School Behavioral Health Support for Army Children and Families

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The Challenges

- Lack of Behavioral Health System of Care for Children and Families
- Inadequate TRICARE resources in most areas near installations
- Effect of War/Deployment on Children and Families
  - 1 of 3 school-aged child at risk for psychosocial problems (About 30% of children with significantly increased anxiety)
  - Children 3 years and older have significantly more behavioral problems
  - Increases in Child Maltreatment
  - Increases in Youth referrals

TAMC—89/326 (27%) related to OIF and/or OEF
Schofield—126/206 (61%) related to OIF/OEF

2. Lester et al, 2009
4. Faran and Saito, unpublished
5. Batzer and Devera, unpublished

Mission Statement

As an integral part of the Army’s force generation and deployment processes, the Proponency supports and sustains comprehensive and integrated behavioral health systems of care for Military Children and their Families at installations throughout the Army.

Objectives

- Coordinate assets (Military and civilian) to develop comprehensive/integrated behavioral health systems of care
- Build capacity and decrease barriers to care (single portal of entry - CAFAC) with focus on prevention and building resiliency
- School Behavioral Health Programs (SBH) to improve access, reduce stigma, and promote resilience
- Train primary care providers in evaluation and treatment of common behavioral health disorders, to include suicide risk assessment and provide timely consultation backup
- Reduce stigma and promote “health seeking behavior” through Command and community support, active marketing, and education
- Provide repository of expertise for evidence-based interventions for Military Behavioral Health
Short Term Plans

• Build Models of total Behavioral Health Care at large deployment installations
• Develop Academies of School Behavioral Health at TAMC and of CAFAC at Schofield
• Train Primary Care Managers at these posts
• Sustain Stigma reduction while enhancing prevention & resiliency programs
• Available for consultation and administrative assistance to all installations

Targeted Outcomes

• Improved Customer Satisfaction
  - Easier access to high quality, integrated BH care
• Improved Clinical Outcomes
  - Increased BH outpatient visits
  - Decreased psychiatric hospitalizations
  - Care management for difficult BH cases
  - Decreased utilization of global medical services
• Fewer, family-related behavioral health OIF/OEF evacuations
• Healthier Sustainable Culture for Army Families

Goals and Outcomes:

School Mental Health Program

OVERARCHING: Develop best practices for School Behavioral Health that include prevention, early identification and intervention

• STUDENT LEVEL, e.g., decreased absences, improved academic performance, fewer behavior problems
• FAMILY LEVEL, e.g., increased cohesion and functioning, decreased family violence, enhanced Soldier readiness
• SCHOOL LEVEL, e.g., decreased aggressive incidents, improved climate, better performance
• MILITARY/COMMUNITY LEVEL—Develop Resiliency and Mental Wellness

Model Improves Access

Introduce to other posts

1. Patients call ONE number = 555-6600
2. Call answered by credentialed provider = 24/7

Rapid Triage

Peds
ACS
Behavioral Health
Chaplain
Social Work
Substance Abuse

Army School Behavioral Health Programs

• Schofield Barracks Hawaii
• Fort Campbell Kentucky
• Fort Meade Maryland
• Fort Lewis Washington
• Baunholder Germany
• Grafenwoehr Germany
• Fort Carson Colorado
• Future Installations
The Proposal Process of A SBH Program

- Proposal Prepared By the MTF
- MOA Signed
- MTF:
  1. Identify Staff Requirements
  2. Prepare MOA for School District
  3. Initiate Proposal
  4. Identify facility requirements with IMCOM

School District / SLO:
- FRAGO to Impacted Schools
- Identify School Requirements
- SIGN MOA with MTF

Proposal status tracked by CAF-BHP
- Approved
  - BY MTF
  - Approved BY RMC

- Submit Proposal To MTF (30 days from site visit)
- Proposal Submitted to RMC (1wk)
- Proposal submitted to MEDCOM (1wk)

CAF-BHP Actions
- MTF/IMCOM/Other Actions

SBH: Organizational Structure
- Advisory Board: Regional. Provides overall guidance and direction, Quality Assurance
- Advisory Group: At each school. Provides specific advise to the SMH program, policy development, PI. Ensures effective collaboration of all care providers.
- Triage Team: At each school. Responsible for clinical case/problem review – referral, management, monitoring.
- Prevention, Training and Education

Advisory Group and PAT
- Stakeholders
  - Principal
  - District Representative
  - Parent
  - Military School Liaison
  - Army Community Service
  - School Behavioral Health
  - Director School BH
  - Community Leaders

Schofield Barracks Hawaii: Evaluation Data
Age Distribution of SMHT Cases - 2009

Diagnostic Characteristics of SMHT Cases (Primary Dx; At DEC 2009)

Note: Does not include cases w/o Axis 1 Dx, or V-code

Clinical Outcomes:
Strengths and Difficulties Questionnaire (SDQ)

Clinical Outcomes: “Customer” Satisfaction, Impact on Functioning

<table>
<thead>
<tr>
<th>Topic</th>
<th>Response</th>
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<tbody>
<tr>
<td>satisfied with the service</td>
<td>100%</td>
</tr>
<tr>
<td>services met needs</td>
<td>100%</td>
</tr>
<tr>
<td>Impact of the service on:</td>
<td></td>
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<tr>
<td>relationships in my family</td>
<td>4.27</td>
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<tr>
<td>emotional functioning of family members</td>
<td>4.15</td>
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<tr>
<td>management of home/work responsibilities for the non-active duty</td>
<td>4.35</td>
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<tr>
<td>parent</td>
<td></td>
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<tr>
<td>adjustment to deployment of the active-duty parent</td>
<td>4.12</td>
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<tr>
<td>management of my family’s stress</td>
<td>4.24</td>
</tr>
<tr>
<td>emotional functioning of my child or children</td>
<td>4.32</td>
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N = ~30
Clinical Outcomes: Satisfaction with Group Programs

<table>
<thead>
<tr>
<th>Workshop Title</th>
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<tr>
<td>Resilience Workshops</td>
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</table>

**Additional Programs**

- School Behavioral Health Academy
- Family Readiness Group (FRG) BH Support
- Several Outreach Programs

**Mission of the School Behavioral Health Academy**

- To ensure standardization of evidenced-based procedures and practices of school behavioral health programs Army-wide.
- To demonstrate a “Community of Practice” model to provision of care.
- To integrate family, school, military, and community systems.
- To harness diverse stakeholders who are committed to a continuum of resiliency, prevention, and care, and to improve behavioral health outcomes for military children and families.

**5-Day Academy**

- Day 1: Critical Steps for Set Up of the School Behavioral Health Team
- Day 2: Organization and Staffing of School Behavioral Health, Administration & Oversight
- Day 3: Administrative Overview: Managing the Program, and Clinical Services in Schools
- Day 4: School on-site Training
- Day 5: Practice Issues, Use of Technology, Record Keeping, Metrics, Operational Procedures

**Evaluation Results**

January 2010

- I have a template for collecting needed data (100%)
- I have an understanding of the need for prompt, accurate admin. oversight (100%)
- I can identify the basic functions of an Advisory Board, Advisory Group & Triage Team (92%)
- I can identify fundamental tech. tools for school mental health processes/personnel (92%)
- I can identify 3 components of the School Mental Health Quality Assessment Questionnaire (92%)

**Evaluation Results, cont’d**

- I can name the overarching philosophy regarding the administration of the program (83%)
- I can understand key differences between traditional clinical services delivery and providing school mental health services (83%)
- I will be involved in discussion regarding clinical team building (83%)
Evaluation Results, cont'd

- I can identify the steps in developing a school mental health program (75%)
- I can identify common obstacles, difficulties, in developing a SMH program (75%)
- I have strategies in mind for enhancing the interagency & interdisciplinary teamwork in my SMH program (75%)
- I can identify common pitfalls/potentials (75%)
- I know where to turn for assistance in my own environment (75%)
- I have learned about and have a basic understanding of the current model for a quarterly report (75%)

Key Points

- Command involvement is essential
- Community Outreach must be included
  - Providers must receive evidenced-based intervention:
  -  education
  -  Coaching
  - AND EBPs must be adapted for use with military youth and families
- Collaboration with other agencies is fundamental
- Stigma must be continuously addressed
- Resources must be under single command and control

Questions

References

2. Lester et al, 2009
4. Faran and Saito, unpublished
5. Batzer and Devera, unpublished