Youth Mental Health Needs Assessment

Report in Brief: Perspectives from parents, mental health professionals, & school counselors in AR

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"...I think we missed out a lot by not focusing on mental health coming back from the pandemic & going straight back to what kids are missing academically. I think we would see a big difference in our educational tasks if their mental health was on track."

"I've got a lot of kids with anxiety that they've come back with... (that) feels like an 8th grader shouldn't have... It's not normal... they're not going to be able to just shake that off overnight."

-Focus group participants

Brief Introduction

Purpose & Background

What were these surveys & focus groups designed to study?

This report combines data from three separate surveys and multiple focus groups with school-based mental health professionals (MHPs), school counselors, and parents.

We conducted these surveys and focus groups out of a desire to deepen our understanding of youth mental health in Arkansas, barriers and facilitators related to accessing high quality care, and potential opportunities to make things better.

We hoped gathering this information would help quality improvement efforts related to our own programs and inform the development of future initiatives led by UAMS, particularly in the Department of Family and Preventive Medicine and the Psychiatric Research Institute, as well as our state agency and community partners.

Why focus on youth mental health?

The health & safety perspective: Youth feel overwhelmed, depressed, and disconnected

Results from a 2021 CDC report[1] suggest that teen mental health is continuing to decline:

- More than 40% of high school students in their survey admitted to being so sad or hopeless they could not engage in regular activities for at least 2 weeks during the previous year.
- 39% said they do not feel close to people at school.
- 29% said they had poor mental health in the last 30 days.
- 22% seriously considered attempting suicide in the past year, and 10% did attempt suicide in the last year.

The education perspective: Mental health concerns & experiences of trauma impact academic success

Arkansas children are exposed to potentially traumatic experiences at much higher rates than the national average.[2] Because of the wide-ranging impacts of trauma on development, executive function, and mental health, traumatic stress reactions can disrupt the educational processes related to teaching and learning.[3]

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[1] https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf

[2] Child and Adolescent Health Measurement Initiative. 2016-2017 National Survey of Children's Health (NSCH) Data Query.; 2020. www.childhealthdata.org

[3] Carlson JS, Perfect MM, Saint Gilles MP, Turley MR, YohannaJ. School-related outcomes of traumatic event exposure and traumatic stress symptoms in students: A systematic review of research from 1990 to 2015. School MentHealth. Published online 2016.

Teachers understand the relationship between mental health and academic success. A 2022 nationwide study by the nonprofit First Book[4] found that educators are also noticing their students' mental health struggles and that it's affecting children's ability to learn in school.

Of the nearly 1,000 educators that completed their survey:

- 98% said mental health challenges act as a barrier to children's education.
- 85% said addressing mental health is a high-level or emergency-level priority in relation to other classroom or program priorities for the year.
- 72% said the pandemic has introduced new mental health challenges among their students.
- On average, educators report that over half (53%) of their students struggle with their mental health.

The business perspective: When youth mental health declines, so does parents' productivity at work

A 2022 report from the On Our Sleeves Initiative, Nationwide Children's Hospital, and the Nationwide Foundation[5] presents data from a three-phase study of thousands of working parents that suggests children's mental health can also be a substantial drain on the productivity and engagement of their parents at work (as well as a driver of absenteeism and disengagement):

- 53% of parents in their second phase study have missed work at least once per month because of concerns about their child's mental health.
- 30 to 50% of working parents' thoughts are on their child's mental health and well-being even while they are at work (exact percentages depend on the subgroup of parents).
- These sorts of disruptions create a noticeable impact on parents work when compared to their colleagues whose children do not have mental health challenges/their child's mental health is well-managed.[6]

The fiscal perspective: An ounce of prevention is worth a pound of cure

A study from the Clarify Health Institute[7] analyzed insurance claim data from 2016 to 2021. They found that use of emergency/crisis services related to children's mental health is on the rise:

- 61% increase in children's in-patient hospitalizations for mental health from 2016 to 2021.

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[4] https://firstbook.org/wp-content/uploads/2022/03/FirstBook_RI_Mental_Health_Final.pdf

[5] https://www.onoursleeves.org/about/research/workplace

[6] The first group was 37-38 percentage points more likely to say that their child's mental health challenges resulted in the following over the past month: 1) The stresses of their jobs were much harder to handle, 2) They were distracted from taking pleasure in their work, 3) They felt hopeless about finishing certain work tasks, 4) The quality of their work was negatively affected, and 5) They missed work or how to come in late/leave early.

[7] https://clarifyhealth.com/wp-content/uploads/2022/09/The-Clarify-Health-Institute-Research-Brief_The-Kids-Are-Not-Alright.pdf

- 20% increase in mental-health-related emergency room visits.
- When broken down regionally, the four-state region that contains Arkansas (AR, LA, TX, and OK) had an 81% increase in child/youth in-patient hospitalizations for mental health.

The on-the-ground perspective: Parents & professionals share their experiences & ideas with us

There is an abundance of information about the crisis of youth mental health nationwide, however much less information is available about the state of Arkansan youth specifically.

By better understanding participants' experiences regarding mental health and interacting with mental health care providers, UAMS and its partners[8] can identify opportunities for improvement and develop plans to better the mental health of people (and especially youth) in Arkansas.

Our work began with one-on-one conversations with stakeholders. The topic of mental health, even for a sub-population of youth, is a large one.

Because of that, we relied on subject matter experts within Arkansas to inform us and provide focus to what is most critical and urgent. These conversations and their expertise informed the content of the surveys and focus groups.

How were the surveys delivered?

We used the online platform REDCap[9, 10] to deliver a School-Based Provider survey, School Counselor survey, and Parent survey.

The Provider Survey was emailed to participants through a public link that was distributed to a network of both school personnel and mental health providers in Arkansas.[11] The survey was open from January 17th 2023 to February 2nd 2023 and was completed by 124 people.

The Counselor Survey was emailed to participants through a public link that was distributed to a network of school personnel in

[8] Among these partners were leaders in the mental health space in Arkansas who have extensive knowledge of the system and were able to aid us in our initial work. These partners were instrumental in helping us understand existing gaps, construct our focus group and survey questions, and distribute our surveys.

[9] PA Harris, R Taylor, R Thielke, J Payne, N Gonzalez, JG. Conde, Research electronic data capture (REDCap) – A metadata-driven methodology and workflow process for providing translational research informatics support, J Biomed Inform. 2009 Apr;42(2):377-81. PA Harris, R Taylor, BL Minor, V Elliott, M Fernandez, L O'Neal, L McLeod, G Delacqua, F Delacqua, J Kirby, SN Duda, REDCap Consortium, The REDCap consortium: Building an international community of software partners, J Biomed Inform. 2019 May 9 [doi: 10.1016/j.jbi.2019.103208]

[10] PA Harris, R Taylor, BL Minor, V Elliott, M Fernandez, L O'Neal, L McLeod, G Delacqua, F Delacqua, J Kirby, SN Duda, REDCap Consortium, The REDCap consortium: Building an international community of software partners, J Biomed Inform. 2019 May 9 [doi: 10.1016/j.jbi.2019.103208]

[11] The link was distributed to subscribers of the Trauma Resource Initiative for Schools (TRIS) mailing list and the Arkansas Building Effective Services for Trauma (ARBEST) mailing list, as well as distributed through partners at the Arkansas Department of Education.

Arkansas.[12] The survey was open from January 17th 2023 to February 2nd 2023 and was completed by 268 people.

The Parent Survey was emailed to participants through a public link that was distributed by multiple partners throughout the state. Requests were made to 31 organizations with parents of teens as their patrons.

Consideration to distribution across regions within the state and urban/rural areas were considered as well. The survey was open from February 21st 2023 to March 20th 2023 and was completed by 621 people.

Results for all three surveys include data from both full and partial responses.

How were focus group participants chosen?

Each survey contained a question asking participants if they would like to also participate in a focus group to give more detail about their answers and experiences. Those who said yes were contacted by email and invited to attend a focus group.

We conducted a total of nine focus groups with 34 overall participants, between February 7th 2023 and April 14th 2023 (there were four provider/school counselor groups with 18 total attendees, and five parent groups with 16 total attendees.

How are open responses & focus group excerpts displayed?

The conventions for this shortened report are as follows:

Open responses to survey questions and focus group excerpts will appear in italics with quotation marks and should be considered direct quotations.

We use ellipses (…) to indicate a significant break between words/sentences that we omitted for readability and parenthesis to add words needed for context or readability.

With focus group excerpts, there were times when multiple people talked about the same issue or agreed with one another OR a participant talked about an issue in one part of the focus group and later doubled back to add more to their thoughts.

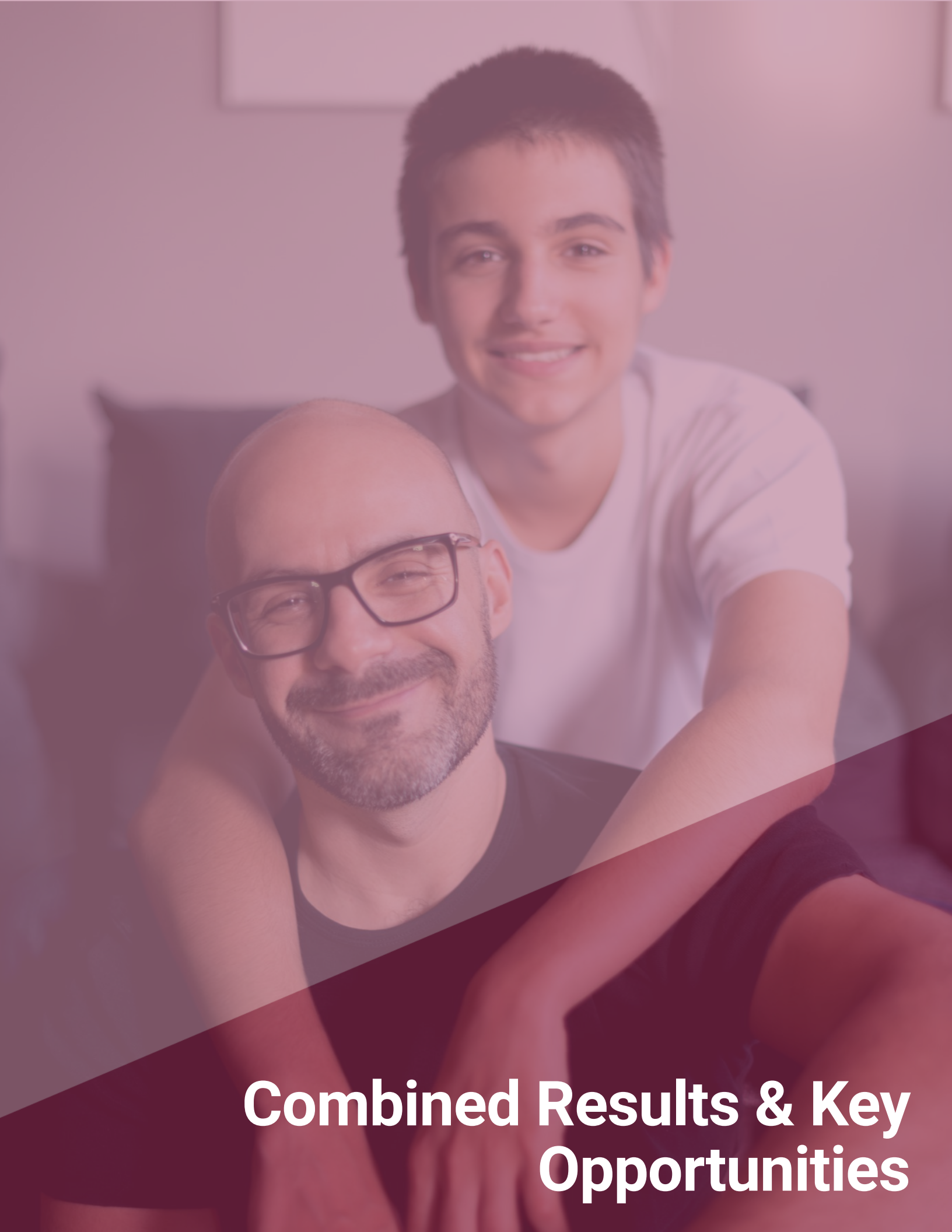
In these instances, we summarized participants' statements, often using as much of their own words as feasible, to improve readability. Any time an excerpt is summarized it will be noted at the end of the excerpt in brackets and the text will not be in italics or use quotation marks.

Who funded this needs assessment?

This needs assessment was made possible by a grant from the Blue & You Foundation for a Healthier Arkansas[13] to the UAMS Trauma Resource Initiative for Schools.

[12] The link was distributed to subscribers of the Trauma Resource Initiative for Schools (TRIS) mailing list and the Arkansas Building Effective Services for Trauma (ARBEST) mailing list. It was also distributed by partners at the Arkansas Department of Education.

[13] https://blueandyoufoundationarkansas.org



Combined Results & Key Opportunities

Combined Results & Key Opportunities

This section combines survey and focus group results from all groups in our study (school counselors, school-based mental health professionals, and parents).

School counselors work to maximize student success for all students through academic planning and goal setting, short-term counseling to students, referrals for long-term support, collaboration with families/teachers/administrators for student success, and acting as a change agent to improve access, achievement, and opportunities for all students.[14]

School-based mental health professionals (from here on, we will use MHP for short) are licensed mental health professionals (e.g. clinical social workers, licensed professional counselors) who are trained to evaluate a person's mental health and provide therapeutic services such as individual or group counseling, and who provide services in a school setting.[15] When referring to both school counselors and MHPs, we will use the term "professionals" (ex. the professionals' focus groups)

The term "parent" is used throughout this report to represent the adults in a child's life that play the primary role of support for a child. This

We use Eiraldi's four-step model of mental health care "help seeking" to organize our results & show how/where our participants face challenges.

Each step below shows examples of factors that influence peoples' experiences & whether or not they move to the next step in the process.

[14] https://www.schoolcounselor.org

[15] https://mhanational.org/types-mental-health-professionals

includes biological parents, step-parents, resource/foster parents or extended family members (such as grandparents) who serve as the primary adult providing support and care to a child.

Key findings & the four stages of seeking mental health care

To help inform our survey creation and better understand our results, we used Eiraldi's[16] framework of mental health "help-seeking." This model covers the four major steps involved when families are seeking out and using mental health services, particularly for their children and adolescents. The four steps and factors that affect them are listed in the figure above.

In addition to providing a way to organize our writing, this framework helps translate our results into a practical view of how people move through the mental health system, and where they are telling us barriers or facilitators exist.

After this section, we present several opportunities to address these barriers.

Step 1: Problem recognition

The first step of the help-seeking process is recognizing the existence of a problem.

Being able to do so can be influenced by several things such as if parents/teachers notice behavioral, emotional, or social changes from children, and if so, how they interpret those changes.

For example, it's possible they notice a child is getting in trouble at school more often, their grades have dropped recently, they are having increased conflicts with peers and family members, and perhaps feeling more irritable, volatile, or withdrawn at home.

Some adults will see these changes and recognize them as potential signs of mental health challenges. Others may interpret the same signs as simple "teenage angst" or as behavior/discipline problems.

Other things may impact problem recognition, such as family dynamics, the nature and quality of parent-child relationships, the frequency and severity of conflicts within the household, and parents' own stress levels and mental health.

Key findings that relate to this step are listed below:

- Forty-six percent (46%) of parents said their child's emotional wellbeing, behaviors, and/or substance use had ever caused them serious concern or worry and 28% said someone else (such as a teacher, school counselor, or pediatrician) had expressed a similar concern to them.

  When combined, 47% of parents said yes to one or both.

- MHPs and school counselors agreed that youth being hesitant to talk to their parents about symptoms/concerns was a large barrier, with 45% of MHPs and 50% of school counselors saying that it was

[16] Eiraldi RB, Mazzuca LB, Clarke AT, Power TJ. Service utilization among ethnic minority children with ADHD: A model of help-seeking behavior. Administration and Policy in Mental Health and Mental Health Services Research. 2006;33(5):607-622. doi:10.1007/s10488-006-0063-1

"Often/Almost Always" a barrier ("Sometimes" rated at 49%/33%).

- This theme emerged in focus groups as well. One participant in the parent focus groups (who was also a teacher) talked about the discomfort many teens have discussing mental health concerns with their parents,

  "I know a lot of kids who have struggles but they don't want their parents to know. "

  Another added to this when saying, *"…I think that's why a lot of them tiptoe around when it comes to who they tell. And they'll be more likely to tell a friend than an adult, because adults are required to do certain things while kids will just listen and give advice.*

  So that's another reason why it's good for kids to know what to look for… We realize you and your friends have secrets, but … If someone says they're going to do harm to themselves or someone else, you can't keep that a secret anymore."

Step 2: Decision to seek help

After recognizing a problem exists, the next step is deciding whether to seek help. During this step, someone's decision is often influenced by any fear and stigma about mental health, their level of knowledge about the mental health system/their child's specific issue, and their expectations about services.

Key findings that relate to this step are listed below:

Finding information

Of those with concerns about their child's mental health, 79% said they had tried to access mental health therapy services for their child. For those who were concerned but chose not to seek services, we asked why.

The most common response was looking to other places for help, such as church, a physician, family, etc. (32%). A quarter also said they did not think that therapy would help their child (24%).

When asked where they would go for information about mental health, Doctor/physician was the most popular source (80%) followed by friends/family (39%), school counselor or other school staff (38%), faith community (28%), the Internet (17%), and "other" (5%).

Both professionals and parents talked about how families often have trouble finding the information they need about what services exist/are available, what issues their child might be having, and just generally understanding how to navigate the mental health system before and after a first appointment.

One participant from the parent focus groups shared the following, *"I think most parents would bend over backwards to do whatever they need for their child… but I think the biggest question is knowing where to go, who to go to…what types of treatments are effective, and where that's provided."*

Other participants from the professionals' survey and focus groups talked about the importance of making the process as easy and simple to understand for parents as possible.

One of these survey responses noted that, *"Ease of the process is incredibly helpful. Oftentimes parents of students in crisis are*

struggling themselves, and don't have a lot of bandwidth for a lengthy/difficult process."

Stigma

Focus groups with parents revealed that the fear of being stigmatized was a major barrier to deciding to seek mental health treatment. Themes that emerged included the practical difficulties of maintaining privacy for in-person treatment in rural areas, youth fear about peers finding out they are in treatment, and adult attitudes about "pulling up your bootstraps" and fearing their child will be labeled by others and/or treated as "less-than" if people found out about their treatment.

One focus group participant summarized the unique privacy concerns of those living in rural areas trying to find care when saying, *"Rural areas need more therapists from somewhere else. Rural towns are too small to tell your innermost feelings to people who know all your friends and family."*

Parent focus group participants shared potential solutions to this stigma, including changing the way we communicate about mental health, helping youth to help their friends, and adult modeling that going to therapy is okay.

For example, one parent used the metaphor of tools and houses to reframe the usefulness of therapy, and how we communicate about mental health*:*

"Maybe you can use this (as a way) to talk about mental health. When you first buy a house, you only have is a screwdriver & wrench because that's all you needed at that point…

Then, you come to a point where something else happens in your life or to your house and so you need another tool… so you get counseling to get additional tools…I think when people hear analogies, it doesn't put off the parent generation. There is major stigma on improving your mental health."

Similarly, one focus group participant in the professionals' groups talked about how a local mental health clinic began sponsoring kids' sports teams to raise awareness of their existence, reduce stigma, and hopefully begin softening residents' attitudes about therapy.

Parental stress/mental health

School counselors reported on parental stress, family-related barriers and the decision to seek mental health care. One focus group participant captured this when saying,

"I have kids that need a social worker. I've tried to go online (to help kids)… Holy cow. I don't know how anybody ever gets services…., especially if you have an overwhelmed parent that's not tech savvy.

It's very time intensive when you sit down to do that with a family…But what do you do when someone says they need a place to live or food? You do what you can."

One barrier was parents having their own behavioral health needs or serious family stressors, with 42% saying this was "Often" or "Almost Always" a barrier (another 42% said it was "Sometimes" a barrier).

This was echoed in professionals' focus groups, *"Reducing trauma for kids starts with the parents… With educating parents and breaking those generational cycles…"*

Another participant in the professionals' survey summed up the difficulty getting consent from/coordinating parents by saying, *"My biggest barrier in supporting students is often their parents. Their parents won't answer, don't have a phone, don't follow through with things, won't sign papers, or are struggling with their own mental health."*

Similarly, distrust of the system and not wanting outside interference in family life was an issue (39% "Often/Almost Always" and 44% "Sometimes").

Step 3: Access/service selection

The third step involves finding out what services are available and deciding on which to try.

This step is influenced by things like having people in your family/friend group who are supportive or knowledgeable about what services are available and how to access them, the existence of services nearby that match their child's needs, and economic factors such as insurance, transportation, financial resources, and paid time off at work/employers willing to be flexible with their schedules.

Key findings that relate to this step are listed below:

Barriers to accessing services

When we asked parents who attempted to access services about challenges encountered, some top difficulties were agencies not taking new patients or having a long waiting list (38%), parents having difficulty finding a qualified therapist for the child's needs (38%), and clinics not taking the insurance parents have (36%).

This was demonstrated clearly in an open response from the parents' survey, "*Finding a therapist who takes our insurance AND works with kids AND is in our town AND who is familiar with (the needs they have) AND that my child trusts is like looking for a unicorn."*

These barriers were echoed in parent focus groups along with additional themes

involving lack of knowledge of the system and difficulty navigating it, issues with scheduling and transportation, additional financial barriers, and a lack of access to services that are adequate for high-need students (particularly those in foster care).

One focus group participant summed up the frustrationn many parents feel trying to navigate the system,

" A list…surely there are therapists out there that take X insurance, but how do you find that? I don't know where that list lives, but there needs to a be a list."

Professionals said being underinsured (having severe limits on sessions/high co-pays or deductibles) or being without insurance altogether was a commonly experienced barrier.

For under-insurance, 34% of MHPs said this was "Often/Almost Always" a barrier and 33% said "Sometimes" (school counselors rated this at 39%/31%).

For lack of insurance altogether, 34% of MHPs said this was "Often/Almost Always" a barrier and 33% "Sometimes" (school counselors also rated this at 39%/31%).

One of the parents in our focus groups captured how many families are caught in a "no-man's land" between publicly funded care and being able to reasonably afford care, saying, *"We make too much money to qualify for (Medicaid-covered) therapy but somehow not enough to actually pay for therapy."*

Facilitators of access

We asked parents whose child attended therapy what was most helpful in getting them started. Several themes emerged including having a formal or informal referral from someone they trust, knowing someone who works in the mental health field, and having support with logistical challenges (e.g. grandparents providing transportation, going to therapy at school).

One school counselor from our surveys said, *"Having a therapist that will come to the school is the most helpful. If we don't have services in the school building, we have an incredibly low success rate in referrals."*

Both MHPs and school counselors agreed that parents and school personnel were the most important people to target with educational information to increase the number of youth accessing services (40% of MHPs and 63% of counselors said parents; 41% of MHPs and 19% of school counselors said school personnel).

Step 4: Service utilization

The last step involves receiving care and recognizes that if/how often people utilize services and how consistent they are in attending/participating in treatment can be influenced by things like whether the services they need are conveniently located, if they receive needed referrals for specialty services, and the quality of care they receive (including how well different professionals communicate and coordinate with each other about their care).

Key findings that relate to this step are listed below:

Parental Involvement

Parent involvement in their child's mental health is crucial for improving the benefits of therapy for most youth.[17, 18]

Both MHPs and parents in focus groups agreed with this idea. However, the parent survey showed that only 32% of families received family therapy, and most families were "Never" (23%) or "Rarely" (49%) involved in sessions. MHPs reported that lack of parental involvement in ongoing treatment (67% said “Often/Almost Always”, 32% said “Sometimes”) was a key barrier to providing high-quality treatment.

One common barrier was the conflict between work schedules and the times when treatment options were available for students.

Many families expressed a desire for therapy options after school or work hours. MHPs mentioned that the timing of a student's appointment could be somewhat unpredictable.

Factors such as the student's academic schedule, special school events, and more urgent needs of other students made it challenging for parents to plan ahead and coordinate with their employers so they could attend the sessions.

Gap between referral & enrollment for school-based services

School counselors report that half (50%) of youth referred to school-based therapy actually start services. For MHPs, that number was 71%. This means that between 29-50% of youth who were referred to services did not begin treatment.

Some of this difference in perception between school counselors and MHPs may be because school counselors often know many youth in need of services, whereas MHPs often only know the ones that are formally referred for therapy services.

Either way, it’s clear that many people who are referred to school-based services are unable/choosing not to utilize them.

Turnover

According to school counselors, turnover in MHPs is a key challenge, with 53% saying turnover is “Often” or “Always” a barrier.

This theme was echoed in open-response questions. For example, one participant said *“Turnover rate in school-based (care) is high. Kids become tired of getting used to a new therapist, (and then) don't take it seriously.”*

One focus group participant explained some of the causes of turnover, *saying “We have a lot of turnover with counselors (MHPs) and sometimes they're very green… We have severe*

[17] Dowell, K. A., & Ogles, B. M. (2010). The effects of parent participation on child psychotherapy outcome: A meta-analytic review. Journal of Clinical Child & Adolescent Psychology, 39(2), 151-162. doi: 10.1080/15374410903532585.

[18] Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature. Clinical psychology review, 26(1), 50-65. doi:10.1016/j.cpr.2005.09.001

poverty, severe trauma… all of these things impacting our kids. And so we really need experienced counselors who are going to be here for the long haul, not that are just popping in and out, because that just reinforces that stereotypical distrust of that institution..."

Space & privacy concerns at school

For school-based services, both MHPs and school counselors agreed that limited space and/or privacy concerns was the biggest barrier related to schools and school systems that they experienced while trying to provide care. Sixty-nine percent (69%) of MHPs and 59% of school counselors said this was "Often" or "Always" a barrier.

In addition, they reported difficulty providing services because of the limits on removing youth from classes. Sixty-four percent (64%) of MHPs and 39% of school counselors said this was "Often" or "Always" a barrier.

Participants from the professionals' surveys agreed, with one saying, *"Most of the schools are working do not provide a dedicated space for the therapist to meet with the client. They have asked as a therapist, that I meet with my client in the cafeteria or library, where there are other students and staff coming in and out."*

Training of mental health professionals

When we asked MHPs how equipped they feel to provide care for various common diagnoses, 76% said they felt "Very much" equipped to treat anxiety (24% said "Moderately") and 71% felt equipped to treat depression (26% said "Moderately").

However, fewer MHPs felt equipped to treat PTSD (47% "Very much", 41% "Moderately), substance use (10%/23%), neurodevelopmental disabilities (7%/29%), or eating disorders (4%/23%).

One of our focus group participants expanded on these training deficits, saying,

69% of MHPs & 59% of school counselors said **limited space & privacy concerns are the biggest school-related barrier they experience** while trying to provide quality care.

"(Where I live), we have several providers that offer mental health services. However not all of them are trauma trained and you know a lot of students have experienced trauma and not every therapist is created the same…. There's only a handful of them who know how to adequately deal with the problems that a lot of students face."

Another stated, *"The biggest missing link in Northwest Arkansas is attention to eating disorders and substance abuse in children... People are more familiar with ADHD, anxiety, OCD, etc., but few people know how to treat eating disorders, and co-occurring disorders like eating disorder/anxiety combos or ED and substance abuse."*

Perspectives on the role of school-based mental health professionals

The professionals' survey reveaed that many teachers and administrators in schools view counseling primarily as a way to manage student behavior.

About 64% of MHPs and 51% of school counselors said this was often or always a problem. This suggests that there could be a difference in how school staff, like school counselors, view the role of MHPs and how the MHPs think the school staff perceives their role.

One of the parents in our focus group captured the overall sentiment, saying,

"*What we saw was just a bunch of behavior management, it wasn't trying to actually tackle the root cause to make progress. It was mostly very surface level…. At school they don't necessarily want to get past superficial. They don't want to dive into the deeper stuff because they don't want to deal with the behavior that comes afterwards. For us it was sad to watch because it was like a golden opportunity to get help he so desperately needed."*

Only a third of MHPs said they feel "Moderately" (23%) or "Very Much" (10%) **equipped to treat substance use & even fewer feel equipped to treat eating disorders** (23% "Moderately" & 4% "Very Much").

Coordination of care: Difficulty with the Medicaid PASSE system

An additional factor in whether people initially/continue to access care is how easy the process is and whether there are complexities related to insurance.

We heard repeatedly from both professionals and parents about issues they encountered with the Medicaid PASSE system and how those issues extend wait times and restrict access to care.

For example, two open-responses from our professionals' surveys talked about the scarcity of MHPs who will accept Medicaid because the difficulties involved in PASSE:

"There are fewer and fewer therapists who will see kids with Medicaid because of the PASSE/Managed Care system in place now (for those with Medicaid)."

"The PASSEs are a huge barrier with delays in payments, poorly engaged care managers, and waiting for the independent assessor. Private Insurance clients are not required to go through an assessor, so why is this barrier in place?"

Additionally, one parent from our focus groups summed up their frustration in trying to navigate the PASSE requirements and restrictions by saying, *"I am sick to death of PASSE and sick of a third-party deciding that my children can no longer get care because they've paid out all the money."*

Coordination of care: Access to medication management services

One participant in our professionals' focus groups pointed out a gap in service coordination for MHPs who are independent contractors. As they explained, MHPs who are independent contractors often have to seek out and develop relationships with physicians and/or psychiatrists who are willing to offer the medication management service their clients need in a timely fashion:

A big barrier to treatment is not having access to psychiatry services. If the MHPs that work in schools are independent contractors (ILPs) they don't have access to services like they would if they work for an agency. So, they have had to develop their own relationships with a couple of doctors that will write some medications until kids can see a psychiatrist. Often the wait time is 6 months. Finding doctors that will work with you can be especially difficult if you see mostly Medicaid folks. [focus group summary statement].

Another in our professionals' survey talked about how trying to build these partnerships with physicians can end up causing them to lose their clients, *"Lack of access to medication management is huge. We try to coordinate with PCPs (primary care physicians), but often when we do, our student gets referred elsewhere for therapy where a psychiatrist is on staff, even though we have been providing therapy, sometimes for an extended time. And some PCPs are not comfortable managing psychotropic meds…"*

Coordination of care: PCP referral requirement

Many professionals explained that some insurance types require a referral from a primary care physician before intake can even begin, and that this adds weeks of wait time to a child's initial visit.

Both MHPs and school counselors said that obtaining this referral from a primary care physician could be difficult, with 31% of

MHPs and 24% of school counselors saying it is "Often" or "Always" a barrier ("Sometimes" was rated at 37%/35%).

Two open responses from that survey provided additional detail on these difficulties and how they add on to the already existing wait times for those seeking care face:

"We need more MHPs and less red tape. For example, I have several students who are waiting on primary care physician referrals for Medicaid, and no one seems to be in a hurry to process that information."

"The provider typically does not start services until obtaining (a PCP) referral, even though there are 10 services allowed (beforehand), the provider does not know how many of the remaining 10 are available. There is a risk of providing services without reimbursement…The primary care physician referral (requirement) is one of the main barriers to treatment. "

Beyond the four steps: Prioritizing youth mental health & social interaction skills in schools post-COVID

Both professionals and parents in our focus groups talked about the importance of integrating behavioral health concepts into school curricula and/or prioritizing mental health programming over traditional academics.

One of our professional focus group participants captured this sentiment when saying, *"So many classes and hours that have to be spent in the classroom. What if 30 minutes was put aside each day for them to learn self-regulation, self-soothing, self-help, and stuff like that?"*

Similarly, another professional participant from our survey said, *"I wish that schools, and really our society in general, would try to treat behavioral health through more prevention and education. We have almost a solely treatment-only approach and there are simply not enough therapists to be able to do this. We will keep struggling until we do this.*

Think of diabetes - we treat this not by waiting for people to develop it and then treat but by educating about health, exercise, and healthy eating from early on."

Another parent summarized the 11 other comments in parent groups on this topic by saying, *"I'm not the Department of Education, but I think we missed out a lot by not focusing on mental health coming back from the pandemic and going straight back to what kids are missing academically. I think we would see a big difference in our educational tasks if their mental health was on track."*

Key Opportunities

Consistent with national data, our surveys and focus groups suggest that youth mental health concerns in Arkansas are widespread. Parents and professionals working in schools point to the necessity of addressing the mental health needs of youth if schools are to meet their goals for student performance and success.

The findings point to numerous opportunities to strengthen supports for youth mental health, including promotion, prevention, and intervention. While not an exhaustive list, we highlight a few such opportunities in the section below.

1. *Support youth mental health through multi-tiered systems of support in schools*

The widespread nature of mental health concerns in youth identified in this survey point to a need for multi-tiered systems of support (MTSS[19]), which follow a public health approach to address the address the social, emotional, and behavioral needs of students.

Tier 1 focuses on promoting mental health and strengthening positive social, emotional, and behavioral skills. These are designed to support the well-being of all students.

Tier 2 supports focus on children with risk factors or emerging emotional or behavioral concerns, and include supports such as targeted classroom interventions, small-group interventions, or brief individual interventions.

Tier 3 focuses on individual student interventions that address more serious concerns services, and may include individual or family mental health services.

When there are strong Tier 1 and 2 supports for the social, emotional, and behavioral needs of students, fewer children will need Tier 3 services.

Our findings also support The Council of Chief State School Officers (CCSSO) report entitled Advancing Comprehensive School Mental Health Systems – A Guide for State Education Agencies.[20]

The report states that a *"Comprehensive School Mental Health System (CSMHS) involves collaboration between schools and community partners to create a positive school climate, foster social and emotional development and promote mental health well-being, while reducing the prevalence and severity of mental illness."*

It also states that *"implementing an effective CSMHS benefits schools, students, and staff, leading to greater academic success; reduced exclusionary discipline practices; improved school climate and safety; and enhanced student social and emotional development."*

This recommendation was echoed in Arkansas within the 2022 Arkansas School Safety Commission[21] recommendation that,

"All school districts should have access to training and ongoing support for the implementation of evidence-based programs that develop and maintain a positive climate, encourage trauma-informed practices, deter bullying behaviors, and promote social-emotional learning (SEL) and healthy peer relationships."

Several efforts are underway to support this work, including the Arkansas Department of Education initiatives such as the G.U.I.D.E.

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19 https://wwwschoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Dialogue-Guides/BFF_SMHGuides_CoreFeature4.pdf

20 https://753a0706.flowpaper.com/CCSSOMentalHealthResource/#page=1

21 https://dese.ade.arkansas.gov/Files/2022_Arkansas_School_Safety_Commission_Final_Report_10-6_2022[92]_COMM.pdf

for Life (Growth, Understanding, Interaction, Decisions, and Empathy), THRIVE Arkansas, and Project A.W.A.R.E (Advancing Wellness and Resiliency in Education).

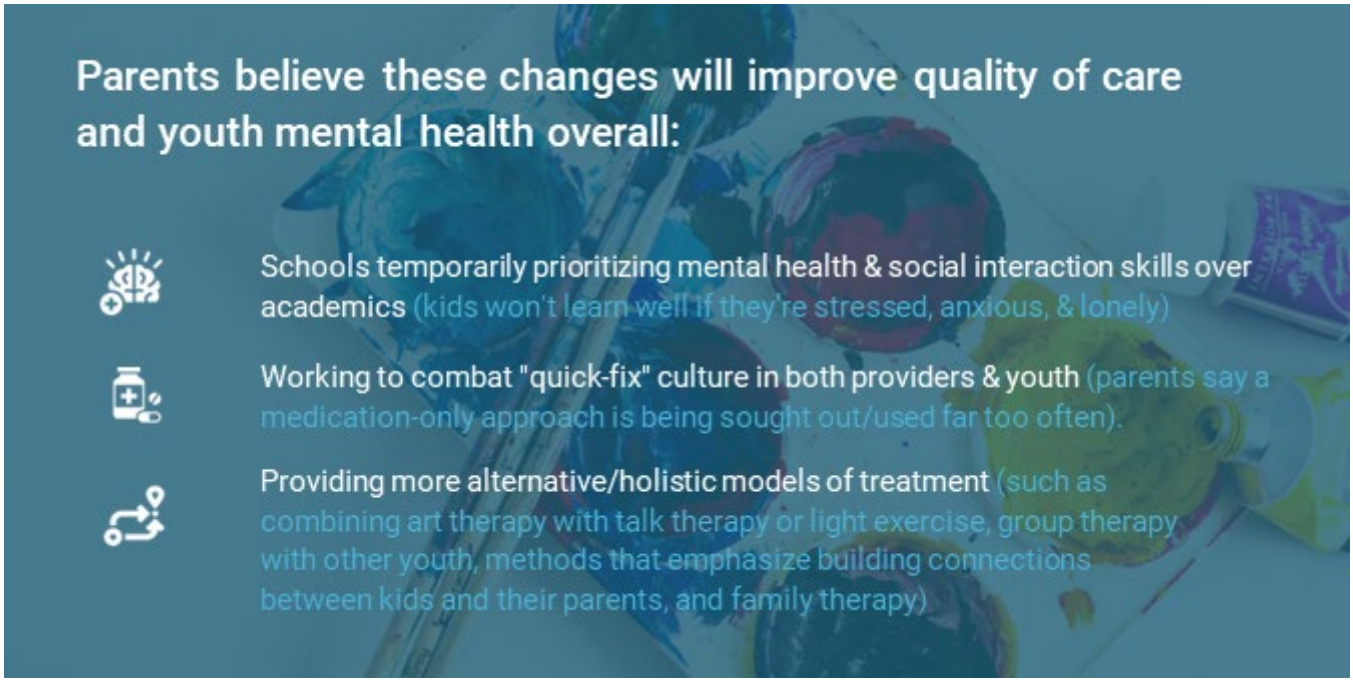
The UAMS Trauma Resource Initiative for Schools (TRIS) is another example of a program supporting this goal. There are opportunities to continue and expand such efforts.

2. Continue & expand efforts to reduce stigma & normalize the conversation about youth mental health

Mental health interventions, particularly those based in a school setting, may reduce mental health stigma.[22]

Similarly, students may need guidance on identifying concerns in friends and appropriate avenues to support friends (e.g., telling a trusted adult figure, having a supportive conversation).

Current initiatives such as the faceyourfeelings[23] youth campaign and trainings such as Youth Mental Health First Aid (currently disseminated through the Arkansas Department of Education's Project A.W.A.R.E. team, the Arkansas Center for School Safety, Arkansas Blue Cross Blue Shield, and other community partners) are



[22] Ma, K. K. Y., Anderson, J. K., & Burn, A. M. (2023). School-based interventions to improve mental health literacy and reduce mental health stigma–a systematic review. Child and Adolescent Mental Health, 28(2), 230-240. doi:10.1111/camh.12543

[23] https://www.faceyourfeelings.org/

examples of efforts that may help address this challenge.

Additionally, it's important to recognize that parents and other adults may need education or support to have conversations that can help normalize mental health concerns and treatment.

3. Ensure physicians, faith leaders, school counselors, & others who parents look to as sources of information about mental health are well equipped to respond to family needs

Our findings suggest that families seek information about mental health from these trusted sources. Ensuring they are well equipped may require continuing/expanding community engagement, outreach, and educational efforts targeting these groups of trusted professionals. The Arkansas Chapter of the American Academy of Pediatrics and the Arkansas Faith Network are two groups who have prioritized such initiatives.

4. Increase parent awareness of mental health, mental health concerns & treatment

Our finding suggests many parents may benefit from education and information from trusted sources to help them know the difference between mental health concerns and normal challenges of teenage life. They may also need easily understandable information to explain the various types of mental health treatment and become aware of what supports are available.

5. Provide a roadmap or navigation support to assist parents in obtaining appropriate care for their child

Our findings indicate that parents would benefit from additional guidance on the steps involved in accessing mental health care.

For example, parents may require support in identifying available mental health resources in their community, understanding and obtaining necessary referrals (e.g., from a primary care physician), and selecting a clinician with appropriate expertise to address their child's needs.

The UAMS tele-health program AR ConnectNow is an example of a program that offers care navigation support in addition to therapy sessions via telehealth, and there are opportunities to increase awareness of this service.

6. Increase & support access to behavioral health service opportunities for parents to address their own behavioral health needs or serious family stressors

Our findings provide a reminder that a key way to support youth mental health is to support the well-being of parents. Youth and parents face different barriers to accessing services and when parent mental health needs are left unaddressed, their children are impacted.

7. Create opportunities for parents to share & learn from peers alongside a mental health professional

Parents repeatedly mentioned the challenge of knowing when they were observing typical behaviors in their child and when the behavior(s) warranted concern.

Even more frequently, parents noted a lack of general conversation about youth mental health in their community and peer groups. Because of this, parents often wondered whether others have gone through/are going through similar situations and felt isolated and/or unprepared for supporting their children.

Resource (Foster) parents were particularly interested in having opportunities to network and learn from others. They often mentioned wanting more chances to learn how to better help their children. However, they also pointed out that there weren't enough resources available to help them do so.

8. Identify solutions to financial barriers for underinsured youth

Our findings highlighted numerous financial barriers for underinsured youth, such as limits on sessions and co-pays that quickly add up over time.

A wide range of studies find that even relatively small levels of cost sharing (for Medicaid), in the range of $1 to $5, are associated with reduced use of care, including necessary services.[24]

Survey and focus group participants pointed to opportunities to lessen these barriers through strategies like schools/districts directly employing mental health professionals and allowing them to provide care at no cost.

These and other creative solutions may be needed to solve this multi-faceted financial challenge.

9. Strengthen best practices in school-based mental health

On the provider side, our findings suggest there are opportunities to address training needs of MHPs, so they are more fully equipped to address the range of common concerns likely to be present among youth (e.g. substance use, trauma).

System changes may be needed to address the underlying reasons for high turnover in MHPs and the reasons that the least trained MHPs are often supporting clients with complex needs.

On the school side, there are opportunities to support school administrators in thinking through goals for on-site mental health services, and trouble-shooting logistical issues that create barriers for MHPs, such as space, privacy, and scheduling.

The Arkansas Department of Education (ADE) office of School Health Services as well

[24] https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

as the A.W.A.R.E. team provide guidance and technical assistance for the development of best practice school-based mental health programs within Arkansas public school districts, including a practice certification manual.[25]

10. Continue progress within Medicaid system to streamline PASSE processes (to minimize barriers to services for youth needing more significant support) & address workforce issues that can result in least experienced MHPs serving highest need youth

Our findings echo discussions that took place in 2022-2023 in the Mental and Behavioral Workgroup convened by the Arkansas General Assembly. Efforts to address these barriers are ongoing and key to improving youth mental health.

[25] https://dese.ade.arkansas.gov/Offices/learning-services/school-health-services/school-based-mental-health-sbmh

“I wish that schools, & really our society in general, would try to treat behavioral health through more prevention & education.

We have almost a solely treatment-only approach, & there are simply not enough therapists to be able to do this. We will keep struggling until we do…”

-Survey participant

This needs assessment was made possible by a grant from the Blue & You Foundation for a Heathier Arkansas to the UAMS Trauma Resource Initiative for Schools. For more information, contact Dr. Nicola Edge (naedge@uams.edu).

Suggested Citation: Fox, Lauren B., Edge, Nicola A., Smith, Allison B., Dickey, Geania, Connor, Pam, Boaz, Anthony, Johnson, Danya L., (2023). *Youth Mental Health Needs Assessment: Perspectives from parents, mental health professionals, & school counselors in Arkansas*.

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