvement been sustained since the end of the MHET initiative?
__ *Yes*
__ *No*

Notes:

12. The next objective area is CODING –

According to your SBHC's pre- and post-assessments, there was perceived **XX IN THE USE OF DIAGNOSTIC AND PROCEDURAL CODES.**

PROVIDERS reported XX IN THEIR FAMILIARITY WITH DIAGNOSTIC OR PROCEDURAL CODES, NOR WITH THEIR FREQUENCY OF USE OF DIAGNOSTIC OR PROCEDURAL CODES.

Chart Audits an **XX IN THE USE OF MENTAL HEALTH PROBLEM CODES, and an XX in the use of assessment codes and intervention codes.**

What do you think might account for this discrepancy between the providers' perception of change and the chart audit reports?

In your opinion, what may have contributed to these findings?

Has this improvement been sustained since the end of the MHET initiative?
__ *Yes*
__ *No*

Notes:

13. The next objective area is PRIMARY CARE – MENTAL HEALTH INTEGRATION/COLLABORATION.

According to your SBHC's pre- and post-assessments, there was perceived **XX** in the area of Primary Care-Mental Health Integration/Collaboration. **Providers reported XX in the communication between providers, joint case conferencing, sharing of diagnostic information and effectiveness of the referral process.**

In your opinion, what may have contributed to these findings?

Has this improvement been sustained since the end of the MHET initiative?

__ *Yes*
__ *No*

Notes:

14. **The next objective area is the USE OF EVIDENCE-BASED SKILLS IN THE TREATMENT OF ANXIETY, DEPRESSION, DISRUPTIVE BEHAVIOR DISORDERS AND SUBSTANCE ABUSE.**

According to your SBHC's pre- and post-assessments, there was an **XX** in providers' knowledge of evidence-based intervention skills.

Chart Audits showed an **XX** in evidence-based skills for the treatment of disruptive behavior disorders, depression, anxiety, and substance abuse.

What do you think might account for this discrepancy between the providers' perception of change and the chart audit reports?

In your opinion, what may have contributed to these findings?

Has this improvement been sustained since the end of the MHET initiative?
__ *Yes*
__ *No*

Notes:

15. **Your SBHC received training in the manualized intervention called:**
___ Cognitive Behavioral Intervention for Trauma in Schools
___ FRIENDS
___ Skillstreaming

a. Did you implement the intervention?
___ *Yes*
___ *No*

If group was implemented:
b. What were the barriers to implementation? *(e.g., fidelity, attendance)*
c. What were the successes?
d. How many cycles of the intervention were conducted?
e. How many students *(approximately)* received the intervention?
If the group was <u>not</u> implemented:
f. Why not?

For all:
g. Since MHET, has your SBHC implemented any other manualized, evidence-based mental health interventions? *Please explain:*