

Jane Chandler

Senior Director Mental Health Youth Service Bureau



URBAN SERVICES YMCA

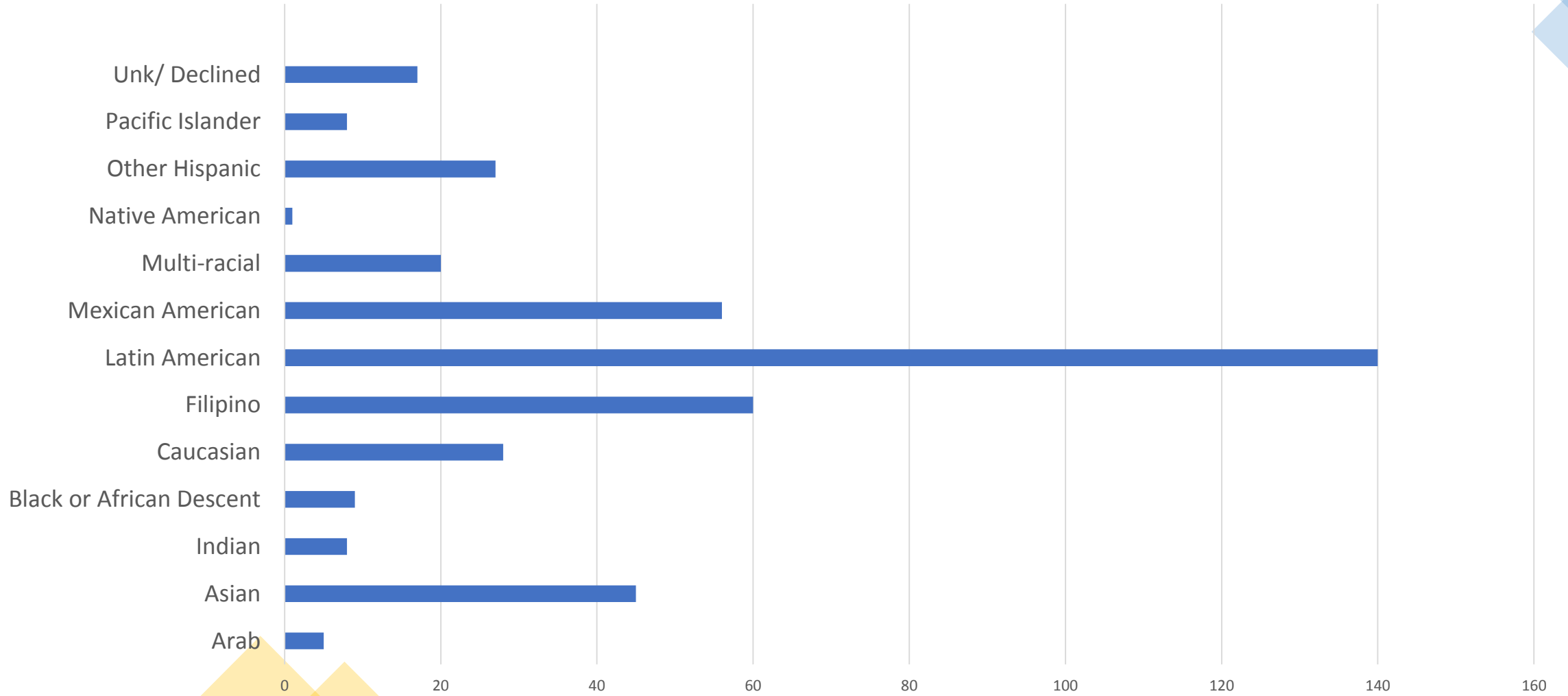
SAN FRANCISCO COMMUNITY ACTION AGENCY

San Francisco Unified School District
Mental Health Services Program
In collaboration with the YMCA of SF
Youth Services Bureau
2020-21

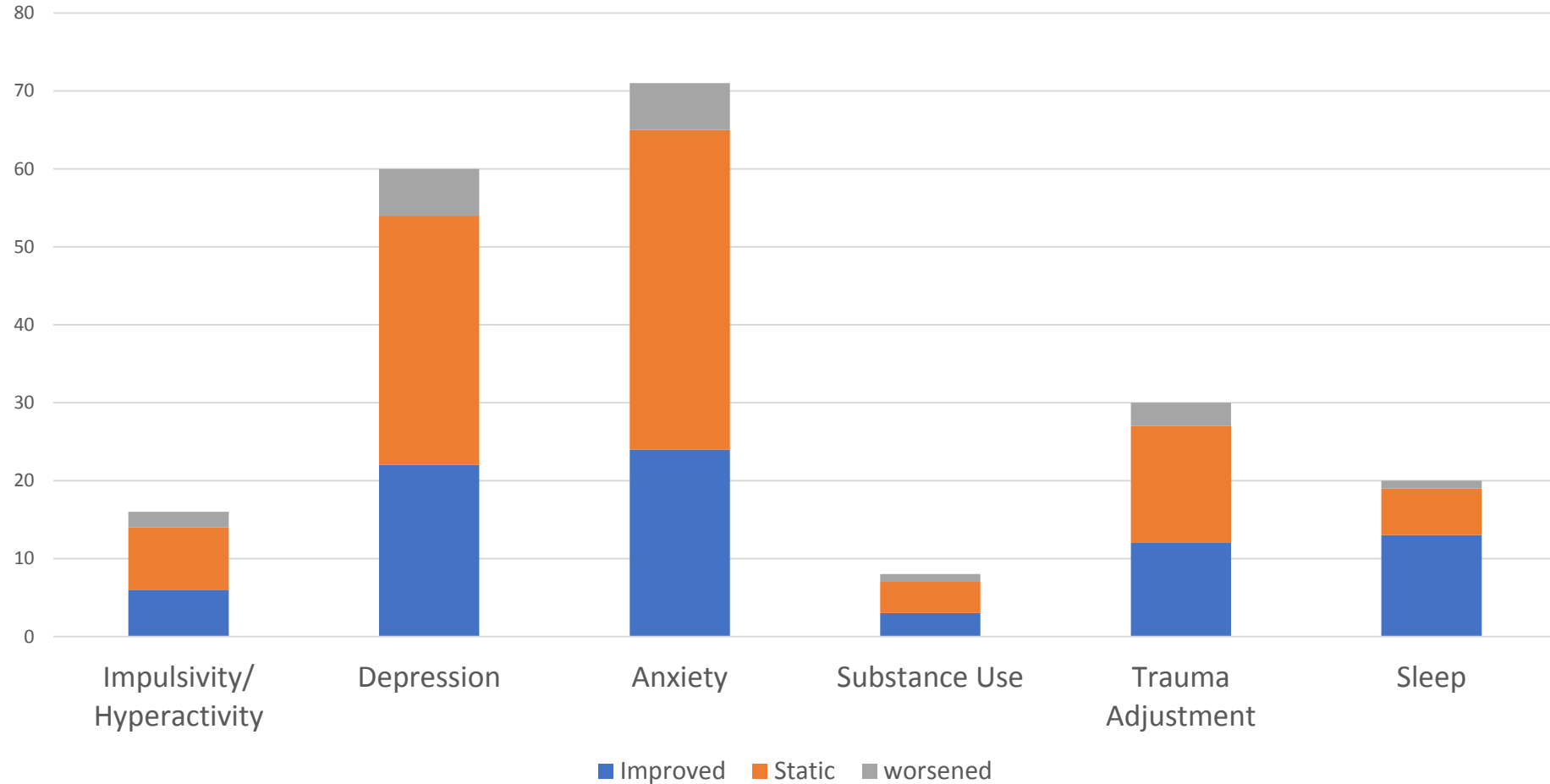


SSFUSD School Campus	Clients Served*	Assessment/ Plan Dev	Individual Therapy	Group Therapy, classes and small group activities	family therapy, family/parent collaboration & treatment planning	Case Management	Total Services	Average services per client	No Show	Therapist Cancel	Client Cancel	Total scheduled sessions
Alta Loma Middle	65	73	379	20	18	0	490	8	45	5	30	570
Baden High	12	46	115	5	0	0	166	14	6	0	0	172
Buri Buri Elementary	25	68	117	2	2	0	189	8	13	1	3	206
El Camino High	40	91	138	7	17	0	253	6	29	0	8	290
Junipero Serra Elementary	17	34	54	15	26	0	129	8	17	0	0	146
Los Cerritos Elementary	15	22	152	0	33	0	207	14	52	0	2	261
Martin Elementary	10	8	3	16	25	0	52	5	4	0	1	57
Monte Verde Elementary	6	14	66	0	23	0	103	17	19	8	1	131
Parkway Heights Middle	66	71	204	42	13	2	332	5	13	4	0	349
Ponderosa Elementary	18	55	161	0	21	0	237	13	23	2	3	265
Skyline Elementary	11	17	84	0	39	0	140	13	10	8	3	161
South San Francisco High	59	7	124	0	9	2	142	2	4	10	10	166
Spruce Elementary	39	11	346	43	62	2	464	12	43	6	7	520
Sunshine Gardens Elementary	17	43	128	0	26	0	197	12	15	0	0	212
Westborough Middle	79	97	151	79	2	2	331	4	9	3	9	352
Grand Total	479	580	2,094	194	718	8	3432		302	47	77	3858

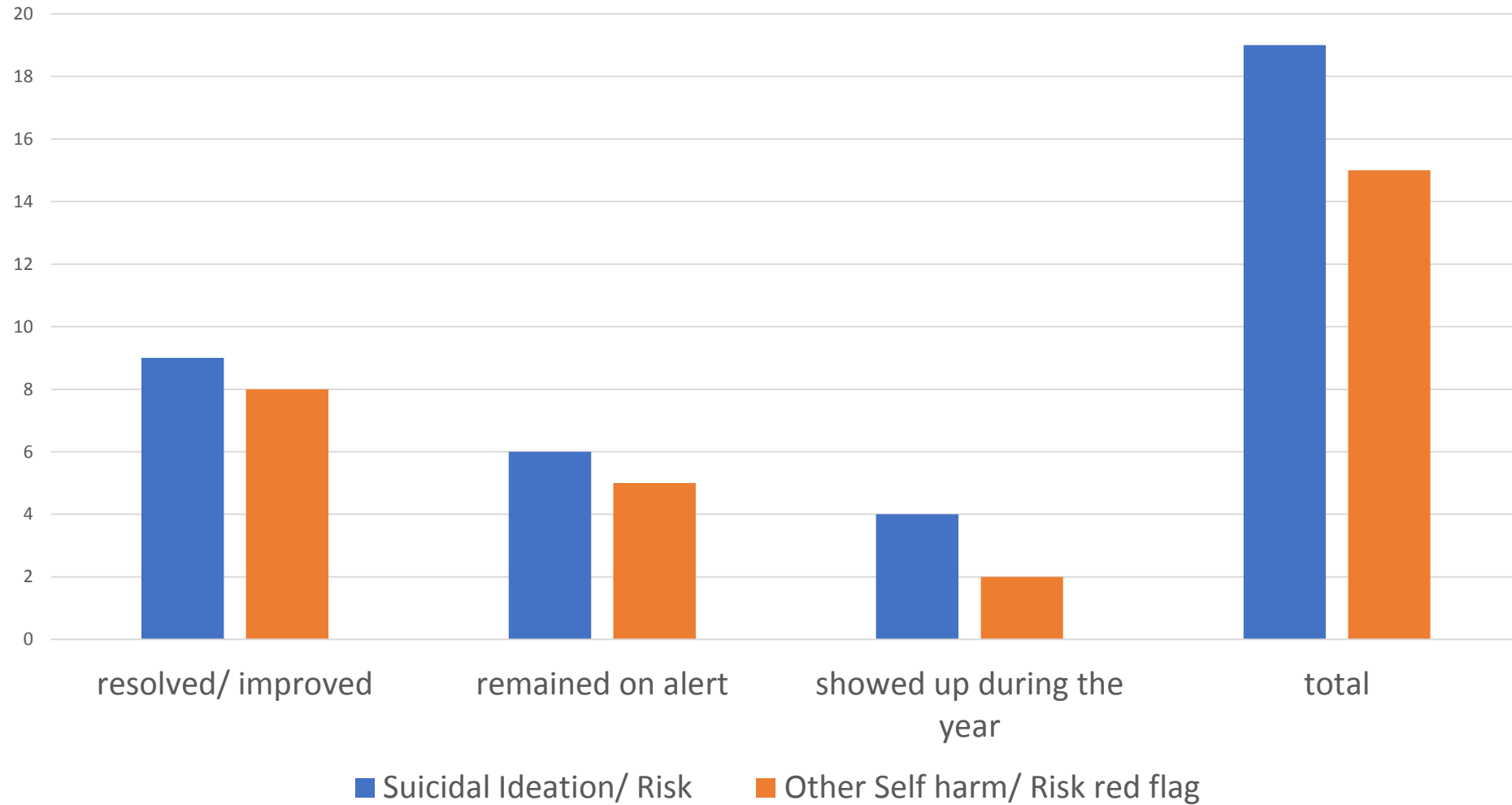
SSFUSD Demographics 2021-2021 (n=424)



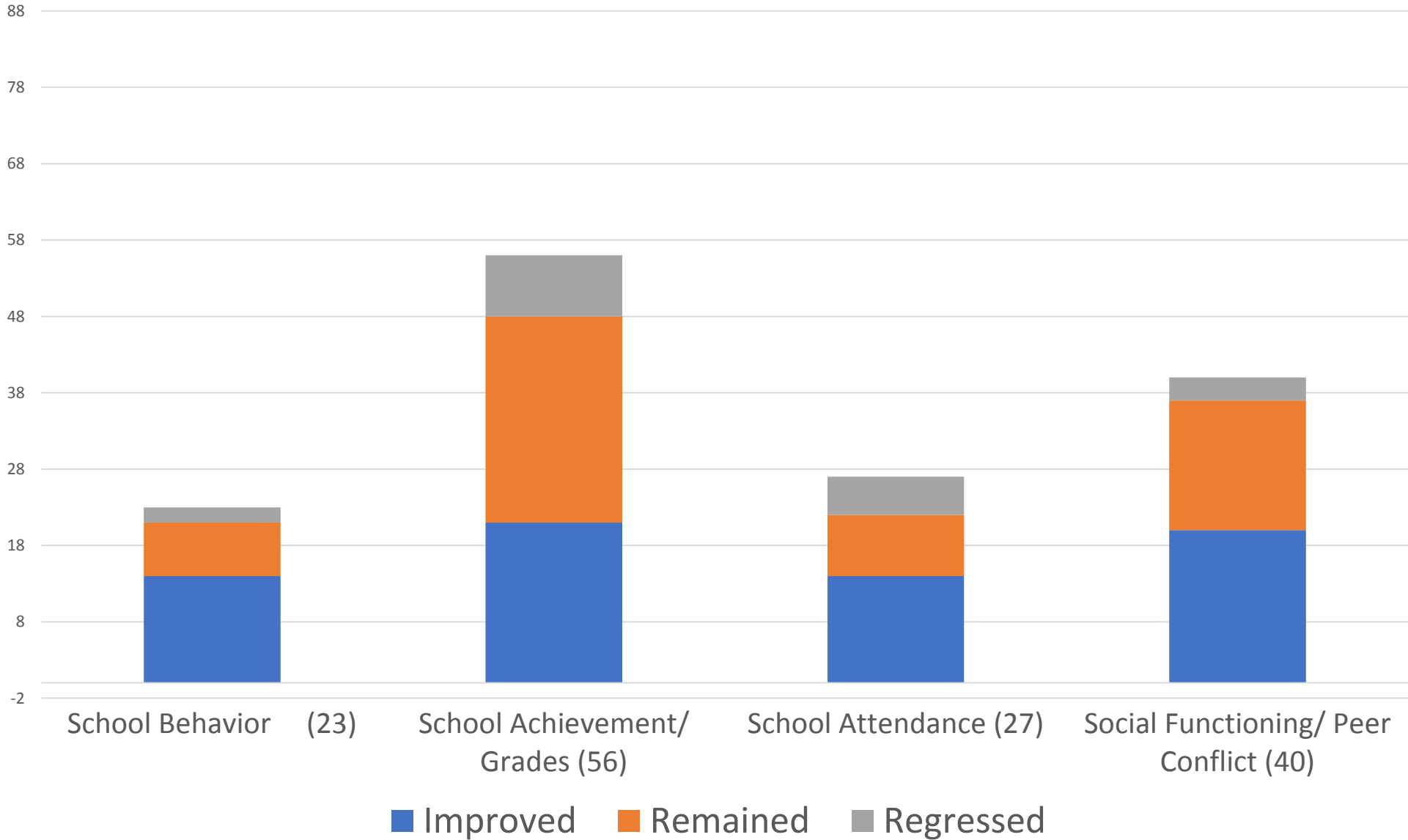
Most Frequent Presenting Mental Health Categories this year



25 Students seen for Safety/ SI/SA/ Self-Harm



School Life (n)



Our Students Environments this year



Fifteen of 88 students in our assessment cohort were referred to us for the cluster of behavior that includes oppositional, conduct, anger outbursts, sexual aggression and/or danger to others. All but two students showed improvement in treatment plan of care goals with their clinician

65 of the 88 showed one or more actionable needs on the assessment under the umbrella of family needs and/or functioning, and 13 of those specifically to challenges specific to immigration with US government.

CPS was called in to support with 8 situations that warranted safety concerns

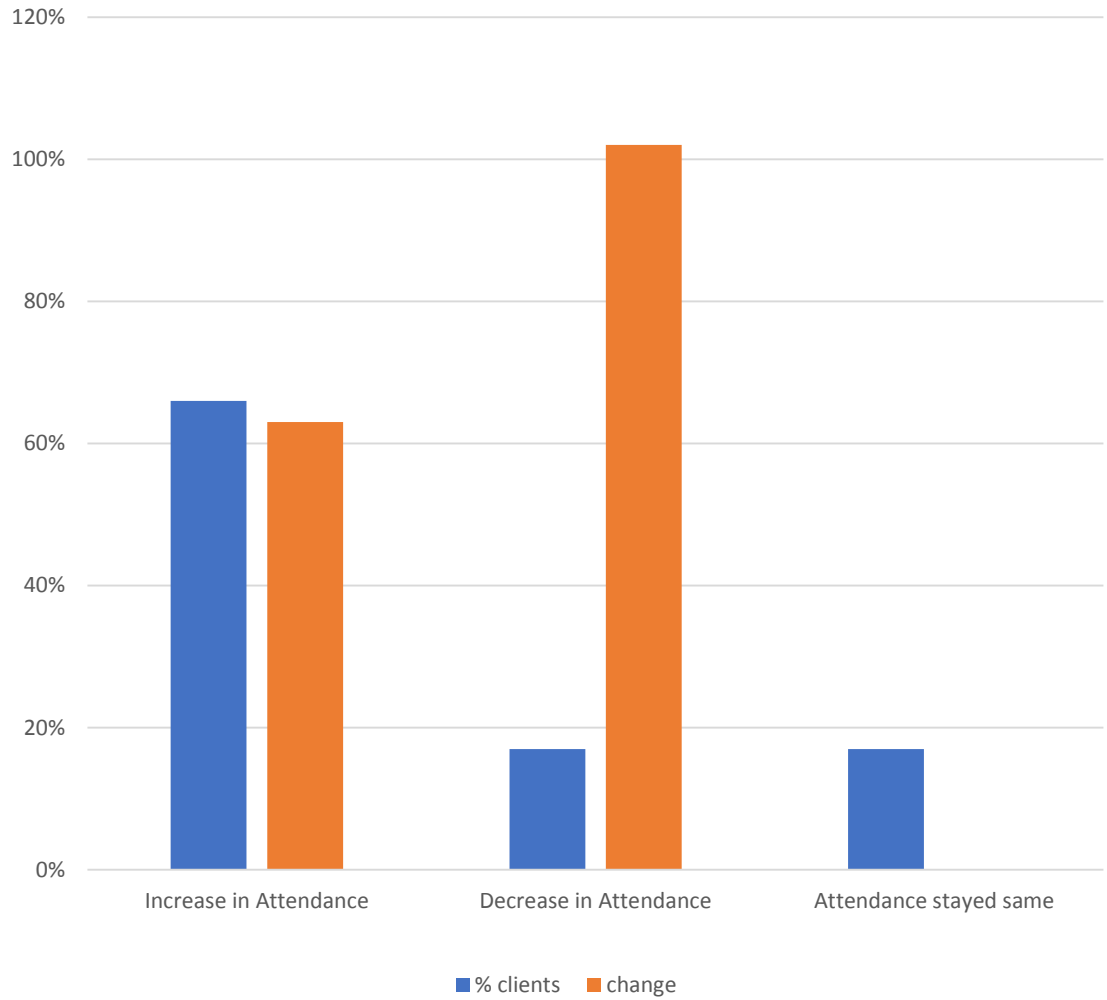
Community Life and Connection

54 students of the 88 assessed had identifiable needs in our Strengths/ Needs continuum of ratings. The categories, in order of prevalence were:

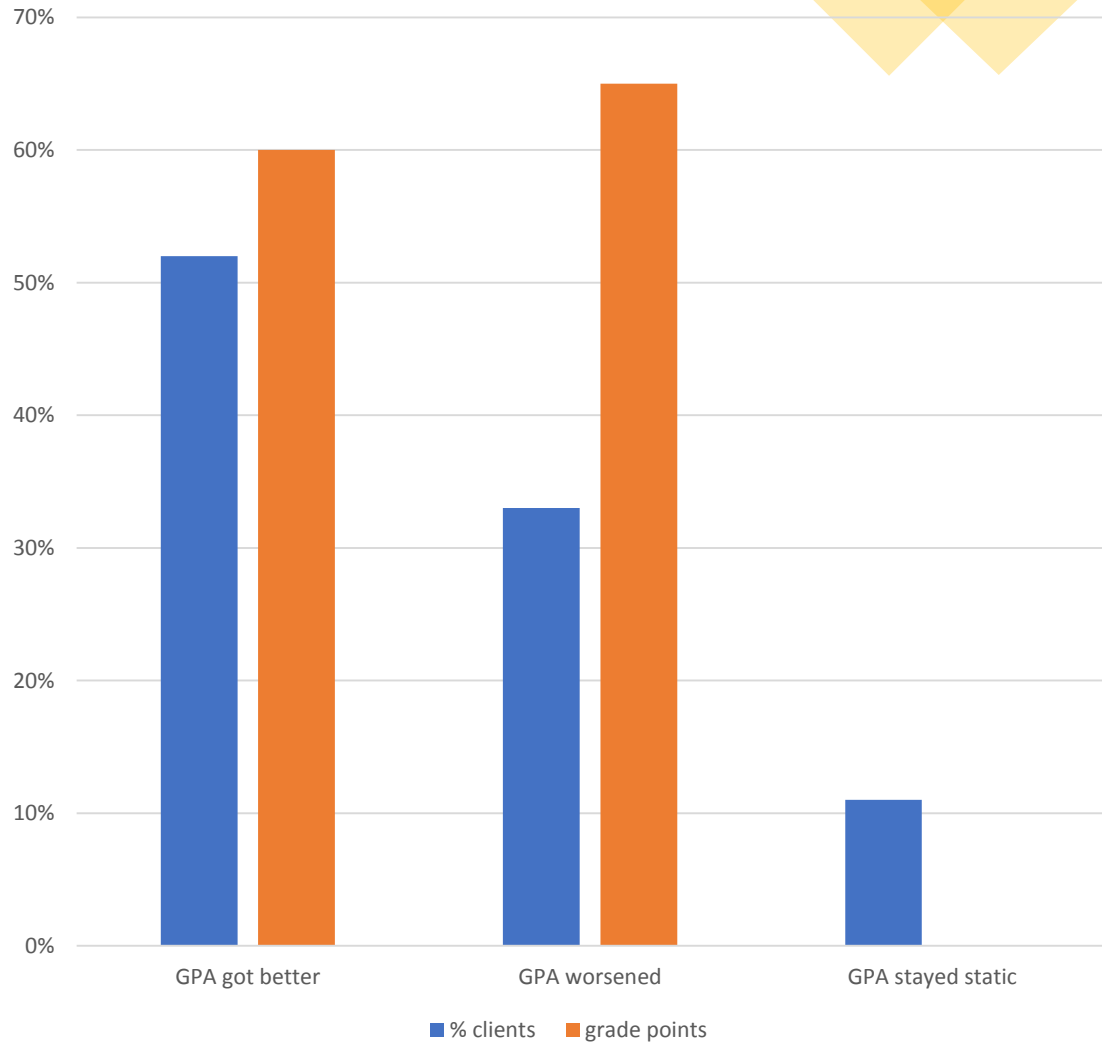
- 1) Talents and Interests
- 2) Resiliency
- 3) Community Life

More than half of the students with identifiable needs in this category showed measurable improvement in functioning by the end of the year. Our clinicians have a myriad of interventions and activities designed to help students find interests, grow participation in positive and pleasurable activities and learn skills to weather the day-to-day difficulties and accept challenges, working on reframing through resilience

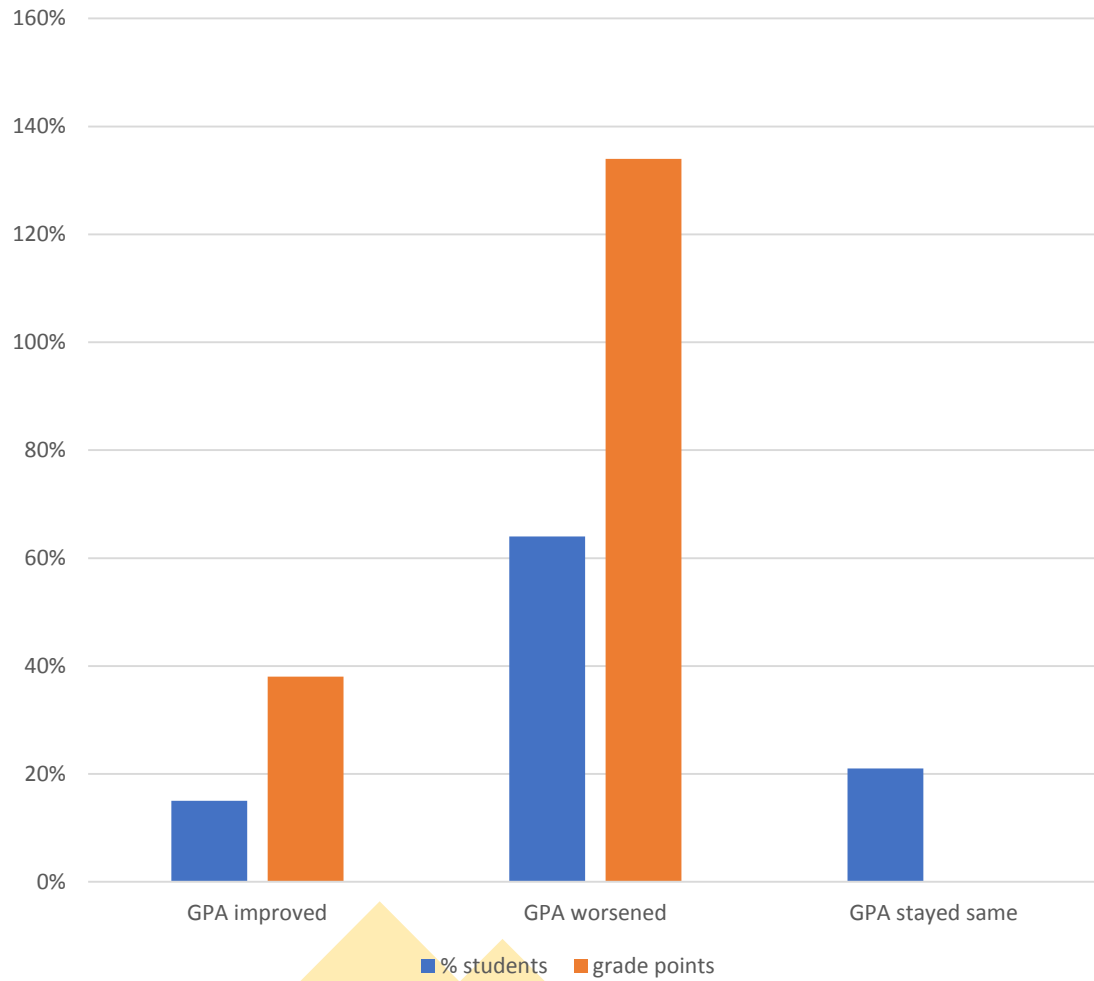
Middle School Attendance



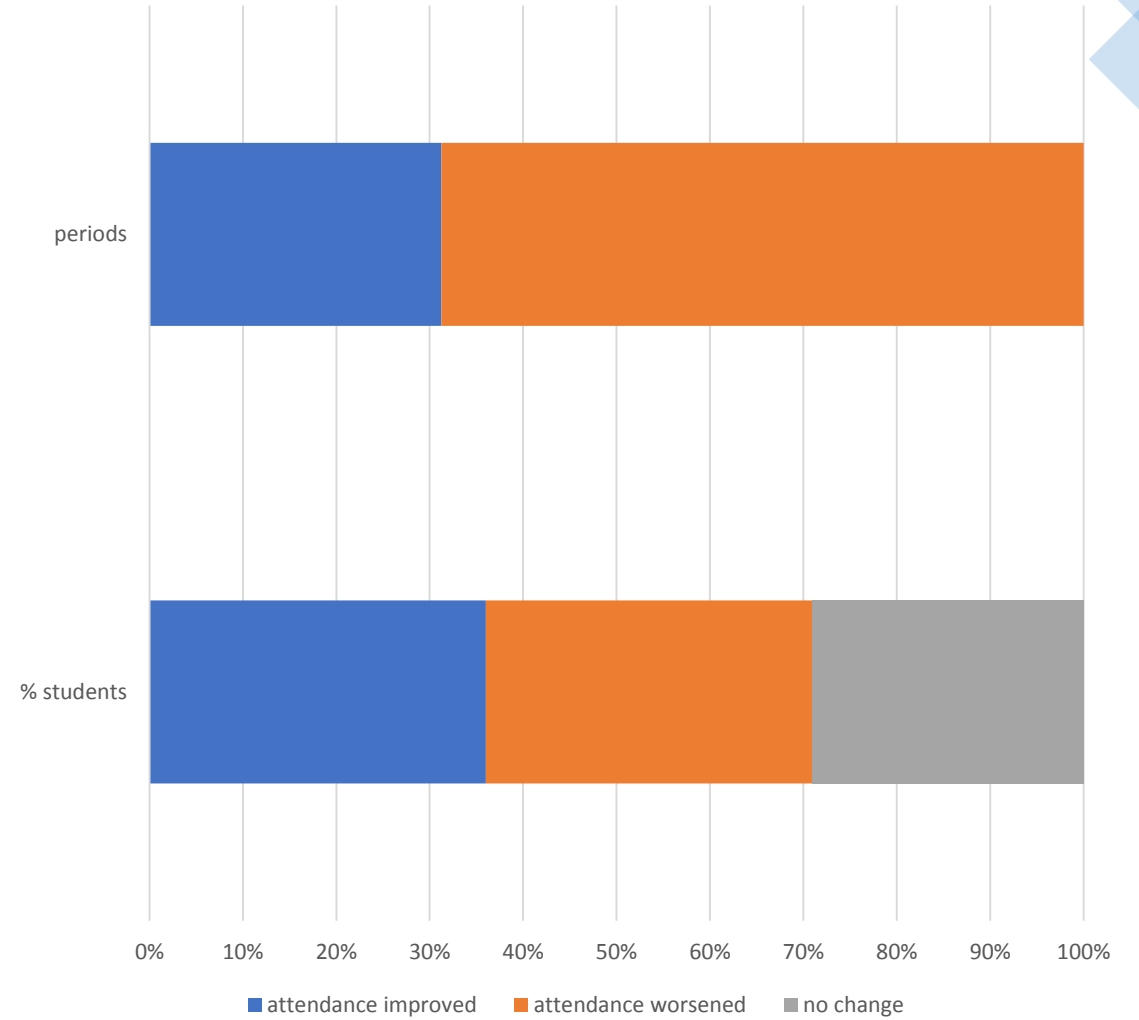
Middle School Grades



High School GPAs dropped from 2.9 to 1.93 average



High School Attendance



SSA #1 composite qualitative feedback “the pandemic year”

What are caseloads made up of? (what are the reasons you meet with kids/ what do the schools have you doing?) My caseload was made up of clients with various psycho-social-emotional disturbances including trauma in the home, divorce, COVID related deaths, suicide/murder of loved ones, family conflict, academic stress, pregnancy, housing instability, immigration issues, anxiety, depression, substance abuse, suicidality, and much more. Because of this, I was asked to provide a lot of crisis and case management often for Spanish speaking households where the client spoke English, but the parents did not. Throughout the year, I have also hosted a Parent Engagement night in English & Spanish regarding Stress Management in the Pandemic, provided Spanish interpretation for other school wellness staff with Spanish speaking parents, attended multiple IEP and 504 meetings, been available as the therapist on-call for crisis when the wellness counselor was out or unavailable, provide consultation for the wellness staff and counselor when they needed insight into ethical legalities, and recently held a stress management therapy group setup for 90 minutes on Tuesdays in May with no attendees.

How many students are on waitlists? Unfortunately, I was never told this number. the Wellness Counselor returned and fielded referrals to me and my two other colleagues from StarVista. Each Monday, we would meet together as a team to determine if there was more availability as the year went on. As clients moved off my list, I was told that more would be coming (especially Spanish speaking clients).

How many students did not respond to a referral? What were the major reasons for referrals? 8 Declined, 36 Did not respond. Major reasons for referrals were academic stress/progress, family disputes, and COVID related stress (home/school environment, deaths, etc.).

Can you also tell us the process and/or forms and criteria used to refer students for services during distance learning and how the interface with students has been managed?

Our wellness coordinator created a google form that she distributed to staff and faculty to refer clients to the wellness center for services. This form and all responses were managed solely by her. When distributions were made, she would consult with all wellness clinicians to discuss incoming cases and ask first if YSB had a history with the potential client. If so, they were automatically assigned to me (along with all Spanish speaking clients as I was the only Spanish speaking clinician on the team). Aside from this, clients were also brought up via the admin support team meetings that happened on Tuesday. Here, staff and faculty would bring up students for a team referral that would either need follow up from an Assistant Principal, Academic Counselor, or Wellness Coordinator/Clinician. Often times, I would grab clients from these meetings if YSB had a record of them in our agency's internal system and immediately add them to my caseload due to the crisis level nature of their needs at these meetings. Consultation would regularly be had with the Wellness Counselor about my workload as I served the largest number of students on the team



SSA #2 composite qualitative feedback “the pandemic year”

What are caseloads made up of? (what are the reasons you meet with kids/ what do the schools have you doing?) My caseload was made up of students that had been referred to me this school year as well as the previous school year. I provided 15 minute check-ins for students to build skills in time management, interpersonal skills, academic stress, and coping with anxiety and depression.

How many students are on waitlists? I did not have an official waitlist, but one student currently getting outside services, but the mother expressed possible interest for the next year. I made a note for me to outreach to this family next year.

How many students did not respond to a referral? What were the major reasons for referrals? By the end of the school year, I had four kids still on the referral list. 2 of these parents never responded to my calls or emails. One parent was ready to go through the consent process but wanted to check in with the client. She never responded to my calls after that. Lastly, one of my parents was currently getting outside services, but expressed possible interest for the next year. The remaining referred families either signed the consent form or declined services. 14 of those families declined services, and two verbally consented but declined prior to child being seen. Two families verbally consented but their child was never seen as family never responded to call and outreach. The main reason for referrals were academic stress, anxiety, family changes, and depressive and low-self-esteem symptoms.

Can you also tell us the process and/or forms and criteria used to refer students for services during distance learning and how the interface with students has been managed? For my referral process I created a Microsoft Forms sheet that I shared with the school personnel. This form mimicked the usual referral sheet given to teachers in the school but allowed it to be completed remotely and without having to email information. I was the only one who had access to the data completed in the forms allowing the information to remain confidential from others. Eventually an additional form was created by our intake coordinator that allowed parents to fill out a similar form in case they wanted to refer their child on their own. Some referrals received also came from those parent referrals. Once the referrals were received I access the clients face sheet on Infinite Campus, created a chart, reached out to teacher or the referral person if I had more questions, and then outreached to the family.

SSA #3 composite qualitative feedback “the pandemic year”

What are caseloads made up of? (what are the reasons you meet with kids/ what do the schools have you doing?)

My caseload this year has primarily consisted of students with concerns surrounding academic stress and anxiety, with some difficulties with family relationships, likely spurred on by the boundaries placed due to Shelter-In-Place as well as distance learning. This year I focused on 15-20 minute check-ins with students to focus on anxiety management, relationship skill building, as well as time management.

How many students are on waitlists?

At any given time this past school year, I had anywhere from 1-3 students on my waitlist. There is a small list of students that was provided to me by my MFT Trainee whom she feels could benefit from continued/further services when the new school year starts. That particular list consists of 4 students.

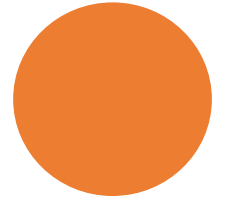
How many students did not respond to a referral? What were the major reasons for referrals?

Roughly 4 students did not respond after I reached out following their initial referrals. The major reasons for referrals were concerns raised by their parents about a lack of engagement with schoolwork, negative changes in mood/affect, etc.

Can you also tell us the process and/or forms and criteria used to refer students for services during distance learning and how the interface with students has been managed?

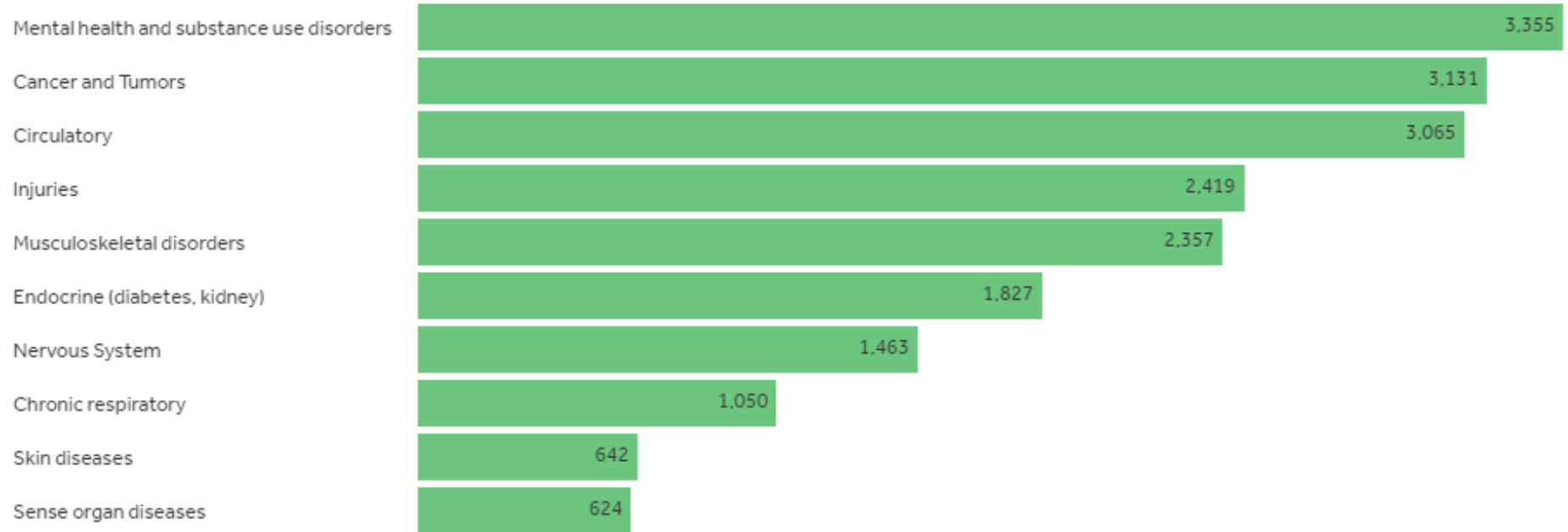
As was the case with in-person learning, the majority of my referrals came from the teachers and the academic counselors, as they were generally the first people to observe any behaviors or points of concern with their students. They would then contact the students' parents/caregivers to gauge their interest in YSB services. They would then fill out an electronic referral form to further elaborate their concerns, where I would then communicate with the parents myself to hear their concerns more directly. Once consent for treatment was obtained, I would then coordinate with either the parents or the students' teachers to figure out times during the school day where I could meet with the students, and this usually took place via Zoom or over the phone, if students were experiencing Internet connectivity issues on a given day.

The following 7 slides come from data shared with us from the California Children's Trust. It is important to understand the context and culture of our current young generation. In the information age of social media, there is no "locality" that is isolated. This data is important for all of us to understand and pay attention to for the sake of the well-being of our youth, families and fellow neighbors and friends.



**MENTAL HEALTH
AND SUBSTANCE
USE DISORDERS
ARE THE LEADING
CAUSES OF
DISEASE BURDEN
IN THE US**

Age standardized disability adjusted life years (DALYs) rate per 100,000 population, both sexes, 2015



DALY, or the Disability-Adjusted Life-Year, is a metric that combines the burden of mortality and morbidity (non-fatal health problems) into a single number. One DALY can be thought of as one lost year of "healthy" life.

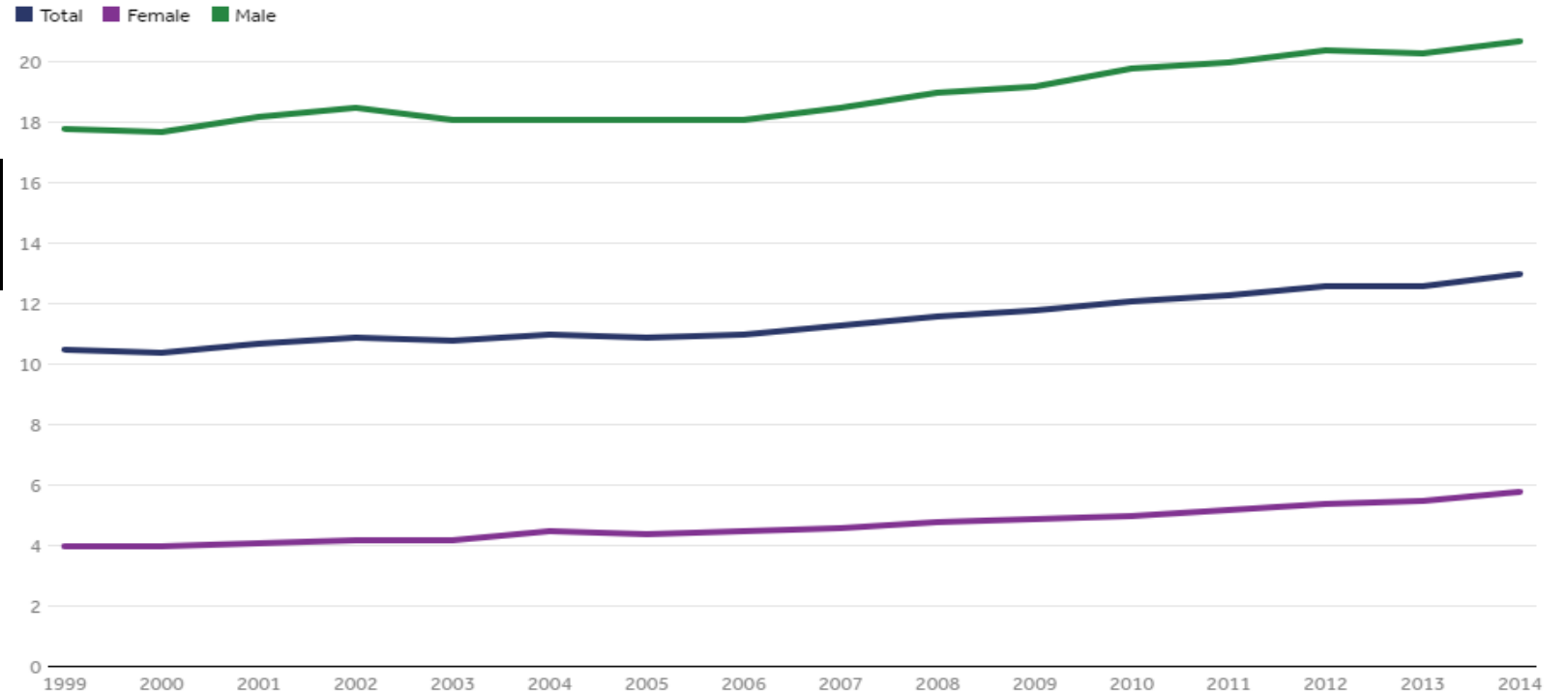
DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences: **DALY = YLL + YLD**



BEHAVIORAL HEALTH IS THE FUNDAMENTAL DRIVER OF MORBIDITY FOR 10- TO 24-YEAR-OLDS

Suicides per 100,000 people

Age-adjusted suicide rates, by sex, 1999-2014



Homicide, suicide, and unintentional injury (mostly car-related) are the three leading causes of death for youth ages 10-24.

In the last 10 years, suicide has leap-frogged cancer and unintentional injury and become the second leading cause of death for youth and young adults.

Suicide Data is Striking

After almost steadily declining between 1986 and 1999, the national suicide rate increased a startling 24% between 1999 and 2014, with a 2% increase per year beginning in 2006.

The suicide rate for young women ages 10-14 increased the most in that time, jumping 200% from 0.5 suicides per 100,000 to 1.5 suicides per 100,000.

And it's not just suicide rates...

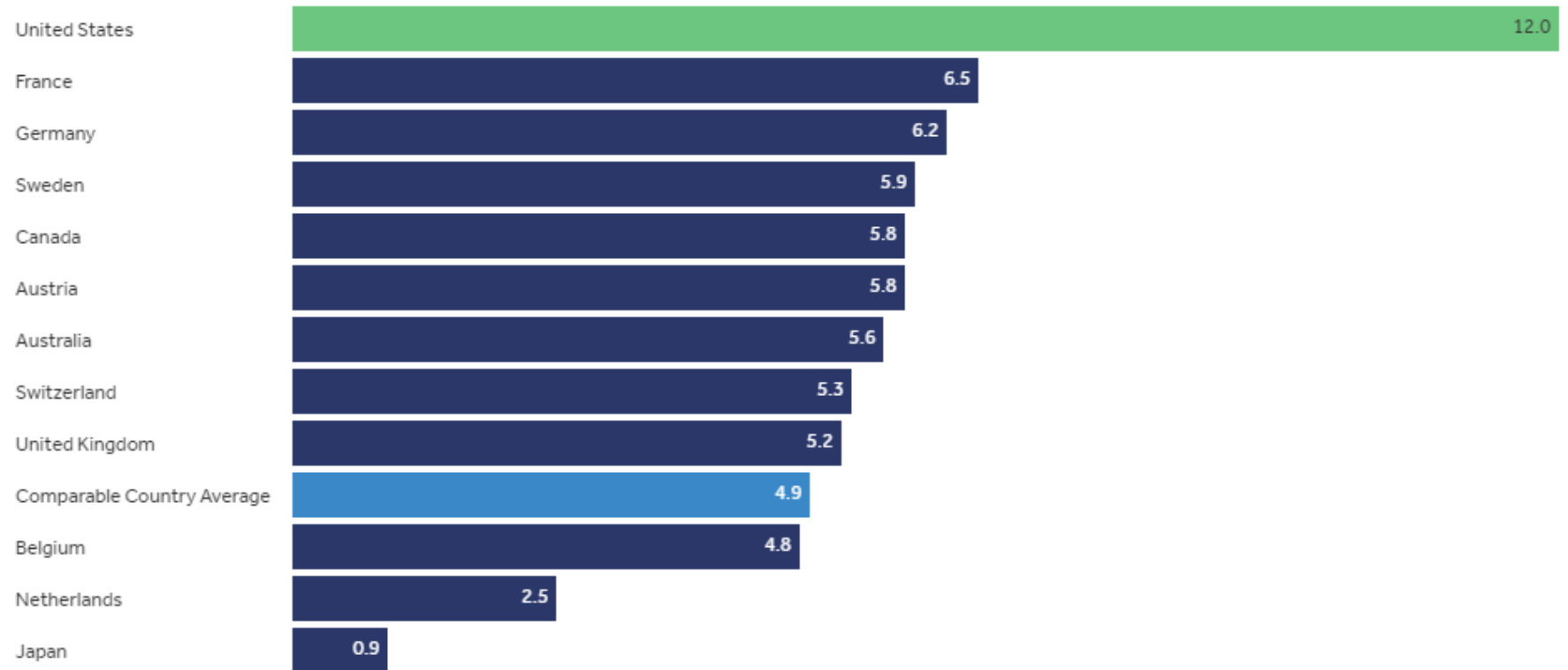
There have been striking increases in both self-reported need (surveys) and demonstrated acuity (diagnosis and utilization of crisis and inpatient services) over the last 10 years of available data.

Overall All Cause children's hospitalizations are not increasing. **The primary drivers of increases in hospitalizations among youth and young adults are behavioral health conditions.**



AMONG
COMPARABLE
COUNTRIES, THE
U.S. HAS THE
HIGHEST RATE OF
DEATH FROM
MENTAL HEALTH
AND SUBSTANCE
ABUSE DISORDERS

Age standardized death rate per 100,000 population due to mental health and substance use disorders, both sexes, 2015



THERE IS A CRISIS IN YOUNG PEOPLE'S MENTAL HEALTH

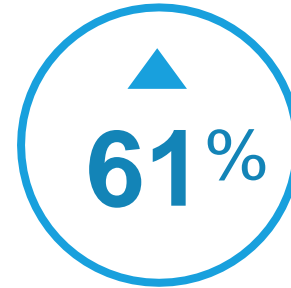
Consider the facts before COVID-19:



Increase in inpatient visits for suicide, suicidal ideation, and self injury
for children ages 1-17 years old, and 151% increase for children ages 10-14



Increase in mental health hospital days
for children between 2006 and 2014



Increase in the rate of self-reported mental health needs
since 2005



California ranks low in the country for providing behavioral, social, and development screenings that are key to identifying early signs of challenges



THE “PRICE” IS HIGHER FOR BLACK AND BROWN CHILDREN

Many receive the wrong services at the wrong time...in restrictive or punitive settings.

81%

81% of children on medicaid are **people of color**.

2X

The **suicide rate for black children**, ages 5-12, is 2x that of their white peers.

70%

70% of youth in California's **juvenile justice system have unmet behavioral health needs**, and youth of color are dramatically over-represented.

Making Healing Centered Schools a reality isn't simply a matter of tweaking access or programs...

It requires acknowledgment of how racism and poverty impact the social and emotional health of children



Healthcare System stats RIGHT NOW

**ED
VISITS**

Beginning in April 2020, the proportion of children's mental health-related ED visits among all pediatric ED visits increased and remained elevated through October

24/31%

Compared with 2019, the proportion of mental health-related visits for children aged 5–11 and 12–17 years increased approximately 24% and 31%, respectively

25%

One in four young adults between the ages of 18 and 24 say they've considered suicide because of the pandemic, according to new CDC data that paints a bleak picture of the nation's mental health during the crisis.

RADY CHILDREN'S HOSPITAL IN SAN DIEGO:

Between FY2011 and FY2019, annual behavioral health volume has increased

1746%

From 163 visits to 3,009 visits in 8 years

Comparatively, total Emergency Department visits has grown 23% during this same time period



SCHOOLS CAN (and must) BE ESSENTIAL ACTORS IN OUR RESPONSE:

Schools are ground zero for the youth mental health crisis!



The Health Care System Needs Schools: Children ages 8-18 have the lowest rate of primary care utilization of any demographic in MediCal—and 75% of mental illness manifests in adolescence. Not only are schools essential actors in a reformed mental health system that overtly addresses healing, justice, and structural racism, but they are also essential service settings for children with clinical needs.



The Finances Align: Schools have what the publicly funded Medicaid system needs....access to kids and the non federal dollars to claim against (CPE). (more about that in future discussions)



Thank you, SSFUSD, for being a valuable community partner in whole-child care and striving, each year, to help our youth grow academically, physically, emotionally and socially.

