Pain in the Nation: What Roles can School Health Play in a National Resiliency Strategy?

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Trust for America’s Health (TFAH)

- Non-profit, non-partisan
- Evidence-based policy & advocacy
- Dedicated to improving the health of every community and making disease prevention a national priority
Pain in the Nation Report

- TFAH & Well Being Trust
- Released Nov. 2017
- Calls for National Resilience Strategy
- 60+ research-based policies, practices & programs
Snapshots of a Crisis

- Life expectancy in the US decreased last year for the first time in 2 decades
- Increases in drug, alcohol and suicide deaths are major factors
- Need to address underlying pain, despair, disconnection and lack of opportunity
- Call for a National Resilience Strategy
Projections

Alcohol, Drug and Suicide Deaths in the United States

<table>
<thead>
<tr>
<th>Year</th>
<th>Alcohol Deaths</th>
<th>Drug Deaths</th>
<th>Suicide Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>7.0</td>
<td>10.3</td>
<td>10.5</td>
</tr>
<tr>
<td>2015</td>
<td>10.3</td>
<td>16.3</td>
<td>13.8</td>
</tr>
<tr>
<td>2025</td>
<td>13.1</td>
<td>28.4</td>
<td>16.5</td>
</tr>
</tbody>
</table>
1 in 12 high school students attempted suicide in 2015
1 in 12 teens who needed substance misuse treatment received treatment in 2016
1 in 5 children and teens, either currently or at some point in the past, have had a serious debilitating mental disorder
90 percent of adults who develop a substance use disorder began using before they were 18 years old
Opportunities

- Promote protective factors in addition to reducing risk factors
- Focus on tween, teen and young adult years when depression, substance misuse and suicidal ideation emerge
- Transition times can be trigger points
- Prevention programs show benefits for all children but benefit those at risk most
Key Policies

- Invest in social-emotional learning
- Adopt evidence-based substance misuse prevention programs in schools
- Support anti-bullying programs
- Expand mental health personnel and professional development opportunities in schools
Key Policies, cont.

- Create healthy, positive school climates
- Require school-based suicide prevention plans and training
- Increase school health services
- Improve coordination across education, health and other social services
Invest in Evidence-based Social-emotional Learning, Life and Coping Skills Programs

And leverage cross-sector investments in these programs

<table>
<thead>
<tr>
<th>Evidence-based Approach/Program</th>
<th>Benefits per $1 of Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse-Family-Partnership®</td>
<td>$1.61</td>
</tr>
<tr>
<td>The Incredible Years® – Parent</td>
<td>$1.65</td>
</tr>
<tr>
<td>Strengthening Families 10–14</td>
<td>$5.00</td>
</tr>
<tr>
<td>Early Childhood Education Programs (state and district)</td>
<td>$5.05</td>
</tr>
<tr>
<td>Good Behavior Game</td>
<td>$64.18</td>
</tr>
<tr>
<td>Life Skills® Training</td>
<td>$17.25</td>
</tr>
</tbody>
</table>
Adopt Evidence-based Substance Misuse Prevention Programs in Schools

$3.80 - $34

ROI for every $1 invested in five of the strongest school-based substance misuse prevention strategies
Strengthen Anti-Bullying Prevention

22 States Have Comprehensive Bullying Prevention Laws

Source: American Academy of Pediatrics

Trust for America's Health
WWW.HEALTHYAMERICANS.ORG
Expand School Behavioral Health Services

- Expand school counselors and other mental health personnel and professional development opportunities in schools

Source: Kaiser Family Foundation
Create Healthy, Positive School Climates

- Conduct needs assessments
- Adopt wellness plans
- Implement CDC defined strategies to improve positive protective factors through school connectedness and parent engagement
<table>
<thead>
<tr>
<th>Indicator</th>
<th>HSPF States Meeting Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Require Annual Training for School Personnel on Suicide Prevention</td>
<td>NE, TN</td>
</tr>
<tr>
<td>Mandate Training in Suicide Prevention for School Personnel but Do Not Specify it be Annual</td>
<td>IL, MA, MS, NJ, SC, WA</td>
</tr>
<tr>
<td>Have Laws that Encourage Suicide Prevention Training for School Personnel</td>
<td>CA, CO, MN, VA</td>
</tr>
</tbody>
</table>
Increase Provision of Health Services in Schools

- Including physical, mental, behavioral and oral health
- Improve coordination across education, health and other social services
Thank You

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Resources:
• TFAH’s website: http://healthyamericans.org/
• Pain in the Nation interactive website: http://www.paininthenation.org/
MA Statewide SBIRT Initiative

Healthy Students, Promising Futures Learning Collaborative
Trust for America’s Health
December 4, 2017

Carol Girard
Massachusetts Department of Public Health
Bureau of Substance Addiction Services
Today

• SBIRT - Screening, Brief Intervention, Referral to Treatment
  – What it is
  – Research basis
  – Effectiveness

• Massachusetts SBIRT experience

• SBIRT in Schools
  – Pilots, Mandate, Scale
What is SBIRT?

Process addressing full spectrum of use; normalizing conversations about AOD in healthcare

- **Universal Screening**: Asking validated questions to identify patient drinking patterns and level of risk

- **Brief Intervention**: Feedback and short, MI-based conversation about the harmful effects of risky drinking with patients who are drinking too much

- **Referral & Treatment (or assessment)**: When necessary, engaging patient in conversation about specialized help

[Pyramid diagram showing percentage distribution of SUD, at risk, lower risk, and abstinence]
Teen Alcohol Use Wires the Brain for Addiction

Reference: Hingson et al., 2006

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Screening and Brief Intervention

NO USE
Negative Screens: Positive Reinforcement

SOME USE
Positive Screens: Brief Negotiated Interview

HIGH RISK
Referral to Treatment, as needed

FOCUS:
PREVENT USE & REDUCE HARM

UNIVERSAL Screen using validated tool identifies substance use
SBIRT efforts in MA before Mandate

• 2003/2006 – Part of Interagency Council on Substance Abuse Treatment and Prevention Strategic Plan

• 2006-2007 - MA law: Mental Health EPSDT/Medicaid
  – CRAFFT one of approved screening tools
  – Led to CRAFFT Toolkit

• 2006-2012
  – SAMHSA-funded MASBIRT project (one pediatric clinic)
  – BSAS-funded trainings of School Based Health Center NPs
  – BSAS-funded ED SBIRT & CHC SBI (included CRAFFT)

• 2012 - Present - DPH/BSAS funded MASBIRT TTA
  – Ongoing adolescent provider efforts

• 2015 New Adolescent toolkit for providers
SBIRT in Schools Pilots

Two Bureaus within MDPH

- Bureau of Community Health & Prevention, School Health Services and Bureau of Substance Addiction Services
  - 2011 Discussions, consultations
  - 2012-13 School year - 3 pilots from statewide meeting
  - 2015-16 10 pilot schools screened youth in one grade

- Pilots included
  - School meetings
  - Implementation planning and team building
  - Team trainings at each school
  - Boosters with each school team before screening
  - De-Brief and nurse feedback

- 6/2014 Hilton Foundation advocacy grant to Children’s Mental Health Campaign (Addiction Free Futures) under the MA Society for the Prevention of Cruelty to Children funded through Community Catalyst
SBIRT Mandate Highlights
‘STEP Act’ Signed by Governor on March 16, 2016

• Annual screenings at 2 different grade levels
  – Each city, town, regional school district, charter school or vocational school district must screen pupils for SUDs;

• Pupil or parent/guardian may opt out in writing at any time;

• Schools must
  – Notify parents or guardians prior to the start of the school year;
  – Use only approved verbal screening tools;
  – Report de-identified results to MDPH not later than 90 days after screening completion;
  – Complete and report on required ‘substance use disorder’ screenings by the 2017-2018 school year.
SBIRT Mandate Highlights

• “Any statement, response or disclosure made by a pupil during a verbal substance use disorder screening shall be considered confidential information and shall not be disclosed by a person receiving the statement, response or disclosure to any other person without the prior written consent of the pupil, parent or guardian, except in cases of immediate medical emergency or a disclosure is otherwise required by state law.”

• Consent must be documented on a DPH approved form; not subject to discovery or subpoena in any civil, criminal, legislative or administrative proceeding.

• “No record of any statement, response or disclosure shall be made in any form, written, electronic or otherwise, that includes information identifying the pupil.”

• ALSO required in the legislation: ‘Substance use prevention and abuse education’
Lessons Learned:
An existing infrastructure has been critical

• Planning team
• Curriculum and process
• Experienced trainers
• Nurse champions ‘Voices from the Field’
• Web presence with printable forms and materials, videos, links to materials for youth, parents and teams
• Existing registration processes for school nurse trainings/meetings
• Aggregate data collection processes in place
Lessons Learned:
Be flexible within your parameters

• Updated training content and materials
  – Curriculum to conform with mandate
  – No longer small school teams; individuals
  – Promote team approach; must rely on teams to form later
  – Required SBIRT 1 (6 hrs.) and optional Essentials (3 hrs.)

• Added contracted (MI) trainers & coordination staff

• Creating more paper, web, video materials (in process)

• Revised aggregate data collection tools - variables may change or be added; consistent reporting may become more difficult

• Continue to respond to school nurses, counselors, administrators, parents, community coalitions, DAs, national inquiries, media (through MDPH), vendors, and others.
Lessons Learned: Funding is critical

- In-kind DPH staff time and resources from 2 Bureaus (extensive still)
- 11/15 - Pre-mandate supplemental funding used for school planning grants through an application process
- 7/16 - 6/18 – Two full years of funding
- 6/18 – No further funding anticipated
Funding pays for:

- Regional Training Sites to accommodate large numbers
- Contract Trainers, logistics, scheduler, coordination, CNE's, CEUs
  - Trainer statewide travel costs
- Form development and translations into 12+ languages
- Coordination of local Essentials trainings - time consuming
- Web presence: More videos and downloadable materials
- Reprinting of youth and parent prevention materials; contribution for material fulfillment vendor services
- Development of ‘evergreen materials’
  - On-line training modules for large numbers of new staff starting each new school year
Caveats

• Knowledge of school operations and school nurse responsibilities is critical

• Nurses/counselors have different cultures/concerns

• School staff will also learn about other problems in students’ lives

• With infrastructure: Over 2 years to train staff from 344 school districts & ramp up to normalize future annual screenings

• Concerned parents: Open part of training to administrators

• Media: All involved parties need clear, consistent messages
  – Information may be misrepresented (e.g. drug testing)
Caveats

• Other departments, bureaus, groups and vendors may add credibility - but also add more complexity

• Athletics: Coaches may want info to AOD users from teams

• Town and state politics

• Others may want to put a foot in school doors with you

• Be prepared to report regularly throughout on training progress

• Continue to expect changes and new requests
We are still ramping up

No data expected till mid-late December
Not sure how aggregate data will be presented
Concerns re: small numbers
For further information

• Carol.D.Girard@state.ma.us

• MASBIRT Training and Technical Assistance
  www.masbirt.org/schools

• School Health Institute for Education and Leadership Development
  http://bucme.org/node/1045