



# Changing Directions in Mental Health Support for Minnesota’s Children

*An Emerging Education and Safety Challenge in our Schools and Communities*

## **Winter 2011 - Summary of Findings**

*Prepared in partnership by Northeast Metro Intermediate District 916, Intermediate School District 917 and Christine Wroblewski*

### **Imagine, your child is having a mental health crisis and you can’t find help.**

Imagine that your son was threatening to harm himself or others, was hospitalized for the threat, then was released within 24 hours without a proper diagnosis or a treatment plan. Or that your daughter was demonstrating aggressive, even violent behavior that you couldn’t control, and her day treatment program said it could not meet her needs, or that your family was denied support to cover the costs of her therapy by your insurance provider. Now swiftly place these students back in school, and picture how these children will respond.

### **Minnesota’s current mental health system is leaving many of our most vulnerable students behind.**

The current quick-fix care wave in Minnesota for mental health disqualifies far too many special education students, particularly those being served in Federal Setting IV programs. Just as needs for children’s mental health services are increasing, the responsibility for addressing them has been shifting, and landing largely on school districts.

This appears to be the combined effect of state and local budget cuts, reduced mental health coverage by insurers, changes in assistance eligibility, and fewer treatment options for families. The overall result: a switch from long-term treatment and support to short-term stability and release. In schools, educators--not therapists--must try to improve academic skills even though frequent emotional and behavioral crises threaten the personal safety of those educators and the students they serve.

### **Mental health solutions are needed to optimize educational gains.**

“When you see one of these students leave our school in the depths of an extreme personal crisis, and they end up back in school the next day with no plan, you keep asking yourself, how can this be?” says Connie Hayes, superintendent for Northeast Metro 916 Intermediate School District.

Trying to identify why is extremely complicated, but the answers appear to be deeply embedded in policies and budgets for schools, counties, hospitals, private treatment centers, and insurers. One thing is clear, however, all but one of these entities has the authority to release these children from their responsibility: our schools.

Superintendents Connie Hayes and John Christensen, Intermediate District 917, whose two school districts serve some of the most emotionally fragile and behaviorally disordered students in the metropolitan area, are developing a paper that attempts to pinpoint both the gaps in our state and local systems and policies that may be causing this growing problem for Minnesota’s children. They are also working to identify possible solutions. Attached is summary of the white paper findings to date.

**Protective devices teachers are using to lessen their personal injuries**



*Safety helmet worn to prevent head injuries.*



*Kevlar sleeves for biting and pinching.*

## **WHAT'S CHANGED**

The ripple effects of financial and procedural changes in recent years are being felt in Minnesota's most intense special education settings in the form of increased injuries to teachers, more disruptions in the special education setting, and greater numbers of students going into crisis at younger ages. In short, many students who most need mental health supports are now going without, or are finding them more difficult to access. Minnesota's students are falling into a widening gap between educational services that are provided by school districts and community mental health providers that are administered by Health and Human Services. And the negative effects and costs are being absorbed by the schools.

While, by law, school districts MUST provide an education to all students identified for special education services — regardless of budget constraints — counties have the flexibility to change the number of children who receive services based on current (often declining) revenue. In addition, state and federal mandates have shifted coverage of mental health services more directly onto insurance providers, a business entity for which mental health services are unprofitable. Mental health service providers can expel or reject aggressive youth due to lack of space or physical harm caused by the child.

These shifts and cuts have resulted in inconsistent service and standards from county to county and variable mental health care options available to children and their families. Without enough mental health support outside of school, students needs IN SCHOOL are increasing and, at the same time, causing dramatically increased safety risks to students and staff.

## **THE SAFETY FACTOR AND ITS EFFECT ON LEARNING AND TEACHING**

In recent years, schools serving high-need special education students, determined to protect staff, have provided staff Kevlar sleeves, gloves and safety helmets to address the biting, pinching, shoving, hitting and throwing staff increasingly encounter. In the Northeast Metro 916 Intermediate School District, the number of staff injuries at its two largest special education programs doubled from 47 in fall of 2010 to 93 in fall of 2011. The reported injuries were directly related to interactions with students and most often the result of biting, hitting, pinching, kicking, shoving and grabbing. This is in spite of the use of behavior intervention programs in schools and the implementation of greater training for staff, such as School Wide Positive Behavioral Interventions and Supports (SW-PBIS) and Professional Crisis Management (PCM).

For Intermediate School District 917, the number of workers compensation cases more than tripled from 23 in 2007 to 88 in 2009. Of the reported injuries in 2009, only 11 of 88 were accidental while the remaining resulted from interactions with aggressive students.

Due to the sensitive nature of the students being served in intermediate special education programs, disturbances in their immediate environment (home or school) can cause agitation and potentially a crisis episode. Special education staff in intermediate schools must walk a delicate balance between pushing students academically and providing support that prevents distress, or expertly de-escalates the distress, among the students. "Education is what we do," says Dan Naidicz, Director of Special Education for Northeast Metro Intermediate School District 916. "To get at the academics, the mental health needs of these students must be addressed. But schools are not mental health clinics."

As the "payer of last resort", a school district that recommends treatment for students without consultation or agreement with county jurisdictions means that the school district may be held financially responsible for the service provided. The collaboration between agencies encouraged by current laws does not work when only one entity is left with the final responsibility. The strain on resources coupled with a tightening of local policies to prevent financial and legal liability means that children are sometimes being left without adequate support, and act out as a result.

The combination of academic support and mental health support appears to be the key to success for these students in the mental health gap. "The mental health challenge is becoming so complex for these students that we can no longer address only the behavior issue to see progress, academically and socially," says Melissa Schaller, Director of Special Education for Intermediate District 917. "That is why we need the mental health component in place for these students."

## **POTENTIAL SOLUTIONS**

The safety net of supports for students and families in the gap appears to be shrinking, and some say that Minnesota has changed its philosophy regarding care and education for the state's most vulnerable children from providing social service to managed care, with school districts left in limbo. The recent shift away from long-term treatment and support to short-term stabilization and release is often incongruent with long-term educational development or significant mental disability.

Solutions offered to the dilemma vary, but can be categorized into three main areas:

1. Increase collaboration (through incentives or directives) across agencies and organizations serving children in the gap, including school districts, counties, mental health service providers and insurance providers. Reconsider "payer of last resort" restrictions on school districts and/or allow school districts the authority to refer children for mental health treatment without direct financial burden for identifying the need.
2. Give school districts more flexibility, incentives, and long-term financial support to provide mental health treatment on-site by promoting alternative options for school districts and continuing and expanding children's mental health services grants or funding. The benefit of on-site supports would:
  - a. Increase access to students,
  - b. Provide treatment/therapy earlier in the process, and
  - c. Keep services geographically close to students or schools to increase the likelihood that students will keep appointments and follow through on treatment, which is otherwise difficult if services are geographically distanced from the school or home of the child.
3. Collapse the bureaucracies of those serving the same group of children, reduce redundancy across agencies, and create one comprehensive public education/human service function for children. This would require a systems overhaul regarding mission, delivery and funding.

The State Advisory Council on Mental Health's subcommittee on early childhood development and mental health in 2010 offered solutions compatible with those of school district and county staff currently serving children in the gap, including:

- Increase accessibility for caregivers of young children to affordable, quality mental health consultation.
- Increase the percentage of children age four and under who are formally screened, with parental consent, for social and emotional development problems, providing assessment at regular intervals.
- Build collaboration between the children's and adult mental health systems to better address the needs of the child and caregiver as well as the child-caregiver relationship.

In the end, state and local authorities will pay, whether through proactive, preventative and therapeutic solutions, or reactive solutions to the crises that result from the unintended consequences of system shifts and cuts. Decisions must be made about which approach best serves children for the long run.