School Navigator Toolkit

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- Background & Definitions
- Workflow & Implementation
- Screening Tools
- Behavioral & Mental Health Framework
- School Navigator Program Model
- Quickstart Guide

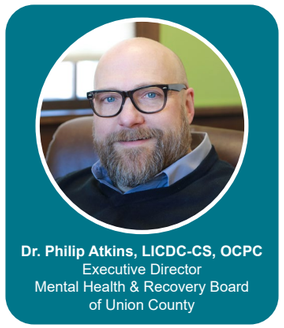
School Navigator Program and Toolkit developed by the Mental Health and Recovery Board of Union County in collaboration with Marysville Exempted Village School District, Maryhaven, and Miami University.

Toolkit funded by The Ohio Department of Mental Health and Addiction Services.

BACKGROUND

The provision of behavioral health supports to children and youth in schools has varied widely in terms of models, availability, and quality. We know that the prevalence of emotional and behavioral disorders has escalated in the past decade. Mental Health America (2021) estimates that nearly 14% of children and youth in Ohio have experienced a major depressive episode in the past year. More than half of those youth did not receive mental health treatment.

These struggles come to school. School faculty, counselors, administrators, and staff are often put in the position to be therapist, social worker, case manager, and parent. It is exhausting. With the best of intentions, schools and community behavioral health organizations have tried to address the most acute concerns. Very often, that has been in the form of deploying a community behavioral health worker (counselor, social worker) to deal with a handful of the most acute emotional and behavioral problems.



Dr. Philip Atkins, LICDC-CS, OCPC
Executive Director
Mental Health & Recovery Board
of Union County

The goal is to "do the best we can" and to try and manage the impact of these disorders on the rest of the class.

While well intentioned, this approach has drawbacks. Here are some that we have identified.

Randi Bargo-Smith, M.Ed.
Youth Systems of Care Director
Mental Health & Recovery Board
of Union County

- Such interventions target too few students when the need is so great. Often children who receive services are already on the case loads of community mental health centers or have to go through complex enrollment and diagnostic hoops in order to be served. This leaves dozens of kids who need the same supports unattended.

- School-based services have been largely dependent on who is paying the bill. Children and youth who have Medicaid coverage are the most eligible so get a disproportionate share of the services. While we know that social determinants such as poverty, transience, hunger, and unsafe physical environments can influence the development of emotional and behavioral disorders, they are to be seen as risk factors and not causal agents in themselves. When services depend on being Medicaid eligible (low income), that again leaves families with private insurance, who are uninsured, or who have very high deductible plans out of the reach of treatment.

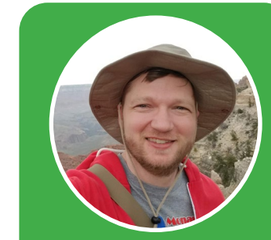
- Additionally, school-based services that focus on intense, clinical services such as counseling fail to consider what we have learned about trauma. Many children and youth who are dealing with emotional and behavioral disorders have experienced horrific adverse experiences that need to be addressed clinically. However, we question the wisdom of taking a child from class, moving them to an office where their peers and teachers know a counselor will be seeing them, and asking that child to describe what they have experienced - only to have the bell ring and be sent back to class without resolution or support. We believe we may have reinforced stigma and re-traumatization with this approach.

- Finally, such school-based services are often isolated from the context of the child's family and community. We see them at school for our convenience, not to engage natural support systems, address issues with parenting or family conflict or abuse. Children go home. Their families will be there. We must help them heal in context.

So, we propose a new model. It's simple and certainly not radical, but one that requires us to work collaboratively as systems. We know that Systems of Care that are family-centered and grounded in the natural environment work best. Counseling is one service, but in the mix of healing interventions and supports for families, it is often the one that needs small doses – and certainly not at the point where families are destabilized and conflictual. We must address first things first.

Melissa Meyer, M.S., LPCC-S
Director of Regional Services
Maryhaven

The Union School Navigator model offers schools and community behavioral health providers the linkages, consultation, networks, and relationship building that have been missing. Often in communities there are great services like High-Fidelity Wraparound or Intensive Home-Based Treatments (IHBT) and a host of other supports for kids and families. However, the best services are useless if schools don't know about them, families can't access them, and referrals disappear into an abyss – with no communication to help all of the supports around the family be effective. Schools are incredible sources of information about kids and families. Often, they know what the kids have had to eat that day or when a dad has lost a job or what kind of weekend the child experienced just by how they get off the bus in the morning. By fully embedding navigators in our schools, we have that communication, that guide to community services, that engagement with the family, and the interlocked arms to help support kids and families when they need us most.



Mark Gallagher, Ed.S.
K-12 MTSS Coordinator
Marysville Exempted Village
School District

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SCHOOL NAVIGATOR TOOLKIT

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DEFINITIONS

CARE/SERVICE COORDINATION: The centralized process by which multiple services and supports, often provided by multiple agencies, are synchronized to address the needs and strengths of each child, youth, or family. ***(https://www.childwelfare.gov/topics/management/reform/soc/communicate/initiative/ntaec/soctoolkits/coordinationofservices/#phase=pre-planning)***

FAMILY CENTERED: Person- and family-centered treatment planning is a collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible. Person- and family-centered treatment planning is care planning that is strength-based and focuses on individual capacities, preferences, and goals. Individuals and families are core participants in the development of the plans and goals of treatment. ***(SAMHSA https://www.samhsa.gov/section-223/care-coordination/person-family-centered)***

LEVEL OF CARE: Treatment and care for mental health-related issues is provided in a variety of settings. The environment, and level or type of care, will depend on multiple factors: the nature and severity of the person's mental condition, their physical health, and the type of treatment prescribed or indicated. ***(https://www.northtexashelp.com/mental-health-treatment-settings.html)***

MTSS/RTI: MTSS is a data-based, problem-solving framework that integrates instruction, intervention, and assessment to meet the academic and behavior needs of all students. It is designed to provide multiple levels of support for all students, including those with disabilities and at risk, to close achievement gaps. MTSS provides universal academic and behavioral instruction and support to all students (Tier 1), adds targeted support/instruction as needed (Tier 2), and intensive, individualized support/instruction as needed (Tier 3). All levels of support are aligned with the universal core academic and behavior instruction and support that is a baseline for all students. This framework focuses on prevention as well as intervention. ***(https://www.sst4.org/MTSS.aspx)***

Multi-Tiered Systems of Support (MTSS) is an integrated framework which addresses **academic** as well as **social-emotional/behavioral** development of children from early childhood to graduation. Response to Intervention (RtI) and Positive Behavior Intervention Support (PBIS) are integral parts of MTSS – but MTSS is more cohesive and comprehensive in the goal of meeting the needs of all learners (Hurst, 2014). MTSS integrates assessment and intervention within a multi-level prevention system to maximize student achievement and reduce behavior problems. ***(https://www.sst8.org/MTSS.aspx)***

NAVIGATION: Navigation refers to the function of linking clients (and their natural supports) with essential health and community services. It is a "barrier-focused intervention" that aims to assist clients in identifying and overcoming barriers to care. ***(https://resourcesforintegratedcare.com/sites/default/files/Navigation_OAT.pdf)***

PAYER: A payer, or sometimes payor, is a company that pays for an administered medical service. An insurance company is the most common type of payer. A payer is responsible for processing patient eligibility, enrollment, claims, and payment. ***(https://www.signatureperformance.com/understanding-the-difference-between-payers-and-providers/)***

Payers in the healthcare industry are organizations — such as health plan providers, Medicare, and Medicaid — that set service rates, collect payments, process claims, and pay provider claims. Payers are usually not the same as providers. ***(https://collectivemedical.com/resources/payers/)***

DEFINITIONS

PREVENTION & PROGRAMMING AS DEFINED BY THE INSTITUTE OF MEDICINE'S CONTINUUM OF CARE

- **UNIVERSAL:** Based on the Institute of Medicine's Continuum of Care, prevention/ programming efforts targeted to a whole population that has not been identified on the basis of individual risk. ***(http://ca-sdfsc.org/docs/resources/SDFSC_IOM_Policy.pdf)***
- **SELECTIVE:** Based on the Institute of Medicine's Continuum of Care, prevention/ programming efforts targeted to populations whose risk is higher than average, but are not showing signs of a specific concern. ***(http://ca-sdfsc.org/docs/resources/SDFSC_IOM_Policy.pdf)***
- **INDICATED:** As identified in the Institute of Medicine's Continuum of Care, prevention/ programming efforts targeted to individuals with higher than average risk who have minimal, but detectable, signs of a behavioral health concern, but do not meet the criteria for a clinical condition. ***(http://ca-sdfsc.org/docs/resources/SDFSC_IOM_Policy.pdf)***

RECOMMENDED LIST OF POSSIBLE LICENSURE/QUALIFICATIONS/CREDENTIALS OF SCHOOL NAVIGATORS: QMHS, CMS, LPC, LPCC, MFT, LSW, LISW, CDCA, LCDC I, LCDC II, LCDC III, or LICDC

SBIRT: Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health-risk behaviors, including substance use. The SBIRT Model is locally adaptable to assess for a variety of mental health concerns not just substance use. ***(SAMHSA)***

SEL: Social and emotional learning (SEL) is an integral part of education and human development. SEL is the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions. SEL advances educational equity and excellence through authentic school-family-community partnerships to establish learning environments and experiences that feature trusting and collaborative relationships, rigorous and meaningful curriculum and instruction, and ongoing evaluation. SEL can help address various forms of inequity and empower young people and adults to co-create thriving schools and contribute to safe, healthy, and just communities. ***(https://casel.org/what-is-sel/)***

SCREENING INSTRUMENTS: Mandatory as part of SBIRT process- Pediatric Symptom Checklist, PHQ-9A and CRAFFT **Optional as part of SBIRT process-** Vanderbilt Assessment Scale, the Burns Anxiety Inventory, GAD-7, ACE, SCARED, SASSI, Columbia Suicide Severity Rating Scale *****See chart on pages 5-6***

TIERED INTERVENTION: The use of a tiered problem-solving model, with each tier differentiated by the intensity of services provided, is at the heart of all MTSS models (including RTI). In general, problem-solving models that seek ways to improve instructional strategies and learning outcomes for students include four steps.

- First, educators define the most important goals (e.g., a change in a student's behavior or academic learning). Defining goals in measurable ways is a critical part of the process.
- Second, educators investigate why the goals have not yet been attained. This step is important as a basis for identifying strategies that will either work around or work through existing impediments.
- Third, educators develop and implement a plan. The plan involves the use of strategies that have a strong likelihood of working.
- Finally, following the implementation of the planned strategy, educators evaluate its effectiveness in relation to the important goals they originally identified.

Three tiers comprise a tiered approach, which can be used for both academic and behavioral interventions. ***(https://ohioleadership.org/mtss)***

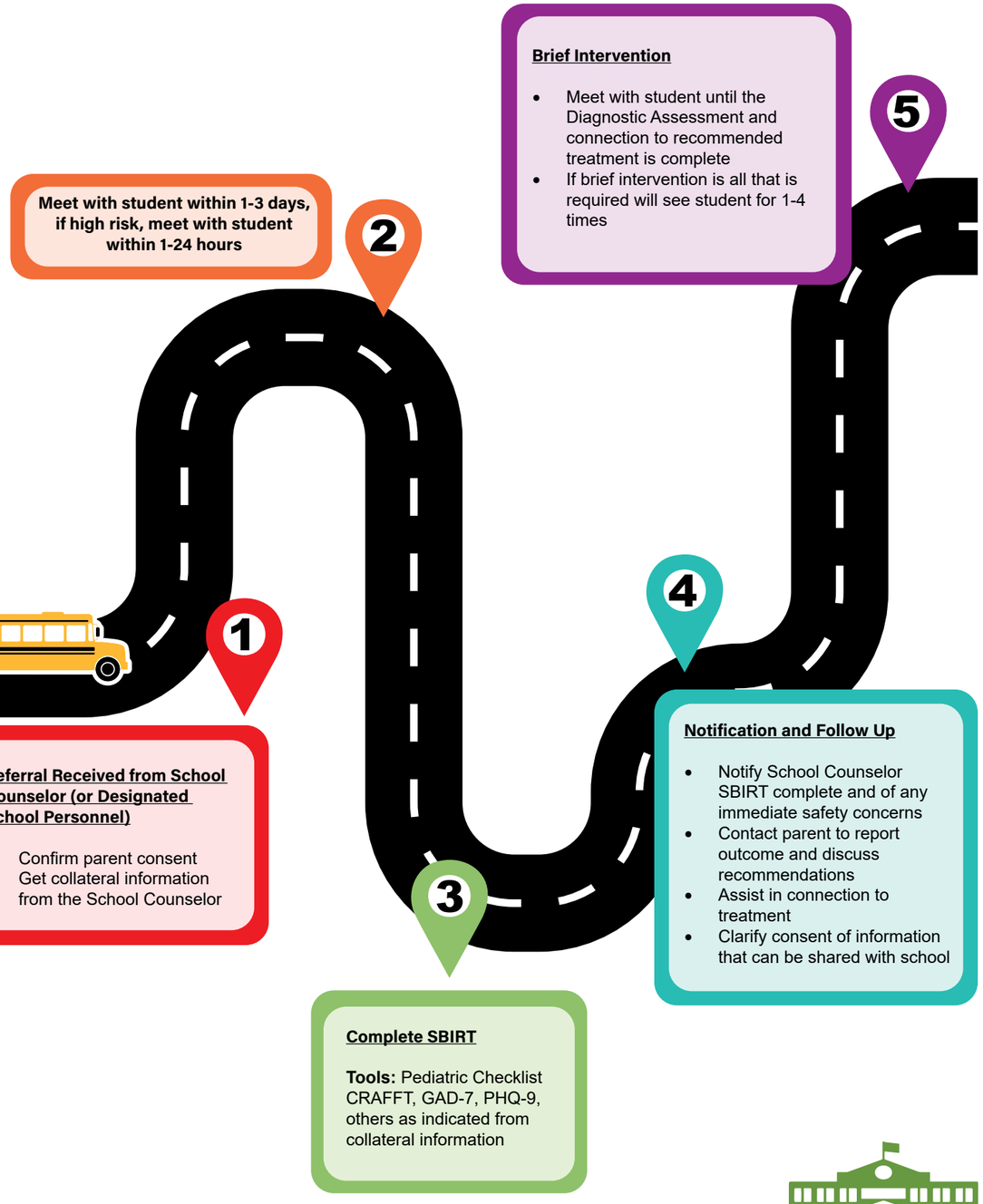
TRAUMA-INFORMED CARE: TIC takes a trauma-informed approach to the delivery of behavioral health services that includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. TIC views trauma through an ecological and cultural lens and recognizes that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. TIC involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma. TIC upholds the importance of consumer participation in the development, delivery, and evaluation of services. ***(SAMHSA https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4420.pdf)***

SCREENING TOOL	TARGET AGE RANGE	PURPOSE
PHQ-9 (Patient Health Questionnaire)	age 12+	The PHQ-9 is a simple, nine question self-administered form used to screen depression and monitor changes in signs/symptoms of depression.
GAD-7 (Generalized Anxiety Disorder 7 item scale)	age 12+	Self-report screening tool for generalized anxiety symptoms.
CRAFFT	age 14+	Can be self-administered or used as a questionnaire with the provider/clinician to screen for substance use disorders.
Pediatric Symptom Checklist	parent version age 4-11 youth version age 11+	A 35-item questionnaire to screen for cognitive, emotional and behavioral problems.

DEFINITIONS

SCREENING TOOL	TARGET AGE RANGE	PURPOSE
Burns/Beck Anxiety	youth version age 7-14	Screens for symptoms of anxiety.
Vanderbilt Assessment Scale	parent version age 6-12	Designed to measure the severity of attention deficit hyperactivity disorder (ADHD) symptoms.
SCARED (Screen for Child Anxiety Related Disorders)	age 8-18	41-item inventory. It comes in two versions; one asks questions to parents about their child and the other asks these same questions to the child directly. The purpose of the instrument is to screen for signs of anxiety disorders in children.
SASSI (Substance Abuse Subtle Screening Inventory)	age 12-18	Self-report screening instruments designed to accurately identify adolescents and adults with high probability of having a substance use disorder (SUD).
Columbia Suicide Severity Rating Scale (C-SSRS)	indicated for all ages, but typically age 12+	Suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs.

WORKFLOW & IMPLEMENTATION



FRAMEWORK

MARYSVILLE EXEMPTED VILLAGE SCHOOL DISTRICT BEHAVIORAL & MENTAL HEALTH FRAMEWORK

Core Evidence-based Preventive Practices Delivered to All Students
PATHWAY 1

Universal Pre-screening of All Students

Low Risk → **Core Supports**

Moderate Risk → **Core Supports & Monitor Domain Specific Needs (e.g. anxiety, depression, etc)**

High Risk → **Domain Specific Screening**

Non-Clinical Severity → **Student Supported at MEVSD with Doman Specific Interventions**

Clinical Severity → **Student Referred for School Navigation Support**

Monitor Progress

Interconnected Systems Framework at Community Level

FRAMEWORK

MARYSVILLE EXEMPTED VILLAGE SCHOOL DISTRICT BEHAVIORAL & MENTAL HEALTH FRAMEWORK

Core Evidence-based Preventive Practices Delivered to All Students
PATHWAY 2

Frequency and/or Intensity of Behavior

Level 1
Occurs for 8 Weeks

- Refusing to Complete School Work
- Sleeping
- Non-aggressive Noncompliance
- Non-participation
- Verbal Defiance
- Head Down on Desk
- Hyperactivity or Restlessness
- Invasions of Personal Space
- Poor Impulse Control
- Pacing

Level 2
Occurs for 4 Weeks, at Least 3+ Times per Week

- Swearing or Profanity
- Verbal Aggression
- Leaving Class without Permission
- Fist Clenching
- Aggressive Body Language
- Crying
- Inappropriate Vocal Level
- Defying Adult Directives (e.g. Refusing to Move, Leave, etc)

Level 3
2 Instances in 2 Weeks

- Running
- Physical Danger to Themselves or Others
- Indecent Exposure
- Destruction of Materials
- Spitting
- Requires Physical Restraint
- Screaming & Tantrums
- Sobbing & Intense Meltdowns
- High Intensity Behaviors

FBA & BIP Completed by Building Data Team, Led by Building Psych

FBA & BIP Completed by Multidiscipline Planning & Placement Team

SCHOOL NAVIGATOR PROGRAM MODEL

MARYHAVEN®
Helping People Restore Their Lives®

Screening Brief Intervention and Referral to Treatment Model

In this model of School Navigator program the provider utilizes a Mental Health Screening tools that allows them to assess the level of identified need and appropriate treatment recommendation. Further, the tool directs the provider to a brief intervention delivery model, wherein there may be limited (up to four) individual intervention sessions with a student. If, and when, a child is determined to require more intensive treatment, the treatment provider will transition the student to office-based treatment, school based treatment or other community resources as appropriate.

With this model, the entire spectrum of mental health services is offered to the school in a way that best manages treatment - both clinically and financially.

1. **Screening -** with the goal of identifying the presenting problem and the level of care necessary for the most clinically appropriate treatment intervention.

2. **Brief Intervention & Referral to Treatment –** working with families and youth in order to engage them into the appropriate level of care. The level of care may include, for both Mental Health and Alcohol or Drug issues:
   - Individual Counseling
   - Group Counseling (Targeted Group work developed if a common trend of behavior or need presents)
   - Case Management
   - Intensive Home-Based Treatment (IHBT)
   - Hi Fidelity Wraparound

3. **School Staff Outreach: classroom consultation, stress relief, etc. –** the goal to work with teachers and administrators to assist in providing a nurturing atmosphere within the school setting, offered on an as-needed basis.

This Brief Intervention Model allows for a more prescribed level of treatment based on individual youths needs as identified in the screening process.

SCHOOL NAVIGATOR PROGRAM MODEL

MARYHAVEN®
Helping People Restore Their Lives®

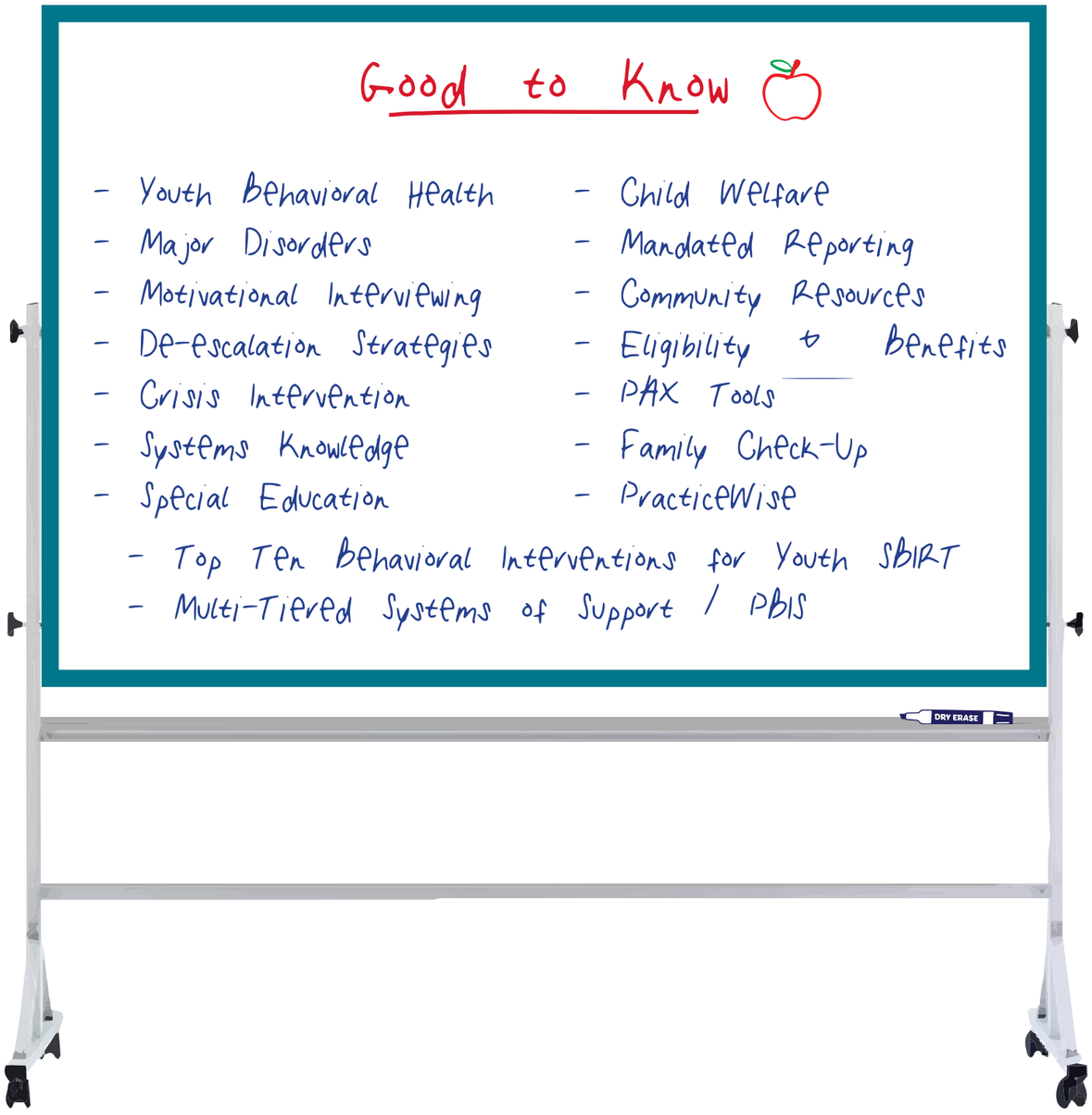
School Navigator/Case Manager Role

The overall purpose of the position is to develop a cohesive collaborative relationship with school staff and families to allow for unified intervention and communication for the sake of overall improvement of
the youths educational experience.

- Provide consultation support to school staff regarding programming, intervention, or behavioral concerns of a student.
- Complete SBIRT screening to allow for identification of Level of Care need. (these referrals are received from identified school gatekeeper after at least verbal consent has been obtained by parents to complete SBIRT)
- Complete SBIRT compile a summary of outcomes with recommendations to be provided to the parents, and with parent permission to the school.
- May provide brief intervention to a child (up to four contacts) without becoming enrolled in Maryhaven as a patient.
- If ongoing treatment is recommended the Navigator will assist family in accessing an assessment to engage in treatment with Maryhaven.
- Navigator would be the identified Case Manager if this level of service is determined necessary and would provide Case Management support in the home, community, and school for this child.
- Facilitate group if there is a number of youth that are struggling with similar issues. This would be developed in coordination with the school staff and permission of the parents.
- May attend school staffing, student team meetings, teacher in service as necessary or warranted helpful for the purpose of collaborative communication.
- Will advocate for the student and the school in a neutral objective manner
- As a case manager for the youth the duties may include

  - Linkage to community resources for needs that have been identified
  - Support the youth and family in implementing interventions they may have learned in therapy session.
  - Visit the youth and family in natural environments (home, community, and school) to offer support in implementation of plans and interventions
  - May be available to school staff if additional support is needed during the school day

RECOMMENDED SCHOOL NAVIGATOR TRAINING TOPICS



QUICKSTART GUIDE

Prepare to successfully implement the School Navigator Program in your school district by assembling the appropriate team of key community and school partners for a series of five collaborative and targeted meetings.

Key School Personnel:

a. District-Level Personnel (ex. Superintendent, Student Services)
b. Building-Level Administration
c. Personnel with PBIS/MTSS Expertise
d. Personnel with Youth Mental Health Expertise
e. School Psychologist

Key Community Personnel:

a. ADAMH Board Director
b. Director of Youth Services
c. Youth Behavioral Health Provider

Meeting Agenda 1: **Introductions, School Navigator Program, & Needs Analysis**

1. Introductions
2. Review School Navigator Toolkit
3. Needs/Gap Analysis (ex. ***http://www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Quality-Guides/Needs-Assessment-&-Resource-Mapping-2.3.20.pdf)***
4. Resource Mapping (What is currently available in the school and community?)
5. Role Assignments
6. Action Items (Gather current data to inform next steps: office referrals, attendance, community needs assessment, YRBS or OHYes!, MTSS/PBIS)

Meeting Agenda 2: **Definitions and Expectations**

1. How do we define the following?
   a. Academic Challenges
   b. Behavioral Challenges
   c. Social and Emotional Challenges
   d. Mental Health Challenges
   e. Executive Functioning Challenges

Meeting Agenda 3: **Providers and Funding**

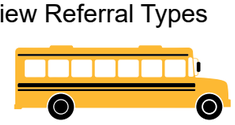
1. Staffing - Recommended 1 School Navigator per 1,700 Students
2. Cost - Approximately $70,000 per School Navigator
3. Pooled Funding Opportunities (School, ADAMH board, other organizations)
4. Potential School Funding Sources - examples include Student Wellness & Success Funds (HB 166), Ohio School Safety Grant, IDEA Part B, General Fund, Disadvantaged Pupil Funds
5. Potential ADAMH Funding - examples include Block Grant, GRF, SAPT Block Grant, K-12, Levy, Grants (System of Care/Strong Families)
6. Funds Recovery - Billing threshold (TBS/Case Management - 20% max billable - 208 hours per full year). School Navigators will bill much less during the school year than in the summer.
7. Contracting/Agreements

Meeting Agenda 4: **Process**

1. Review Workflow and Implementation Section of Toolkit
2. Identify Process Flow for your District
3. Appoint Key Personnel
4. Identify Available Space/Meeting Times
5. IT Access for School Navigators including Student Information System
6. Confidentiality

Meeting Agenda 5: **Launch or Rollout**

1. Create a Customized Fact Sheet
2. One-Pager on School Navigation
3. Best Practices - Weekly Meeting with School Navigator, School Administrator, & School Counselors
4. Referral Process & Participation on Building-Level Teams
5. Review Referral Types




School Navigator Toolkit

Mental Health & Recovery Board of Union County
131 N Main Street, Suite A
Marysville, OH 43040
937.642.1212 mhrbuc.org