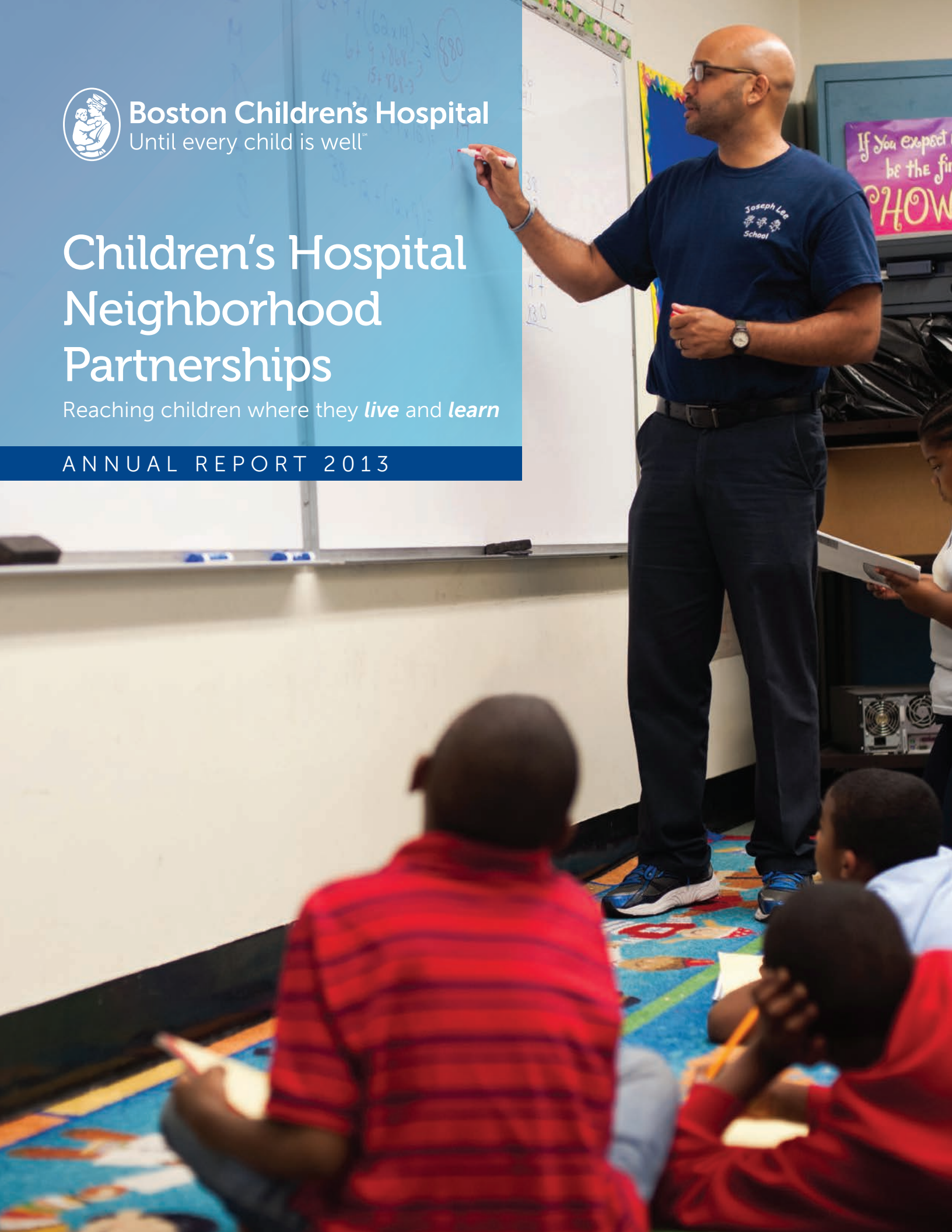
Boston Children's Hospital
Until every child is well℠

Children's Hospital Neighborhood Partnerships

Reaching children where they ***live*** and ***learn***

ANNUAL REPORT 2013



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Executive Summary

For more than 10 years, the Boston Children's Hospital Neighborhood Partnerships (CHNP) program has placed social workers, psychologists, and psychiatrists in schools and community health centers throughout underserved neighborhoods of Boston to provide a comprehensive array of mental health services to children and adolescents where they live and learn.

The overall goals of CHNP are 1) to increase access to children's mental health services; 2) to promote children's healthy social-emotional development; 3) to build the sustainable mental health capacity of partner organizations; 4) to promote systemic change in mental health service delivery; and 5) to provide services that achieve a high degree of satisfaction with all stakeholders.

In its **School-Based Program,** in the 2012/2013 academic year CHNP provided clinical, early intervention, and prevention/promotion services to nearly 2000 students, and provided nearly 1500 hours of training and consultation to more than 200 teachers and 50 parents. Of the 11 CHNP partner schools, half are designated by the state as underperforming academically. Four-fifths of students attending these schools are children of color, nearly two-thirds qualify for free or reduced lunch, and one-fifth are English language learners. Nearly three-quarters of school staff rate family stressors, nearly one-half rate disruptive behavior, and from one-fifth to two-fifths rate anxiety, trauma, and depression as significant problems in their schools that impair their ability to teach, and their students' ability to learn.

CHNP's school-based program addresses these problems by bringing child-centered, prevention-oriented mental health services to children in their own schools. In the past year, CHNP was successful in improving access to care by reducing the wait-time for crisis response and therapy services, preventing adverse outcomes in crisis situations, and increasing the number of therapy sessions, compared to traditional mental health services. CHNP was successful in promoting children's social-emotional development by reducing psychiatric symptoms and functional impairment among students receiving clinical services, and by improving coping strategies, social-emotional competencies, and depression-related knowledge, attitudes, and self-efficacy among students receiving early intervention and prevention services. CHNP was successful in building partner schools' capacities to create a safe and supportive environment. CHNP was successful in promoting systemic change in mental health service delivery by training professionals in community mental health, partnering with the Boston Public School District to develop and implement a new model of school-based mental health services, broadly disseminating a nationally-recognized depression awareness program, and partnering with multiple organizations to draft and pass legislation to improve mental health service delivery throughout the Commonwealth. And CHNP was successful in achieving high satisfaction with all services provided to school staff, students, and parents.

In its **Community Health Center Program**, in 2012/2013 CHNP provided early identification, psychiatric assessment and treatment, and mental health care coordination to over 200 children, adolescents, and young adults. Two-thirds of these youth are children of color, one-quarter live in poverty, and one-half speak a language other than English in the home. Nearly all health center staff rated family stressors, and over one-half rated trauma, anxiety, disruptive behavior, depression, and anger management as significant problems for their patients. CHNP's community health center program addresses these problems by bringing family-centered mental health services into the children's medical homes in their own communities. Health center staff report a high level of satisfaction with this integrated model of service.

As detailed in this report, CHNP continues to bring a broad array of top quality mental health services to children and adolescents in greatest need **where they live and learn**. In so doing, CHNP strives to contribute to a brighter future for the children and families of Boston.

Introduction

For more than a decade, the Boston Children's Hospital Neighborhood Partnerships (CHNP) Program has worked with public schools and community health centers across Boston to provide mental health services where children and adolescents live and learn.

CHNP focuses its services on some of the most underserved and under-resourced neighborhoods in Boston to help increase access to services, promote healthy social-emotional development, build the sustainable mental health capacity of partner organizations, and create systemic change in the delivery of mental health services.

Children growing up in these communities are some of the most in need of high quality, accessible services. These children face multiple factors that put them at greater risk for experiencing mental health problems, including living in communities with high rates of poverty, exposure to interpersonal violence, and systemic discrimination. Though the need is high, these children and their families also experience formidable barriers when attempting to access mental health services. CHNP seeks to reduce these barriers through its two community-based programs: the School-Based Program and the Community Health Center Program.

The **School-Based Program** includes partnerships with public schools in Boston, Jamaica Plain, Roxbury, West Roxbury, Dorchester, and Roslindale, including elementary, K-8, middle, and high schools. Boston Children's Hospital (BCH) social workers and psychologists work onsite to provide clinical, early intervention, and prevention and promotion services to students, and mental health training and consultation to school staff. Family engagement is a critical component of CHNP's work in schools.

The **Community Health Center Program** includes partnerships with community health centers in Jamaica Plain and Roxbury. BCH child and adolescent psychiatrists work on-site to provide early identification, assessment, treatment, and care coordination services to children and adolescents receiving primary medical care at the health centers. The psychiatrists also provide mental health training and consultation to health center staff.

The overall goals of CHNP are:

1. To increase access to children's mental health services;
2. To promote children's healthy social-emotional development;
3. To build sustainable mental health capacity of partner organizations;
4. To promote systemic change in mental health service delivery; and
5. To provide services that achieve a high rate of satisfaction with all stakeholders.

This report provides an overview of CHNP's school and community health center programs during the 2012/2013 academic year.

School-Based Program

CHNP Partner Schools

The 11 CHNP partner schools enroll almost 7,000 students; half of the schools are designated by the state as underperforming academically, and two are at highest academic risk. The sociodemographic characteristics of students in CHNP schools are presented in Table 1. Eighty percent of the students in these schools are Black and/or Latino and nearly two-thirds qualify for free or reduced lunch. Just under 20% are classified as English Language Learners or qualify for special education services.

The clinical staff in CHNP schools includes 9 social workers, 4 psychologists, and 6 graduate and post-doctoral trainees and 5 psychiatry fellows. The allocation of CHNP clinician time across partner schools is shown in Table 1.

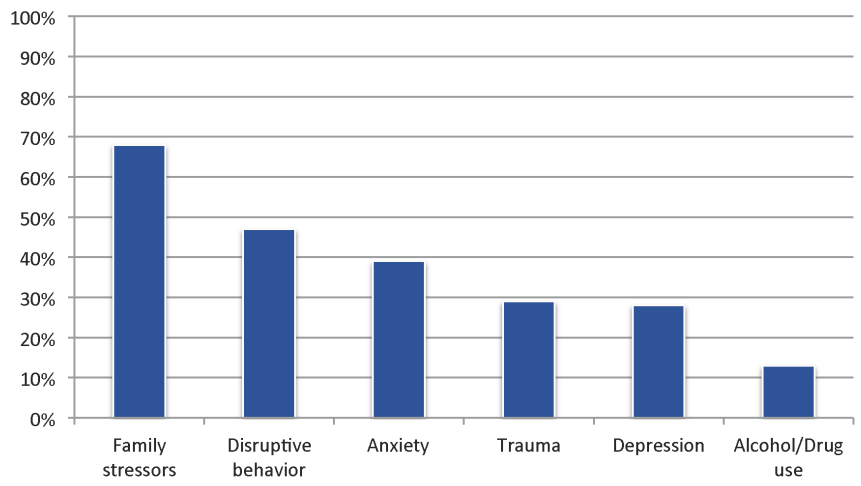
School Needs Assessment

Each year, CHNP conducts a needs assessment with the staff in all partner schools to identify which mental health problems are perceived as most problematic. As Figure 1 illustrates, nearly 70% of teachers and school staff rated family stressors as having a "big" or "very big" impact on their students. Disruptive behavior and anxiety were also viewed as pressing concerns.

Table 1. *Sociodemographic Characteristics of CHNP Partner Schools*

	Clinician FTE	% Male	Grade Levels	Total Enroll	% Asian	% AA	% Latino	% White	% Free Lunch	% ELL	% SPED	Partner Since
Boston Arts Academy	1.5	40.2	9-12	420	2.4	43.8	35.5	15.0	56.4	5.5	14.8	2002
Boston Latin School	0.5	44.9	7-12	2,353	29.2	10.3	9.7	47.5	22.8	0.4	1.1	2002
Dorchester Collegiate Academy	1.1	54.0	4-12	141	0.7	71.6	19.9	3.5	61.7	0.0	7.8	2009
English High School	1.0	54.9	9-12	610	1.8	44.4	47.5	4.4	70.7	36.9	27.9	2003
Lee Complex	1.5	55.9	K-8	605	5.5	55.5	31.0	3.8	75.6	17.9	26.6	2005
Lyndon K-8 School	2.0	49.6	K-8	548	1.3	7.3	47.3	42.9	46.4	29.9	21.9	2002
Marshall Elementary School	1.8	50.6	K-5	688	1.7	51.0	41.4	1.5	75.7	34.9	15.6	2003
Match Middle School	0.8	51.8	6-8	244	0.6	58.5	34.8	3.1	61.6	2.1	17.4	2009
Match High School	0.5	51.8	9-12	233	0.6	58.5	34.8	3.1	61.6	2.1	17.4	2006
Sumner Elementary School	1.0	51.2	K-5	529	1.5	23.4	66.2	7.4	78.1	40.6	21.9	2002
Tobin K-8 School	0.8	50.2	K-8	434	0.9	23.5	71.9	1.8	80.6	46.3	14.1	2004
Average	1.1	50.5	N/A	618.6	4.2	40.7	40.0	12.2	62.8	19.7	17.0	

Figure 1. *Percent of School Staff Who Rate Each Mental Health Problem as Having a "Big" or "Very Big" Impact on Their Students (N=328)*



Nearly three-quarters of staff in CHNP schools reported that these mental health problems substantially impaired their ability to focus on teaching, and nearly two-thirds viewed mental health problems as a significant barrier to learning for their students.

Yet despite this high level of perceived need, only 13% of teachers believed that there are sufficient mental health resources in their schools and only a quarter feel confident in their ability to address mental health issues when they arise in their work (Figures 2 and 3).

School Service Delivery Model

CHNP provides four levels of mental health services in the schools, as shown in Figure 4. This model is aligned with the public health model, with each level increasing in intensity for students with a more acute level of need.

1. The **Clinical Intervention** level includes services for students with *clinically significant mental health problems.* Clinicians provide or refer students for urgent or routine clinical assessment and ongoing treatment.
2. The **Early Intervention** level targets students who may be at *greater risk for developing mental health problems* or who are demonstrating early warning signs. Clinicians provide brief targeted group interventions, referrals for strategic supports, and/or care coordination.
3. The **Prevention and Promotion** level aims to promote a *safe and supportive learning environment*. Clinicians teach social-emotional skills to students, provide psychoeducation about mental health, coordinate school-wide initiatives/campaigns, and provide workshops and support to parents.
4. The **Capacity Building** level targets *systems-level and organizational issues* by providing mental health training and consultation to teachers, administrators, and other school staff.

Across these levels, CHNP provided mental health services to 1932 students, representing approximately 20% of the total school enrollment, during the 2012-2013 school year. Nearly 1500 hours of consultation were provided and over 200 teachers participated in CHNP professional development workshops.

Table 2 presents the distribution of these services across the 11 CHNP partner schools.

Figure 2. *Percent of Teachers Who Think Their School Has Enough Resources to Address Student Mental Health Needs (N=328)*

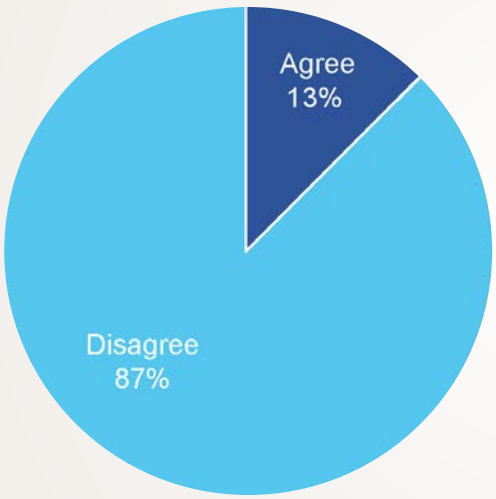


Figure 3. *Percent of Teachers Who Feel Confident in Their Ability to Address Mental Health (N=328)*

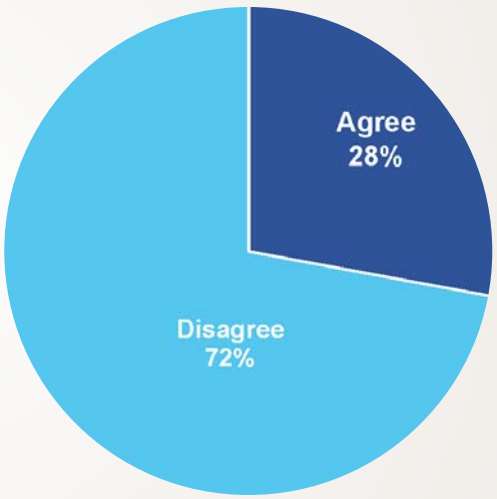
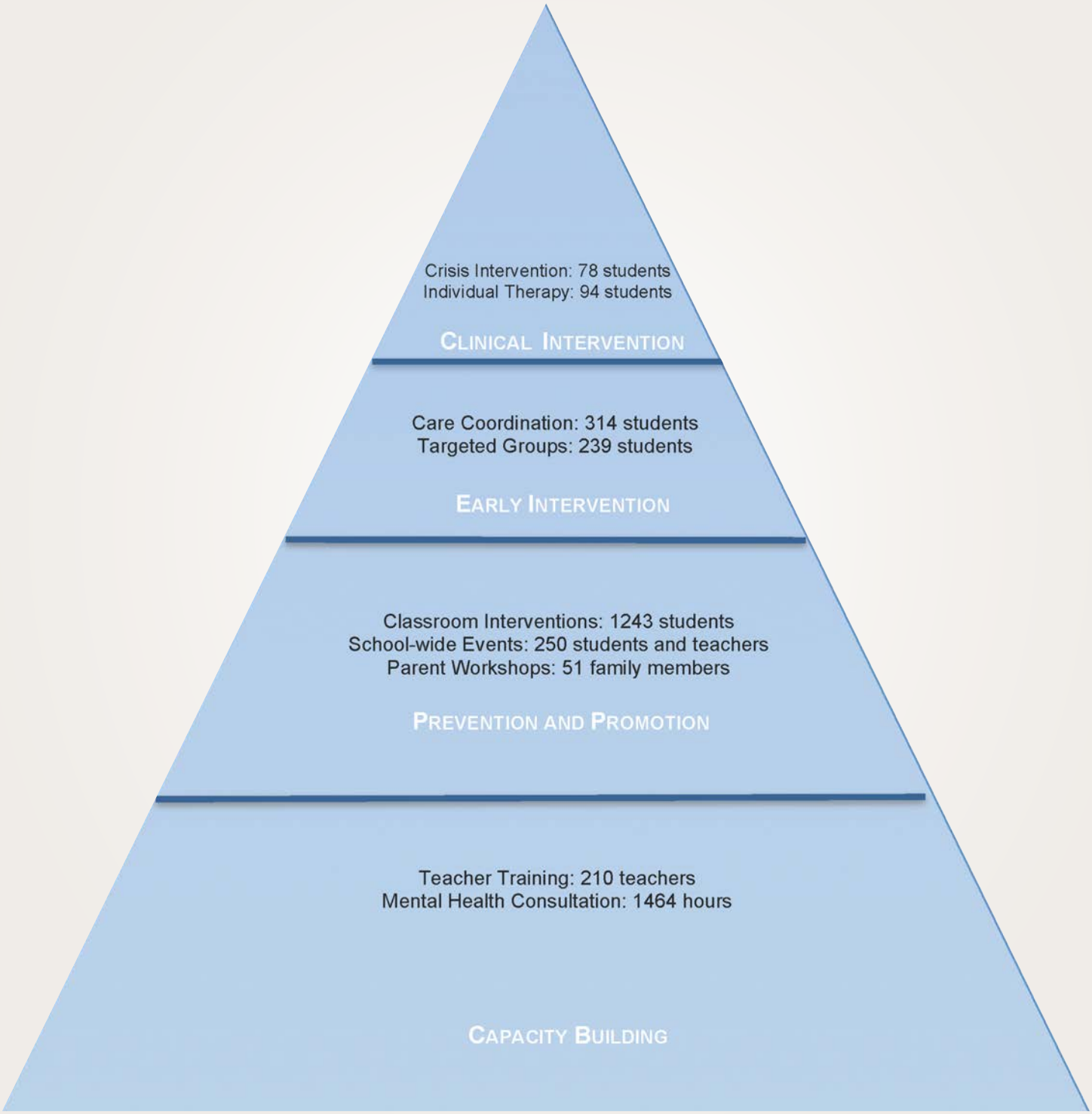


Figure 4. *CHNP School Service Delivery Model*

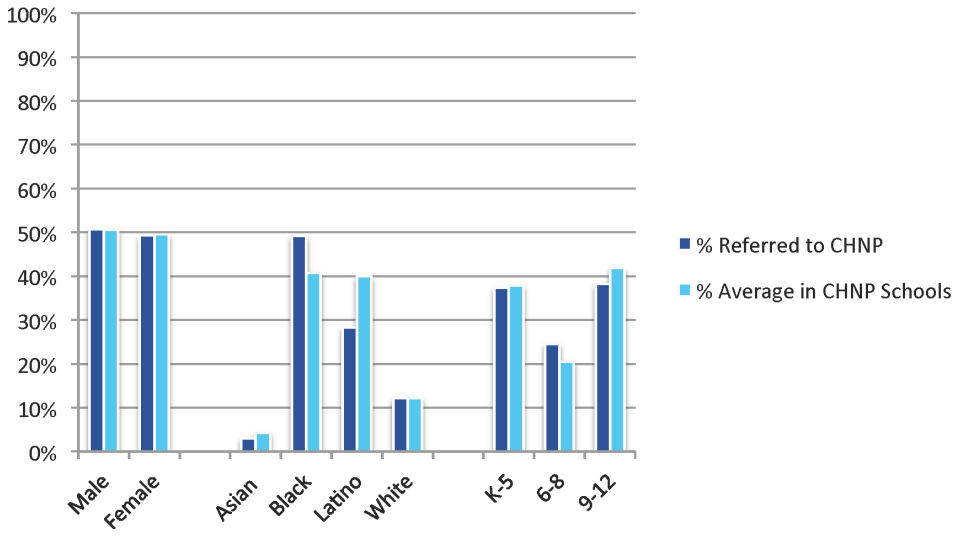


* The number of students exceeds 1,932 because some students received multiple services.

Table 2. *Distribution of Services in CHNP Partner Schools*

	Crisis Intervention	Individual Therapy	Care Coordination	Targeted Groups	Classroom Interventions	Parents Trained	Teachers Trained	Consultation Hours
Boston Arts Academy	3	20	45	15	99	--	--	106
Boston Latin School	5	--	49	--	92	--	--	25
Dorchester Collegiate Academy	--	10	35	22	--	--	13	148
English High School	5	5	29	19	68	--	3	71
Lee Complex	26	8	24	20	323	30	11	165
Lyndon K-8 School	7	22	5	46	40	--	--	192
Marshall Elementary School	9	12	17	17	66	--	70	140
Match Middle School	14	4	22	38	247	--	50	106
Match High School	4	1	74	--	68	--	63	158
Sumner Elementary School	5	--	3	52	190	21	--	315
Tobin K-8 School	--	12	11	10	50	--	--	38
Total	78	94	314	239	1243	51	210	1464

Figure 5. *Sociodemographic Characteristics of Students Referred to CHNP as Compared to CHNP Schools (N=699)*



School Service Utilization Characteristics

In the 2012/2013 academic year, 699 students (approximately 10% of the total enrollment) were referred to CHNP for Clinical and Early Intervention services. As depicted in Figure 5, Black students and those in the middle school grades (population groups typically underserved by the traditional mental health system) were overrepresented among those referred, whereas Latino students and older students were underrepresented.

Figure 6 depicts the presenting problems for referred students. One quarter of these students were referred for behavior or disciplinary issues. Internalizing problems (anxiety, depression) accounted for one-fifth of all referrals. Family stressors, peer conflict, and academic/learning issues were also common presenting problems.

As Figure 7 illustrates, 80% of students referred to CHNP had clinically significant mental health problems, as measured by clinicians' ratings on the Children's Global Assessment Scale (CGAS). Figure 8 depicts the severity of referred students' psychiatric symptoms and functional impairment by type of service provided. A score less than 70 indicates that students' level of symptoms and impairment warrant clinical intervention.

Figure 6. *Primary Presenting Problem for Students Referred to CHNP (N=699)*

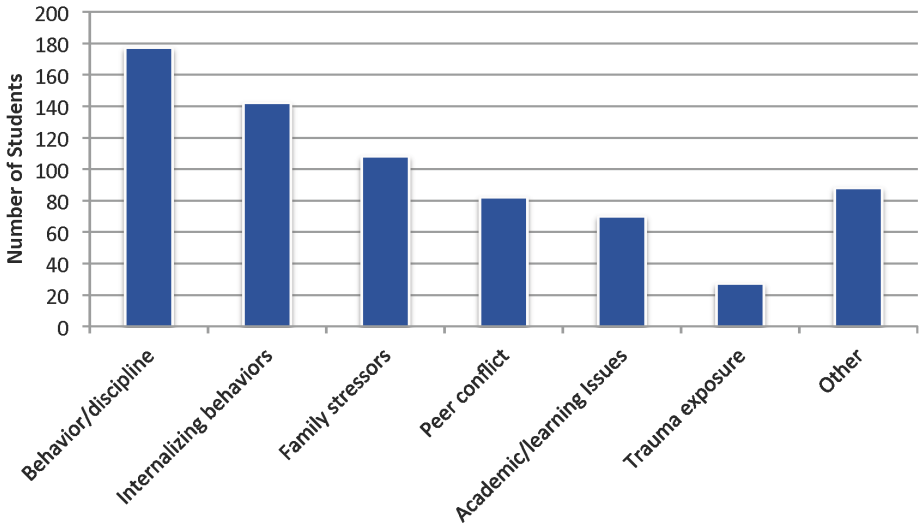


Figure 7. *Percent of Students Demonstrating Clinical Impairment at Initial Assessment (N=699)*

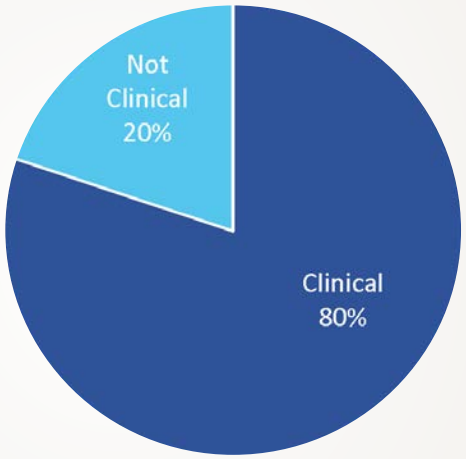
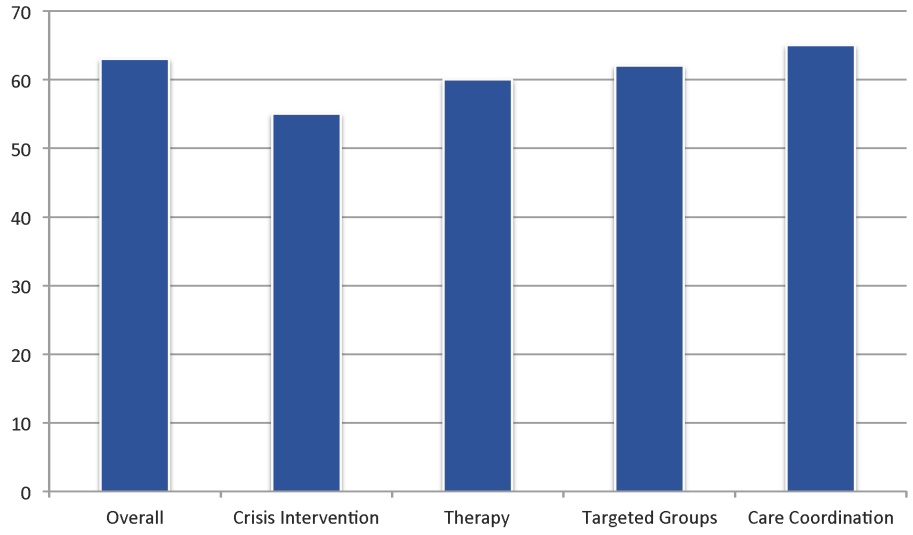


Figure 8. *Average CGAS Score for Students Referred to Each Service Type (N=699)*



Clinical Intervention Services

Crisis Intervention

Seventy-eight students were referred to CHNP because they were in crisis and needed immediate mental health attention. As shown in Figure 9, nearly two-thirds of these students were in emotional distress, meaning they could not regulate their emotions or be calmed after an extended period of time. Almost 20% of students demonstrated suicidal thoughts or behaviors, and another 20% exhibited out of control behavior and could not be contained in the classroom.

After the initial assessment and triage, CHNP clinicians provided an additional session of follow up care to nearly one-third of students who presented in crisis. In addition, clinicians also made an average of one collateral contact with parents, teachers, or outside providers on behalf of these students. More than one-third of these students were referred for other services, most frequently for mental health services (51%) or an additional assessment/evaluation (32%).

There were 255 crisis situations that required response by CHNP clinicians, which includes students first seen in crisis as well as students being seen in other service modalities who experience crises. One of the benefits to providing crisis intervention services in the school setting is that children can be assessed by a mental health professional without a long wait. Figure 10 compares the **average wait time** for crisis intervention services across these emergency situations at CHNP schools with the average wait time in community settings. In CHNP schools, the average wait time is 3 minutes, compared with at least 90 minutes in a community setting, such as in a hospital emergency room or waiting for the Boston Emergency Services Team (BEST) to arrive at the school.

Having a mental health provider in the building also helps ensure that students receive an appropriate level of care. Without CHNP services, many students in crisis would be referred to unnecessarily restrictive service sites (e.g., hospital emergency rooms), would be subjected to inappropriate disciplinary action, or would receive no care. Figure 11 displays the distribution of **adverse outcomes prevented in crisis situations.**

Individual Therapy

CHNP clinicians provided individual therapy to 94 students. Over 25% of students in therapy were struggling to adjust to a stressful situation (Adjustment Disorder). Attention/behavior, depressive, and anxiety disorders were also highly represented. Figure 12 depicts the psychiatric diagnoses of students receiving individual therapy.

Providing therapy services in schools helps children access services more quickly. Figure 13 shows the **median wait time** from referral and the first therapy appointment, as compared between CHNP schools and community treatment venues. In CHNP schools, the median wait time is 10 days, compared to at least 6 weeks in community settings, such as health centers or outpatient clinics.

Receiving therapy in school also helps children stay in therapy for longer than they would otherwise. Students who receive therapy services from CHNP receive an average of 17 sessions, which is the equivalent to an average of 3 sessions each month. Nearly half of the students seen in therapy were also seen in the previous school year, further extending the length of care. Figure 14 compares the average number of therapy sessions between CHNP and community treatment venues. Typically in urban community settings, only half of the patients receive five sessions; and many do not even make it to their first appointment. In addition to therapy sessions with the student, clinicians also provide an average of 2 collateral contacts each month, most frequently with teachers and parents.

Figure 15 compares the therapist-rated proportions of students demonstrating clinically significant psychiatric symptoms and functional impairment, as measured by the Children's Global Assessment Scale (CGAS), before and after therapy. More than three-quarters of the students referred to CHNP for therapy demonstrated clinical impairment at the initial assessment, as compared with just over half at termination, representing a nearly 20% decrease in clinical impairment. Overall, 62% of students demonstrated improvement in their clinical status.

This finding was supported by therapist-rated global improvement from before to after therapy as measured by the Clinical Global Impressions (CGI) scale. Overall, nearly 85% of students in therapy were rated as demonstrating much or very much improvement at termination (Figure 16).

Figure 9. *Nature of Crisis (N=78)*

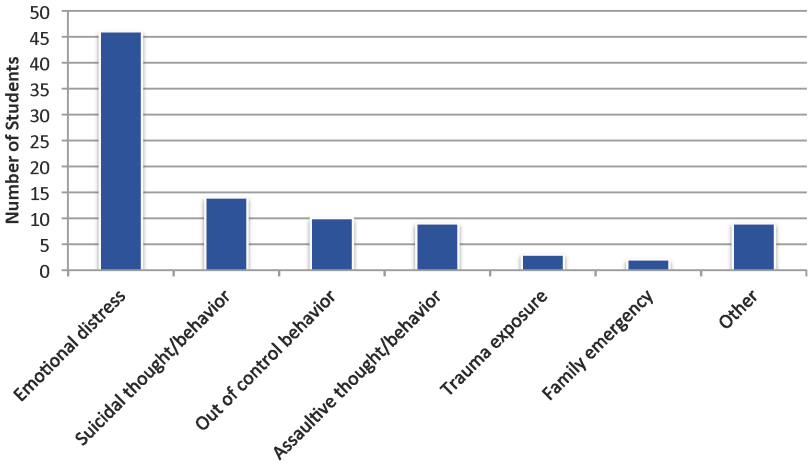


Figure 10. *Average Wait-time for Crisis Intervention Services (N=255)*

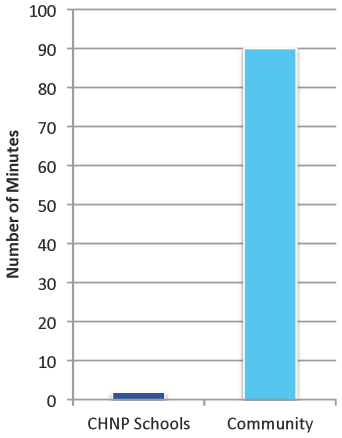


Figure 11. *Adverse Outcomes Prevented in Crisis Situations (N=255)*

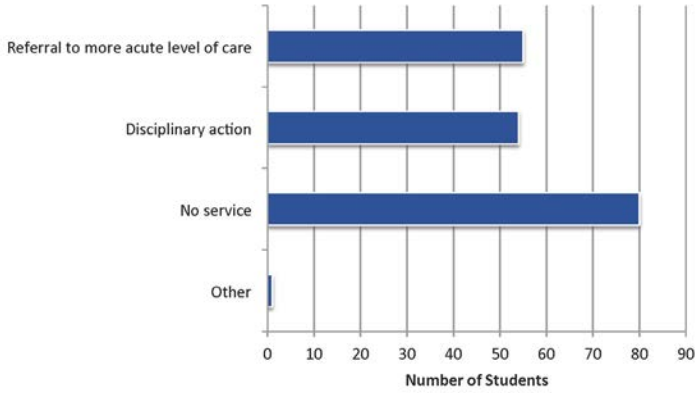


Figure 12. *Primary Diagnostic Categories for Students in Therapy (N=94)*

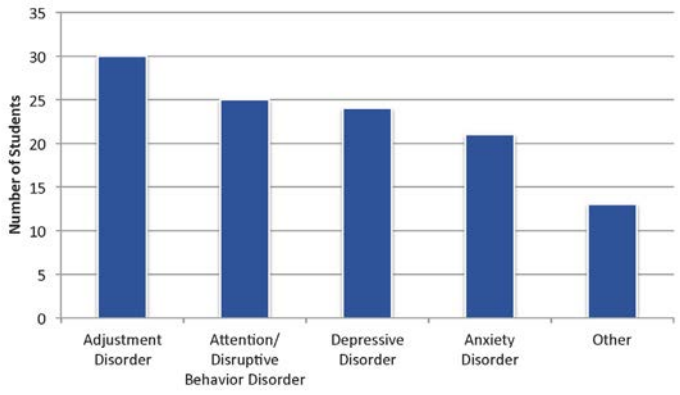


Figure 13. *Median Wait-time for Therapy Services (N=94)*

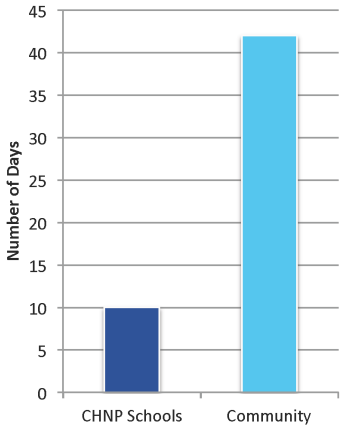


Figure 14. *Average Number of Therapy Sessions (N=94)*

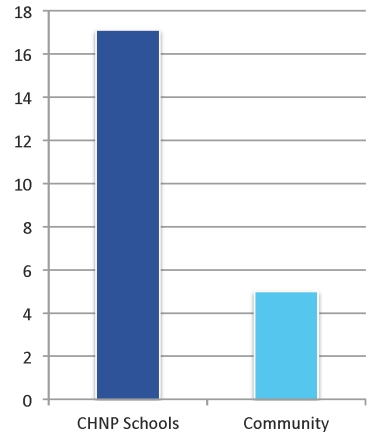


Figure 15. *Percent of Students in Therapy Demonstrating Clinical Impairment (N=94)*

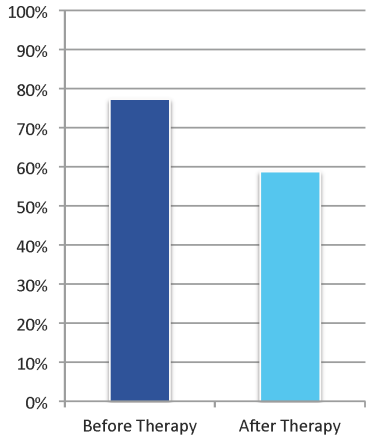


Figure 16. *Improvement Categories for Students in Therapy at Termination (N=94)*

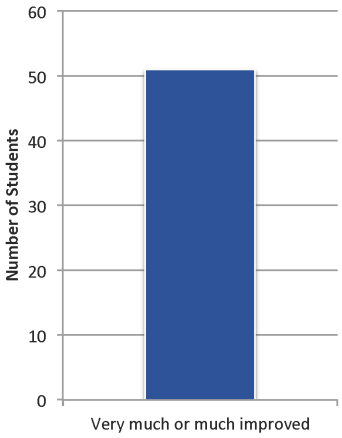


Figure 17. *Parent Satisfaction with Therapy Services (N=34)*

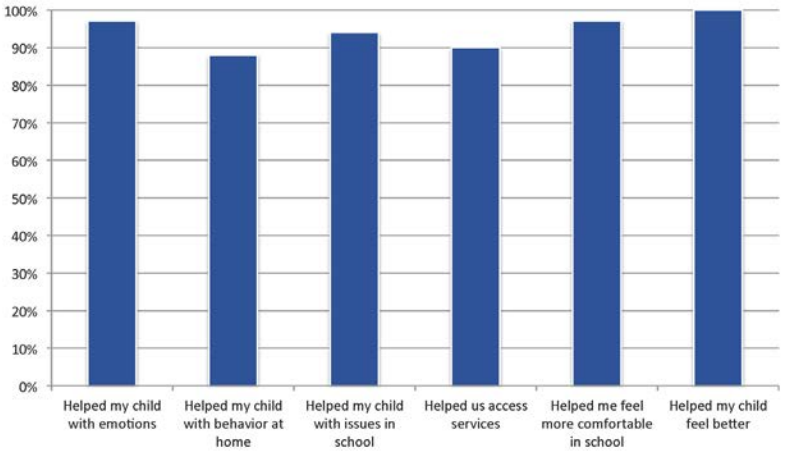
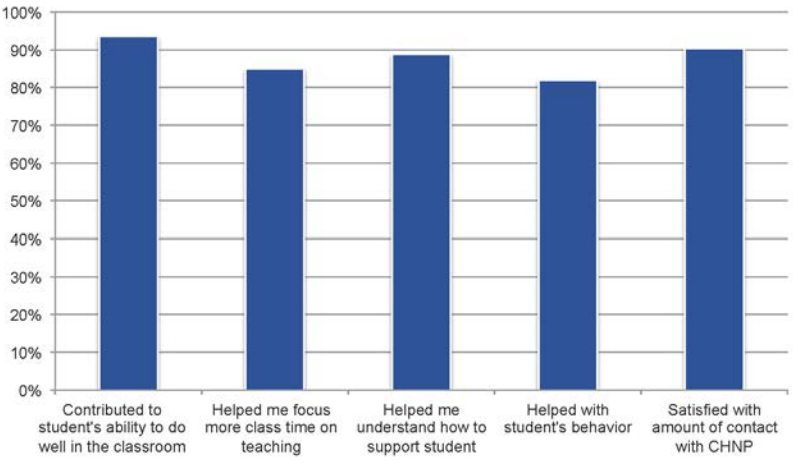


Figure 18. *Teacher Satisfaction with Therapy Services (N=62)*



Satisfaction with Therapy Services

As Figures 17, 18, and 19 show, parents, teachers, and students all demonstrate a high level of satisfaction with CHNP therapy services.

What parents find helpful about therapy services:

"Initially, I was very nervous about my child receiving services. However, the CHNP staff at the school did a great job with making us feel comfortable by easing us into the counseling and follow up regularly to let me know how things were going. The services offered helped turn this school year around for my daughter."

"My child received excellent care this school year and is much more aware of some of the issues he is dealing with and is equipped to find positive solutions, instead of immediately acting out or being disruptive."

"The guidance that the CHNP clinician has provided my son and my family is priceless. His time with my son enabled him to grow and mature and process his emotions on a deep level. The CHNP clinician and the services he provided will always have a special place in our hearts."

What teachers find helpful about therapy services:

"Counseling with CHNP seemed to give my student a space to develop a deeper level of self-awareness as well as a time outside of her classes to socialize and thoughtfully reflect."

"Through the CHNP services, this student has built on the skills to help him cope with anger management, communication and self-awareness."

"The CHNP services were very helpful to my student as well as to myself as a teacher. It helped the student by teaching him strategies on how to deal with different situations and also it helped him during his difficult time. The services made a difference on the student behavior and performance in class, in school and at home."

"My student greatly benefitted from the one-on-one attention provided and from the opportunity to discuss and troubleshoot problem interactions with peers, allowing me to focus more of my energy on teaching."

"The professionalism of the service providers, respectful interactions with students, communication with school staff, willingness to go out of the way to assist with any issue that arises, listening to staff and following up with children and families."

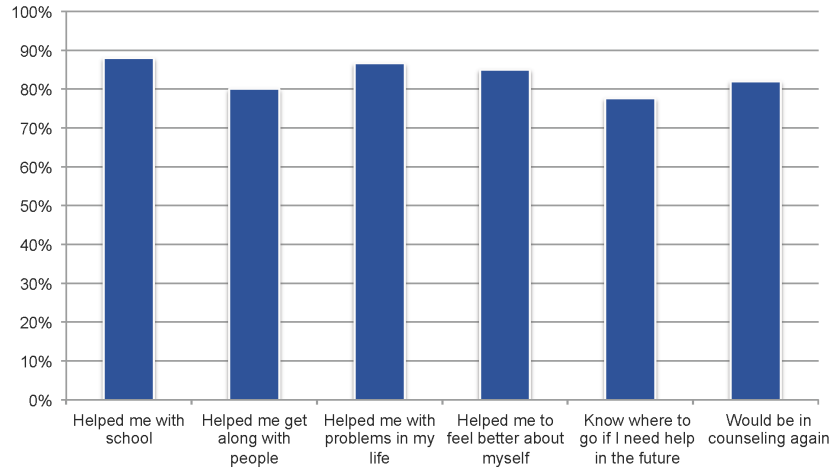
What students find helpful about therapy services:

"My counselor has helped a tremendous amount this year. He was the one person I felt like I could really trust and count on in school, and I can definitely say counseling with him helped me gain confidence and understanding of myself."

"Counseling has helped me with complicated feelings like anger and nervousness."

"It was a good experience. She helped me be patient and let me open up and tell her if the sessions weren't working or I was frustrated."

Figure 19. *Student Satisfaction with Therapy Services (N=67)*



Early Intervention Services

Care Coordination

CHNP clinicians provided care coordination services to 314 students. As Figure 20 shows, the most frequent presenting problems for students receiving care coordination included internalizing problems (anxiety, depression), family stressors, and behavior/disciplinary issues. Academic/learning issues and peer conflict were also frequent reasons for referral.

After conducting an initial assessment, clinicians typically met with students referred for care coordination an average of three times. In addition, clinicians provided an average of two collateral contacts with parents, teachers, and/or outside providers. In nearly 85% of the cases, clinicians made referrals for additional mental health services. The most common referral locations for these students were school-based support services and CHNP as shown in Figure 21.

Targeted Groups

CHNP clinicians facilitated targeted groups for 239 students. The most frequent presenting problems for these students are shown in Figure 22. Behavior/discipline was the most common presenting problem, comprising nearly one-third of all group referrals; internalizing problems (anxiety, depression) were also prominently represented.

Clinicians facilitated two main types of groups: those developed as original programs by CHNP clinicians (one-third of groups) and those that followed an existing evidence-based curriculum (two-thirds of groups). Nearly all of the evidence-based groups followed the Coping Power curriculum. Coping Power is a preventive intervention targeted at students in the late elementary and middle school years who are at increased risk for behavioral problems and aggression. The curriculum promotes key social-emotional skills and behaviors, including social competence, self-regulation, and conflict resolution.

For those groups that were developed by CHNP clinicians, 40% focused on self-regulation skills, which includes how to identify one's emotions, problem-solve, and control one's behavior (Figure 23).

Coping Strategies

Figure 24 compares the average student-rated coping strategy scores, as measured by the Coping Strategies Checklist (CSC), before and after students' participation in targeted groups, both those that were developed by CHNP and those that used the Coping Power curriculum. The checklist measures students' abilities to solve problems and seek support from others in stressful situations.

The average coping strategies scores for students in CHNP developed groups at pre-test was 2.5, compared to the average post-test scores of 2.9, representing a gain in adaptive coping of 16%. For students who participated in Coping Power groups, the average coping strategy pre-test scores was 2.5, compared to the average post-test scores of 2.7, representing a gain in adaptive coping of 8%.

Figure 20. *Presenting Problems for Care Coordination (N=314)*

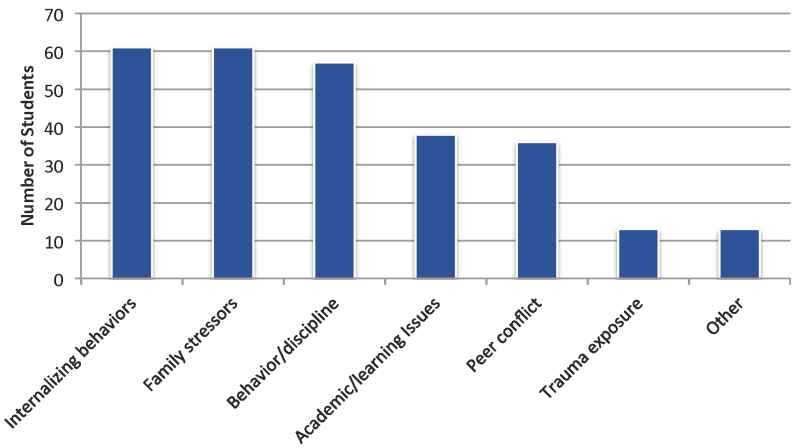
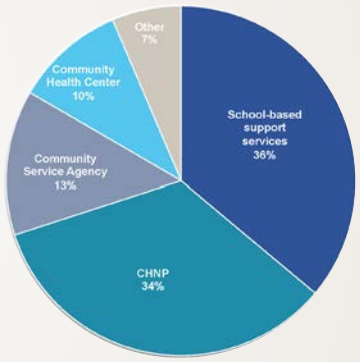


Figure 21. *Referral Locations for Care Coordination (N=98)*



Social-Emotional Competencies

Figure 25 compares the average teacher-rated social-emotional competence scores, as measured by the Social Competence Scale (SCS), before and after students' participation in targeted groups. This scale measures students' abilities to identify and manage feelings and manage interpersonal relationships. The average score at pre-test for students in targeted groups that were developed by CHNP was 2.32, compared to 2.57 at post-test, representing a gain in social competency of nearly 11%. For students who participated in Coping Power groups, the average pre-test score was 1.53, compared with 1.92 at post-test, representing a gain in competency of 25%.

As Figures 26 and 27 show, teachers and students are highly satisfied with these targeted groups.

What teachers find helpful about targeted groups:

"The patience and skill to communicate with the students. The care that they are providing is making a huge difference in student's behavior in class by relieving stress and anxiety and promoting positive skills."

"I thought it helped him with his social skills and learning appropriate behavior with friends."

"My student seems much calmer and less volatile in stressful social situations. She consciously works to control behavior that may be seen as disrespectful to authority figures. I think that CHNP has definitely made her feel more comfortable appropriately expressing her opinions and emotions within a social context."

"My student seems much more able to focus on his school work. He is not having as many behavioral difficulties and seems much calmer and more collected."

What students find helpful about targeted groups:

"I always looked forward to this group. I really like meeting with everyone and feeling accepted."

"Group has made me better at coping with problems and stress and I feel just much happier with life."

"I really enjoyed group and wish it was an everyday thing. I'm going to miss it."

"Gracias! This group has made me feel that I always have someone to talk to when I need someone."

"I liked that I could ask questions comfortably."

Figure 22. *Presenting Problems for Students in Targeted Groups (N=239)*

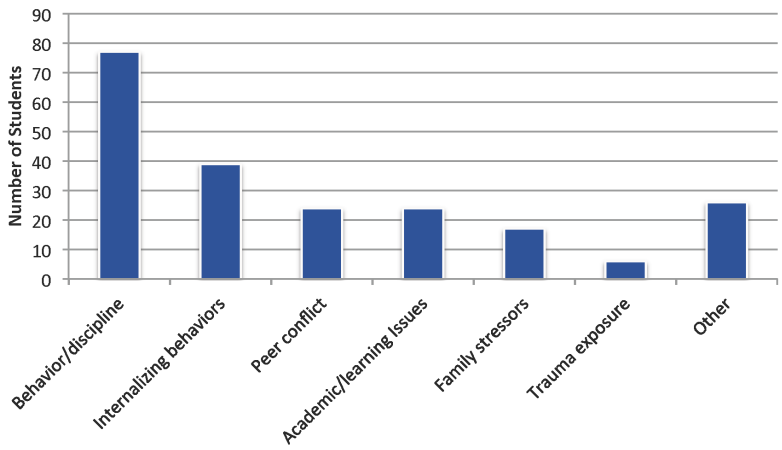


Figure 23: *Topics of CHNP-Developed Targeted Groups (N=22)*

Figure 24. *Change in Coping Strategies*

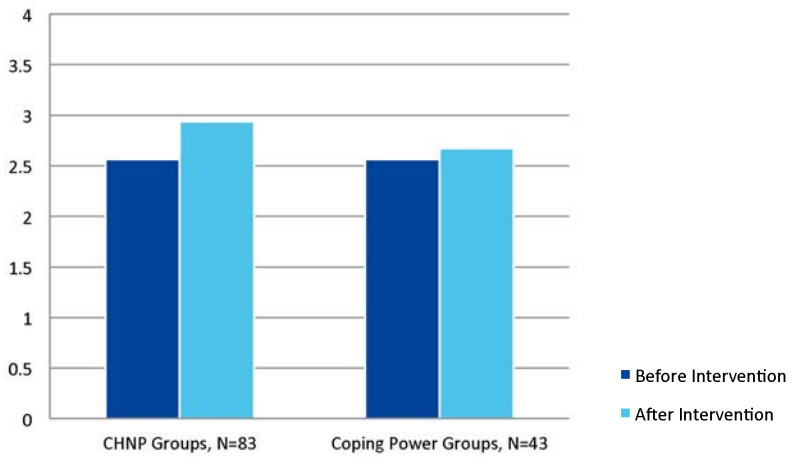
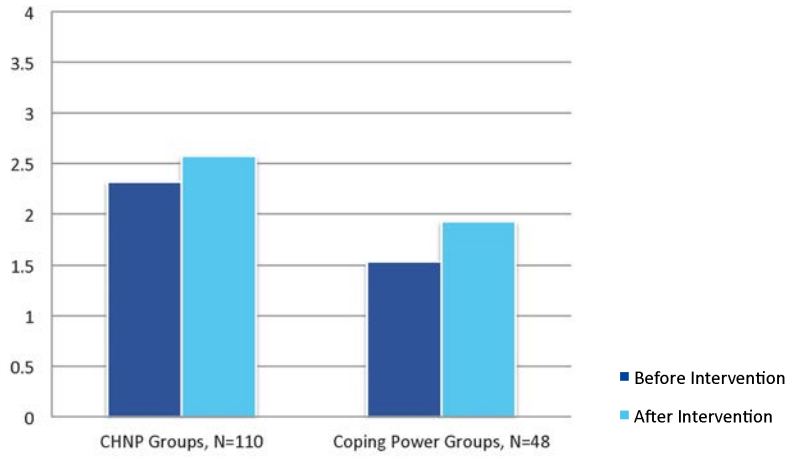


Figure 25. *Change in Social Competence Skills*



"Gracias! This group has made me feel that I always have someone to talk to when I need someone."

Figure 26. *Teacher Satisfaction with Targeted Groups (N=166)*

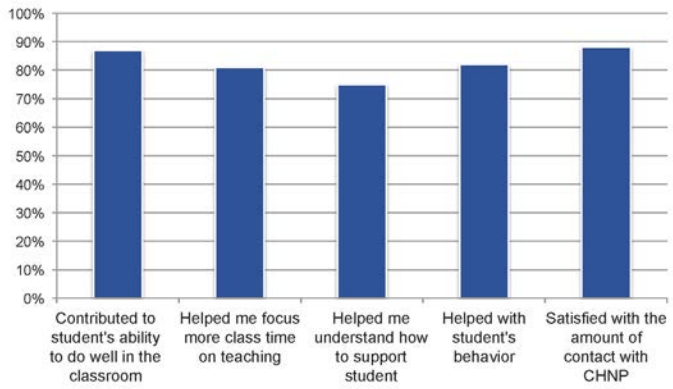
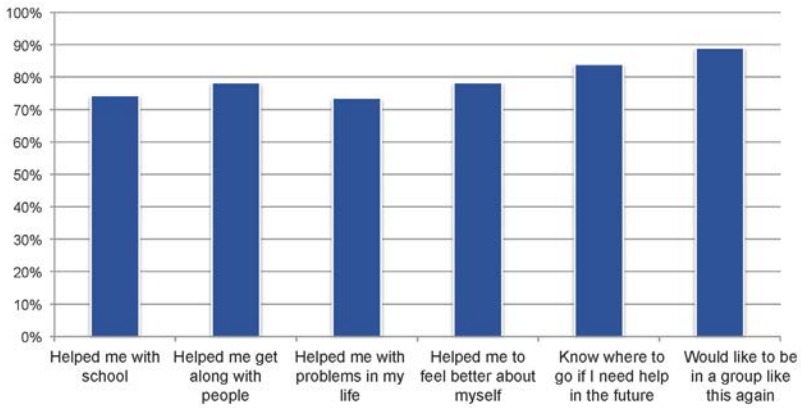


Figure 27. *Student Satisfaction with Targeted Groups (N=153)*



"I thought it helped him with his social skills and learning appropriate behavior with friends."

Children's Hospital Neighborhood Partnerships

Transforming mental health care for Boston's youth in schools

Most school districts across the country, including the Boston Public School (BPS) system, define a student's success based primarily on academic achievements. A critical component of academic success, however, is based on appropriately addressing a student's mental health needs. "The reality is that many youth are struggling academically because their social and emotional needs are not being met," says Shella Dennery, PhD, LICSW, director of the Children's Hospital Neighborhood Partnerships (CHNP), the community mental health program in the Department of Psychiatry at Boston Children's Hospital.

It's a sentiment echoed by BPS administrators, including Andria Amador, acting director of Student Services at BPS. "We want kids to read, so we teach them to read. We also want them to behave and have relationship skills—but we don't teach them how to do these things," she says.

School leaders have recognized the necessity of adding a social and emotional health element to their paradigm—one that takes into consideration the mental health needs of urban students in a resource-strapped school system. And while BPS has been eager to expand schools' mental

health services, they needed help to implement such big changes.

BPS turned to its long-time partner CHNP, which already was working closely with staff and families in BPS to help address students' mental health needs. CHNP's prevention-focused model provides clinical services, small group and classroom interventions, as well as consultation services and training for teachers and school staff. Team members also provide crisis management and care coordination.

Over the last school year (2012-2013), CHNP and BPS piloted a Comprehensive Behavioral Health Model (CBHM) in 10 schools. The number of schools participating will increase by 13 more during the next school year. The goal is to reach all 127 schools in the BPS system. The model includes three key elements:

1) a universal behavioral health screening tool to identify children at increased risk;
2) a social-emotional skills curriculum for all students; and
3) professional development for teachers specifically on behavioral health.

Recently, the BPS School Committee adopted the CBHM to be included in the district's new wellness policy.

"One of the reasons we're so excited about the new Comprehensive Behavioral Health Model is because it will be the same system across all schools in BPS. There will be continuity of care for students," says Catherine MacCuish, principal at the Charles Sumner School in Roslindale and one of CHNP's partner school sites.

CHNP and BPS also have worked together with other stakeholders to advocate for state-wide legislation to improve schools' capacities to address the mental health of their students. Their efforts have been critical in securing substantive legislative support for a comprehensive school-based mental health bill: An Act Relative to Safe and Supportive Schools. "For more than a year, we've been working collaboratively with advocacy groups and Massachusetts Advocates for Children to ensure passage of the safe and supportive schools legislation," says Dennery. "Our mental health work aligns with the models proposed in the pending legislation."

"This kind of work has not been done before. It puts Massachusetts on the map as a pioneer and champion for children's health," says Dennery.

For more than 10 years, CHNP's social workers and psychologists have worked in public schools in underserved Boston neighborhoods. All the while, CHNP has gathered data to determine what works best to build the capacity of both teachers and schools to address mental health issues directly. "CHNP is well positioned to partner with the entire district to create change on a systemic level," says John Riordan, director of community partnerships at Boston Children's. "Part of our four-part mission is community, and this partnership underscores our commitment to reaching kids who might not have access to mental health services by providing those services in schools. This opportunity to collaborate on improving access to care is precisely the kind of impact that the hospital strives for."

By being the first to design and pilot a new model that integrates the key elements of the proposed legislation, BPS is not only leading the way in Massachusetts, but it also has the potential to impact the national dialogue on school-based behavioral health services. As the pilot rolls out this year, the BPS and CHNP leadership team will ensure that data collection is maximized and analyzed to identify what is working. They also are establishing benchmarks and evaluation criteria to assess the model.

The team hopes that this model will be invaluable to other schools across the state as they begin to integrate the pending legislation's requirements. "This kind of work has not been done before. It puts Massachusetts on the map as a pioneer and champion for children's health," says Dennery.

Prevention and Promotion Services

Classroom Interventions

Over 1200 students participated in CHNP classroom interventions. As Figure 28 shows, these activities focused on a range of topics; the most common was education about mental health issues. Clinicians facilitated these activities in classrooms, frequently co-facilitating with teachers. On average, each intervention comprised four sessions.

Coping Strategies

Figure 29 compares the average student-rated coping strategy scores, as measured by the Coping Strategies Checklist (CSC), before and after students' participation in classroom interventions. The checklist measures students' abilities to solve problems and seek support from others in stressful situations.

The average coping strategies scores for students in classroom interventions at pre-test was 2.54, compared to the average post-test scores of 2.63, representing a gain in adaptive coping of 3.5%.

Social-Emotional Competencies

Figure 30 compares the average teacher-rated social-emotional competence scores, as measured by the Social Competence Scale (SCS), before and after students' participation in classroom interventions. This scale measures students' abilities to identify and manage feelings and manage interpersonal relationships; the teacher rates the classroom as a whole. The average score for classrooms at pre-test was 2.23, compared to 3.00 at post-test, representing a gain in competency of nearly 35%.

As Figures 31 and 32 show, teachers and students are highly satisfied with these classroom interventions.

What teachers find helpful about classroom interventions:

"The CHNP clinician makes herself available to meet with and speak with classroom teachers. I value her opinion and experience."

"Lessons were interesting and children were able to use strategies in a drawing that represented a bullying situation and a good solution."

"Activities, discussions and coping strategies were very helpful to my students. Students were always attentive and engaged in the CHNP clinician's well planned lessons."

"Classroom lessons supported earlier lessons on positive behaviors. She provided more common language to be utilized in classroom settings."

What students find helpful about classroom interventions:

"This class helped me relieve my stress and stay out of trouble."

"The thing we do in this class helped me understand more about life and the things worth it in life."

"This class calmed me down so I can keep on going. I love it. It's relaxing to me."

"I liked that everyone got to speak in this class. We all got to ask our questions and I learned a lot."

"We learned things that we need to know about things that will help me make better decisions in middle school."

Break Free From Depression

Break Free From Depression (BFFD) is a 4-session classroom intervention to enhance adolescents' depression awareness skills developed by the Swensrud Depression Prevention Initiative, a part of the CHNP Program. The cornerstone of the intervention is an engaging and innovative documentary that features a diverse group of adolescents speaking in their own words about their experiences with depression and suicidal thoughts, with commentary provided by a local sports celebrity. Surrounding the viewing of the documentary are skills-building sessions to teach students the signs and symptoms of depression, effective strategies for coping with distressing feelings, resources for accessing social and professional support, and how to seek help for themselves and their peers. The BFFD program is intended to be facilitated by trained school staff. Facilitators can access training and consultation from BFFD program staff. To date, the curriculum has reached over 3500 Boston area teens in over 20 schools. Results on page 22 are from 10 schools across Massachusetts that implemented the curriculum in the 2012-2013 school year, including all 4 CHNP partner high schools.

Figure 33 presents the change in scores pertaining to knowledge about depression and suicide for students participating in the *Break Free from Depression* program. At pre-test, students answered 71% of the questions correctly,

Figure 28. *Topics of Classroom Interventions (N=52)*

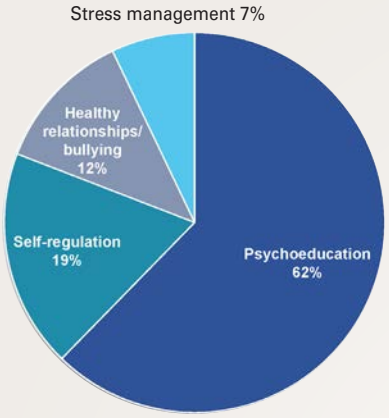


Figure 29. *Change in Coping Strategies (N=113)*

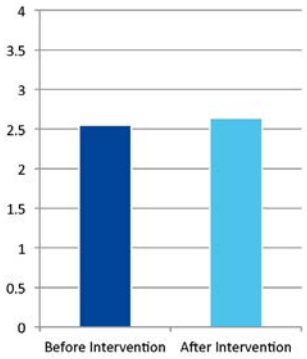


Figure 30. *Change in Social Competence Skills (N=6)*

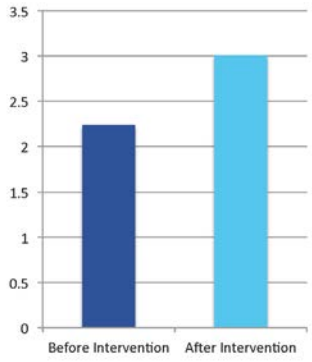


Figure 31. *Teacher Satisfaction with Classroom Interventions (N=22)*

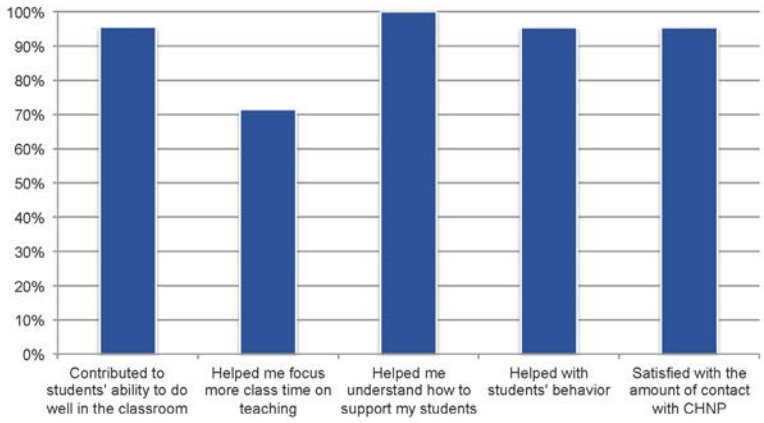
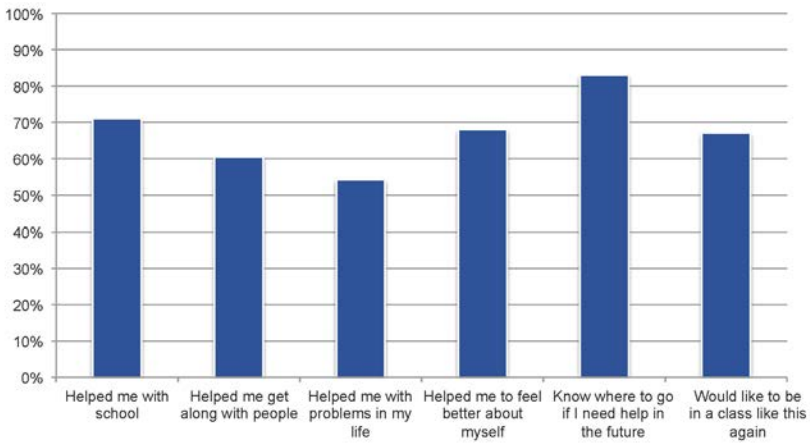


Figure 32. *Student Satisfaction with Classroom Interventions (N=284)*



compared to 81% at post-test, representing a gain in knowledge of 14%.

Figure 34 presents the change in scores pertaining to attitudes about the stigma related to depression and suicide for students participating in the *Break Free From Depression program.* At pre-test, students answered 77% of the skills questions correctly, compared to 83% at post-test, representing a gain of 8% in attitude.

Figure 35 depicts the change in students' confidence before and after participating in the *Break Free from Depression* program. At pre-test, 76% of students rated themselves as confident in their ability to identify signs of depression and suicide in themselves and their peers, compared to 87% at post-test, representing a gain of 14% in self-efficacy.

Students demonstrated a high level of satisfaction with the *Break Free From* Depression program. Figure 36 shows the satisfaction ratings for students; the overall satisfaction rating was 89%.

These results suggest that Break Free From Depression achieves its goals of 1) increasing students' knowledge about depression and suicide, 2) changing their attitudes about the stigma related to depression and suicide, 3) promoting their confidence in identifying the signs as well as seeking help for themselves and others, and 4) achieving high rates of satisfaction with the program. The *Break Free from Depression* program has been included in the Best Practices Registry for Suicide Prevention by the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention. *Break Free From Depression – A 4-Session Curriculum to Address Adolescent Depression,* published by the Swensrud Depression Prevention Initiative, Boston Children's Hospital, 2013, is available at bostonchildrens.org/breakfree.

Parent Workshops

CHNP clinicians facilitated four workshops that reached 51 parents in CHNP partner schools. The goal of these workshops was to help connect parents with each other, build their social support networks, and provide them with strategies to best support their children. Parents report a high level of satisfaction with parenting workshops, as shown in Figure 37. The average satisfaction rating was 98%.

What parents find helpful about workshops:

"I learned a lot of information."

"The workshop was easy to understand, accessible."

"This will help me to change my family's habits."

Figure 33. *Percent Correct on Knowledge Items (N=1308)*

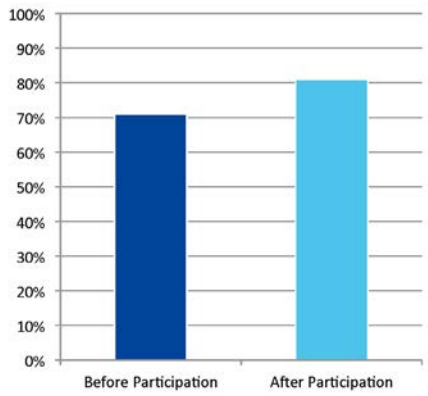


Figure 34. *Percent Correct on Attitudes Questions (N=1308)*

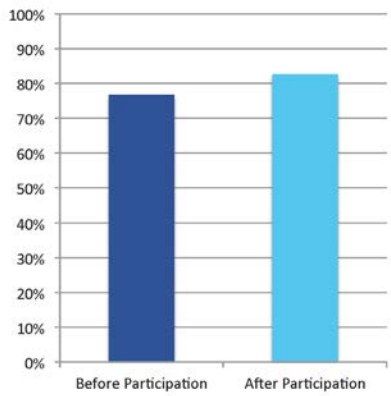


Figure 35. *Percent of Students Reporting Self-Efficacy (N=1308)*

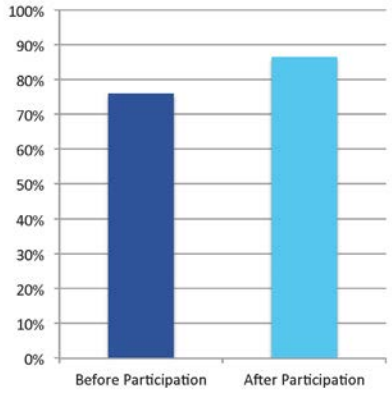


Figure 36. *Student Satisfaction with the Break Free From Depression Program (N=1308)*

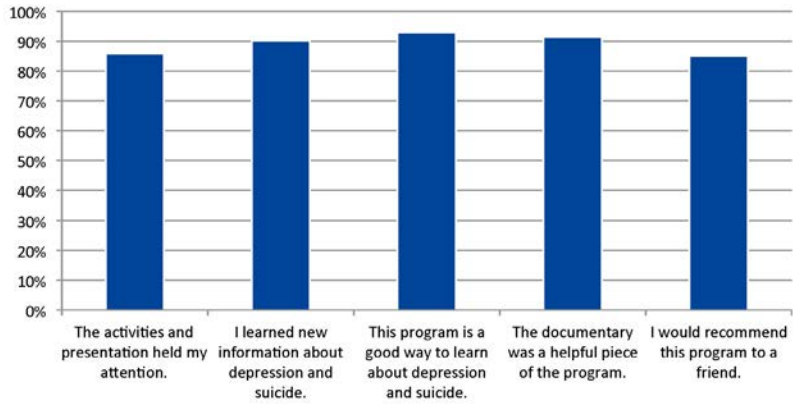
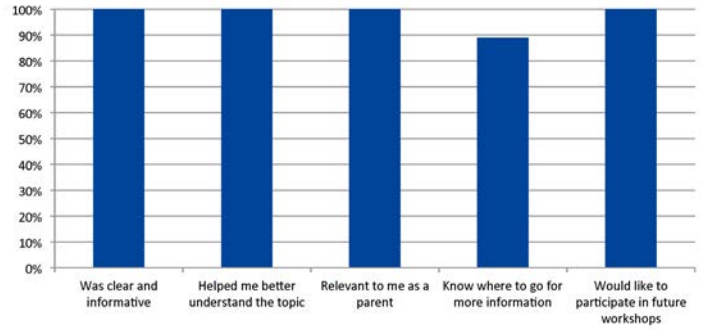


Figure 37. *Parent Satisfaction with Workshops (N=11)*



Bully Prevention Week Success in Jamaica Plain

If your child were being bullied, would you know about it? Most of us would like to believe that if our kids were being targeted at school they'd tell us right away, but unfortunately that's not always the case. Data shows that many bullying victims fail to report their harassment. This could be for any number of reasons, but in many cases the victim stays silent because he's scared that telling someone will make the bullying worse, is embarrassed about being picked on or thinks the adults in his life can't do anything to stop it.

It's a difficult cycle to break, but it's not impossible. To help, Boston Children's Hospital has teamed up with teachers, administrators and students in one Boston school to empower kids to take a stand against bullying.

Andie Hernandez, LICSW, EdM, a school-based clinician and consultant in Children's Hospital Neighborhood Partnerships, recently organized Bully Prevention Week at the MATCH Charter Public School in Jamaica Plain, a middle school that focuses on preparing students for college and beyond.

As a school social worker Hernandez is often called upon for student counseling or consultation when a bullying issue arises at MATCH. Along with Principal Lisa Hwang and Dean of Students Kyle Quadros, Hernandez dealt with plenty of instances of student bullying, and the three adults felt more could be done to eliminate bullying at the source.

"After a while it felt like we were putting out fires. The moment we took care of one problem, another arose," Hernandez says. "We knew that something needed to be done to get

our message out to the entire school instead of reacting to issues as they occurred."

Because of her relationship and involvement with the school's community, Hwang asked Hernandez to help organize an anti-bullying curriculum that could reach all of MATCH's student body and staff. The end result is a series of four, hour-long lessons on bullying prevention and education that Hernandez presented to teachers, who in turn delivered the lesson to students in the classroom.

"Having an in-house social worker who understands our school culture, knows our students, staff and families, is integral," says Hwang. "The partnership is essential. If Andie didn't have the relationships and understanding of our school culture and systems, she wouldn't have the kind of impact she has to directly support students and our 70-plus staff members."

Each lesson focuses on a different bullying theme and cumulates in a creative project where the students share what they learned by calling on their inner poet, artist and rapper to offer peaceful solutions to end bullying.

Other topics addressed include:

Identify the problem. Traditionally, bullying has been described as a physical attack, but there's much more to it. Anytime someone is made to feel scared or hurt by someone else it could be considered bullying. Behaviors like excluding, spreading hurtful rumors and online harassment have been explored, and students were offered a detailed explanation as to why they're considered bullying.

"Having an in-house social worker who understands our school culture, knows our students, staff and families, is integral," says Hwang.

Bystander education. In many cases chronic bullying is allowed to happen because people who see it don't know what to do or say. Experts agree that if you give students clear, easy to follow instructions about what to do if they see bullying you can reduce its prevalence. MATCH addresses this by suggesting multiple ways for students to inform adults about bullying and tips on how kids can discourage bullying when they see it themselves. Because bullying is a school-wide problem, providing the entire student body with strategies to counter it will have the most impact.

Spread the word. The media is covering more and more bullying stories these days and there's no shortage of celebrities willing to speak out against it. But you don't need to be famous to take a stand against bullying. By encouraging students to use creativity to express themselves, the anti-bullying campaign uses an innovative and effective approach.

Take the pledge. At the end of MATCH's Bullying Prevention Week, many students signed a pledge vowing to take a stand against bullying. In exchange for the promise they were given a custom made T-shirt, which was co-designed by two students who had been involved in a bullying incident earlier in the year. Principal Hwang, who first had the idea to celebrate the week with a T-shirt, has said the shirt will be considered part of the school's standard uniform from now on. Hernandez and Hwang hope that seeing the shirt in classrooms and halls throughout the year will remind students to stand up against bullying.

Hernandez has now expanded the bullying prevention week into an anti-bullying program called "Respect for All." The program was implemented in 2012-2013 and consisted of nine lessons delivered in every classroom over three weeks. The Respect for All program aimed to provide students with education on acceptance, tolerance, and kindness in addition to standing up against bullying.

"Going into this we didn't really know how the kids were going to react, but we heard many thoughtful responses from students," she says. "It was exciting and I'm anxious to see what new things we can come up with to tackle the bullying problem head on."

"The message empowered all staff members and students to take a stand and look out for each other," added Hwang. "We will definitely continue to build upon this project in the future."

Capacity Building Services

Teacher Training

CHNP clinicians facilitated 12 workshops that reached 210 teachers. As Figure 38 shows, the most common topic for these workshops was student support, which includes information about specific mental health issues facing students. Information about how to respond to a crisis and fostering a positive school climate were other frequent topics.

Teachers report a high level of satisfaction with CHNP professional development workshops, as Figure 39 shows.

What teachers find helpful about professional development workshops:

"She was clear and concise. She presented concrete strategies that I can use and wasn't bogged down in the theoretical."

"The CHNP clinician was very enthusiastic and engaging. I really appreciated how she would give us the info, have us practice and then talk about it again before moving on to the next topic."

"This workshop helped me understand that considering all the reasons a student is off-task or not complying can help me help them achieve more or feel more comfortable."

"I have a better understanding of how to handle issues involving students with mental health needs."

"I think this workshop gives me a good framework for thinking about anger and how it might be de-escalated in the classroom."

Mental Health Consultation

CHNP clinicians provided nearly 1500 hours of mental health consultation. As Figure 40 shows, school administrators and teachers were the most frequent recipients of consultation; however, student support staff, parents, and other mental health providers also received consultation.

Mental health consultation addressed a variety of topics, as shown in Figure 41. The most common topic was student support, which includes consultation around the management of struggling students. Clinicians also offer consultation around program planning, which includes the implementation of social-emotional learning curricula, as well as consultation around behavioral issues facing individual students and classrooms.

Figure 42 shows the average school staff-rated mental health capacity scores, as measured by the School Mental Health Capacity Instrument (SMHCI), for CHNP partner schools over the past seven years. The SMHCI measures a school's ability to address mental health in three main areas: intervention, early recognition and referral, and promotion and prevention. Though there has been some fluctuation in partner schools' capacity scores across school years, more than 80% of CHNP schools demonstrated positive change in capacity during the 2012/2013 academic year and, on average, CHNP schools exhibited a nearly 20% increase in capacity over the last seven years of partnership.

Satisfaction with CHNP Clinicians

Overall, staff in partner schools demonstrate a high level of satisfaction with CHNP clinicians. Figures 43 and 44 display the percent of staff across all partner schools that agree with each statement.

What school staff say is helpful about having CHNP clinicians in the building:

"We don't think of him as 'CHNP.' We think of him as part of our staff. He has fully, seamlessly integrated himself into our school culture."

"The CHNP clinician is very knowledgeable and she responds very quickly to any questions or concerns that may arise when working with students. She also provides detailed strategies and information about resources that can help our students and their families."

"The CHNP clinician is a wonderful asset to our school community. His ability to connect with many of our students is invaluable and we rely on him for his insight and knowledge around next steps and how to approach students with mental health related issues."

"Our CHNP clinician has been instrumental in helping deal with students with mental health difficulties in my class. I could not have survived this year without her."

"The CHNP clinician does amazing work and is an excellent support for the students she works with. We often say she 'works wonders.' I cannot imagine school without her."

"The mere presence of our CHNP clinician is incredibly calming and positive. What's been most helpful about working with her is having her remind us that kids are kids and stress affects them differently."

Building Systemic Change

Community Mental Health Graduate Training Program

The Graduate Training Program provides school-based clinical training for master's, doctoral, and post-doctoral trainees in social work, psychology, and child and adolescent psychiatry. The Training Program aims to prepare trainees to provide high quality community mental health services and increase the capacity for service delivery in greater Boston. Trainees receive weekly on-site supervision from experienced CHNP staff clinicians. Trainees participate in bimonthly seminars on topics such as cultural competence, crisis intervention, short-term therapy, and prevention programming. In the 2012-2013 academic year, three social work trainees, one Harvard Graduate School of Education intern, one social work fellow, one postdoctoral psychology fellow and five psychiatry residents were placed at CHNP school sites. Four graduate students also interned with research and evaluation projects.

Break Free From Depression

In the 2012-2013 school year, nearly 200 educators and mental health professionals across Massachusetts were trained to facilitate the *Break Free From Depression* program. Two day-long workshops were sponsored by the Massachusetts Department of Public Health, and 11 schools hosted workshops for their school staff and on-site facilitators. These *Train-the-Trainer* workshops aim to enable the wide dissemination of the BFFD curriculum by teaching participants the knowledge and skills necessary to safely and effectively implement the curriculum in their schools or other community settings.

Evaluations of these *Train-the-Trainer* workshops suggest that the training is highly effective in preparing participants to implement the BFFD curriculum in their schools. Participants demonstrated positive change in their knowledge about depression and suicide; their attitudes about implementing a depression awareness curriculum in school; and their confidence in their ability to recognize the signs of depression and suicide in their students. Participants also expressed a high level of satisfaction with the training and their likelihood to implement the curriculum at their schools.

Partnership with Boston Public School District

For the past two years, CHNP staff has been working closely with BPS to develop and pilot a comprehensive behavioral health model that would integrate behavioral health supports and services. In 2012-2013, the model was piloted in 10 schools, half of which were CHNP partner schools. As part of the model, all students in the school were screened for behavioral health issues and information was used to help match students with the appropriate level of service. Teachers also received professional development about behavioral health and the resources available in their schools and across the district. Principals in the pilot schools participated in three convenings, where they shared successes and challenges of implementing the model in their schools. Thirteen additional schools have been selected to participate in the model in 2013-2014 and CHNP staff will continue to be involved in the monitoring and evaluation of these efforts. Over time, the goal is for the behavioral health model to be adopted district wide in Boston.

Advocacy Efforts

CHNP continues to be a leader in the development of the approach to reforms in education and children's mental health. For over two years, CHNP has worked collaboratively with Massachusetts Advocates for Children and advocacy groups to advocate for state-wide legislation to improve schools' capacities to address the mental health of their students. CHNP's efforts have been critical in securing substantive legislative support for a comprehensive school-based mental health bill: An Act Relative to Safe and Supportive Schools. This legislation will require all schools to develop action plans for creating safe and supportive environments by 2017. From testifying in support of the legislation to chairing the Children's Mental Health Campaign Workgroup on Education and Mental Health, CHNP continues to be involved in the advocacy efforts to pass this pending legislation.

Figure 38. *Primary Topics for Teacher Workshops (N=12)*

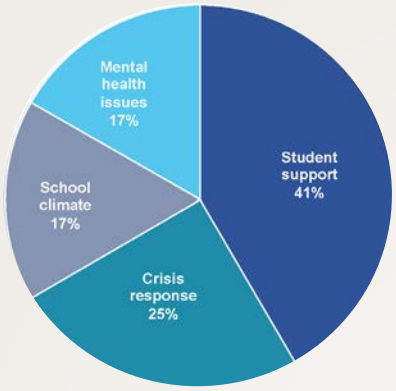


Figure 39. *Teacher Satisfaction with Professional Development Workshops (N=93)*

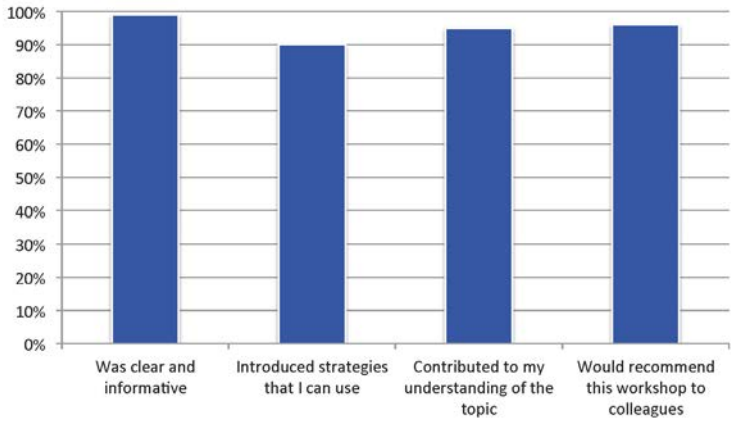


Figure 40. *Role of Consultee (N=1464 Hours)*

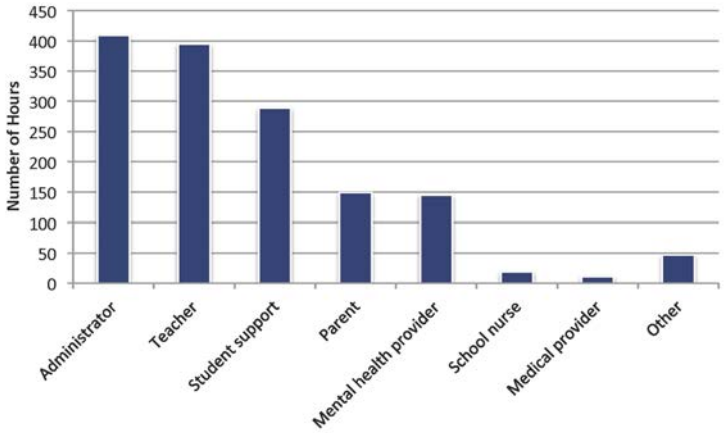


Figure 41. *Primary Topics for Consultation (N=1464 Hours)*

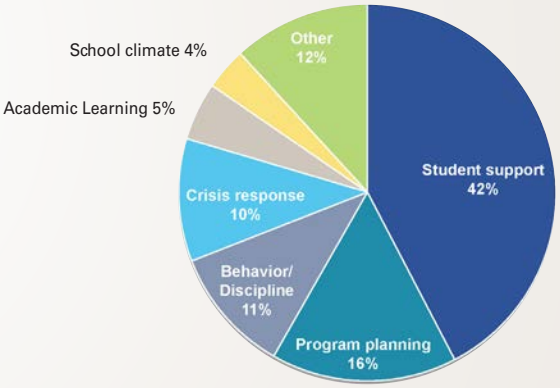


Figure 42. *Change in School Mental Health Capacity*

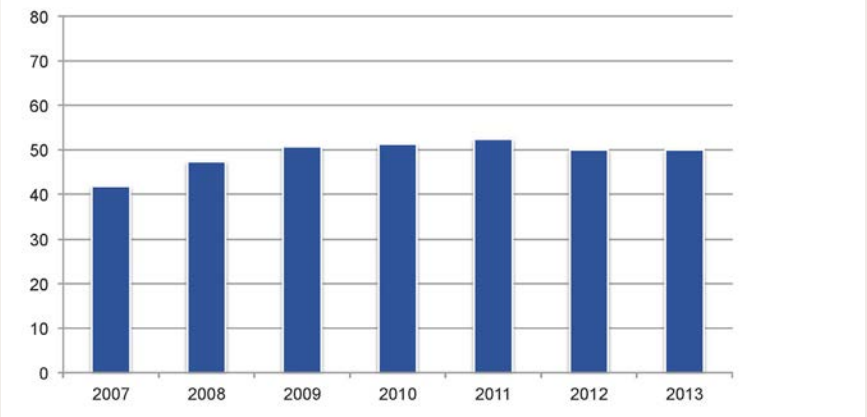


Figure 43. *School Staff Satisfaction with CHNP Clinicians (N=268)*

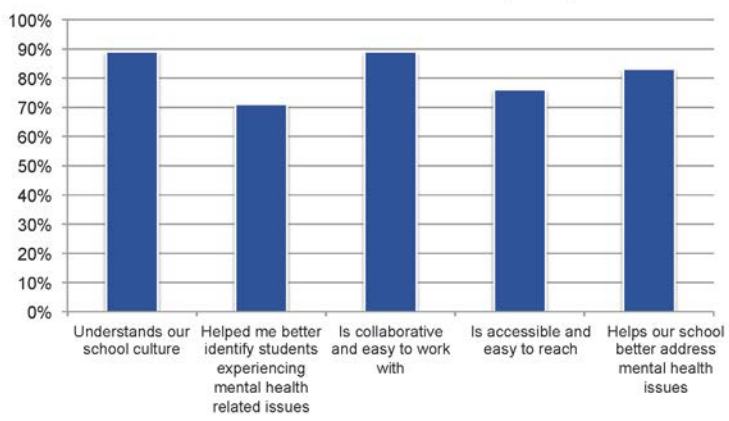
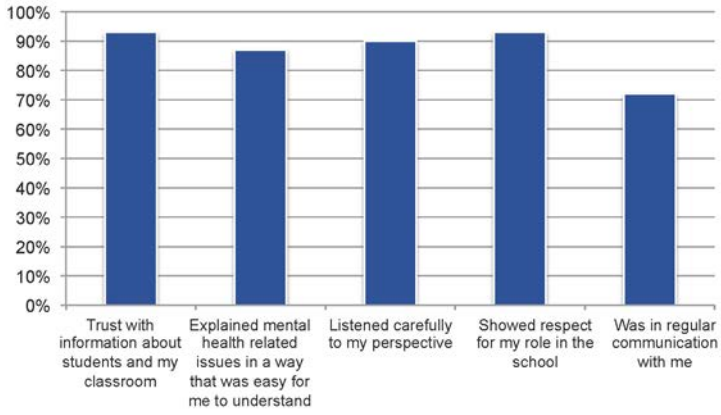


Figure 44. *School Staff Satisfaction with CHNP Clinicians (N=268)*



Next Steps

1. CHNP will continue to integrate evidence-based programs into targeted groups as well as classroom interventions. Additional programs have been selected to address the specific stressors and risks facing students in partner schools. We will also continue to standardize the groups that CHNP clinicians develop in an effort to better align the needs of the students with evidence-based practices, and to further strengthen outcomes.
2. CHNP will continue to be active in the planning, implementation, and evaluation of the comprehensive behavioral health model with the Boston Public Schools. In the 2013-2014 school year, the majority of CHNP's partner schools will be included in the model.
3. CHNP will continue to disseminate the Break Free From Depression curriculum, both in all CHNP high schools as well as other high schools across the Commonwealth. The program manual has been revised and CHNP will continue to evaluate the impact of this program as its use expands.

Community Health Center Program

CHNP Partner Community Health Centers

This program includes partnerships with 4 community health centers in Boston's urban core. Nearly 4,000 children live in each community surrounding partner health centers (Table 3). Half of the children in these communities are children of color, nearly one-quarter live in poverty, and more than one-half speak a language other than English in the home. BCH child and adolescent psychiatrists currently devote a total of .8 FTE's to these health centers. An additional 0.5 FTE is dedicated to the Dimock health center; this position was open during the 2012/2013 academic year.

Community Health Center Needs Assessment

To assess which mental health problems were perceived as most problematic for children and adolescents in CHNP health centers, a needs assessment was conducted with 33 mental health and primary care providers from three health centers this year. Nearly 90% rated family stressors as a "big" to "very big" problems for youths in their clinics (Figure 45). Trauma, anxiety, and disruptive behavior were also frequently rated as a big or very big problem.

Community Health Center Service Utilization Characteristics

CHNP provided psychiatric services to 202 children, ages 4 through 24, between September 2012 and June 2013. Figure 46 shows the racial/ethnic background of the children referred to CHNP as compared with the average for the population in the communities surrounding the health centers.

The most common diagnoses among children assessed were Attention/Disruptive Behavior (nearly 40% of all children seen) and Anxiety Disorders, which includes Post-Traumatic Stress Disorder (Figure 47).

Satisfaction with CHNP Staff

Overall, staff in the community health centers express a very high level of satisfaction with CHNP psychiatrists. Ninety-four percent of staff rate psychiatric services as good or excellent. As Figures 48 and 49 show, staff also report that the psychiatrists are integrated into the pediatric and mental health teams, helping the health center better meet and address the mental health needs of children.

What health center staff find most helpful about having CHNP services on-site:

"She provides case consultation in a manner that expands my conceptualization of some cases. She provides education, information on various topics. She is a valuable resource to have available to us to refer parents."

"Having a child psychiatrist on staff who sits on family/child team is great-as psychiatry perspective is valuable. She is collaborative and respectful of the diverse perspectives on the team. She has the best interests of the child and family out front."

"Having a CHNP psychiatrist onsite is extremely helpful as families are much more likely to engage with services and trust services if they are here. Also, she is very good at proactively engaging us in person about cases when needed. We can access her notes and vice versa in our electronic medical records. I find it very helpful to see her management in cases, as it teaches me indirectly on psychiatric care and management."

Next Steps

1. CHNP plans to work with the Department of Psychiatry's Outpatient Service to enhance the current level of integration of child and adolescent psychiatrist services into pediatric primary care at community health centers including analysis of services provided, involvement in care coordination, and education for primary care clinicians.
2. CHNP will work with the Department of Psychiatry's Outpatient Service to implement additional clinical outcome measures (e.g., Children's Global Assessment Scale) that can be used in our partner health centers.

Table 3. *Sociodemographic Characteristics of Communities Where CHNP Partner Health Centers are Located*

	FTE	Community Population	% Under 18	% AA	% Latino	% Asian	% White	% Poverty	% English Spoken at Home
Brookside	.25	4795	18	20	38	3	53	8	56
Dimock	---	4760	26	49	48	1	20	54	39
Martha Eliot	.40	3265	32	36	53	3	29	25	50
Southern Jamaica Plain	.15	5751	12	7	10	5	81	2	80
Average	0.27	4758	19	23	30	14	44	24	53

* Average percentages of race/ethnicities exceed 100.

Figure 45. *Percent of Health Center Staff Who View Each Mental Health Problem as Having a Big or Very Big Problem on Their Child and Adolescent Patients (N=33)*

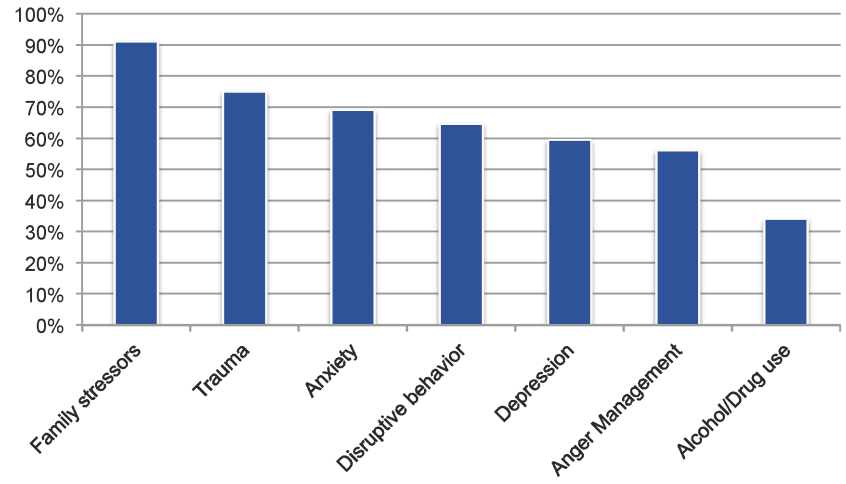
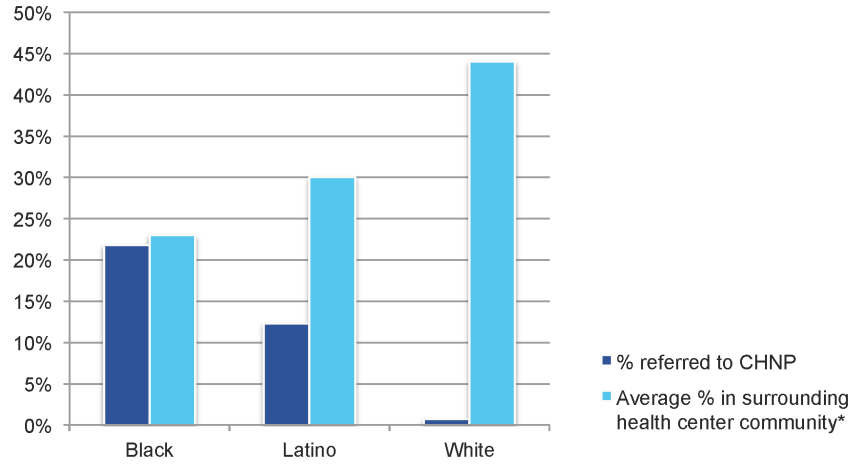


Figure 46. *Racial/Ethnic Background of Patients Referred to CHNP as Compared to an Average in Surrounding Health Center Community (N=202)*



* *Data compiled from 2010 census tracts.*

Figure 47: *Primary Diagnostic Category of Children Seen in Health Centers (N=202)*

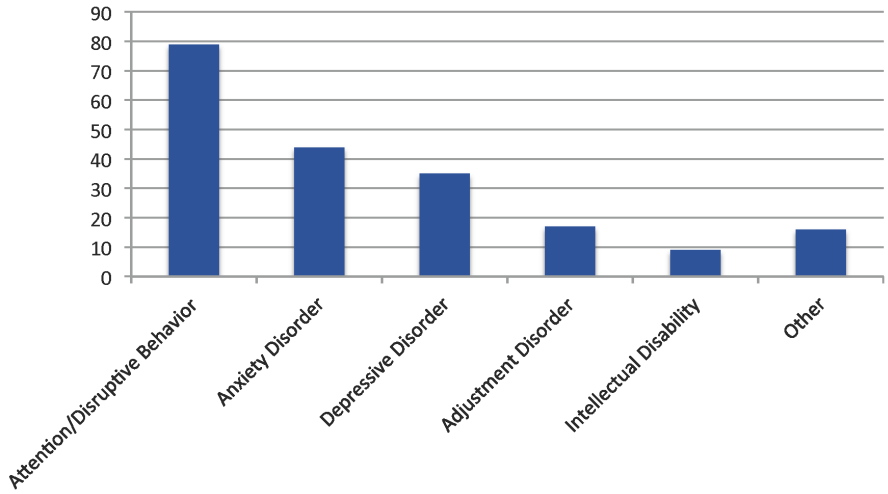


Figure 48. *Health Center Staff Satisfaction with CHNP Psychiatrist (N=22)*

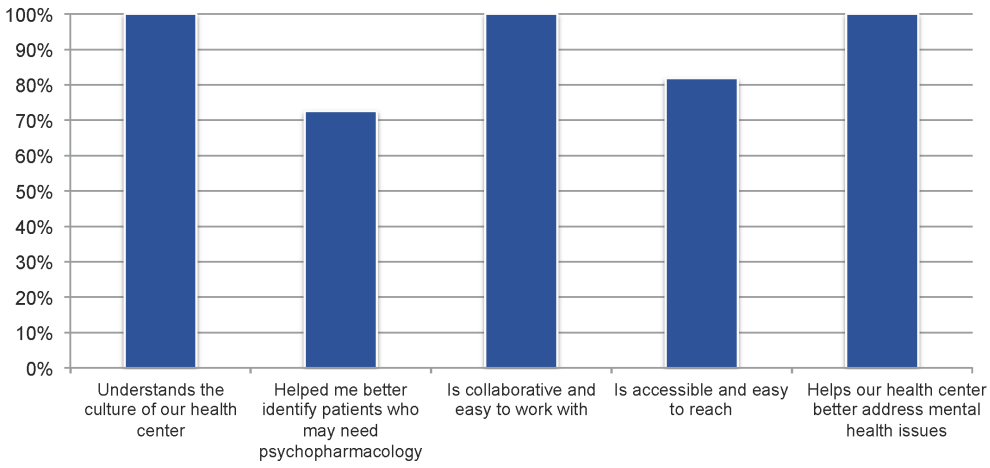
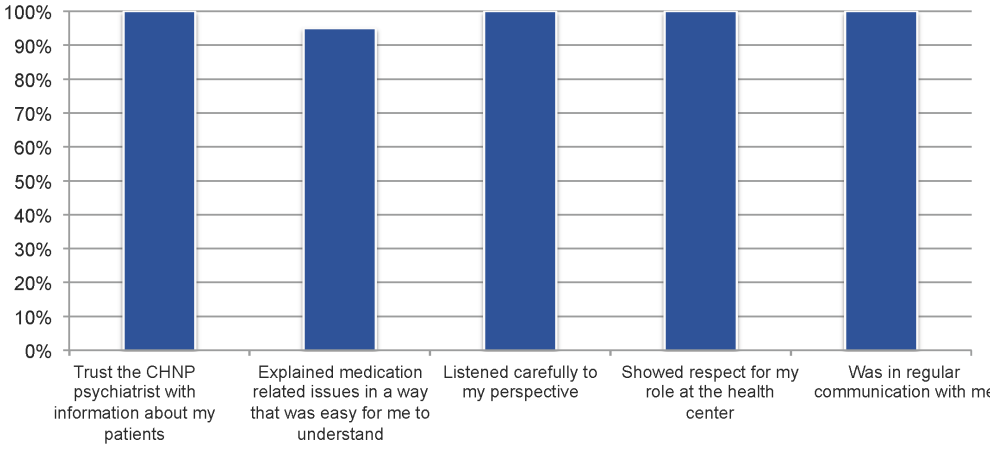


Figure 49. *Health Center Staff Satisfaction with CHNP Psychiatrist (N=22)*



Home field advantage

Children's therapists team up with schools to improve mental health where kids live and learn

Five years ago, Kevin was struggling academically and acting up in class. Dr. Joanne Cox, his primary care provider at Boston Children's Hospital suggested he see the school-based therapist, Shella Dennery, PhD, LICSW, who directs Children's Hospital Neighborhood Partnerships (CHNP), the community mental health program in the Department of Psychiatry. As part of CHNP, Dennery worked in Boston area public schools to provide free-of-charge mental health services to children and their families. "Many students in urban schools are unable to receive the mental health care they need—not because families don't want it, but because access to services and navigating the mental health system is challenging," says Dennery.

Established in 2002, CHNP has school partnerships throughout Boston. By offering services in environments that are familiar to children and their families, CHNP aims to increase access to care, promote social-emotional development, and build the capacity of partnering schools to address mental health, as well as to reduce the stigma associated with mental health needs. This model allows clinicians to work with students from pre-school through high school providing a range of services from individual therapy, crisis management, group counseling, family engagement and classroom interventions.

The need for such services is huge: Nationwide, one in five kids has a mental health problem, and only 20 to 30 percent receive the proper care. In low-income, urban settings, these

CHNP clinicians Osob Issa, MSW and Sue Costello, LICSW

numbers are much higher, since issues like poverty, exposure to violence and systemic discrimination put children at greater risk for developing mental health problems. These problems manifest in the classroom, where teachers struggle to help children with self-regulation, family stress and behavioral problems.

Two of CHNP clinicians, Mwaniki Mwangi, LICSW and Karen Capraro, EdM, LICSW have seen Kevin and two of his siblings at the Tobin K-8 school in Roxbury, Mass., for years. "At first, I was nervous," says Maria, a single mother of four. "I didn't know how much to share, and what they'd think of my situation. But they made us feel comfortable and my son wanted to talk to his therapist—and even looked forward to it. He needed that time to express himself and ended up loving them. We all did." Soon, the CHNP team was meeting regularly with Maria's whole family. "Our therapists help us express ourselves and come up with ideas on how to solve problems, whether they're about home or school matters," says Maria. "Family sessions are amazing; we find out what's at the heart of an issue and what we can we do better." Maria finds her own relationship with the therapists to be an invaluable outlet. "It can be overwhelming to juggle a full-time job, going to school at night and the kids, and it helps to have someone just listen."

The consistent, ongoing relationships that the clinicians have developed with Maria's family have allowed her children to feel comfortable talking to them about nearly any topic. "My teenage daughter is more comfortable talking about peer pressure and sex with her therapist than with me, and her therapist fills that communication gap for us," she says. Maria has seen the direct relationship between having mental health services and her children's performance at school. Concerned phone calls about Kevin's academics and behavior have given way to glowing report cards. "Now, teachers say how wonderfully he's doing, and that has a lot to do with the help he gets from Children's," she says. "He does his homework, he's on the honor roll and he got one of the highest scores in a math test in the city. It's amazing."

What makes CHNP unique is its integration into the fabric of the school and how closely its clinicians work with teachers. In working hand in hand with schools, the program builds the capacity of schools to address students' mental health. The partnership's benefits—to students, teachers and the community—are clear to Cheryl Watson Harris, principal of the Tobin K-8 school. "Because the clinicians are school-based, the supports are aligned with school-wide practices, and the children and parents feel as though the approach is more holistic and comprehensive," she says. "Many of my colleagues have marveled at this partnership, as the support from CHNP helps create a comprehensive care program that maintains open communication among school staff, parents and CHNP. Most students served by CHNP have made tremendous improvements—classes have been turned around."

For Maria, the effects are long-lasting. "My children are good influences on each other," she says. "In our family sessions, we've cried together and we've laughed together, and that has made us stronger. And having people who care about us and help us cope with things differently, we've become like a family. These are people my kids will never forget. I know I won't."

Appendix A

CHNP 2012-2013 Partners

School Partners

Boston Arts Academy
Boston Latin School
Charles Sumner Elementary School
Dorchester Collegiate Academy Charter School
English High School
John Marshall Elementary School
Joseph Lee Elementary School/Lee Academy Pilot School
Match Charter Public Middle School
Match Charter Public High School
Maurice J. Tobin K-8 School
Patrick Lyndon Pilot K-8 School

Health Center Partners

Brookside Community Health Center
The Dimock Center
Martha Eliot Health Center
Southern Jamaica Plain Health Center

University Training Partners

Harvard Graduate School of Education
Simmons College School of Social Work
Wheelock College School of Social Work

Acknowledgements

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Bronner Charitable Foundation
Boston Children's Hospital
Gloria L. and Charles I. Clough Foundation
Joseph and Louise Crane Foundation
George Harrington Trust
Jane's Trust
J.P. Morgan
Karp Family Foundation
Kidvestment
Marion Boynton Trust
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Shella Dennery, Ph.D., L.I.C.S.W., Director, CHNP, Boston Children's Hospital

David R. DeMaso, M.D., Psychiatrist-in-Chief and Chairman, Department of Psychiatry, Boston Children's Hospital

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Boston Children's Hospital
Until every child is well℠