Jefferson County Public Schools
Shaping the Future

Dr. Donna Hargens, Superintendent

Mental Health Counselor Formative Evaluation Report 2015

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2015 JCPS MENTAL HEALTH FORMATIVE EVALUATION REPORT

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2015 JCPS MENTAL HEALTH COUNSELOR DATA REVIEW

BACKGROUND

Prevalence and Impact of Childhood Mental Health Issues

About one in five adolescents experience significant symptoms of mental health disorders with the most common being depression, anxiety, attention-deficit/hyperactivity, and substance abuse (Knopf, Park, and Mulye, 2008). The Centers for Disease Control and Prevention (2015) classify suicide as the third leading cause of death in 10-24 year olds – presence of a mood disorder (such as depression) is a strong risk factor for suicidal behaviors. Recent research connects a restricted ability to self-regulate behavior to neurological development. Issues with self-regulation may manifest itself in ways that significantly impact a child's ability to learn and be taught. This presents a challenge for educators because it is sometimes difficult to distinguish between behaviors that look like attention-deficit/hyperactivity disorder (ADHD), behaviors that are a result of childhood trauma, mental health disorders, and misbehavior. For instance, there is ample evidence that chronic childhood trauma may negatively impact normal childhood development in one or more of the following: (a) developmental milestones, (b) attachment, (c) intellectual capacity, (d) cognitive ability, (e) affect regulation, (f) interpersonal functioning, (g) mental health, and (h) immune/autoimmune system (Bruce Perry, 2015, Behavior Institute). Educators are not trained to identify or respond to mental disorders (nor do most see that as their role).

Obviously, the mental health of children is mired with complexity. Do issues with self-regulation in young children represent the early stages of mood disorders? While there's no definitive answer to this question – the stakes for the child, educational system, and society to provide the right supports are high. Over time, this program will attempt to answer the following question: Are schools with specialized personnel equipped to handle these challenges necessary for the types of improvements in behavior and academics that have eluded many high needs students? This report focuses on the formative outcomes for the pilot year of a program which placed professional mental health counselors in 17 high need schools.

Jefferson County Public Schools (JCPS)

Jefferson County Public Schools (JCPS) is a large urban district located in Louisville, KY with an enrollment of over 100,000 preschool through 12th grade students. In 2012, JCPS Counselors and Family Resource Youth Center Coordinators (N=260) completed a survey to gauge perceptions about mental health needs and support services (Vanderhaar, 2012). Respondents estimated that **at least 1 in 5 students** experienced problems in the following order: (a)

academics, (b) social skills, (c) lack of family stability, (d) low self-esteem, (e) lack of basic needs, (f) bullying, (g) poor peer relations, (h) anger or rage, (i) family drug/alcohol abuse, (j) emotional abuse, and (k) sadness/hopelessness/depression. Of the 17 survey items, only sexual abuse was estimated below a 10% prevalence rate, and an estimated rate of 8.5% for sexual abuse (1 in 12 students) is far from negligible. Additionally, 40% of survey respondents indicated that the availability of mental health supports for JCPS students was either "fair" (30.4%) or "poor" (9.6%).

JCPS MENTAL HEALTH COUNSELOR PROGRAM

JCPS earmarked funds from the District's 2014-2015 operating budget to provide additional student support services aimed at student mental health needs. There is ample research that supports such funding since students with unmet emotional support needs often struggle with learning and behavior management. Existing school financial resources, staff capacities, and traditional disciplinary approaches were not sufficient to address the perceived need. A Multi-Tiered System of Support (MTSS) was expanded to include additional services, primarily intended as Tier 2 and/or Tier 3 interventions (see Figure 1). This report focuses on the provision of 15 mental health counselors (MHCs) to 17 JCPS locations during the 2014-2015 school year. Two other programs, Student Response Teams (SRTs) and Positive Behavior Intervention System (PBIS) are also MTSS interventions which will be addressed in future reports by JCPS program evaluation colleagues. How these three programs contribute to student outcomes and how they may interact in their impact is of interest and will be investigated in future research.

The MHC program addresses the need discussed earlier in this report and aligns with the JCPS Strategic Plan, Vision 2015 in the following ways:

Goal 4.2: The district provides safe, well-staffed, and well-resourced schools to support the needs of every student.

"Implement a coordinated system of academic and behavioral supports and interventions for students that is flexible and timely to the needs of each student for optimal success."

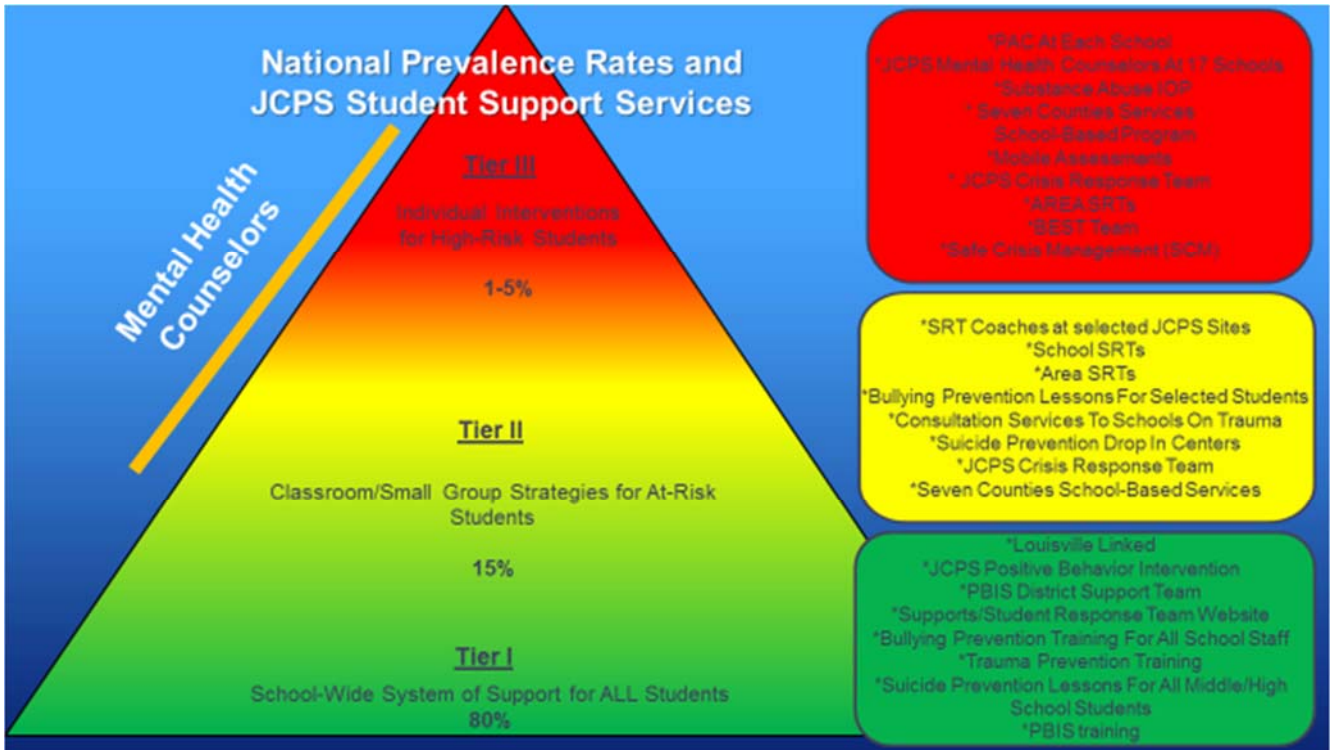


Figure 1. The JCPS Multi-Tiered System of Supports.

Implementation

Fifteen MHCs were hired and assigned in the fall of 2015 to provide services to 17 JCPS locations (9 elementary, 5 middle, 2 high, and 1 combined). However, the MHC at Myers did work with Waggener High School students. Likewise, the MHC at Valley Middle School worked with high school students at Valley High School. A District Positive Action Center (DPAC) was established at Trunnell Elementary School as a pilot to serve 5-6 of the district's most challenged first grade students. Students assigned to DPAC were required to provide their own transportation. The MHC for the DPAC at Trunnell also provided services to Trunnell students. Trunnell served as a transition site for DPAC students ready to assimilate into regular classrooms, at least on a limited basis. Additionally, MHCs were deployed to schools without an

MHC for up to 3 consults by district personnel who screened the requests. Table 2 shows the MHC official assignments for 2014-15.

Table 1 - Mental Health Counselor Locations by Academic Area

MHC LOCATION	LEVEL	Academic Area
Blake*	Elementary	3
Blue Lick*	Elementary	3
Camp Taylor*	Elementary	3
ESL Academy	Combined	5
Farnsley	Middle	1
Gilmore Lane*	Elementary	3
Iroquois	High	2
Klondike	Elementary	4
Myers	Middle	5
Price	Elementary	4
Ramsey	Middle	4
Rutherford	Elementary	2
Seneca	High	4
Thomas Jefferson	Middle	3
Trunnell	Elementary	2
Valley	Middle	1
Wheatley	Elementary	5

**MHC was shared with another elementary school.*

MHC Responsibilities and Qualifications

The MHC positions were advertised on the JCPS website - responsibilities were listed as:

1. Identifies difficulties which interfere with students' attendance, adjustment, and achievement in school by utilizing established school referrals.
2. Consults with referral team when gathering information to identify specific student problems.
3. Contacts parents to obtain signed permission to work with the student and further assess student needs.
4. Provides individual or group counseling for referred students to address specific social/emotional needs and continues to assess student progress.
5. Develops intervention strategies and coordinates with appropriate school, district, and community resources.
6. Works with parents to help increase their understanding and constructive participation in appropriate efforts to help alleviate student's problems.
7. Assesses needs of student population and develops group counseling sessions.

8. Maintains counseling records and statistical data for evaluation purposes.
9. Coordinates with school administration, grant administration, and evaluator to maintain best services and procedures for the needs of the students referred and for the program itself.
10. Performs other duties as assigned by the designated director.

Minimum qualifications were listed as:

1. State credential in School Social Work, School Counseling, School Psychology, Clinical Psychology or Counseling Psychology.
2. Three (3) years successful experience in mental health and/or behavioral counseling with elementary-aged children.

Desirable qualifications included:

1. Master's Degree and credential in Social Work, Psychology, or Mental Health Counseling
2. Experience with family substance abuse counseling, family counseling, and case management
3. Knowledge of local community referral sources

Most of the MHCs hired had a master's degree in social work and a number of MHCs were former employees of the community mental health provider, already providing counseling services in their assigned JCPS school. The DPAC site was also staffed by a nationally certified ECE teacher, two teacher assistants, and a social worker.

Referral Process

Students at MHC locations were referred from a myriad of sources within the school including administrators, teachers, and the students themselves. Students could also be referred from external sources such as a parent/guardian, pediatrician, or clergy.

MHCs were permitted to provide up to three consultations to students at other locations. School personnel made the request using a standardized referral form which was submitted to a District team comprised of the lead psychologist, lead counselor and the student response team coordinator for review. A parental/guardian consent form was signed and received for all students before receiving counseling services.

Data Documentation System

A reporting tool was developed for MHCs to document the various time demands (e.g., administrative meetings, individual student sessions, and parent contacts), services delivered, and students served. MHCs were trained on the system and asked to provide input to the

development/refinement/usability of the tool several times over the course of the year. Specifically, MHCs used drop-down menus to report referral sources, referral reasons, visit types, and intervention techniques. The home page for the MHC reporting tool appears in the Appendix.

Professional Development

MHCs received professional development (PD) monthly throughout the year from experts within and outside of JCPS. JCPS also provided requested reference/training materials and funding to attend local conferences. Topics included crisis response, motivational interviewing, and trauma.

Evaluation Approach

2014-15 was the pilot year for the MHC initiative. Stakeholders were provided data on a regular basis throughout the year to monitor processes and support program improvement. Hence, the data for this year is formative in nature, addressing the following four evaluation questions:

- How many students were served during the school year?
- What were the most common reasons for internal/external referrals?
- What services were delivered?
- What were implementation challenges?

Data addressing outcome indicators such as attendance and behavior during the summative phase of the evaluation (Years 2 – 5) will be reported in future reports. Figure 2 below shows the focus of data collection and analyses for the MHC pilot year.

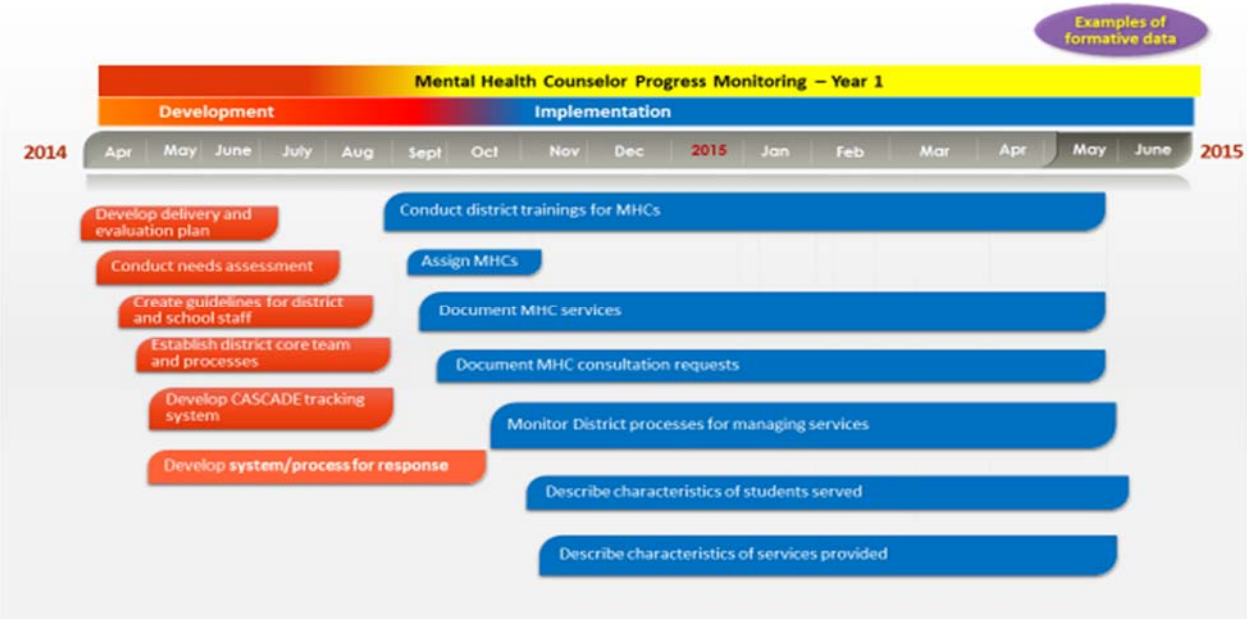


Figure 2. Evaluation approach for pilot year of Mental Health Counselor Program.

PRELIMINARY FINDINGS

Formative evaluation data for the MHC program was shared on a regular basis with key program stakeholders (e.g., Chief Academic Officer, Assistant Superintendent, MHC program management staff, and MHCs). In addition, end of year data was shared with the Superintendent and Board of Education. Originally, a separate evaluation of the DPAC was planned. However, it was determined last spring that the DPAC would not be continued in its current configuration. However, since there were only seven students who attended the DPAC, there are FERPA concerns which limit what can be reported. The majority of students were assessed as eligible for ECE status, and the majority were either placed in an alternative school or self-contained classroom.

Student Demographics

The demographic composition of students who received services from the MHCs was:

33% White	**45%** Female
50% Black	**55%** Male
12% Latino	**90%** F/RL
15% LEP	**19%** ECE

Further analyses showed that the most frequent need was seen with black males who comprised 27% of the students. Forty percent of the students were middle school students, 37% were Grades K – 5. A map of Jefferson County shows the distribution of student resides locations for students receiving MHC services. Figure 3 shows a map of MHCs locations and concentration of student clients by resides address – of course, the concentration is confounded by the availability of MHCs in that area. The map shown in Figure 4, however, does show that the MHCs were placed to a large extent, in areas in the county with the greatest need.

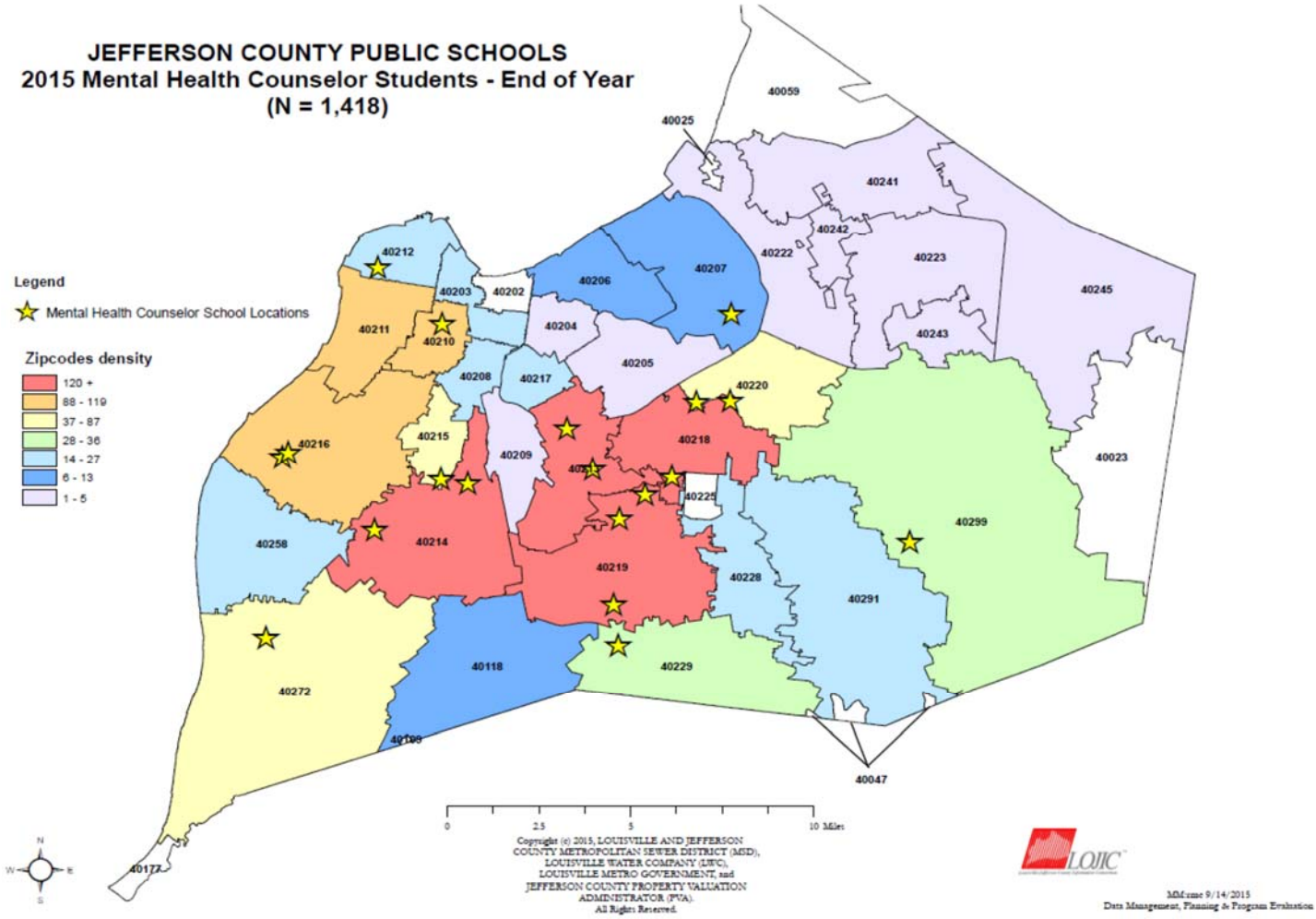
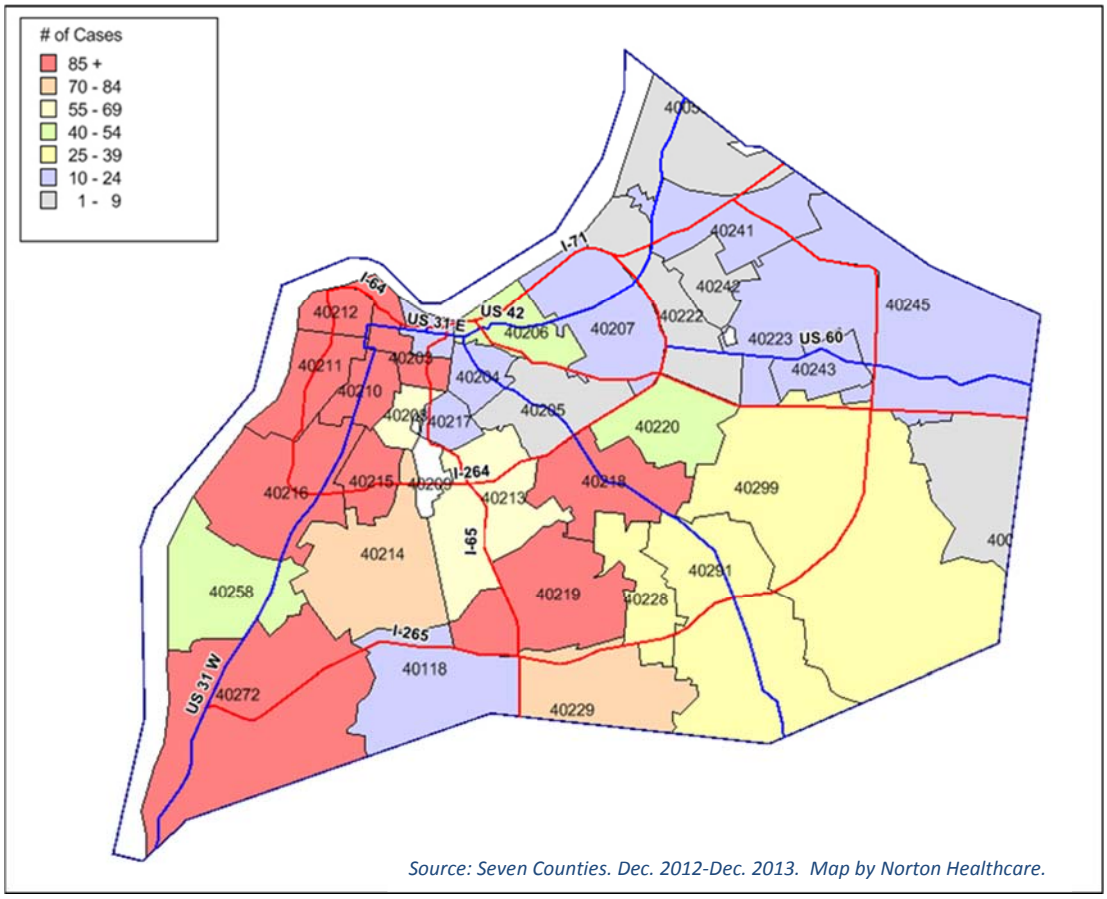


Figure 3. Map of JCPS MHC client addresses and MHC locations.

Services Provided

The map below shows density of Seven County caseloads for “conduct disorders” with all children residing in Jefferson County. It is interesting to note that the placement of MHCs coincides with the highest prevalence rates of conduct disorder for the county. Of the nine highest zip codes for diagnosed conduct disorder cases, seven are zip code areas where MHCs are located in at least one school.



Source: Seven Counties. Dec. 2012-Dec. 2013. Map by Norton Healthcare.

Figure 4. Prevalence of youth cases for conduct disorder treatment by community mental health provider.

Fifteen MHCs were assigned to 17 locations (9 elementary, 3 middle, 2 high, and 3 combined schools). In all, 1600 students were provided 9,889 sessions. The most common reasons for contact were:

17%	Anger
10%	Oppositional Defiance
10%	Peer Relations
10%	Anxiety
8%	Disruptive Behavior

There were 161 cases of self-harm or suicidal behavior. A total of 31 reasons were listed for contact and most records contained multiple reasons.

MHCs documented 17 types of therapeutic services which included 428 scheduled family/collateral sessions and 9 home visits. MHCs made 32 calls to Child Protective Services. The most common therapeutic techniques were:

13%	Cognitive-Behavioral
13%	Solution-Focused
9%	Group Therapy
9%	Coping Skill Development
8%	Behavior Motivation

The number of MHC sessions varied by month of the 2014-2015 school year, with sharp peaks in January, February, and March. In fact, 41% of the 9,889 sessions were provided during those months (see Figure 5).

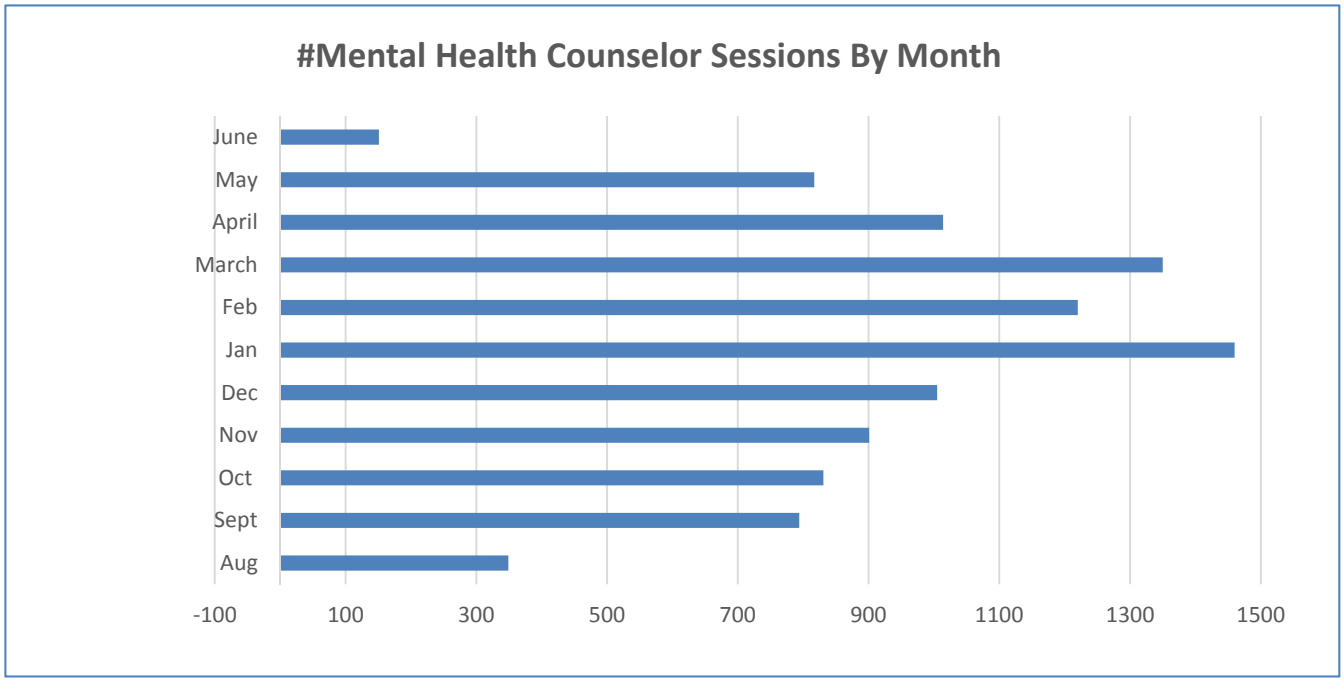


Figure 5. Mental Health Counselor Sessions by Month.

Schools without an assigned MHC were permitted to request up to 3 visits for a student. There were 44 requests from 25 locations. Figure 6 shows that requests peaked during November but were relatively stable the rest of the school year.

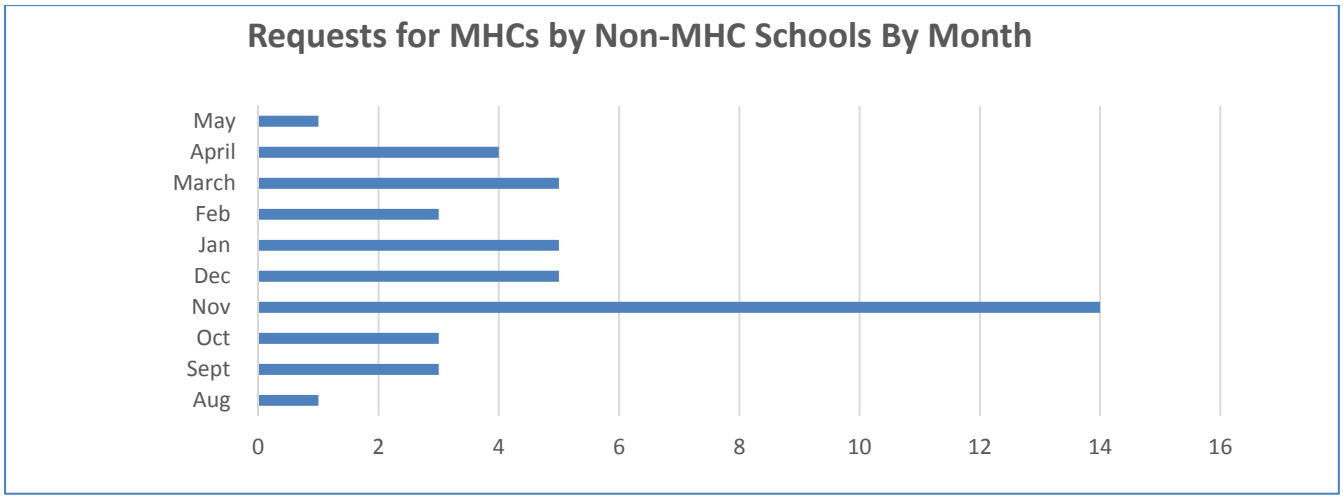


Figure 6. MHC requests by non-MHC schools by month.

Survey Results

MHCs were administered an on-line survey in the spring of 2015. Fourteen of the fifteen MHCs completed the survey. MHCs were asked to comment on how they spend their time, main challenges to doing their job, satisfaction with professional development for the year, and needed resources. MHCs indicated that they mostly spent their time last year: (a) collaborating with school personnel, (b) providing individual sessions, and (c) providing non-crisis interventions. Comments regarding challenges centered on: (a) large caseloads, (b) assignments not related to main job duties, and (c) needing more family contact. Twelve of the MHCs agreed or strongly agreed that the profession development received in the past year was effective in helping them do their job. MHCs requested the following resources:

- Ready-made curriculum for school groups
- Additional time to collaborate with other MHCs
- PD to help learn the language of teachers
- Additional training on specific techniques

Fifteen of seventeen principals responded to a survey administered in the spring of 2015. Principal ratings of the effectiveness of their MHC are shown in Figure 7. 93% of principals rated their MHC as “Very Effective” or “Totally Effective”. When principals were asked about needed MHC resources, they requested:

- Notification from other schools about incoming students with mental health issues
- Access to help outside of school for families and students
- Additional PD on PBIS and SRT

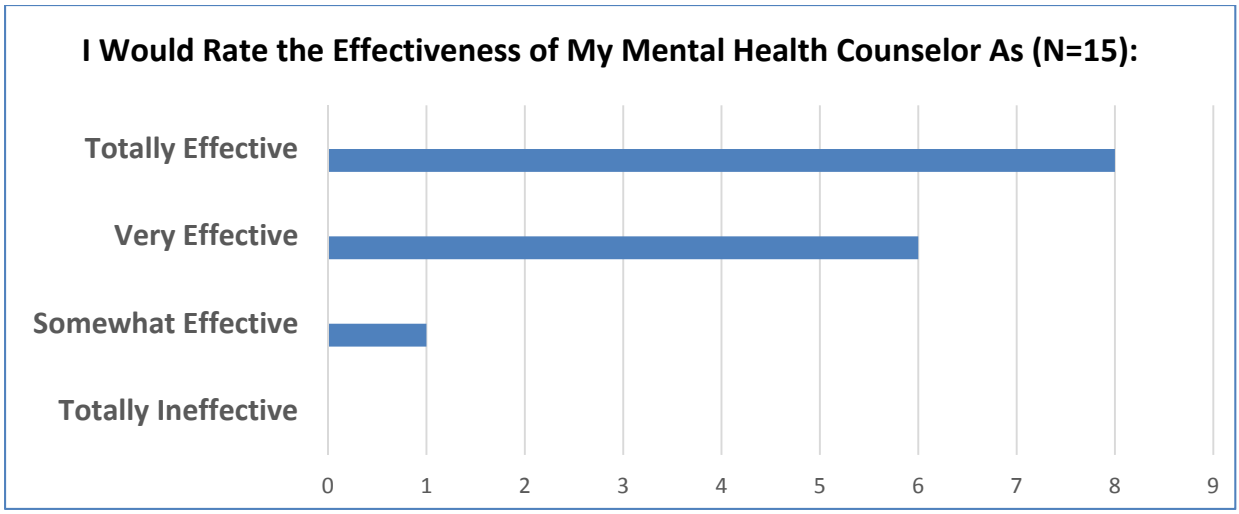


Figure 7. Principal ratings of MHC effectiveness.

Beginning in 2011, teachers in Kentucky public schools have completed the state administered TELL survey every two years. The survey has nine constructs: (a) Community Support and Involvement, (b) Facilities and Resources, (c) Instructional Practices and Support, (d) Managing Student Conduct, (e) Professional Development, (f) Teacher Leadership, (g) Time, and (h) Overall.

Table 2 below shows a comparison of responses for schools with MHCs to the overall responses for JCPS. The 17 MHC sites outgained the district on three constructs (i.e., Community Support and Involvement, Managing Student Conduct, and Time) and kept pace with the district on another (Facilities and Resources). The top five positive item differences are highlighted in green while the top five negative item differences are highlighted in red. It's interesting to see that all item differences for "Managing Student Conduct" show positive differences for the MHC schools. The constructs of "Time" and "Community Support and Involvement" also favored the MHC schools. The constructs "School Leadership" and "Teacher Leadership" require deeper analysis by program stakeholders.

Cost

The district spent approximately $662,000 from the general budget to provide 15 MHCs to 17 locations for the 2014-2015 school year. A rough estimate of cost per student only includes the number of actual students who directly received session-based services (i.e., 1600). This equates to a cost of $414.81 per student or $66.91 per student session. This does not account for time that MHCs spent on required tasks that did not result in direct student services. Another consideration is that it is likely that the benefit of MHCs extends beyond the students who received session-based services. Improvements to the learning climate for teachers and

students as a whole most certainly has a value not reflected in this analysis. Future analyses will assess such benefits.

Table 2 - 2013 vs. 2015 TELL Survey Difference Scores

TELL CONSTRUCTS (Greatest MHC vs. District Item Differences)	MHC 2013 VS. 2015 DIFFERENCE SCORES	JCPS 2013 VS. 2015 DIFFERENCE SCORES
Community Support and Involvement*	**3.1**	**1.3**
Community members support teachers, contributing to their success with students.	**4.9**	**1.3**
Parents/guardians support teachers, contributing to their success with students.	**10.0**	**4.1**
The community we serve is supportive of this school.	**5.8**	**1.3**
Facilities and Resources	**1.5**	**2.0**
Instructional Practices and Support	**-0.9**	**0.4**
Managing Student Conduct**	**1.7**	**-0.9**
Students at this school follow rules of conduct.	**5.2**	**-0.5**
Overall	**-3.1**	**2.2**
Professional Development	**-3.2**	**-1.0**
In this school, follow up is provided from professional development.	**-7.9**	**-1.7**
School Leadership	**-3.1**	**-0.1**
Community support and involvement	**-7.5**	**-0.3**
Facilities and resources	**-6.7**	**-0.8**
Teacher Leadership	**-3.4**	**-0.7**
Teachers are recognized as educational experts.	**-6.4**	**-0.2**
Teachers are relied upon to make decisions about educational issues.	**-5.7**	**-0.2**
Time*	**2.8**	**1.8**
Class sizes are reasonable such that teachers have the time available to meet the needs of all students.	**10.4**	**3.2**
Grand Total	**-0.9**	**0.2**

*Majority of MHC school items outgained District. **All MHC school items outgained district.

CONCLUSIONS AND RECOMMENDATIONS

The mental health needs of today's youth have been demonstrated both nationally and locally. School districts are often looked to as a logical provider of mental and physical health services since there is a critical mass of youth who spend their days in school buildings. Beyond that logical argument - schools have a vested interest in having students with optimal social, emotional, and physical well-being since scores of research studies have demonstrated connections between these factors and educational outcomes. JCPS has been addressing these needs in many of its high need schools by collaborating with the local community mental health organization (i.e., Seven Counties) to provide in-house mental health services, Spalding University, and the University of Louisville Psychology Department. (JCPS also provides school nurses in many of these same schools.) Unfortunately, financial reimbursement is only available for Seven Counties services provided to students who qualify for Medicaid and the capacity of available services to meet the needs of an entire school is often inadequate.

This pilot year evaluation of the MHC program focused on formative outcomes which inform implementation and program "tweaks" that provide a cycle of continuous improvement. The evaluation is challenged by the likelihood that traditional student outcome measures may not demonstrate the value of services for individual students receiving MHC services during the same school year. For instance, many students referred to a MHC may be in a critical (negative) behavior/academic cycle that will take more than a portion of one academic year to show improvement. Therefore, a long-view of this program must be taken when assessing program value. What we can say about the pilot year MHC data is that clearly MHCs are perceived to be of high value by school principals. In fact, several new schools committed their own funds for a MHC during the 2015-2016 school year. MHC survey data showed several suggestions for improvements and program management has addressed each request. TELL data shows at least some promise for MHC schools in behavior management, community support, and time.

Recommendations for the program include:

1. Monitor implementation to ensure that MHCs are only tasked with relevant job duties.
2. Adopt a research-based universal social-emotional program such as Second Steps to proactively address the needs of all students and possibly narrow the flow of students to Tier 2 and/or Tier 3 status.
3. Investigate and consider a research-based universal screening assessment to identify students before behaviors present learning obstacles.
4. Strengthen ability of parents/guardians to manage and support student needs at home.
5. Identify funding sources to sustain and expand MHC services if the Year 3 evaluation outcomes substantiate program effectiveness.

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APPENDIX –Mental Health Counselor Log Entry Screen

Record Type

Student School Classroom

Student Info

School:

First Name: Last Name:

Search

Camp Taylor Elementary

Session Date:

< September 2015 >

Sun	Mon	Tue	Wed	Thu	Fri	Sat
30	31	1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	1	2	3
4	5	6	7	8	9	10

Session Length:

Visit Type: Choose

Referral Source: Choose

Reason For Contact:

Absenteeism
Anger
Anxiety
Appetite Disruptions

Intervention: Choose

NOTES: