



Mountain Plains (HHS Region 8)

**MHTTC**

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration



# Promoting Positive Mental Health in Rural Schools

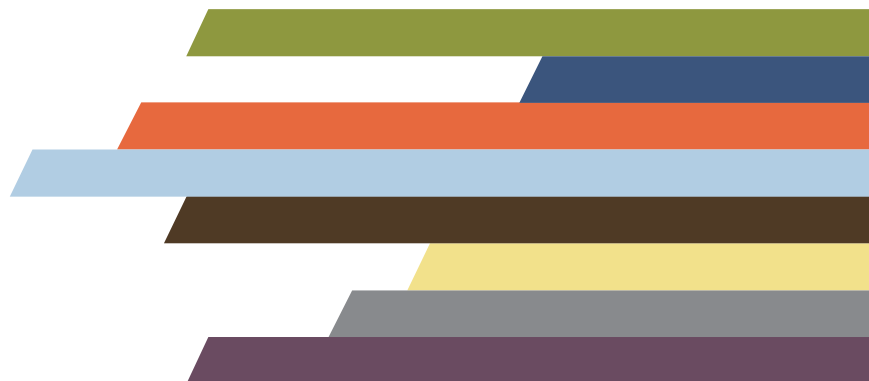
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# INTRODUCTION

*School administrators, faculty, and support staff are facing increasing pressure to respond to a host of unmet mental health needs of students in K-12 and higher education.*

In response, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded funding to the Mountain Plains Mental Health Technology Transfer Center (MHTTC) to provide additional mental health training and technical assistance to school personnel. Additionally, SAMHSA and the Centers for Medicare and

Medicaid Services (CMS) recently released a resource<sup>1</sup> to assist states and schools in addressing mental health and substance use disorders. Underscoring the purpose of the document was a recognition that schools and communities often lack “comprehensive treatment and services for children and youth.” That is particularly true in rural

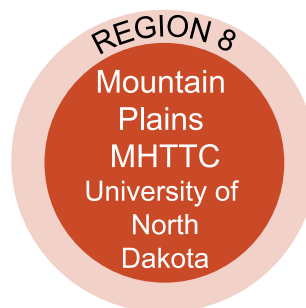
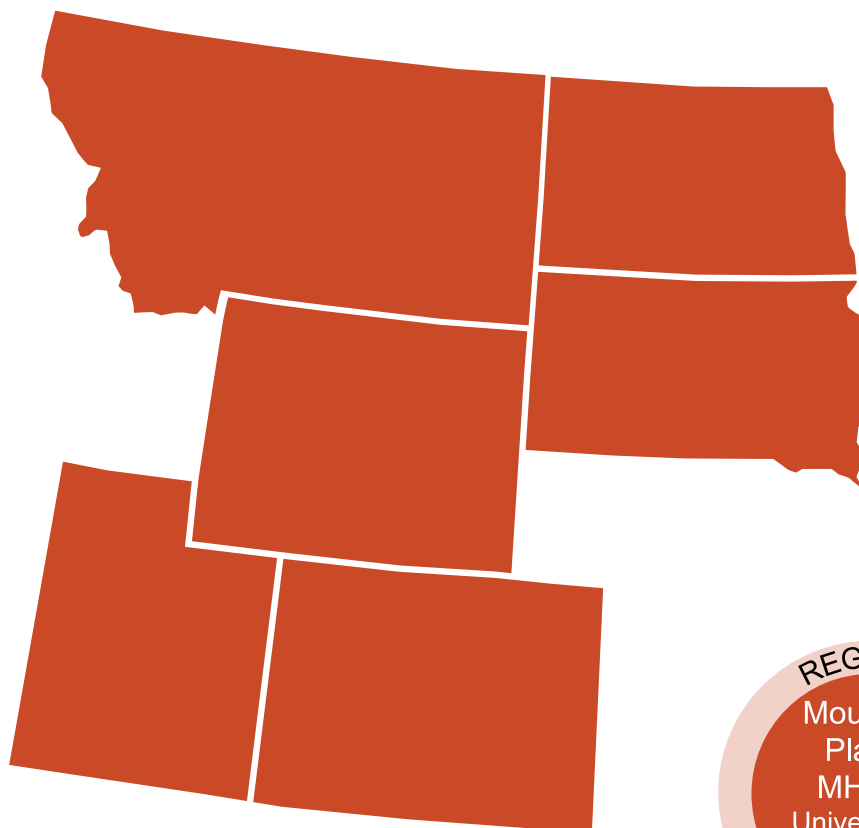
communities. This guide provides resources specific to addressing the unique mental health training and technical assistance needs of schools serving rural and remote communities.

## MOUNTAIN PLAINS MENTAL HEALTH TECHNOLOGY TRANSFER CENTER

Mountain Plains MHTTC serves Health and Human Services (HHS) Region 8, which includes the states of Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming.

The primary focus of the Region 8 MHTTC is to provide training, resources, and technical assistance to individuals serving persons with mental illness, including mental health providers, leaders, and educators.

Special attention is given to developing resources for those who serve persons with serious mental illness or a serious emotional disturbance.



# RURAL MENTAL HEALTH

*Each Mental Health Technology Transfer Center (MHTTC) has a specific area of emphasis.*

SAMHSA was responsive to the request that Mountain Plains MHTTC support rural mental health as their area of emphasis. The objective is to ensure that developed training and technical assistance takes into consideration the unique attributes of rural communities, as well as the barriers these populations face in accessing and utilizing mental health services.

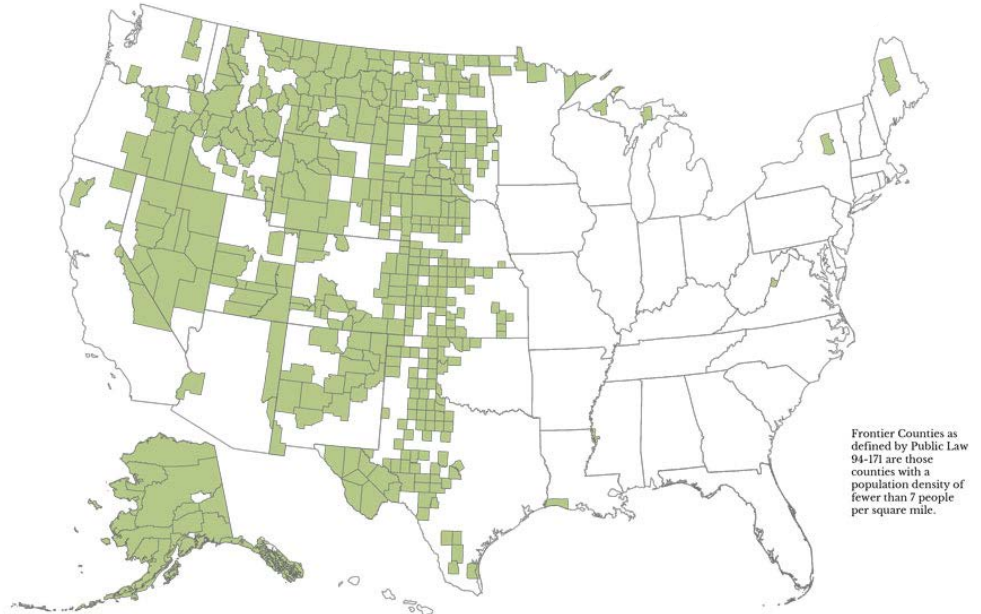
## DEFINING “RURAL”

*There are more than three dozen federal and state definitions of rural areas.<sup>2</sup>*

Applying one definition to “rural” is complicated by changing community demographics, urban sprawl, and diverse geographies.

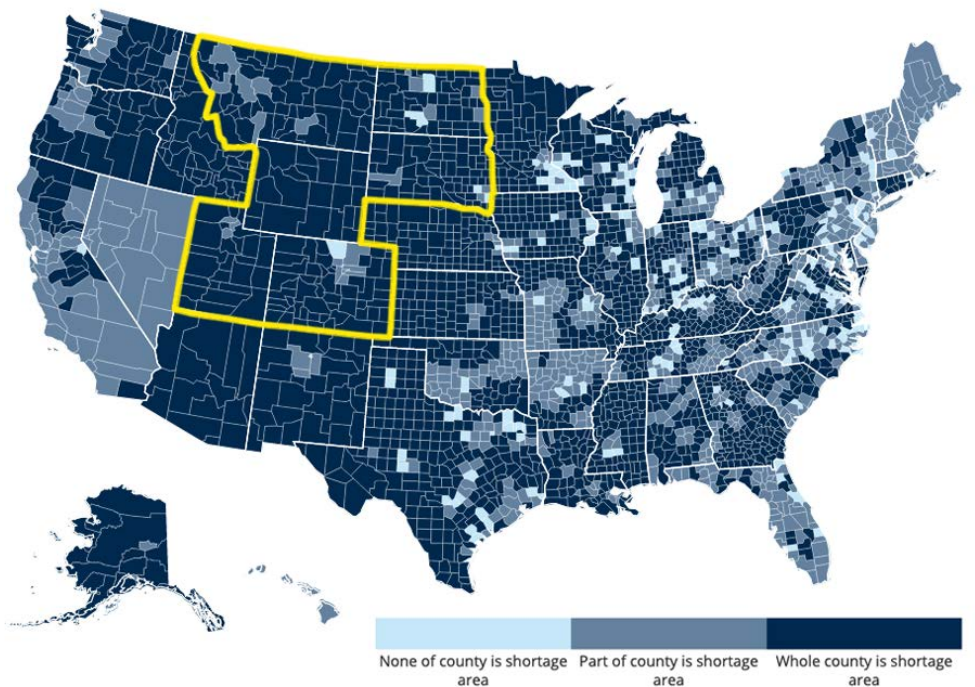
Regardless of the definition, rural areas are commonly characterized by a combination of low population density (sparseness), isolation (distance from an urban center), and small size (total population).<sup>3</sup>

### FRONTIER COUNTIES (FEWER THAN 7 PEOPLE PER SQUARE MILE)



\*Note: Alaska and Hawaii not to scale  
Source(s): U.S. Census Bureau, 2010 Decennial Census, Summary File 1

### HEALTH PROFESSIONAL SHORTAGE AREAS: MENTAL HEALTH, BY COUNTY



# RURAL BARRIERS



*Rural barriers to mental health services are commonly summarized within three categories: accessibility of services, availability of services, and acceptability.<sup>4</sup>*

## MOUNTAIN PLAINS MHTTC'S RURAL MENTAL HEALTH FOCUS AREA

*The six states served by the Mountain Plains MHTTC are predominantly rural in nature and have a significant proportion of their counties identified as “frontier” under public law. Frontier communities are those reporting fewer than seven people per square mile.*

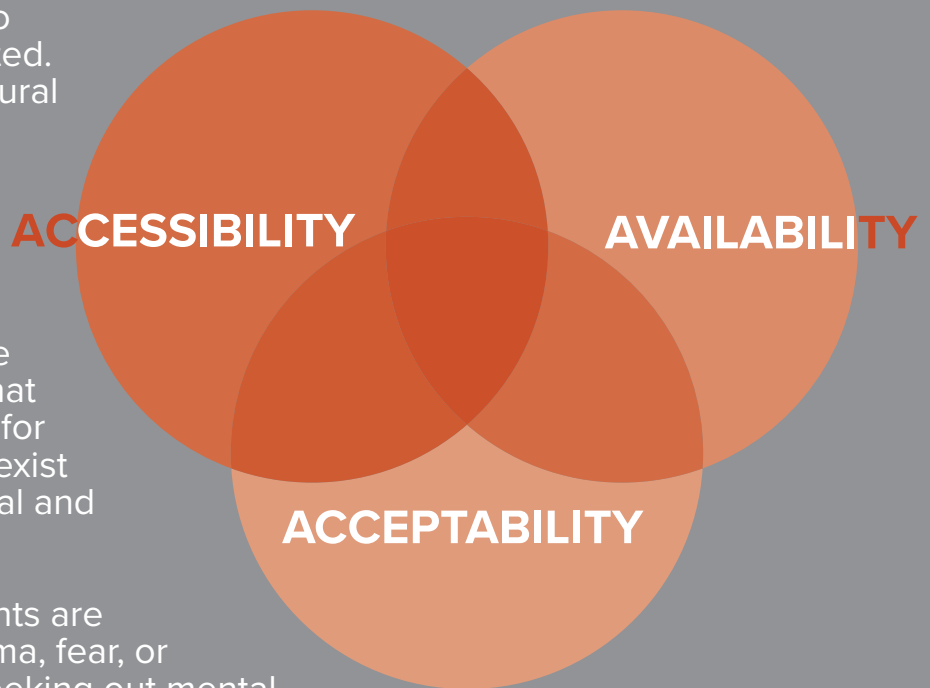
The Mountain Plains MHTTC team acknowledges the unique barriers facing rural communities and understands that rural communities cannot always utilize resources or trainings developed for meeting the needs of individuals with mental illness. Oftentimes the resources and guides omit discussion of the distinctive obstacles present in rural areas. For example, rural mental health programs, community members, and mental health care providers must address perceptions of stigma that arise in rural areas because of denser social networks.

Additionally, evidence suggests that rural populations have a more difficult time recognizing the signs and symptoms of various mental illnesses, which amplifies issues of behavioral healthcare access.<sup>5</sup> Similarly, students attending schools in rural and remote communities likely lack access to behavioral healthcare services, leaving schools as an integral component to addressing mental health concerns of youth.

**Accessibility** – Rural residents may have limited access to mental healthcare due to cost of services, insurance coverage, and lower behavioral health literacy, which allows mental health concerns to go unrecognized and/or untreated. The remote nature of living rural typically requires residents to travel long distances to receive services.

**Availability** – County-Level Estimates of Mental Health Professional Shortage in the United States report that higher levels of unmet need for mental health professionals exist in counties that are more rural and have lower income levels.

**Acceptability** – Rural residents are likely to experience self-stigma, fear, or embarrassment related to seeking out mental healthcare due to internal beliefs, or may not recognize symptoms as mental illness.



## THE RURAL SCHOOL AND COMMUNITY

*Rural communities are diverse and their culture is shaped by many factors including weather, primary options for employment, heritage, access to health and behavioral healthcare, and proximity to urban areas to access goods and services.*

The subject matter in this resource guide examines the complexities of working with rural students who may have a mental illness. A hypothetical case scenario is included to address some of the potential rural barriers impacting access to mental health services for youth.

*Obstacles faced by rural school systems and educators in serving students with mental health disorders include:*

- DISTANCE BETWEEN SCHOOL AND SERVICES
- LACK OF AVAILABLE PROFESSIONAL STAFF
- LACK OF FUNDS
- ISOLATION
- LACK OF INSTRUCTIONAL TIME FOR STUDENTS
- BREADTH OF CURRICULUM
- RECRUITMENT AND RETENTION OF SCHOOL STAFF
- COMPUTER TECHNOLOGY ACCESS
- PARENT INVOLVEMENT<sup>6</sup>



# CASE SCENARIO



**ERIC**

**AGE 14  
GENDER M  
3 SIBLINGS**

THE CASE OF ERIC WAS DEVELOPED BY THE AUTHORS TO ILLUSTRATE THE CHALLENGES OF RURAL SCHOOL MENTAL HEALTH. IT IS NOT BASED ON A PARTICULAR CHILD, BUT IS A COMPOSITE OF ISSUES RURAL YOUTH MAY FACE.



## ERIC DEMOGRAPHICS

(SCENARIO)

Eric is a 14-year-old male living in a rural community with a population of 200. No access to a library or park exists in this community.

He is in ninth grade, enrolled in a geographically remote school that serves youth K-12. His parents work at temporary jobs that pay hourly wages. Eric has three siblings aged 10, 8, and 6.

## REMOTE SCHOOLS

(SCENARIO)

*Eric travels by bus to a school located 32 miles from his home. The school is largely isolated and in an unpopulated area.*

The student body and population is the result of a rural school consolidation and consists of individuals from three surrounding rural communities.

This consolidation was necessitated by decreasing student enrollment in each of the three participating communities, making it financially impossible to sustain a school in each town.

## KEY ISSUES AND TOOLS FOR IMPLEMENTATION

- Schools are considered remote if they are located 25 miles from an urban center.<sup>7</sup>
- Turnover among educators and administrators is problematic for many schools, but particularly for remote and rural schools because faculty salaries are much lower than those of their urban counterparts. In addition, the community amenities are not as extensive and the pool of applicants is often limited.<sup>8</sup>
- Federal educational policy is typically not designed with a solid understanding among policymakers regarding the unique needs of rural areas. This problem is underscored by Gallo & Beckman in their conclusions regarding the general lack of understanding of the needs of rural schools and the distinctive circumstances that are not taken into consideration during policy development.<sup>9</sup>





## TEACHER RETENTION (SCENARIO)

*Eric's school has significant problems with recruitment and retention of teachers, experiencing turnover rates of 26% per-year due to resignations and terminations. Teachers frequently leave to teach in more urban areas with increased social amenities and a work place with more supports. Additionally, the pool of applicants is typically very limited due to unwillingness of teachers to live in a rural setting.*

Hiring qualified people with experience is more difficult, often resulting in terminations and departures. Teacher turnover is a problem for Eric and other students in the school, disrupting social relationships and trust.

It is important for students to have routine, which includes continuity in instructors and curriculum implementation. Rural students spend a significant amount of time with their teachers, and these educators are on the front lines.

The literature is clear that strong teachers are the most important element to ensure students' academic success – not only in school, but also in the future, as they transition into adulthood.

This is more important in rural school districts, as instructors often work across all grades, are acquainted with the students long-term, and are instrumental in the identification of the need for mental health services.

## KEY ISSUES AND TOOLS FOR IMPLEMENTATION

*Preparation for employment in rural schools requires specialized teacher awareness in pre-service and considerations relative to retention of teachers and school administrators. This includes an understanding of the difficulties rural communities face in recruitment and retention of teachers (particularly in the STEM areas) and requires policy change on a federal, state, and local level.<sup>10</sup>*

Some rural schools have adopted creative measures to enhance recruitment and retention that are successful and replicable, including:

- Providing additional salary incentives to work in a rural community
- Opportunities for on-the-job training to advance skills to instruct in areas of need – in particular, STEM
- Ensuring appropriate leadership supports, professional development, and access to mentoring and coaching
- Providing autonomy, flexibility, and adequate instructional resources
- Ensuring a positive school culture
- Offering accessible child care and housing as part of the faculty contracts
- Student loan forgiveness including use of federal programs



# WORKING POOR FAMILIES (SCENARIO)

*Eric's family personifies the problems of the working poor. Both parents are employed at low-wage jobs that are located more than an hour round-trip from their home.*

The family resources are reliant on the price of gasoline and the dependability of their vehicles. Consequently, both parents hold a second part-time job at the local convenience store to supplement their income and to meet their basic family needs.

Still, their combined income for a family of six is at 125% of the poverty level. Their dream for Eric, their oldest child, is for him to attend college as a first generation college student.

## KEY ISSUES AND TOOLS FOR IMPLEMENTATION

- Residents of rural communities are more at risk of living in poverty than their urban counterparts. In 2017, 22.8% of rural children in the United States were poor, compared to 17.7% of urban children. Rural parents often work multiple jobs to make ends meet.
- Local school personnel who understand the impact of poverty on youth is critical. Poverty also contributes to teacher turnover.<sup>11</sup>
- Rural households report a lower median income than urban. In 2010, rural adults were more likely than urban adults to begin the year with incomes below 138% of the federal poverty level.<sup>12</sup>
- Given the current family income and size, Eric qualifies for the National School Lunch Program (and Commodity School Program), School Breakfast Program, Special Milk Program for Children, Child and Adult Care Food Program, and Summer Food Service Program.
  - » *Guidelines change for these programs on a yearly basis and can be found at [Child Nutrition Programs - Income Eligibility Guidelines](#).<sup>13</sup>*
- Depending on the state of residence, the family may qualify for Medicaid/Children's Health Insurance Program (CHIPs).<sup>14</sup>
- A care manager can serve as a navigator to resources for this family, providing assistance with an application to the Supplemental Nutrition Assistance Program (SNAP) and CHIP. The resource can be found through the local social service area community action agency or a secular or non-secular private human service center; however, it may require travel by the behavioral health care manager to the rural area.

# 125% JUST ABOVE THE POVERTY LEVEL

## KEY ISSUES AND TOOLS FOR IMPLEMENTATION (CONTINUED)

- Each school should have access to a local provider that can serve as a care manager to provide hands-on assistance to families. The Advanced Integrated Mental Health Solutions website provides materials that are a useful resource in a host of considerations surrounding school mental health and information regarding a behavioral health care manager's role in expanding access to services for rural families.<sup>15</sup>
  - Funding may include Medicaid benefits available under state plan authority, including benefits required under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit; Medicaid demonstrations and waivers, such as Section 1115 demonstration projects and Section 1915(c) home and community-based services (HCBS) waiver programs; Section 1915(i) HCBS available under the state plan; and non-Medicaid authorities, such as the Individuals with Disabilities Education Act (IDEA) and Title I of the Elementary and Secondary Education Act, as amended by the Every Student Succeeds Act (ESSA).<sup>16</sup>
- While these resources can be difficult to maneuver in term of access, each state has experts on behavioral health that understand funding streams in your behavioral health/mental health/substance use disorder/Medicaid Administration.

## CHILDCARE ISSUES

(SCENARIO)

*Eric's parents are not able to afford childcare for his three younger siblings (ages 10, 8, and 6), so Eric is their provider after school and in the summers. Eric cannot participate in after-school activities due to his responsibility to provide childcare.*

## KEY ISSUES AND TOOLS FOR IMPLEMENTATION

- The development of after-school programs in rural communities is more difficult because of geographic isolation and poor access to transportation.<sup>17</sup>
- A shared community responsibility for planning afterschool programs is beneficial. The 21st CCLC program “supports the creation of community learning centers that provide academic enrichment opportunities during non-school hours for children, particularly children who attend high-poverty and low-performing schools.”<sup>18</sup>
- Working parents with children attending school in rural communities find that after-school programs can serve as a critical resource. Working with a behavioral health care manager will help families to determine if federal funds are available for after-school care in their home community. Since travel to an after-school program (if not offered in their school) would be onerous for this family, care should occur in the home community to the degree possible. This may require Eric's parents to reach out to a local church to determine if a member(s) of the faith-based community may be willing to watch children after school. Churches often play a critical role in access to supports in rural communities.<sup>19</sup>



# **FOOD INSECURITY**

**POOR HABITS**

**LACK OF ACCESS**

**RISK OF OBESITY**

**FOOD DESERT**



## FOOD INSECURITY (SCENARIO)

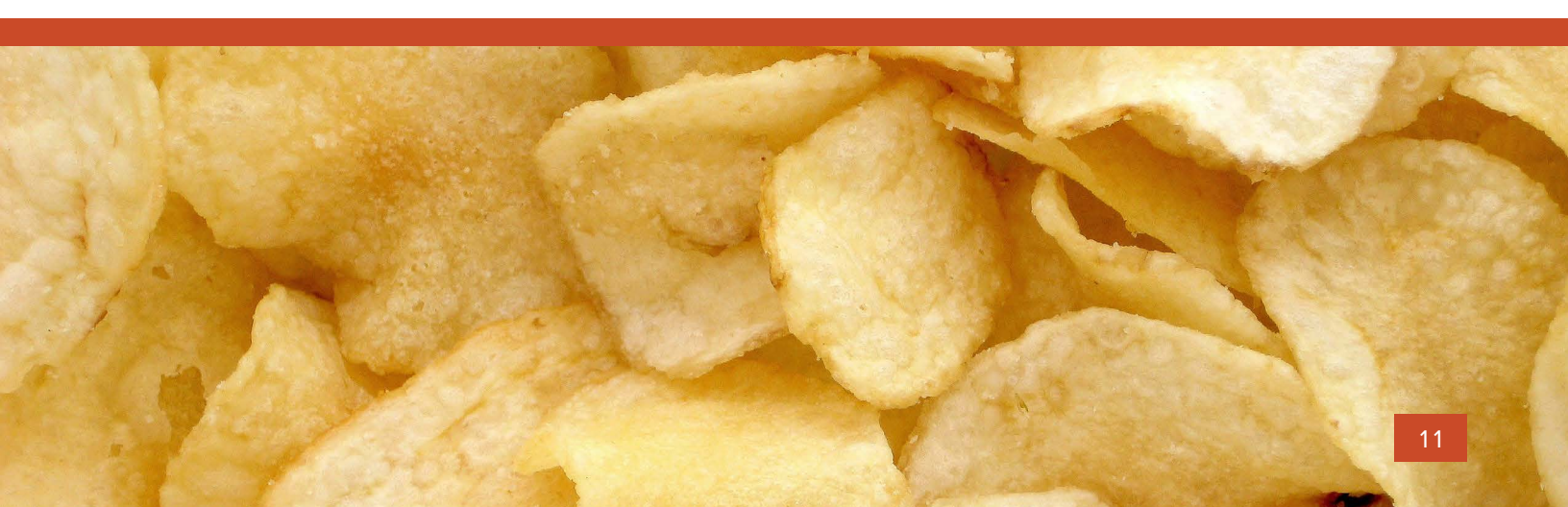
*Eric has developed poor habits that include regular consumption of high fat foods and energy drinks, as well as recurrent internet gaming.*

*As a result, Eric is at risk of obesity due to recent increased weight gain, limited physical activity, and poor eating habits.*

*Additionally, the remote community (population of 200) is considered a food desert with limited access to healthy foods. The local convenience store where his parents are employed sells only processed, high sugar, and high fat foods.*

### KEY ISSUES AND TOOLS FOR IMPLEMENTATION

- Working poor families who reside in rural communities experience greater issues of food insecurity. This problem, combined with “food deserts” in a rural community, result in increased risk for children.<sup>20</sup>
- The lack of access to healthy foods, even though food is typically grown in rural places, is a common problem.<sup>21</sup>
- Strategies to combat food access issues are available through the Rural Food Access Toolkit - Rural Health Information Hub.<sup>22</sup> This toolkit provides specific suggestions for addressing food deserts. The effort focuses on realities of the topography and the limitations of the vegetables and fruits that can be grown.









## ACADEMIC STRUGGLES

(SCENARIO)

*Eric has failing grades and is at risk of not advancing into tenth grade. Eric returns home at 4:15 pm with a backpack full of homework that he rarely completes.*

He is generally lethargic in the classroom. His parents are aware of his poor school performance because they monitor his achievement through the school's electronic platform.

He has not been providing adequate care for his younger siblings because he is distracted by gaming and disengaged in the larger social context of the family. Enacting consequences, both at home and in school, have not been effective in improving school outcomes for Eric.

The school arranged to meet early in the morning with Eric's parents to accommodate their work schedules. School officials know the parents are also involved in the education of his younger siblings.

### KEY ISSUES AND TOOLS FOR IMPLEMENTATION

- A host of literature exists on how to better ensure a successful school conference when a student is struggling academically. The school's decision to not include Eric in the conference likely underscores their concerns about his wellbeing and fears of exacerbating the situation.
- In all school conferences, it is critical for officials to highlight the strengths of the student. Parents should leave with a plan that provides hope to address the concerns being raised.
- Ensuring that resources are provided to improve academic performance is critical, including access to tutoring and an advocate to facilitate implementation. Teachers must be in agreement regarding the plan or it will not be successful. The plan should also scaffold activities so students and parents are not overwhelmed. Section 504 of the Rehabilitation Act of 1973 creates a mandate to accommodate Eric's needs.<sup>23</sup>
- In rural schools the 504 team may be limited in behavioral health providers, due to lack of access. The effort provides support, accommodations, or interventions to assist Eric in the school setting. However, they must have parental permission to proceed.<sup>24</sup>

# LIMITED ACCESS TO PROVIDERS (SCENARIO)

*The closest primary healthcare provider is 26 miles from Eric's home. Care by providers such as pediatricians, psychologists, addiction counselors, or psychiatrists is several hours' round trip from their home and the wait list for an appointment is several months long.*

Eric's parents worry that the stigma of reaching out for assistance will enhance his already existing sense of social isolation. Concerns exist about his increase in cannabis use and the younger siblings' awareness of his use.

Eric's school has limited resources for mental health supports. A school counselor travels to the school only one day a week; there are many youth with mental health needs. There is no school nurse, social worker, or psychologist. These dynamics are all too typical in rural schools, and these challenges can leave schools in a situation where they are asked to serve needs beyond their available expertise.

Staffing issues are not limited to educators only. Rural school districts are fortunate if they have even one person in charge of their technology, and that person is often assigned to other duties. Additionally, poor broadband access while doing schoolwork at home becomes a problem for youth in rural areas.

## KEY ISSUES AND TOOLS FOR IMPLEMENTATION

- The Health Resources Services Administration provides a portal to examine workforce shortage by locations.<sup>25</sup>
- Throughout SAMHSA Region 8, communities are noteworthy in their significant workforce shortages, as described in the introduction to this resource guide.
- 58% of rural residents believe access to high-speed internet is a problem in their area – in contrast to 13% in urban areas and 9% in suburbs. Rural areas are less likely to be wired for broadband, and there are fewer providers available.<sup>26</sup>



## DRUG USE (SCENARIO)

*Eric is a frequent user of cannabis, “pot”, which he claims “calms him down.” This is a concern for his parents. He is able to purchase cannabis from another high school student using funds his parents pay him for providing childcare.*

The youth that tease him about using cannabis use alcohol and binge drink frequently on the weekend; however, teenage alcohol use is not viewed as a problem in this rural community. Eric does not believe his learning problems or depression and anxiety are tied to his use of cannabis. He states that cannabis “makes me lazy.”

### KEY ISSUES AND TOOLS FOR IMPLEMENTATION

- Adolescents should be screened yearly regarding their use of alcohol and drugs.<sup>27</sup>
- An easy way to remember how to screen adolescents for psychosocial problems is to use the mnemonic “HEADSS” (home, education and employment, activities, drugs [including tobacco and alcohol], sex, and suicidality/depression).
- A frequently used substance abuse screening tool is the CRAFFT (car, relax, alone, forget, friends, trouble), which includes a series of six questions that were developed to screen adolescents for high-risk alcohol and other drug use disorders. This tool is brief, but it also allows the screener to assess whether a longer conversation about the context of use, frequency, and other risks and consequences of alcohol and other drug use is warranted. Providing supports in terms of assessment instruments for teachers is critical, including Screening, Brief Intervention, and Referral to Treatment (SBIRT) and depression screenings.<sup>28</sup>

## MENTAL HEALTH (SCENARIO)

*Eric is struggling with both anxiety and depression and has feelings of low self-worth. He states to his parents that he has frequent thoughts about attempting suicide (active suicide ideation) and has a plan.*

### KEY ISSUES AND TOOLS FOR IMPLEMENTATION

- As many as one in six school-aged children experiences a mental health, behavioral, or development disorder, with prevalence and incidence of behavioral health disorders being similar in rural and urban areas.<sup>29, 30</sup>
- Rural schools cannot provide the same access to mental health service as schools in larger population areas because few resources are available to implement evidence-based mental health services.<sup>31</sup>
- Service providers may not be specially trained to serve adolescent children by using evidence-based practices.
- Stigma in rural areas can lead to underutilization and a lack of willingness to talk about mental health issues. A study conducted by the Mountain Plains MHTTC on rural stigma found less stigma than anticipated but more stigma in rural communities.<sup>32</sup>
- It is critical to provide Eric with a thorough assessment of his well-being, including a psychological assessment conducted by a trained professional. This may require that his parents travel to an urban area to secure the evaluation.



## SOCIAL ISOLATION (SCENARIO)

*Eric has no interest in high school organized sports or hunting – either as a participant or as a spectator. Even if he did, he would not be able to participate because he has to provide childcare for his siblings after school.*

His social isolation is evident as classmates berate him on social media as a “freak and pot head.” This isolation is evident to the educators at his school, but he is not a behavior problem in the classroom, so it results in little concern by teachers. Eric and his parents agree he is in need of help, but they are uncertain of the next steps.

Not participating in sports in rural communities isolates students at greater levels than urban communities. Rural communities often define a part of their identity on the accomplishments of their local sports teams.

### KEY ISSUES AND TOOLS FOR IMPLEMENTATION

- Social isolation and feelings of loneliness can be predictors of increased mental health stress and compound symptoms leading to further social isolation, loneliness, and self-stigmatization. Due to geographic isolation, limited community size, and limited opportunities for varied social interaction, it is often difficult for rural youth to find social outlets.
- Connection is a major protective factor, and online communities may provide an avenue for teens with mental health concerns.<sup>33</sup>
- Eric’s interest in social media and access to a cell phone provide opportunities to use technology for positive outcomes. It is important to have awareness of the pros and cons of social media and online chatting about mental health and suicide because school-aged children frequently use these outlets for entertainment. The authors suggest providing Eric with access to the suicide prevention lifeline: National Suicide Prevention Lifeline.<sup>34</sup>
- Social media suicide watch forums such as Reddit, should not be eliminated as a positive resource. Youth are often willing to reach out to these platforms to dissuade their sense of social isolation and increase their network of peers.<sup>35</sup>

## SUICIDE (SCENARIO)

*Eric discloses to his parents that his feelings of inability to cope have resulted in thoughts about attempting to take his own life by putting his father's shotgun (used for hunting) to his head.*

He does not want one of his siblings to find him so he plans to "kill himself" away from the home in a rural ditch. He has these thoughts on at least a weekly basis and the consideration relieves the pressure of his feelings of loneliness and isolation. His feelings of worthlessness are enhanced by his worries about not completing grade 9. He believes there are more reasons to die than to live.

### KEY ISSUES AND TOOLS FOR IMPLEMENTATION

- Suicide is a serious public health challenge. When developing an overall mental health plan, school personnel must consider best practices for prevention, early intervention, immediate response, and long-term recovery.
- Rural populations have experienced persistent increases in suicide, with suicide being the third leading cause of death for 10- to 14-year-olds and the second leading cause of death for 15- to 19-year-olds.<sup>36</sup>

## SUICIDE RISK FACTORS

**Risk factors for suicide include: previous suicide attempts, history of mental illness, limited social support, feelings of hopelessness, stressful events, witnessing suicide, and access to lethal means.**

Information regarding school mental health supports is available through the Mountain Plains MHTTC School-Based Project to include readiness response and recovery resources.<sup>37</sup>

A number of suicide prevention and early intervention programs and resources are available for the elementary, middle, and high school levels through Suicide Prevention Resource Center - Schools.<sup>38</sup>



*The Center for Disease Control provides a summary of strategies to prevent suicide; however, access to resources are limited in rural communities and strategies involve large policy implications. They include:*

## STRATEGIES TO PREVENT SUICIDE

### **STRENGTHENING ECONOMIC SUPPORTS**

*Risk: family is working poor and the access to living wage jobs are minimal.*

### **STRENGTHEN ACCESS AND DELIVERY OF SUICIDE CARE**

*There is limited access to behavioral health care, including tele-mental health.*

### **CREATE PROTECTIVE ENVIRONMENTS**

*In rural communities where recreational hunting is popular, youth often have access to guns with no safe storage practices.*

### **PROMOTE CONNECTEDNESS**

*Sources of strength programs are a considerable driving distance away and social norms are rarely discussed regarding alcohol and drug use.*

### **TEACH COPING AND PROBLEM SOLVING SKILLS**

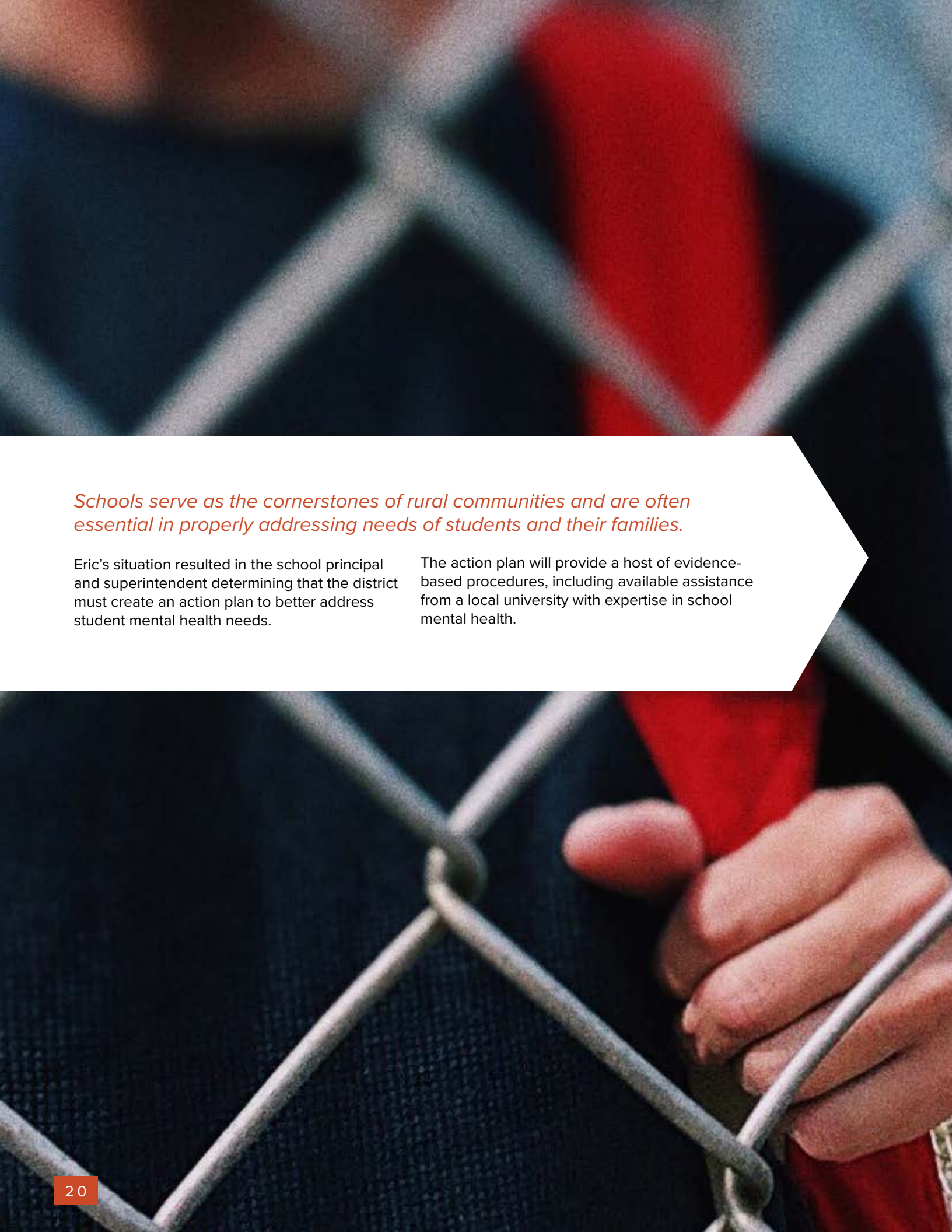
*No mental health counselors are readily available in the school to train and advise on mental health issues.*

### **IDENTIFY AND SUPPORT PEOPLE AT RISK**

*Due to limited supports in rural communities, the role of the church is enhanced.*

### **LESSEN HARM AND PREVENT FUTURE RISK**

*Access to media is not localized.<sup>39</sup>*



*Schools serve as the cornerstones of rural communities and are often essential in properly addressing needs of students and their families.*

Eric's situation resulted in the school principal and superintendent determining that the district must create an action plan to better address student mental health needs.

The action plan will provide a host of evidence-based procedures, including available assistance from a local university with expertise in school mental health.



# PREVENTION AND EARLY INTERVENTION

Prevention and early intervention require that students, educators, and parents have mental health literacy. Mental health literacy includes understanding how to support and maintain positive mental health, identify mental health disorders, decrease stigma, and assist individuals in receiving intervention.<sup>40</sup> A variety of options is available for addressing mental health literacy including mental health curriculums for students and teachers.<sup>41</sup>

Schools should consider approaches to addressing comprehensive mental health literacy, such as including a mental health curriculum. Additionally, because rural schools like Eric's often do not have professional mental health staff onsite, it is recommended that teachers and school personnel be trained to identify signs of mental illness and effectively communicate concerns to families through programs such as Mental Health First Aid.<sup>42</sup>

Programs such as Suicide Prevention Resource Center - Zero Suicide<sup>43</sup> and Sources of Strength<sup>44</sup> are critical resources for schools and behavioral health counselors.

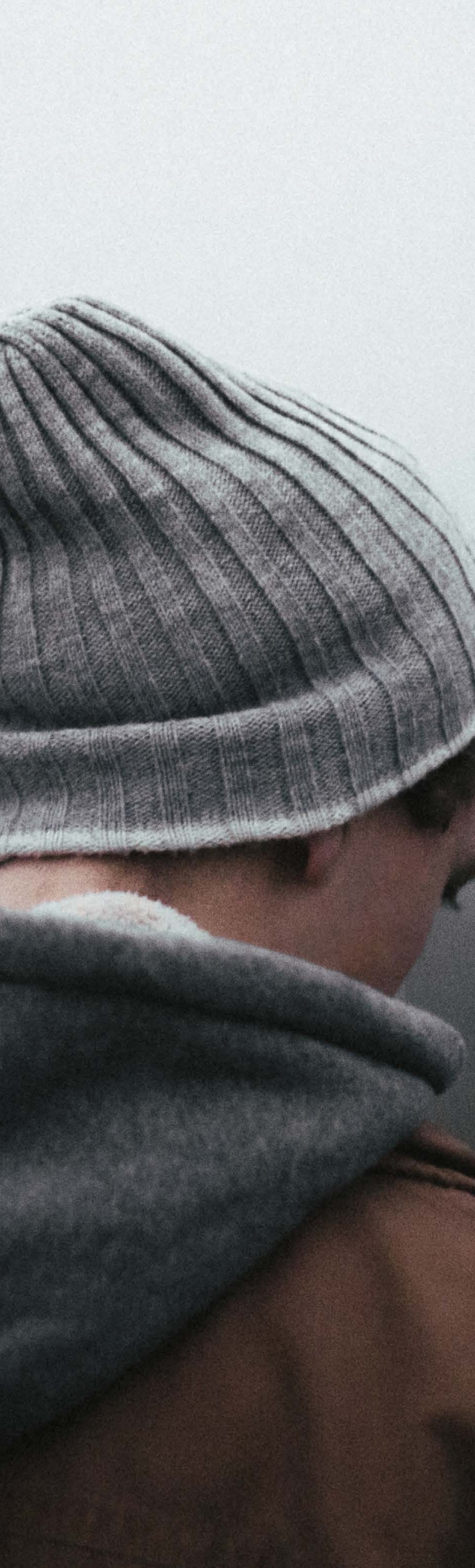
# IMMEDIATE RESPONSE, INTERVENTION, AND RECOVERY

Early intervention and immediate response and intervention are critical to a student's overall well-being. Rural schools are a critical access point for overall youth health.<sup>45</sup>

Early intervention is key and includes screening all students and a referral process. Unfortunately, rural schools may not have well-developed referral systems.

Rural schools should collaborate with local primary clinics, but should also consider school-based telehealth centers to address physical and mental health. If school-based mental health providers are available, identification of regular training needs is critical.<sup>46</sup>

A workforce need identified by educators in the first year of school-based grant funding, is a better understanding of the principles on trauma sensitive schools. Additionally, mental health treatment providers in Region 8 have acknowledged this need.<sup>47</sup>



Rural schools are encouraged to evaluate their capacity to address the mental health needs of children on a regular basis.<sup>48</sup> Best practices include implementing a multi-tiered system of support that addresses:

» **PREVENTION**

» **EARLY INTERVENTION**

» **IMMEDIATE RESPONSE/  
INTERVENTION**

» **LONG-TERM RECOVERY**

*Resources for schools to complete and facilitate a needs assessment and resource identification are available through the National Center for Rural School Mental Health<sup>49</sup> and the National Center for School Mental Health.<sup>50</sup> There is also information to assist in the process of developing a multi-tiered system of support.*

# BULLYING

## EFFECTS OF BULLYING<sup>56</sup>

**STRESS, ANXIETY, AND DEPRESSION**

**ANGER OR FRUSTRATION**

**LONELINESS AND ISOLATION**

**FEELINGS OF REJECTION OR POOR SELF-ESTEEM**

**CHANGES IN SLEEP AND EATING PATTERNS**

**HEALTH COMPLAINTS**

**POOR RELATIONAL SKILLS**

**SCHOOL AVOIDANCE, INCLUDING MISSING OR DROPPING OUT OF SCHOOL**

**POOR ACADEMIC PERFORMANCE**

**SEPARATION ANXIETY**

**SELF-INJURY**

**EATING DISORDERS**

**SUICIDAL OR HOMICIDAL IDEAS OR ACTIONS**


*Youth such as Eric, who are victims of bullying behavior, can experience symptoms of post-traumatic stress disorder. Strategies of zero tolerance have not proven to be effective. Adolescents are vulnerable to the stress of bullying due to the sensitivity to their environment and partially to their reactivity.<sup>51</sup>*

Students typically manifest one of two methods for dealing with stress: externalize stress and act out; or internalize stress, shut down, and be passive and “invisible.” It is important to understand that chronic stress and trauma affects learning, as do Adverse Childhood Experiences (ACEs).<sup>52</sup>

The Mountain Plains MHTTC website includes a video featuring a national expert on Adverse Childhood Experience.<sup>53</sup> Hosts of additional resources exist to describe trauma for school personnel, including *Creating a Trauma-Sensitive Classroom, 2018* by Kristin Souers and Pete Hall.<sup>54</sup>

Strategies to stop bullying found at *Stop Bullying*<sup>55</sup> are helpful. This site provides guidance and is critical as a commitment to creating a safe space for students. It provides support to train all principals, teachers, janitors, cafeteria staff, playground staff, librarians, school nurses, and bus drivers.

Information on short- and long-term effects of bullying is at The National Child Traumatic Stress Network.<sup>56</sup>



*The Every Student Succeeds Act (ESSA) of 2015 underscores the importance of the use of trauma-informed practices based on evidence. The trauma-informed language arose from the behavioral health field and assumes access to clinical practice with a trained therapist.*

**TRAUMA-SENSITIVE** is the term used to refer to educational practices that encourage a safe learning environment that mitigates the impact of trauma on children. Use of the term “trauma-sensitive” is in keeping with the work of educators.



# CASE SCENARIO

## FINALE

Eric was able to secure assistance through the distant primary care clinic, where he was assessed and treated for depression and provided access to counseling services and medication. His behavioral health care manager was successful in securing needed supports for the family, including access to childcare and SNAP. A complete physical examination was conducted to assist in assessment of the depression. This proved to be a financial hardship to the family because both parents are paid hourly wages and are not paid when they are away from their jobs. However, the local employer made an exception when they explained the rationale for the absence.

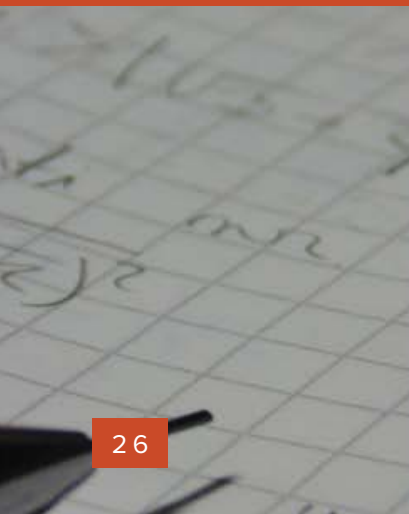
Eric's school undertook the critical work of developing a 504-plan to assist with his success. His English teacher assumed the role of mentor and advocate. The collaboration between the school and the parents was essential.

After addressing the anxiety and depression, combined with tutoring, Eric will pass ninth grade. Eric has been

relieved of his childcare duties and is able to focus on his schoolwork, as the community has pulled together to host an affordable after-school program at a local church. He joined the yearbook staff, which is under the supervision of the English teacher, and is able to car pool with another student who brings him home after school. Eric's parents and school officials are aware of the signs and symptoms of suicide and have an open door policy for discussion.

For Eric, a counselor administers a screening tool via tele-health. The primary care physician's role in reducing stigma was critical for the parents in securing help for Eric and working to secure release time from their employer.

The ongoing treatment plan includes an assessment of Eric's use of substance and depression. A list of appropriate screening tools is provided online at SAMHSA-HRSA Center for Integrated Health Solutions.<sup>57</sup>





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Professor Heitkamp's academic work has focused on advancing inter-professional practice and expanding access to higher education curriculum and training through use of technology. Her expertise is in advancing workforce development in rural communities to address behavioral health issues. She currently leads two teams of faculty and staff who provide their expertise to K – 12 educators and behavioral health practitioners to ensure positive treatment outcomes. Thomasine attended a rural school in a community with a population of 100.



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Sarah has extensive experience working with children and adolescents with mental health disorders in community and hospital settings. She is a technical trainer with the Mountain Plains MHTTC and designs curriculum, trains, and consults with schools implementing multi-tiered mental health approaches. Dr. Nielsen teaches content related to child, adolescent, and young adult development and mental health interventions at the University of North Dakota School of Medicine and Health Sciences. Sarah's high school graduation class was made up of 37 students.



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# ADDITIONAL RESOURCES

## MHTTC NATIONAL SCHOOL MENTAL HEALTH CURRICULUM

*National Center for School Mental Health (ND)*

<http://csmh.umaryland.edu/Resources/Needs-Assessment--Resource-Mapping/>

*If you are interested in learning more about the training and technical assistance provided free of charge by Mountain Plains MHTTC, join our listserve at*

<https://mhttcnetwork.org/centers/mountain-plains-mhttc/subscribe>

To help states, districts, and schools across the United States understand the core components of comprehensive school mental health, as well as engage in a planning process, the Mental Health Technology Transfer Center (MHTTC) Network Coordinating Office and National Center for School Mental Health (NCSMH) developed a national school mental health curriculum focused on the core features of effective school mental health initiatives. The curriculum is intended to be used with district teams that can influence, develop, and oversee school mental health systems at the school district and building levels. It contains trainer and participant manuals and slide decks, divided into eight modules that are each designed for delivery in one-hour in-person sessions or can be adapted for shorter or longer sessions. Also included are five recorded virtual learning sessions that are each about 75 minutes long and include a deeper dive into some of the curriculum content with additional examples from states and districts across the MHTTC Network.

**To access the curriculum, please visit:**

<https://mhttcnetwork.org/centers/mhttc-network-coordinating-office/national-school-mental-health-projects>



Mountain Plains (HHS Region 8)

MHTTC

Mental Health Technology Transfer Center Network

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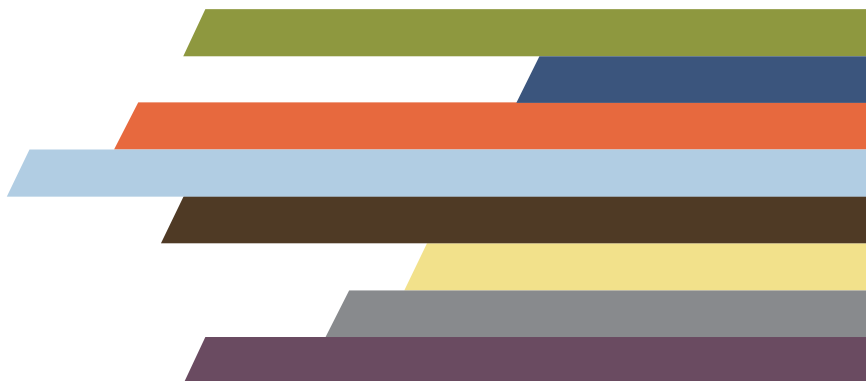
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