

School Mental Health in Detroit Public Schools Community District

A needs assessment from
TRAILS and the Youth Policy Lab



Statement on COVID-19

The findings presented in this report reflect data collected before the COVID-19 pandemic spread throughout the globe, shuttering businesses, schools, and communities, and infecting millions of people. Since March 2020, our health care systems, schools, and communities have all endured significant hardship – though not equally. The disproportionate rate of COVID-related illness and death in communities of color has highlighted historic and systemic inequities that persist both in the United States and globally.

Detroit has experienced exceptional heartache during the pandemic. As of July 16, 2020, Detroit has struggled with 12,835 cases of COVID and 1,547 deaths, more than any other city or county in the state.¹ Black Michiganders account for over 41% of the state's COVID deaths, yet make up only 14% of the state's population.¹ Across the country, Black Americans have an age-adjusted COVID fatality rate that is 3.8 times higher than Whites.² The racial disparity in COVID illness and death in Michigan is one of the worst in the country.²

Within the chaotic environment that clouded the city of Detroit this spring, students were forced to adapt to a world with countless unknowns and significant challenges. Many students have experienced the loss of a family member, a friend, or a beloved community member. Many young people have had no choice but to spend time in an unhealthy home environment or without the presence of a caregiver who was able to stay home. Many students feel isolated, unsafe, distraught, anxious, or helpless.

Schools have long been one of the most important community cornerstones, and the past few months have underscored this role, as schools provided meals, remote instruction, social support, and technology for students and families. Detroit Public Schools Community District (DPSCD), in particular, has been pivotal to the health and wellness of its families. As we look to the next chapter, more than ever, Detroit students will need the support and investment of the many stakeholders that contribute to the strength of the school district. We hope that the findings presented in this report contribute to a better understanding of the experiences of DPSCD students and inspire new and effective efforts to promote the health of all students, especially during these unprecedented times.

The research findings outlined in this report are being considered for peer-reviewed publication. Until the manuscript has been published, the contents of this report should not be widely distributed to the press or public without explicit written permission from the authors.

Requests may be submitted in writing to trailstowellness@umich.edu.

Foreword from Nikolai Vitti



The vision of Detroit Public Schools Community District is to prepare all students to have the knowledge, skills, and confidence necessary to thrive in our city, our nation, and our world. This vision compels us to prioritize a “whole child commitment” in our Blueprint 2020, placing emphasis not only on academic readiness,

but also on the physical health and social-emotional development of our students. We have chosen this approach because we recognize that the ability of students to take full advantage of educational opportunity requires that we create a foundational culture of health and wellness throughout each and every one of our schools.

In our commitment to the whole child, we formed a collaborative partnership with the University of Michigan TRAILS program and the Youth Policy Lab to conduct a districtwide assessment of mental health needs. Survey data was collected from approximately 3,500 staff and 11,000 students, providing an unprecedented view of the well-being of our district and the priority needs identified by our community. These important findings will inform development of data-driven, responsive mental health care programming for all students and associated professional development for all staff, spanning every DPSCD building.

The data presented in this report summarize the primary findings of that needs assessment and will be utilized to inform the following District strategies:

- Building an integrated system of support and care for students where staff apply real-time screenings, interventions, and supports on school campuses to our families and students.
- Increasing our students’ access to evidence-based mental health supports within our school buildings.
- Equipping faculty and staff with high-quality professional development and advanced training to ensure accurate and timely identification of students in need and delivery of effective mental health services.
- Continuously seeking the perspective of our faculty, staff, and families, to better meet their highest needs related to mental health.
- Increasing mental health support for our faculty and staff as they are asked to work in the service of our students and families.
- Involving families and community members in building awareness related to mental health and determining how best to support their children.

We are confident that the continued collaboration between DPSCD, TRAILS, and the Lab will lead to a meaningful, effective, and sustainable behavioral health program for our community that will help our students rise.

Nikolai P. Vitti, Ed.D.
Superintendent
Detroit Public Schools Community District

Foreword from Elizabeth Koschmann



Academia has a tarnished history of conducting research in disenfranchised communities, while overlooking the responsibility to leverage new information generated to promote public health and social equity. Thus, it is in a spirit of reparation that TRAILS seeks to utilize interdisciplinary research to

inform collaborative partnerships with school districts with an explicit, shared goal of improving student, staff, and community well-being.

At TRAILS, we believe that wellness begins with a foundation of equity in health and access to high-quality health care. Further, we believe that those best positioned to support the healthy growth and development of young people in any community are the very individuals living and working alongside those youth, particularly those working in schools. Therefore, TRAILS works to support and strengthen the muscle of teachers, student support staff, administrators, and families in partner districts, by linking them with high-quality, effective, and responsive professional development, programming, and resources, aligned with the unique needs and priority goals of their district.

In 2018, TRAILS was offered the opportunity to begin a partnership with Detroit Public Schools Community District (DPSCD). The primary goals of the partnership were to complete a district-wide mental health needs assessment; and to utilize findings from that assessment to make formal recommendations to the District for a comprehensive mental health strategy. The following pages outline both the primary findings from this needs assessment and select recommendations from TRAILS for student programming, staff professional development, and methods to engage and empower families in support of their children’s mental health.

This report is the culmination of a truly collaborative process. First, the Youth Policy Lab (the Lab), a partnership between the University of Michigan Ford School of Public Policy and the Survey Research Center at the Institute of Social Research was integral to development of the survey items, design of the needs assessment process, and analysis of the data. The Lab will continue to play a critical role in utilizing information generated through this process to advocate for policies that benefit DPSCD students, staff, and families. Second, numerous foundations provided essential support for this work, offering not only financial resources but also wisdom, guidance, and partnership. Finally, the DPSCD leadership and several departments were pivotal in facilitating this needs assessment. The deep commitment to their students, staff, families, and community was evident in every interaction and every decision. We are deeply grateful for their time, energy, and expertise.

This report discusses a number of sensitive topics related to mental health, exposure to trauma, and suicidal ideation. These topics may be emotionally challenging for many readers. We highlight these issues because transformational policy change and implementation of vital mental health programming is only possible through revealing the full extent of need in this local context. This needs assessment is central to data-driven efforts to inform next steps and provide the youth of Detroit with effective tools and resources that will help them reach their full potential.

With gratitude for many individuals, and in collaboration,

Elizabeth Koschmann, PhD.
Program Director
TRAILS

Executive Summary

The DPSCD School Mental Health Needs Assessment was conducted with two overarching aims: 1) to more fully understand student mental health and related factors within the DPSCD community; and 2) to inform professional development (PD) opportunities for staff, and expanded programming for students. In conjunction with the needs assessment, nearly 3,500 DPSCD staff, 11,000 students in grades 8-12, and 800 family members completed comprehensive surveys. Additional data was collected from a variety of stakeholders including DPSCD Police, community mental health care providers, and several Michigan foundations. Surveys included items about health and health care access, availability and satisfaction with current mental health programming, factors influencing staff and student wellness, and priorities for future initiatives.

Many of the main findings will not surprise those familiar with the District: teachers have decades of experience and are deeply committed to their students, administrators want more and better professional development for staff, and students are contending with environmental stressors that stem from living in a city with high rates of poverty, housing inadequacy, and community disenfranchisement, while also trying to do well in class and get their homework done. Other findings may be more surprising, such as the eagerness among staff for training in mental health promotion, or the wish among students for a quiet place to go in school.

Data collected in the needs assessment are already being used to inform professional development for DPSCD staff, guide student programming for the coming academic year, and advocate for District needs to legislators, policymakers, foundations and philanthropists, researchers, and health and education professionals. We are optimistic that this unprecedented data collection effort will positively influence those many stakeholders.

We invite you to read our full report on the following pages, but offer this brief summary of major findings:

- 1. A large portion of students across DPSCD experience substantial symptoms of anxiety, depression, and suicidal ideation; and many have experienced traumatic events. Several groups of students are particularly vulnerable.** Rates of depression and anxiety, and suicidal ideation among students exceed national averages. Students who have had 4 or more adverse childhood experiences (ACEs) were more likely to be depressed than students with fewer ACEs. Academic stress was the top mental health concern identified by students, followed by anxiety, depression, and family stress. Students who identify as gender nonbinary, transgender, or LGBTQIA+ had higher rates of mental health difficulties, and girls had higher rates of depression and anxiety than boys. Students who experienced homelessness were also more likely to be depressed, anxious, and to report ACEs.
- 2. Students who reported symptoms of a mental illness and/or a history of trauma exposure, also reported poorer overall school engagement.** Students with depression, anxiety, and exposure to ACEs were more likely to report chronic absenteeism and difficulties completing schoolwork or studying. Rates of disciplinary action were also significantly higher for students with depression, anxiety, and exposure to 4 or more ACEs.
- 3. A substantial number of students with symptoms of anxiety and/or depression report not accessing any school or community mental health support services.** A variety of local services and programs currently support social and emotional health throughout the District, with teachers and doctors being the most commonly accessed school and community resources. Most students who accessed these resources reported that they were helpful. However, a significant number of students,

including many with symptoms of anxiety and/or depression or with extensive exposure to ACEs, reported not accessing any supports and noted a wide variety of barriers. Overall, students voiced a desire for a quiet place to go in school and more mental health and suicide prevention training for staff. Listening to music and exercising were the most commonly used healthy coping skills, while evidenced-based coping skills, such as facing fears and questioning thoughts, were less likely to be used.

- 4. Staff recognize the need for school-based mental health supports and for available supports to be more effective.** DPSCD staff and leaders are passionate and dedicated to serving students in the Detroit community, and the desire for PD in effective student mental health practices was evident. Top PD interests among teachers and administrators included training in social and emotional learning (SEL), while support staff were most interested in best practices to support students affected by anxiety and depression. Very low mental health stigma was reported among staff. However, many staff reported experiencing burnout and difficulty managing student behavior. New teachers experienced the highest level of burnout among staff. The majority of staff also expressed interest in learning about self-care strategies to promote their own wellness and help them cope with burnout and vicarious trauma.
- 5. There are discrepancies in perspectives on the identification, referral, and risk response systems within schools.** Most staff were either unaware of mental health management systems in their schools or reported that their school did not have such a system. Over half of all staff said there was no formal system in their school to refer students to school-delivered mental health services. Most staff also said there was no formal system for responding to students at risk of suicide in their school. Conversely, over half of administrators said there was a system in place in their school to identify students in need of mental health services.

Key Recommendations

Based on findings from this needs assessment, TRAILS offers several key recommendations for expansion of District mental health programming, including training and resources for staff and direct services for students. [Page 75](#) of this report highlights these recommendations. By providing DPSCD students with access to evidence-based mental health care in schools, students impacted by mental illness, trauma exposure, or environmental stressors will be more likely to develop adaptive coping strategies that will lead to greater resiliency during hardship; better impulse control in moments of anger, anxiety, or hopelessness; better alignment of immediate behaviors with long-term goals; and improved overall mental and behavioral health. With improved management of symptoms of mental illnesses, these students will be able to participate more meaningfully in school, improve attendance and academic performance, engage in fewer noncompliant and high-risk behaviors, remain in school longer, and ultimately benefit more fully from the academic opportunities available to them in their Detroit schools. We at TRAILS are grateful for the opportunity to share these recommendations and look forward with optimism to the next phases of collaboration with DPSCD.

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Introduction

Over the last decade, the United States has been overwhelmed by a public health emergency.

In recent years, rates of child and adolescent mental illness have skyrocketed, yet only 20% of those affected are able to access treatment.³ Among youth ages 10-24, suicide has become the second leading cause of death, killing almost 8,000 young people annually.⁴ Today, a second public health emergency has amplified the crisis: In March, COVID-19 closed schools nationwide and cut off millions of students from critical support services, exactly as they were experiencing higher levels of trauma, grief, anxiety, depression, and isolation than ever before. No one can predict the toll this will take on the mental health of young people, but we do know that our schools are facing a massive crisis, particularly as they head toward resuming operations this fall.

As stated elsewhere in this report, the impact of COVID-19 is not distributed equitably, hitting hardest among communities of color and families contending with poverty. These disparities are not new, but rather, COVID-19 shed a new light on pervasive and persistent ways in which individuals who represent social, ethnic, and cultural minority groups are disproportionately affected by illness and inadequate medical care.

“...the impact of COVID-19 is not distributed equitably, hitting hardest communities of color and among families contending with poverty.”

Detroit is much like other districts nationwide, in that the schools have long offered critical mental health supports for their students. While most school-age youth who need mental health services do not ever receive treatment, nationally, 75% of those who do access care receive those services exclusively in their school.^{5,6} Students also express more willingness to seek mental health care in school than in any other setting.^{7,8}

The leadership of DPSCD is acutely aware of the challenges their students face and identified the need for additional mental health support programs in their Blueprint 2020 Strategic Plan, which includes a “Whole Child Commitment” priority. In 2018, TRAILS began a partnership with the District, with the goals of learning about their existing resources and priority needs and then working together to implement a set of responsive practices and programs. Over the last two years, DPSCD leadership has worked closely with TRAILS and partner organization, the Youth Policy Lab (the Lab), and has committed substantial time and resources to ensuring the partnership moves forward in the best interest of the students.

The first priority for the project team was to conduct a comprehensive needs assessment to identify areas of greatest need, identify potential implementation barriers, establish baseline measures against which success can be measured, and to ensure that all stakeholders were included in the planning process.

Over the last year, TRAILS and the Lab have collected data from DPSCD teachers, administrators, school staff and students, and families. Nearly 3,500 teachers, administrators, and other school staff responded to a survey, providing detailed information about their needs and the needs of their students around mental health.⁹ Student surveys were completed in December 2019, with responses from over 10,700 students in grades 8-12, representing 78 school buildings. In addition, more than 800 DPSCD family members completed surveys and others participated in a focus group, providing their perspective on the needs of their children and the ways in which they believe schools can be most helpful.

This report provides a comprehensive look at the responses of the needs assessment by detailing the following:

- 1. The social determinants of health, school climate, and other contextual influences on mental health.
- 2. The symptoms of anxiety and depression, and exposure to traumatic events experienced by students, and the degree to which these are associated with school engagement, absences, and other behaviors.
- 3. The degree to which school personnel and students are interested in resources to address mental health difficulties among students.
- 4. The challenges staff face with regard to referral and coordination of services for their students.
- 5. The barriers and challenges present in the District, including teacher and staff burnout.

This report concludes with a set of recommendations for moving forward with a variety of mental health programs in DPSCD schools, including many supports offered by TRAILS.

About the Authors

TRAILS (Transforming Research into Action to Improve the Lives of Students) is a program within the University of Michigan Medical School that aims to promote more equitable access to effective mental health care by increasing the use of evidence-based mental health practices in schools. TRAILS programming is organized around a 3-tiered conceptual framework: universal prevention for the whole school community (tier 1), early intervention targeting students with identified mental health concerns (tier 2), and crisis response to help schools manage risk among their highest needs students (tier 3). Today, more than 2,800 school staff and mental health care providers have attended TRAILS trainings. This has brought the program to 370 schools, impacting an estimated 90,000 young people.

The University of Michigan Youth Policy Lab (the Lab) helps community and government agencies make better decisions by measuring what really works. The Lab team are data experts who believe that government can and must do better for the people of Michigan. They are also parents and community members who dream of a brighter future for all of our children. The Lab works to make that dream a reality by strengthening programs that address some of our most pressing social challenges. The well-being of youth is intricately linked to the well-being of families and communities, so the Lab engages in work that impacts all age ranges. Using rigorous evaluation design and data analysis, the Lab works closely with partners to build a future where public investments are based on strong evidence, so all Michiganders have a pathway to prosperity.

The following individuals contributed to this report:

TRAILS: Elizabeth Koschmann, Jennifer Vichich, Maureen Smith, Jill Paladino, Meredith Ollila, Destiny Franks, Hannah Countryman

Youth Policy Lab: Robin Jacob, A. Foster, Hersheena Rajaram, Katja Robinson, Megan Foster Friedman

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Introduction

Where Our Data Came From

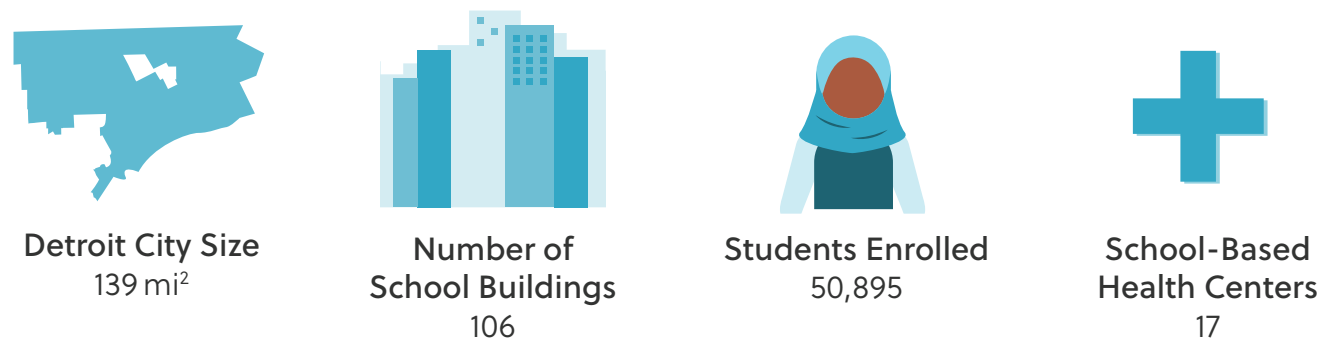


TRAILS and the Youth Policy Lab worked together to develop several different surveys for students, administrative staff, instructional staff, and support staff in DPSCD schools, as well as for families and members of the DPSCD police department.

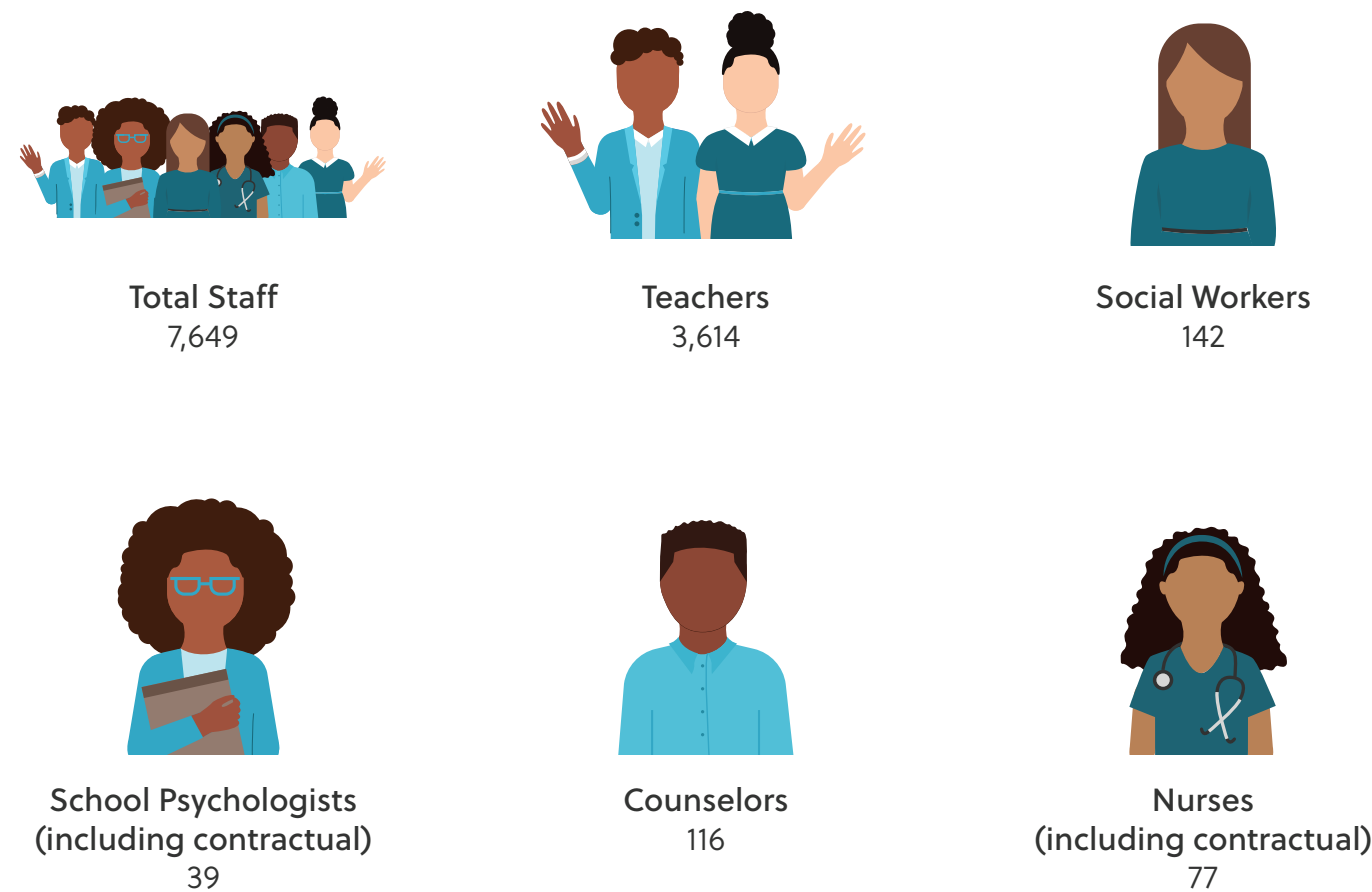
Our research focused on the public school setting, and therefore did not include the perspectives of students or staff from charter or private schools in Detroit or from students who live in Detroit and attend school elsewhere.¹⁰ Each survey contained approximately 50-75 items and was organized by topic area. Topics on school staff and police surveys included: perceptions of student mental health and factors impacting mental health in schools; current school climate and available mental health programming; beliefs about mental illness (stigma); self-reported burnout / exhaustion; and professional development satisfaction and interests.

The family survey focused on perceptions of student mental health, satisfaction with current school mental health programming, and beliefs about mental illness. The student survey included many of these same topics as well as school engagement, school and community safety, exposure to adverse childhood experiences (ACEs), and mental health coping skills. The student survey also briefly assessed symptoms of depression, anxiety, and suicidal ideation.

Detroit Public Schools Community District Overview^{11, 12, 13, 14, 15}



DPSCD Workforce



Family Survey

Demographic Characteristics of Family Survey Respondents

Race / Ethnicity (n = 808)			Gender Identity (n = 637)		
	#	%		#	%
Black / African American	464	57.4%	Female	563	88.4%
Hispanic / Latinx	94	11.6%	Male	55	8.6%
White	34	4.2%	Gender Non-Binary	1	0.2%
Asian	5	0.7%	Prefer not to answer	18	2.8%
Middle Eastern / North African	5	0.6%			
American Indian / Alaska Native	4	0.5%			
Hawaiian / Pacific Islander	3	0.4%			
Other	4	0.5%			
Prefer not to answer	44	5.4%			

Staff Surveys

79 DPSCD Pre-K - 12 school buildings represented

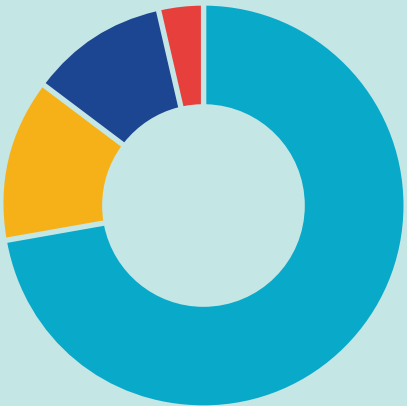
78% of all eligible staff reporting

3,480 DPSCD staff surveys analyzed

Professional Characteristics of Staff Survey Respondents

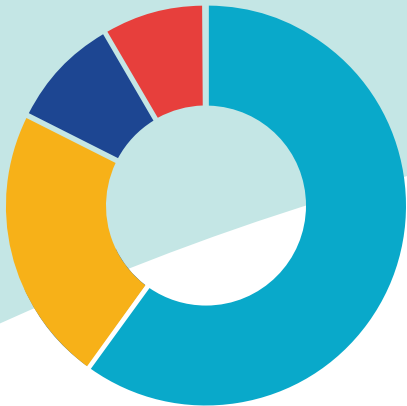
Years Experience in Professional Field
(n = 3,473)

- 11 or more years (n = 2,511, 72.3%)
- 6-10 years (n = 389, 11.2%)
- 1-5 years (n = 451, 13%)
- Less than 1 year (n = 122, 3.5%)



Years Experience in DPSCD
(n = 3,473)

- 11 or more years (n = 2,080, 59.9%)
- 6-10 years (n = 290, 8.4%)
- 1-5 years (n = 779, 22.4%)
- Less than 1 year (n = 324, 9.3%)



Years Experience in Current Job
(n = 3,473)

- 11 or more years (n = 1,132, 32.6%)
- 6-10 years (n = 486, 14.0%)
- 1-5 years (n = 1,222, 35.2%)
- Less than 1 year (n = 633, 18.2%)



Professional Role

(n = 3,473)

- Teacher (n = 2,153, 61.9%)
- Other Instructional Staff (n = 540, 15.5%)
- Health Professional (n = 199, 5.7%)
- Other Support Staff (n = 279, 8%)
- Administrative Leader (n = 178, 5.1%)
- Other Administrative Staff (n = 124, 3.6%)

Highest Educational Degree Earned

(n = 3,464)

- Doctoral degree or professional degree (n = 168, 4.9%)
- Master's degree (n = 2,080, 60%)
- Bachelor's degree (n = 666, 19.2%)
- Associate's degree (n = 250, 7.2%)
- High school graduate (n = 174, 5%)
- Other (n = 125, 3.6%)

Responses not visible on graph:
Some high school, no diploma (n = 1, 0.03%)

Demographic Characteristics of Staff Survey Respondents

Race / Ethnicity (n = 3,275)	#	%
Black / African American	1,908	58.2%
White	632	19.3%
Multiracial	135	4.1%
Hispanic / Latinx	98	3%
Asian	38	1.2%
Middle Eastern / North African	13	0.4%
American Indian	12	0.4%
Hawaiian / Pacific Islander	2	0.1%
Other	41	1.2%
Prefer not to answer	396	12.1%

Gender (n = 3,287)	#	%
Woman	2,437	74.2%
Man	605	18.4%
Non-Binary	5	0.2%
Other	3	0.1%
Prefer not to answer	237	7.2%

Student Surveys¹⁶

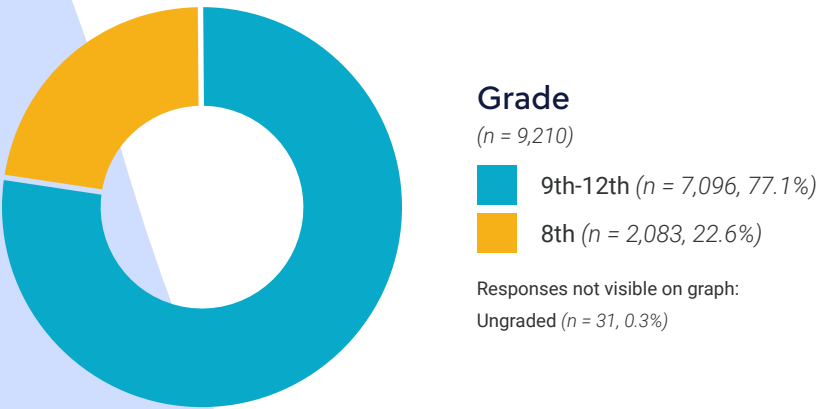
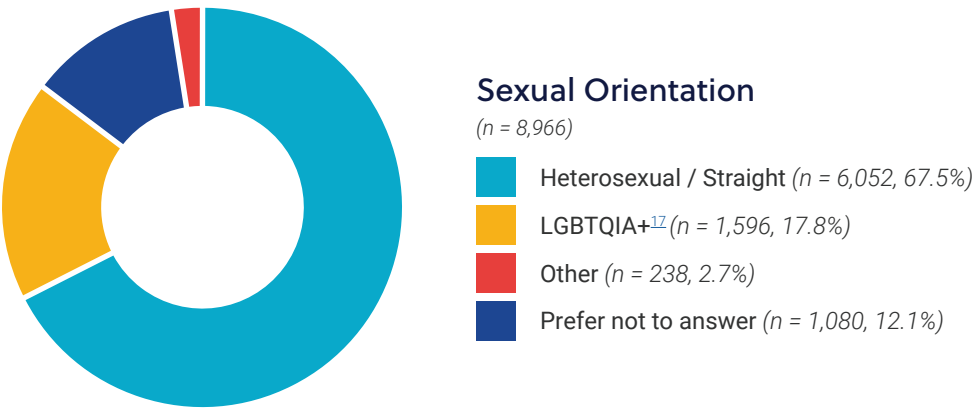
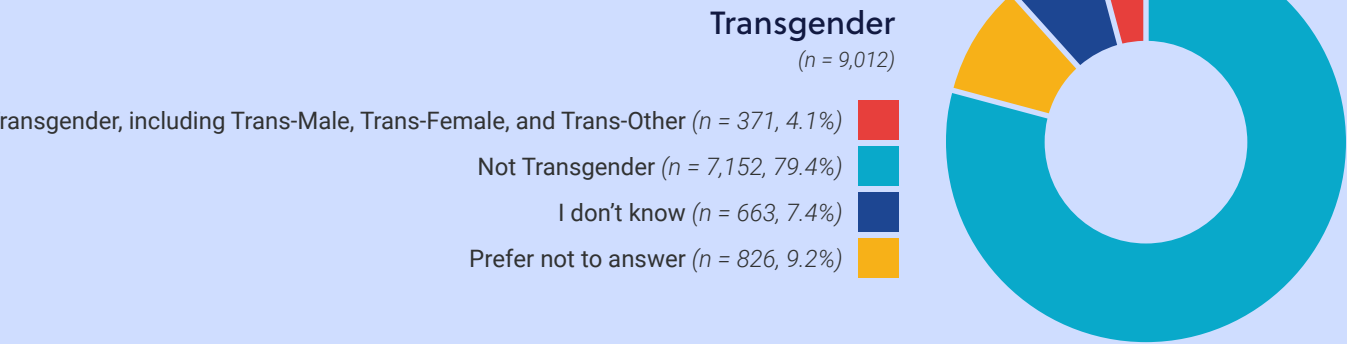
90% of eligible school buildings represented

64% of eligible students responded

10,747 student surveys analyzed

Students grades 8-12 surveyed.

Demographic Characteristics of Student Survey Respondents

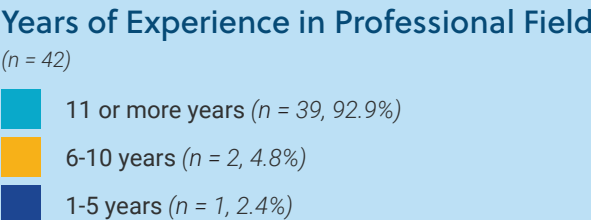
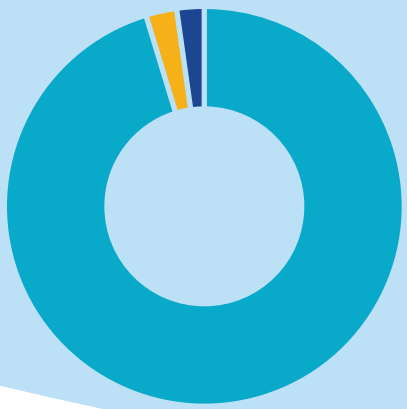
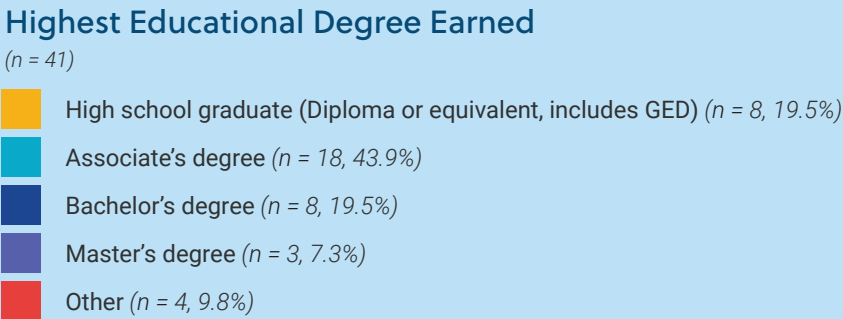
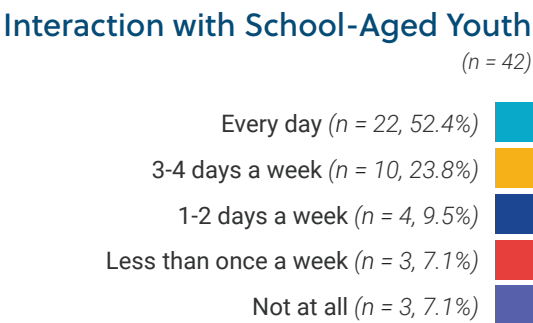
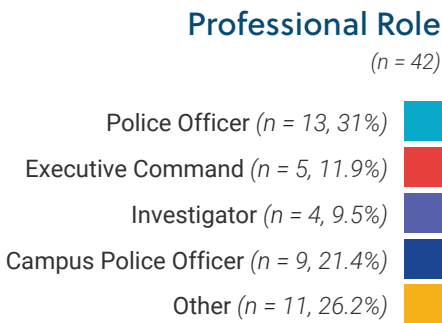
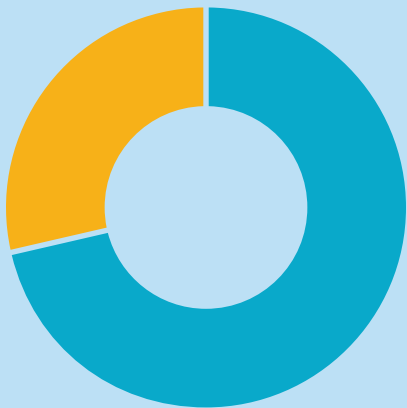
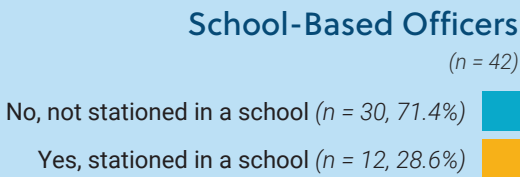


Race / Ethnicity (n = 9,301)	#	%
Black / African American	5,831	62.7%
Multiracial ¹⁸	1,444	15.5%
Hispanic / Latinx	1,077	11.6%
Asian	268	2.9%
American Indian	177	1.9%
White	77	0.8%
Middle Eastern / North African	57	0.6%
Hawaiian / Pacific Islander	14	0.2%
Other	53	0.5%
Prefer not to answer	303	3.3%

Gender Identity (n = 9,287)	#	%
Girl / Woman	4,961	53.4%
Boy / Man	4,071	43.8%
Gender Non-Binary	91	1.1%
Other ¹⁹	13	0.14%
Prefer not to answer	151	1.6%

Police Survey

Professional Characteristics of Police Survey Respondents



Demographic Characteristics of Police Survey Respondents

Race / Ethnicity (n = 42)			Gender (n = 42)		
	#	%		#	%
Black / African American	29	69.1%	Woman	23	55.8%
White	4	9.5%	Man	17	40.5%
Prefer not to answer	9	21.4%	Prefer not to answer	2	4.8%



02

Findings

A substantial portion of DPSCD students contend with symptoms of anxiety or depression, or experience suicidal ideation; and many have been exposed to adverse childhood experiences (ACEs) and other traumatic events.

The following pages highlight some of the major findings analyzed from over 15,000 survey participants. Survey topics included: perceptions of student mental health and factors impacting mental health in schools; current school climate and available mental health programming; beliefs about mental illness (stigma); self-reported burnout / exhaustion; and professional development satisfaction and interests. Analysis of this data was crucial, as it informed all recommendations regarding strategies to improve District mental health programming. TRAILS and the Lab will continue to consult this data throughout the partnership with the District.



Findings

Community Context

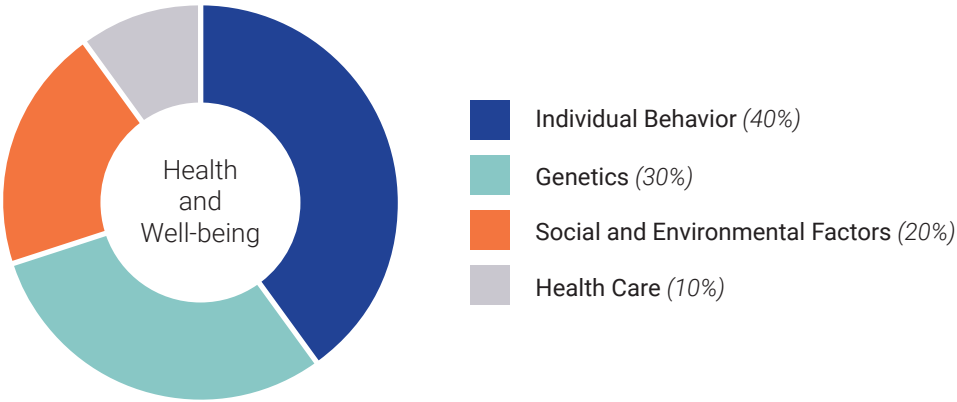
The conditions in which people live, learn, work, and play, as well as the experiences they have within their environment, impact a wide variety of outcomes across the lifespan.

Many different environmental and experiential factors influence the health and wellness of community members. Collectively, these factors are referred to as social determinants of health (SDOH).²⁰

Primary SDOH include socioeconomic status, material resources, educational systems, neighborhood infrastructure, community safety, and access to health care. Extensive research has documented that individuals living in neighborhoods with high levels of poverty, inadequate resources, housing and food insecurity, or community violence are at increased risk of both physical illness (such as asthma, diabetes, or heart disease) and mental illness (such as anxiety, depression, or suicidality).²¹ Rates of depression and anxiety among school-age youth living in these conditions can be more than 2 times higher than national averages²²; and these youth experience a significantly increased risk of suicidal ideation, attempt, and completion.²³

In addition, people of color are more likely to experience health and mental health difficulties, and have a heightened risk of suicide. These trends are hypothesized to reflect the stress and impact of broad systemic racism, higher rates of disenfranchisement and trauma exposure in predominantly African-American communities,^{24,25,26} and significant racial disparities in access to effective health and mental health care.²⁷ Together, these findings have significant implications for the city of Detroit and for DPSCD, as many young people living and learning in the city may experience conditions that are stressing their physical and mental health. Despite monumental effort on the part of school district and city leaders, and recent improvements to many conditions in Detroit, numerous challenges remain.²⁸

Impact of Different Factors on Risk of Premature Death



Examples of Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social Integration	Health Coverage
Income	Safety	Language	Access to Healthy Options	Support Systems	Provider Availability
Expenses	Parks	Early Childhood Education		Community Engagement	Provider Linguistic and Cultural Competency
Medical Bills	Playgrounds	Vocational Training		Discrimination	Quality Of Care
Support	Walkability, Zip Code, Geography	Higher Education		Stress	

Health Outcomes

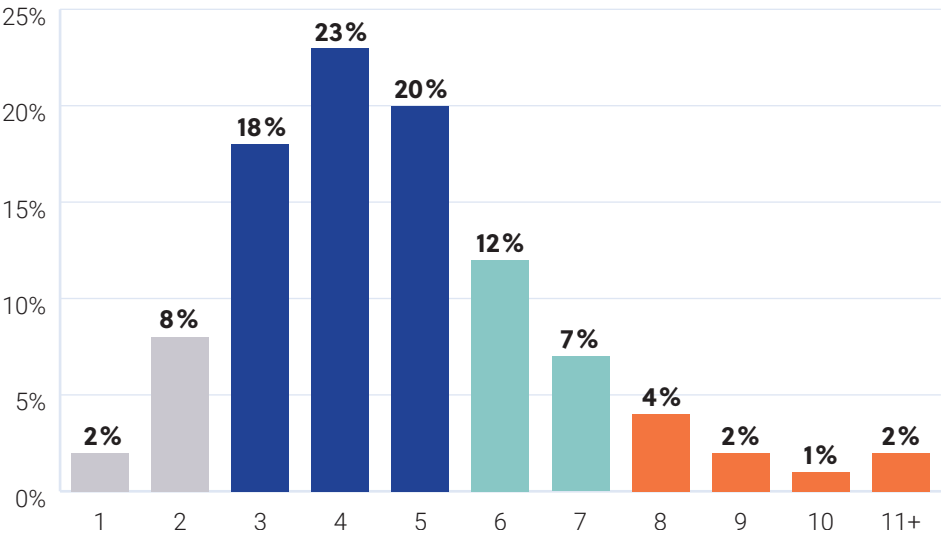
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Source: <https://www.issuelab.org/resources/22899/22899.pdf>

Housing

Nationally, approximately 3% of all public-school students (or 1.5 million students) experienced homelessness in the 2017-2018 academic year.²⁹ **In contrast, 14% of DPSCD students surveyed (n=1,253) experienced homelessness during the past year.** Of these, roughly 3 in 4 (n=919) reported living doubled-up in another family's home. Among all students surveyed, nearly 4% (n=380) reported that where they live changes frequently.

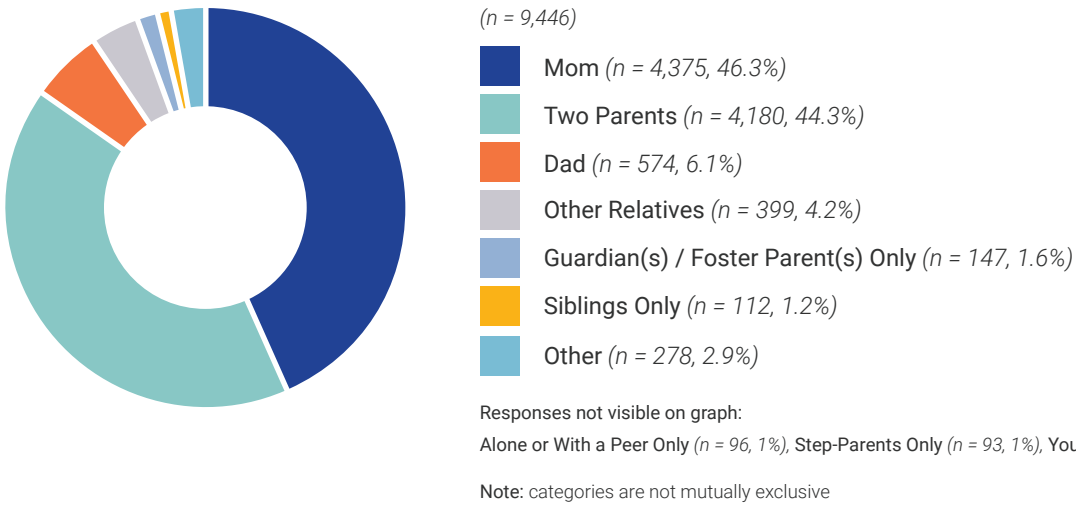
Student View:
How Many People Live With You, Including Yourself?
(n = 8,734)



Following the guidelines from the McKinney-Vento Homeless Assistance Act, our Definition of Homelessness includes living in:

- A shelter
- A hotel or motel
- A car, van, or other vehicle
- Alone
- With friends
- Outside
- Doubled up with another family

Student View:
With Whom Do You Live Most of the Time?
(n = 9,446)



Responses not visible on graph:
Alone or With a Peer Only (n = 96, 1%), Step-Parents Only (n = 93, 1%), Your Own Children Only (n = 41, 0.4%)
Note: categories are not mutually exclusive

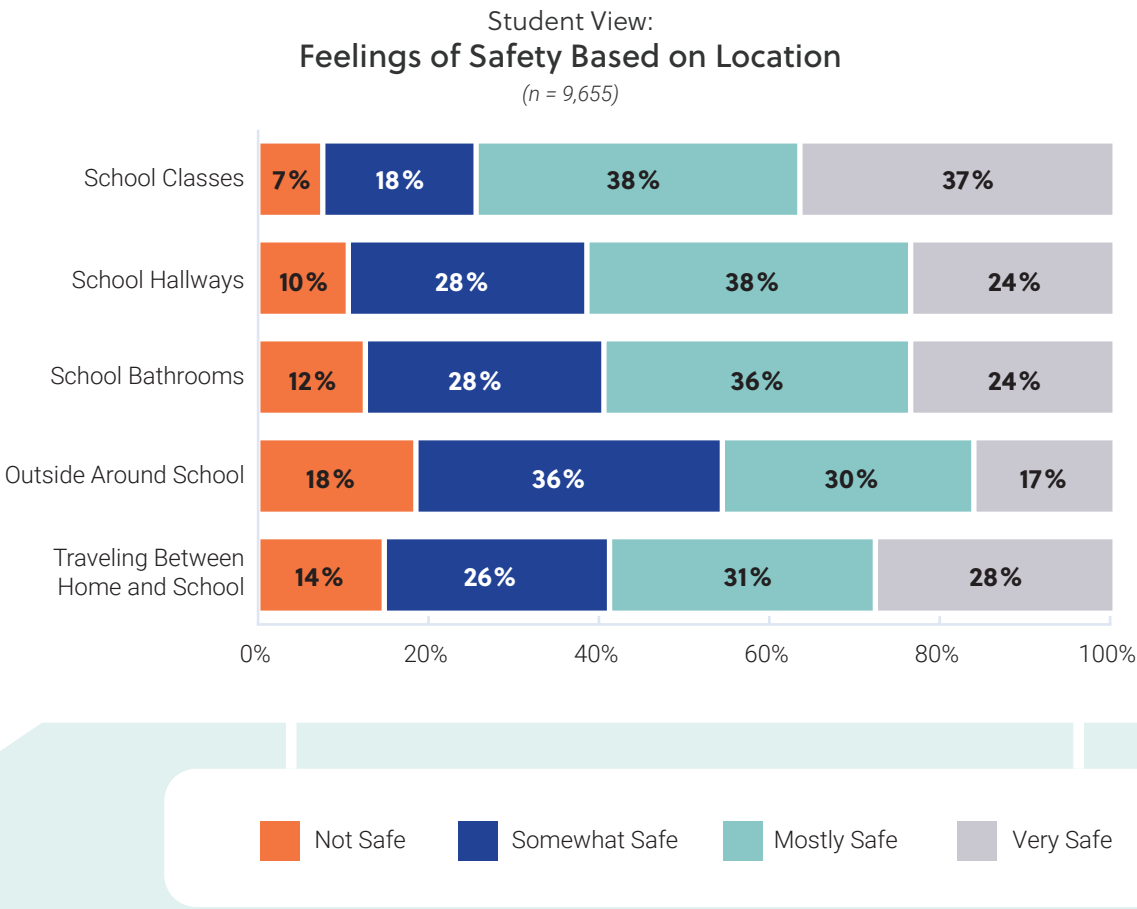
249 students (2%) reported living with siblings, alone or with a peer, or with their own children only.

School Climate

Students spend a substantial portion of their time in school. As a result, the overall climate of the school can have a large impact on student health and well-being. A positive school climate has been identified as an important protective factor against suicidal behavior; and research has shown that school connectedness, trusted adults at school, and perceived teacher support are associated with a lower likelihood of suicidal ideation.^{30,31,32,33} Here we describe districtwide findings regarding school climate, acknowledging that each individual school may vary from these averages.

Student Safety

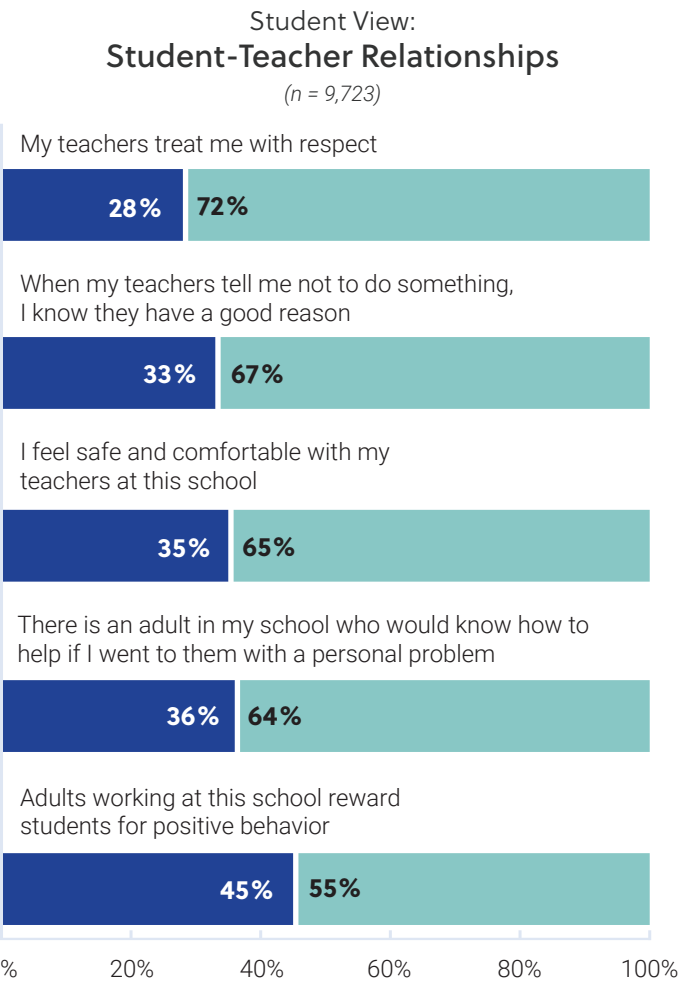
The majority of students reported feeling mostly or very safe in school, and feeling safest in their classes, with 37% indicating that they feel very safe and 38% indicating they felt mostly safe in class. Students reported feeling less safe traveling between home and school, and in particular, outside around the school.



Student and Staff Relationships

The majority of students (72%) reported that their teachers treat them with respect; and 65% of students said they feel safe and comfortable with their teachers. More than two-thirds of students (67%) said that when teachers tell students not to do something, they have a good reason for it. Similarly, 64% of students said that there is an adult at their school who would know how to help if they went to them with a personal problem.

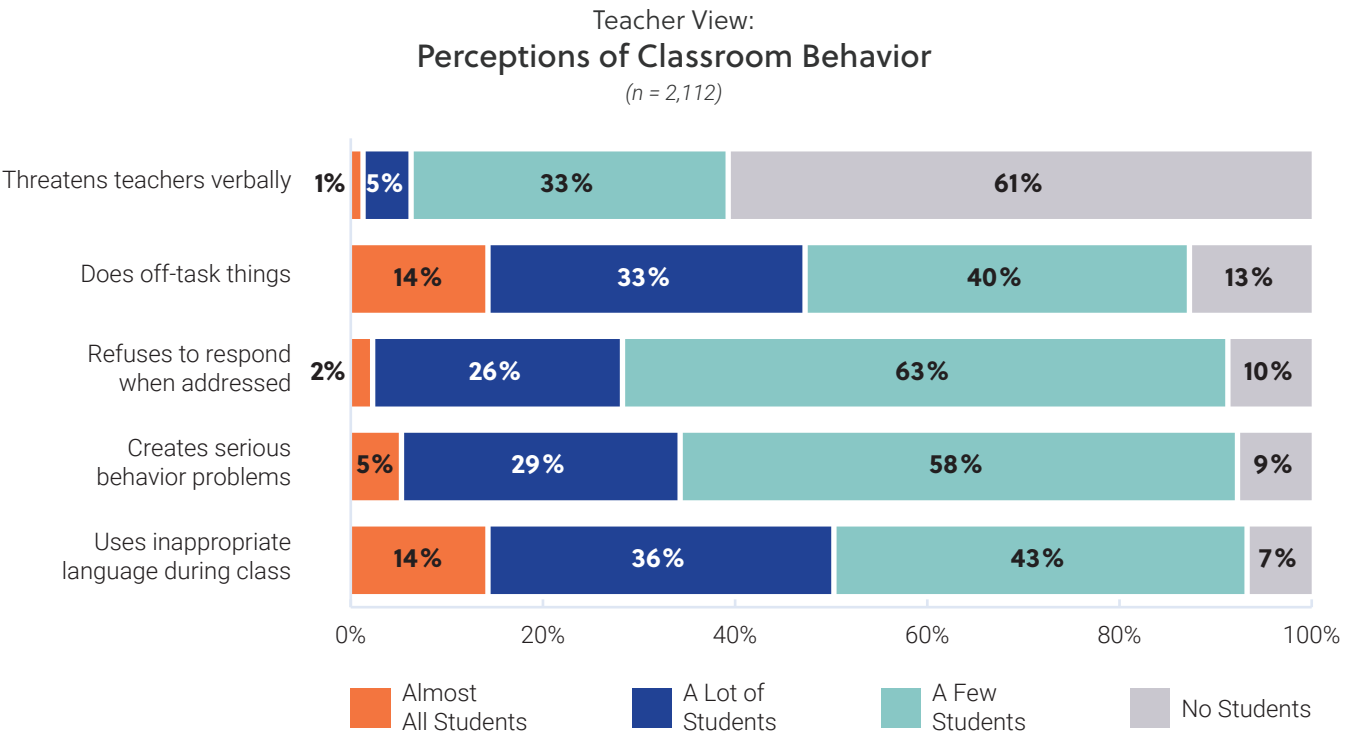
When teachers were asked if they felt students value their relationships with teachers, only 55% agreed or strongly agreed. Further, only 9% of teachers agreed or strongly agreed that students openly share their feelings and experiences.



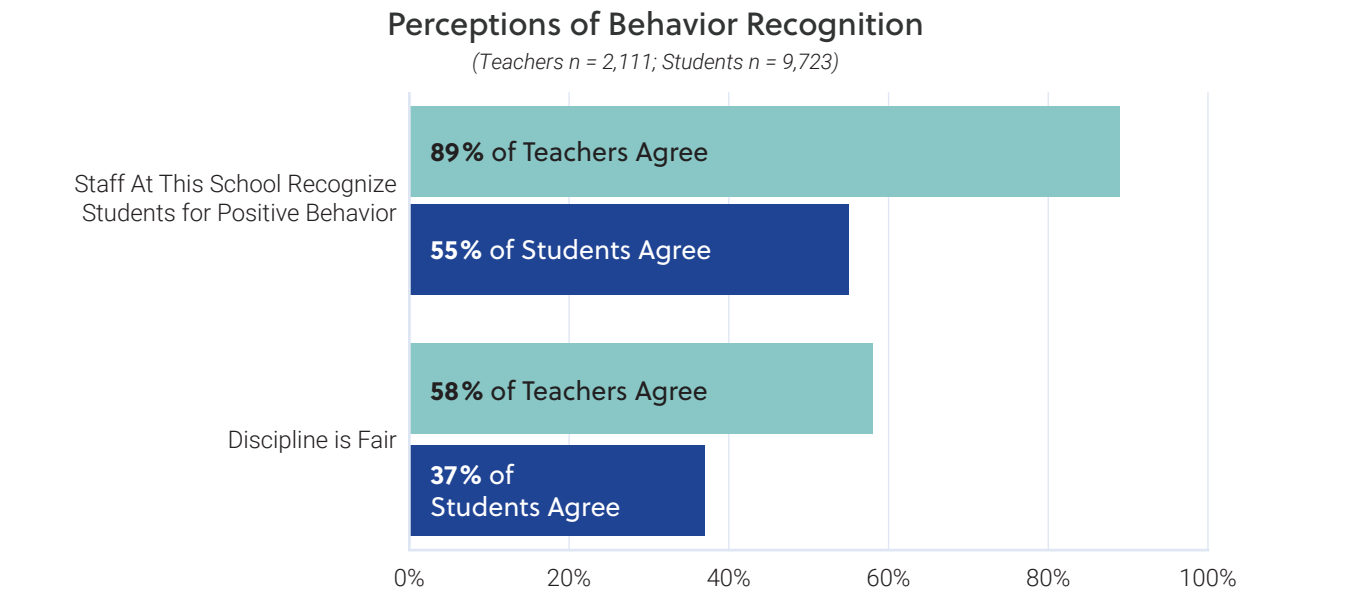
“If teachers want us to be more open about what we’re going through they need to show a level of serious / genuine concern with us as we walk in, rather than being rude due to us not completing our work because they never know what is going on with us at home, and we do not trust them enough to let them know.”

- Student

In addition, 50% of teachers reported that a lot or almost all students use inappropriate language during class, 28% reported that a lot or almost all students refuse to respond when addressed, and 34% indicated that a lot or almost all students create serious behavior problems. Overall, 39% of teachers reported that at least a few students have threatened them verbally.

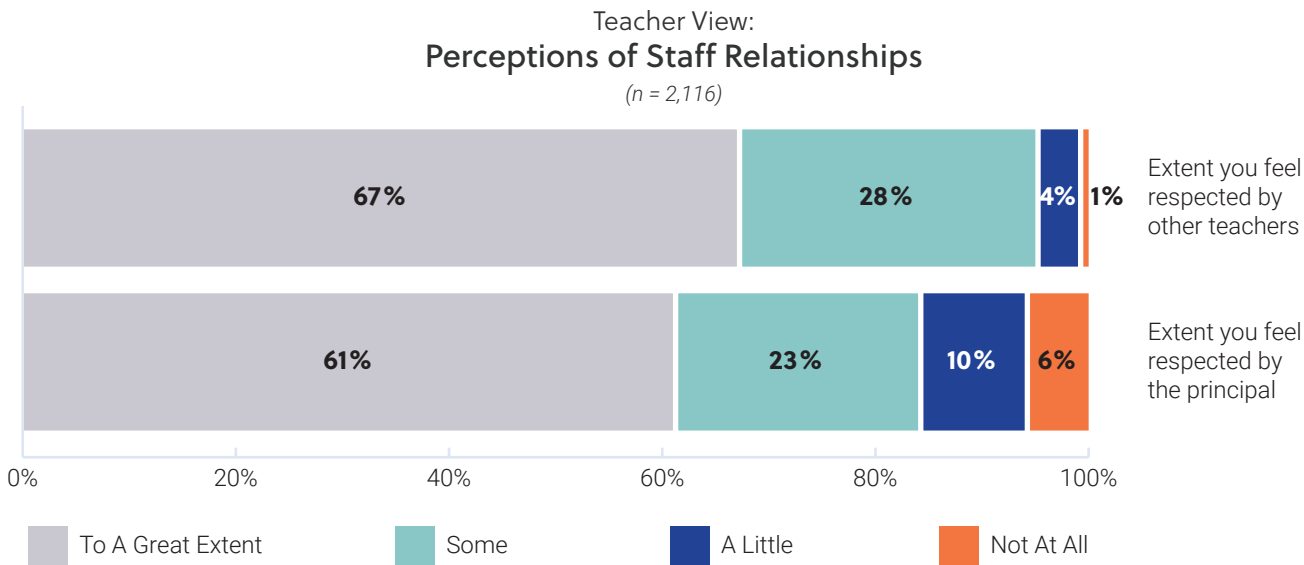


Despite their generally positive reports regarding their relationship with their teachers, many students reported that discipline in their school is harsh and unfair: 60% of DPSCD students reported that their teachers scold and criticize students for poor behavior, and 58% said that teachers at their school yell, shout, or use a harsh voice when students don't behave. Conversely, 61% of teachers reported that staff at their school effectively handle student discipline and behavior problems, and 58% believed that discipline was fair at their school.



Relationships Among Staff

A majority of teachers identified as feeling respected by their school principal and other staff at their building.



88%
of administrative staff
agreed that building staff
trust and respect one another.



92%
of administrative staff
agreed that students get along
with staff well at their school.



Findings

DPSCD Staff



“Burnout is a state of emotional, physical, and mental exhaustion caused by excessive and prolonged stress. It occurs when one feels overwhelmed, emotionally drained, and unable to meet constant demands.”³⁴

Staff Burnout

It is common for educators and other school staff to experience burnout throughout their careers. Teachers in particular have been found to experience high levels of burnout because they often do not have decision-making abilities at higher, administrative levels, which can impact what happens in their classrooms.³⁵ High levels of burnout can lead to poor work performance, low student performance, and high turnover rates.³⁶

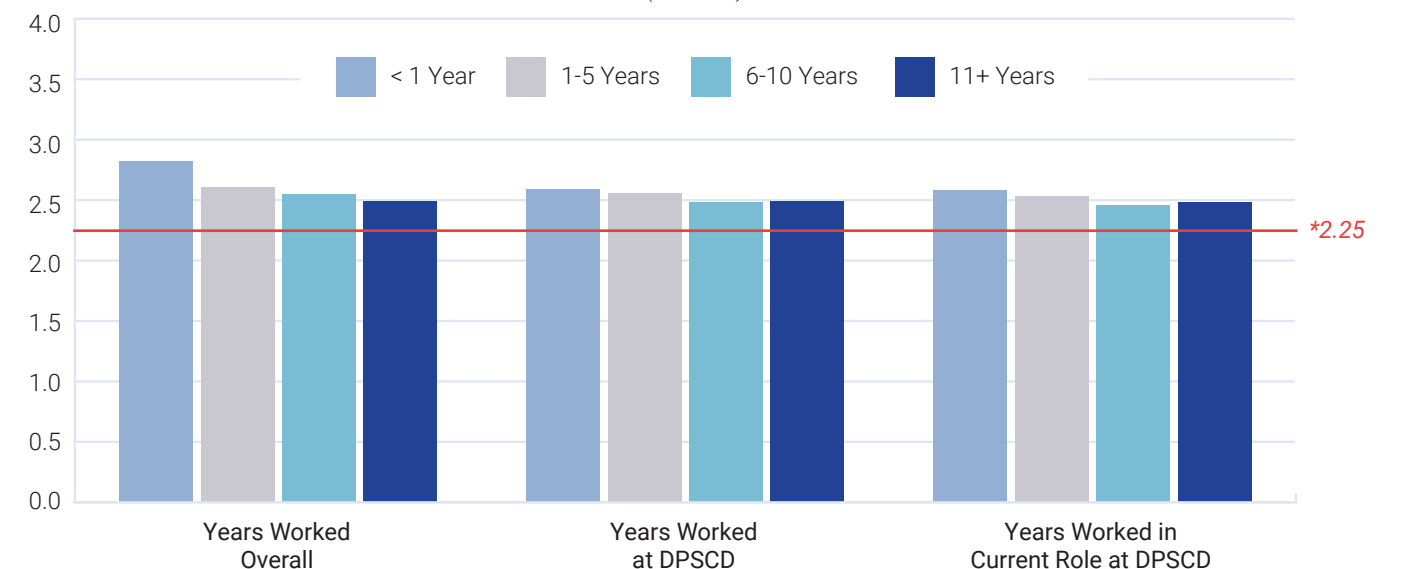
DPSCD staff were asked to respond to questions about exhaustion and burnout included in the Oldenburg Burnout Inventory.³⁷

The mean burnout score for all 3,349 DPSCD staff across all professional roles was 2.41, indicating a

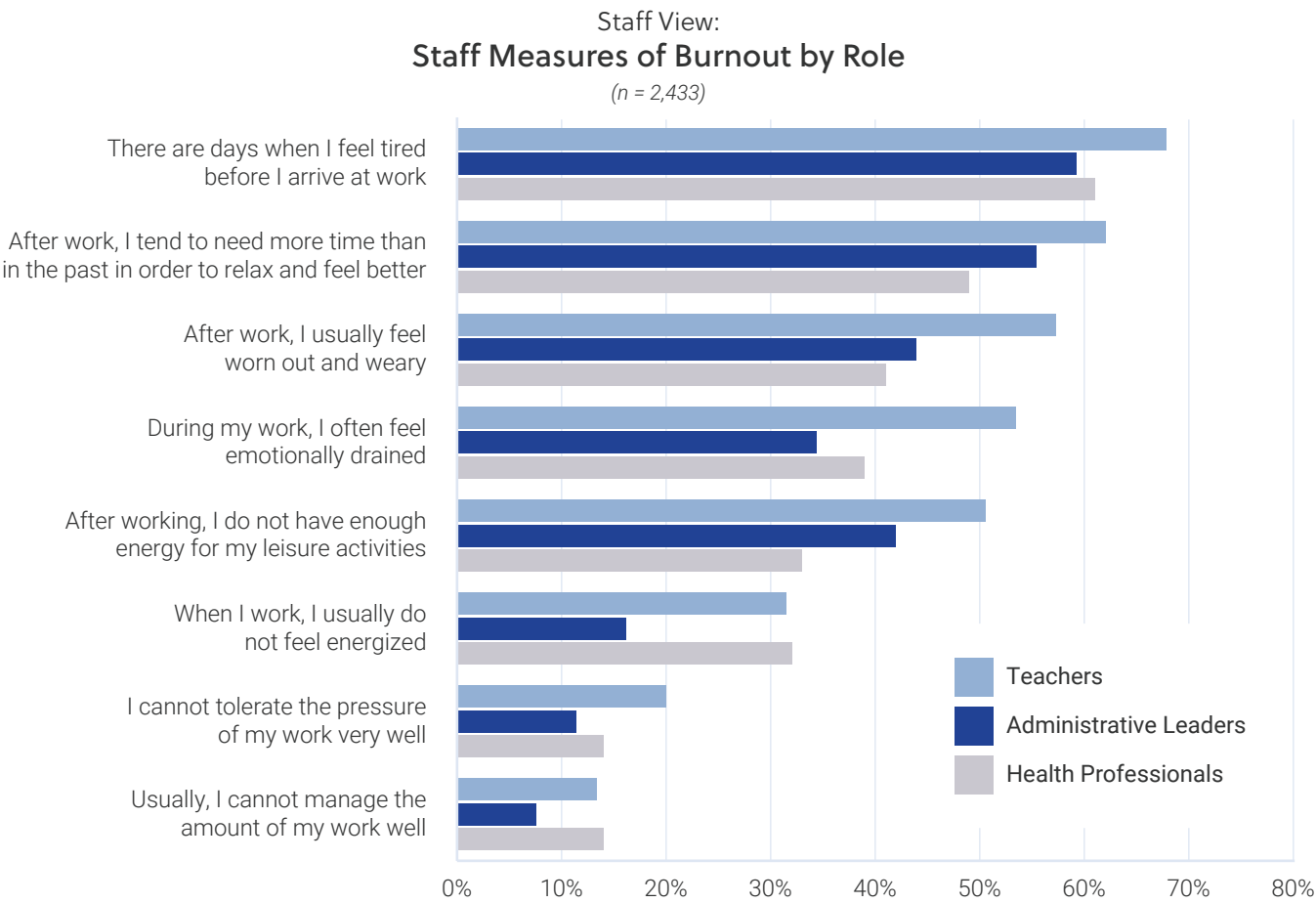
relatively high level of exhaustion, on a scale of 1-4 (1 = low burnout, 4 = high).³⁸

Over half of staff across almost all roles reported feeling tired before arriving at work, and 40-50% of staff across almost all roles reported feeling worn out and weary after work, and needing more time after work to relax and feel better. However, despite the relatively high levels of burnout, most staff felt they could tolerate and manage their work. Among DPSCD staff surveyed, teachers exhibited the highest overall levels of burnout. Burnout is highest among teachers who are in the first year of their current job, in their first year at DPSCD, or in their first year of teaching altogether.

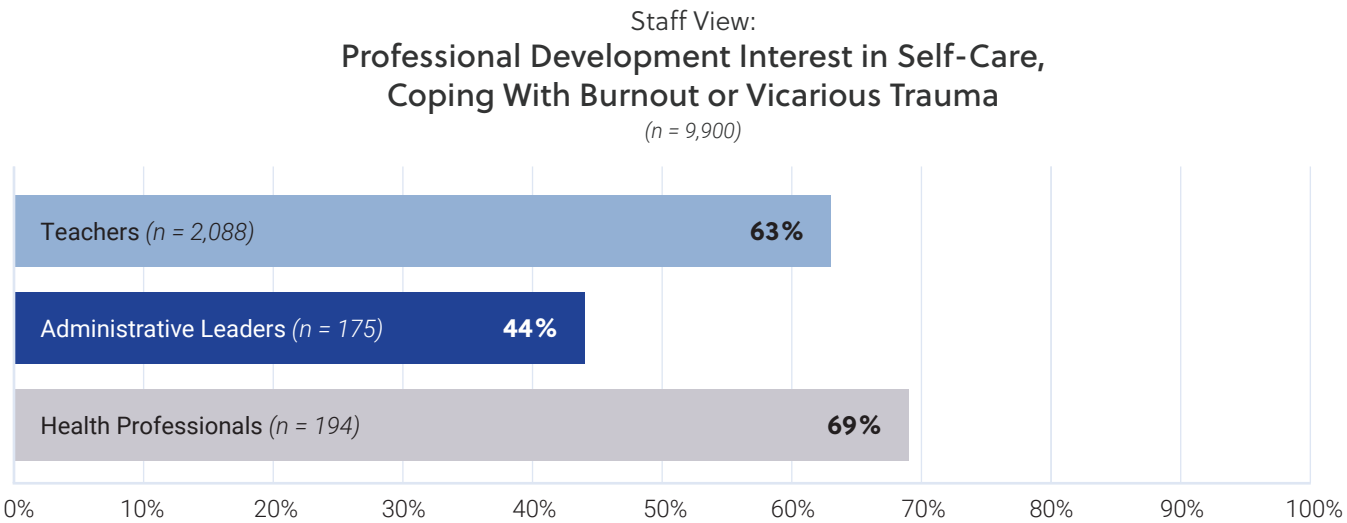
Teacher View:
Mean Burnout Score by Years Worked
(n = 2,073)



*2.25 = indicator for high burnout



The graph above shows the percentage of teachers, administrative leaders and school health professionals who endorsed each item in the burnout scale. Relatedly, 69% of health professionals, 63% of teachers, and 44% of administrative leaders all expressed interest in receiving training in self-care, and coping with burnout or vicarious trauma.



Professional Development Interests and Barriers

Surveys provided all DPSCD staff the opportunity to convey their interest in professional development (PD) programming related to mental health and to list factors that might impede or facilitate their likelihood of participation.

Interest

Survey responses indicated a high degree of interest in PD related to supporting student mental health. **Overall, 95% of all respondents showed interest in at least one mental health program or PD option suggested.**

Staff View:
Professional Development Topics of Interest

Topics of interest for future professional development	Teachers (n = 2,088)	Administrative Leaders (n = 175)	Health Professionals (n = 194)
Strategies for incorporating social and emotional mindfulness in the classroom (Teachers)	78%	70%	n/a
Best practices for supporting students affected by depression or anxiety (Health Professionals)	n/a	50%	78%
Best practices for supporting students affected by trauma or PTSD	76%	48%	75%
School staff self-care, coping with burnout, or vicarious trauma	63%	44%	69%
General information about mental illness	63%	n/a	44%
General information about trauma / PTSD	58%	n/a	48%
Strategies for talking with families about mental health	55%	18%	61%
Suicide risk identification / prevention / intervention	53%	30%	58%
None - training in these topics is not of interest to me	4%	n/a	10%

Professional Development Barriers

The biggest barrier to accessing PD is scheduling. Most teachers (64%) and health professionals (48%) mentioned the incompatibility of their own work schedule or workload as a barrier to attending. Additionally, 51% of teachers emphasized their personal schedule as a barrier.

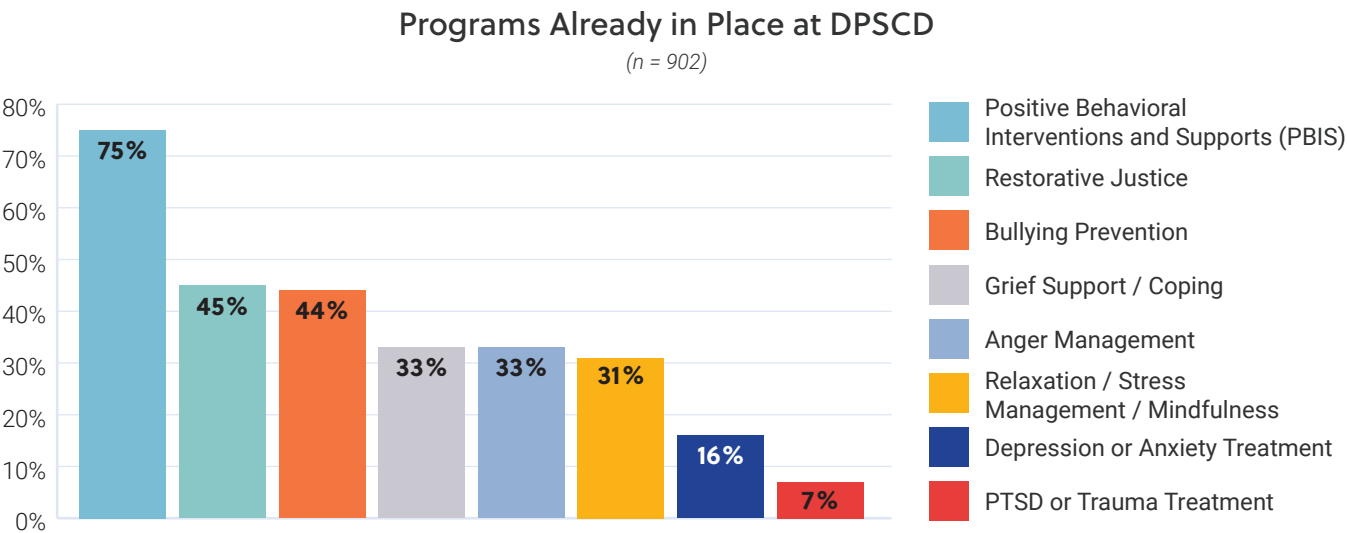
A majority of administrative leaders (72%) believed that the best time for their staff to attend PD opportunities was before school hours during the academic year. This stands in contrast to the teachers’ and health professionals’ time preferences regarding PD: only 9% of teachers and 14% of health professionals expressed interest in PD opportunities before school. However, administrative leaders, teachers, and health professionals agreed that during the school day and during the 1-2 weeks prior to the start of school in the fall were good times for offering PD.



Priority Needs Identified by Staff

Supports / Programming Currently in the Building

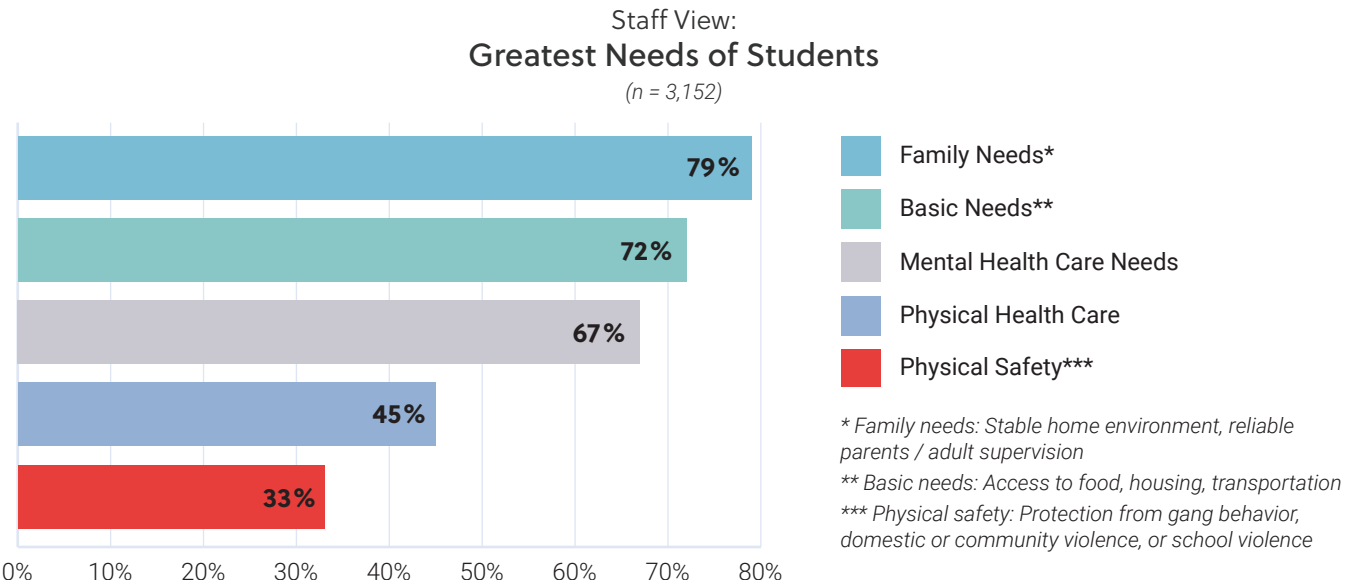
Administrative and support staff were asked what formal student mental health programs are currently offered in their school buildings. By far, the most commonly identified program was Positive Behavioral Interventions and Supports, or PBIS (75%). Substantially fewer staff identified programs like grief support (33%), anger management (33%), depression or anxiety treatment (16%), or trauma treatment (7%).



Given staff perceptions of the various factors that are impacting their students’ mental health, the relative prevalence of bullying prevention programming and restorative justice practices demonstrates ways in which DPSCD is responding to identified student needs.

Perception: Greatest Needs of Students

As discussed elsewhere in this report, factors outside of school impact student learning and, more importantly, students’ well-being. The majority of instructional and support staff (67%) indicated that mental health care and physical safety were among the greatest needs in their school community, while 3 out of 4 instructional and support staff said that basic needs and family needs were among the highest priorities. Further, over 80% of instructional staff and over 90% of health professionals reported that family stress had a moderate or strong impact on student mental health.

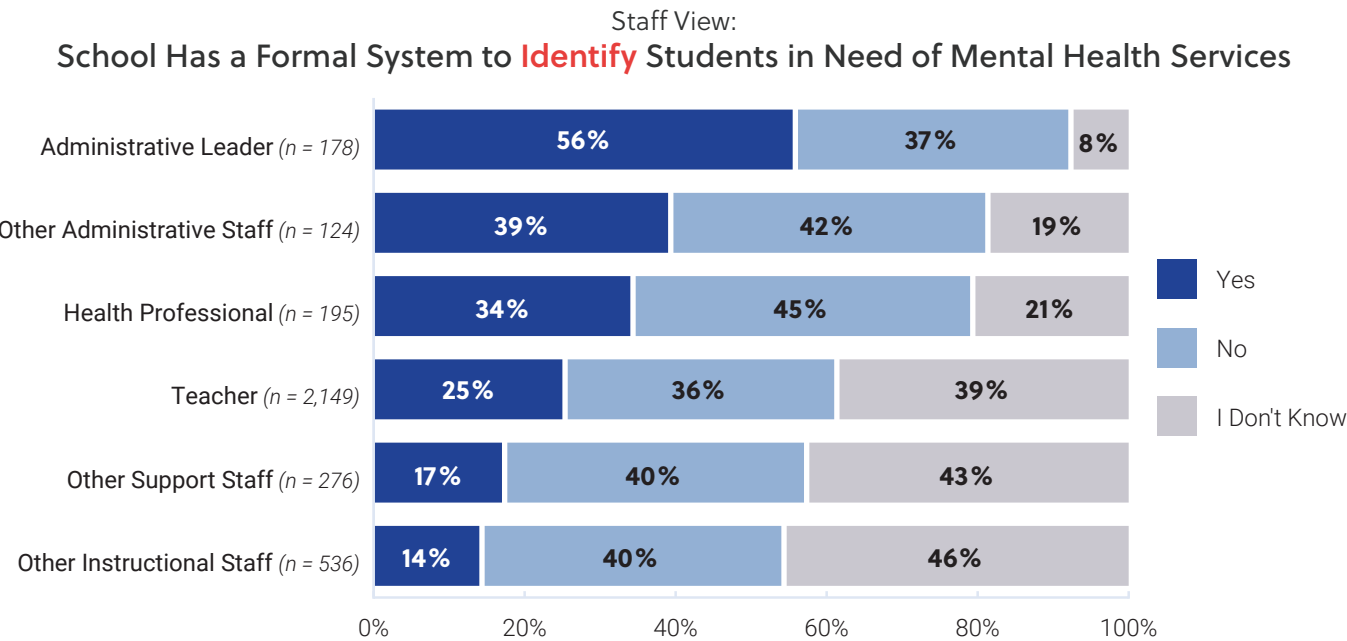


Coordination of Services

Schools are uniquely positioned to reduce widespread inequities in access to effective prevention and early intervention services, and to identify and respond to students at risk for suicide. [39](#), [40](#) All schools should have a protocol or system in place to identify students in need of mental health services, refer those students to appropriate school staff or programs, and respond quickly to students at risk of suicide. However, these systems are effective only if all staff members in a school are aware of and utilize associated protocols and services. Our survey data indicate a mixed level of awareness among DPSCD staff of the existence of student risk identification and referral systems.

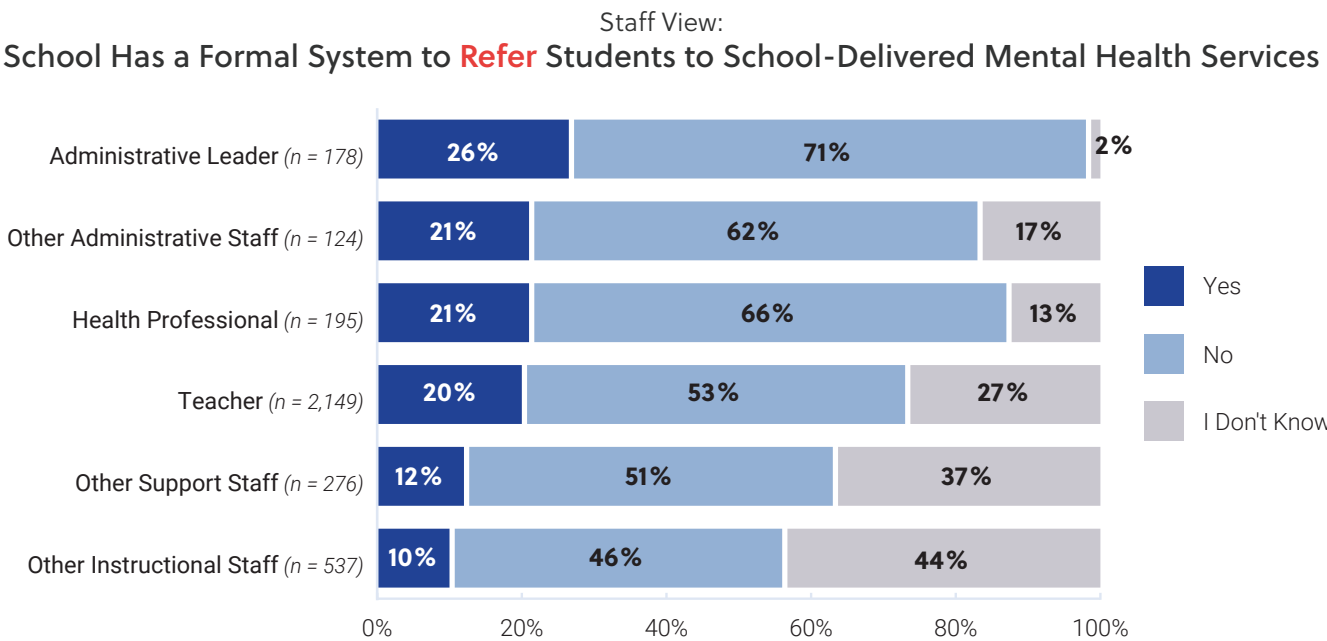
Identification

Only 25% of all DPSCD staff (including 25% of teachers and 34% of health professionals) said they were aware of a protocol or system in place at their school to screen or identify students in need of mental health services. A greater portion of administrative leaders (56%) said they were aware of such screening protocols. Among all staff who knew of these procedures, only 17% reported that they work well or work very well.



Referral

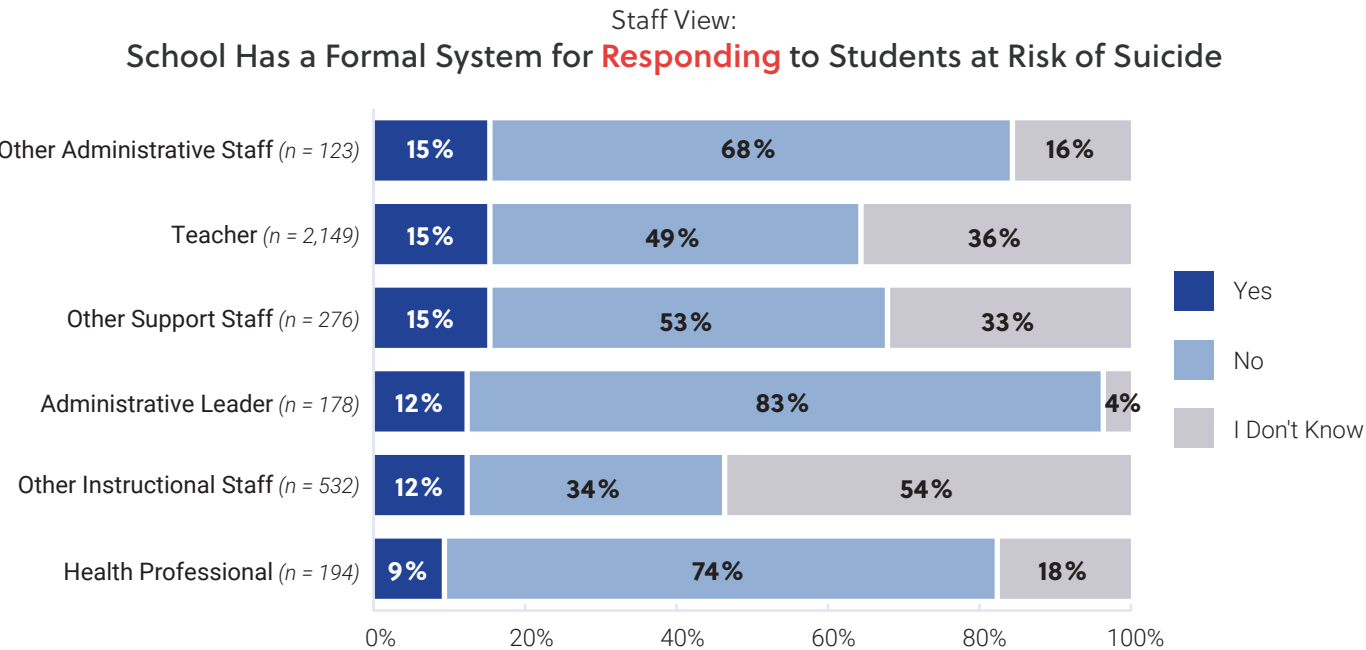
Only 18% of all DPSCD staff said that they were aware of a system at their school to refer students for school-delivered mental health services. Administrative leaders were most likely to be aware of such a system. Among staff who knew of such a system, only 19% reported it works well or very well. Only 14% of teachers reported the system works well or very well, while 25% of health professionals, and 36% of administrative leaders reported this level of efficacy. Once a student is referred to school mental health services, 57% of all staff reported that the services themselves were helpful.



Risk Response

Staff were also asked to report whether or not they were aware of a formal system in place at their school to respond to students at risk of suicide. Only 14% of all staff said that such a system was in place at their school. Administrative leaders, teachers, and other support staff were the most likely to report having such a system in place. Among health professionals, only 9% were aware of such a system, and nearly 75% said that such a system was not in place at their school. Among staff who reported having these systems in place, 76% thought the system was effective.

Nearly **75%** of school health professionals and **50%** of teachers stated there was no formal system at their school for responding to students at risk of suicide.



Student mental health crises can challenge even the most experienced counselors, particularly because they can occur at any time. There are agencies in Detroit (e.g., The Children’s Center) who offer immediate, walk-in care, but school staff may not know that these agencies exist or how to engage them.



“Students come back to school from psychiatric hospitalization or after a suicidal attempt and just go back to class without training or plans.”

- Instructional Staff

Findings

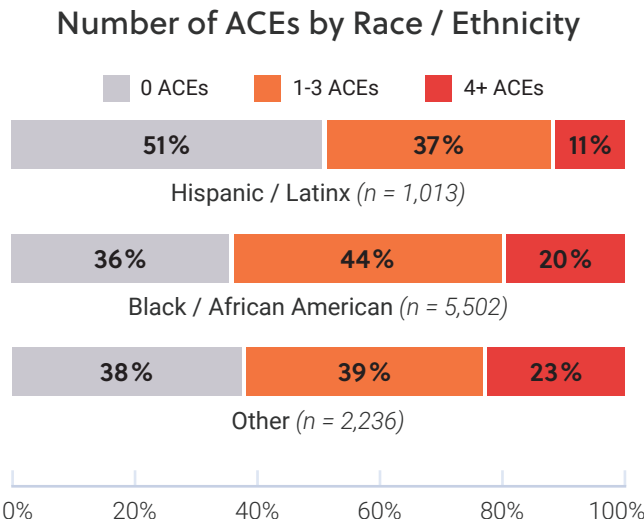
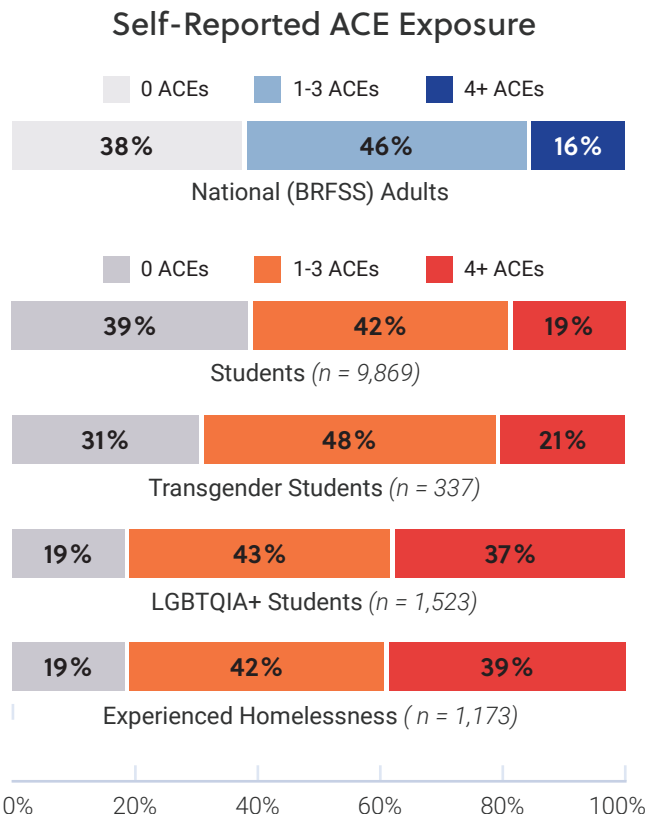
Adverse Childhood Experiences



Adverse Childhood Experiences (ACEs) are potentially traumatic events experienced during childhood.

The CDC estimates that nationally, about 62% of adults have experienced at least 1 ACE and another 25% have experienced 3 or more.⁴¹ Children who experience ACEs are more likely to have negative health outcomes as they grow into adulthood and ACEs are associated with several leading causes of death.^{42, 43, 44} Exposure to ACEs are measured using a validated scale that asks about experiences of childhood abuse (e.g., physical, sexual, and emotional abuse), household challenges (e.g., parental separation or divorce of parents, incarceration of parents or a loved one), and neglect.⁴⁵

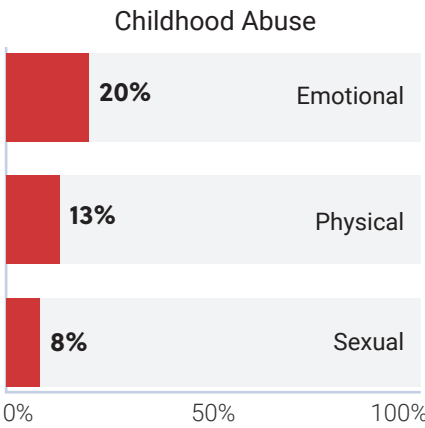
In DPSCD, 61% (n = 6,035) of students reported that they had experienced at least 1 ACE, 40% reported 2 or more ACEs, and 19% indicated they had experienced 4 or more ACEs. These rates are similar to those seen in data collected from a national sample of adults by the Behavioral Risk Factor Surveillance System (BRFSS)⁴⁵; however, DPSCD students may experience additional ACEs before they reach adulthood. Several groups experienced notably different numbers of ACEs: 37% of LGBTQIA+ students and 39% of students who have experienced homelessness reported experiencing 4 or more ACEs compared to 19% of all DPSCD students surveyed. Additionally, Hispanic / Latinx students reported fewer ACEs than students who identified as other races / ethnicities.



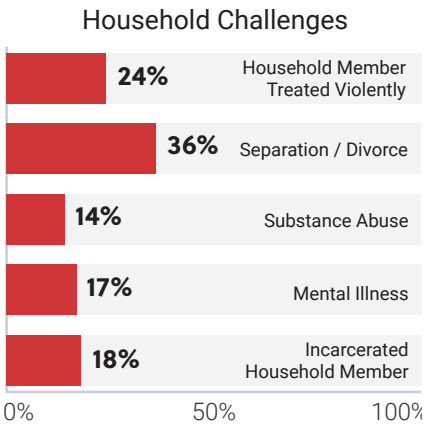
These graphs show the number of responses to each of the individual ACE items. Divorce / separation was the most frequently experienced event at 36%, followed by 24% of students witnessing violence or threats of violence in the household, and 22% of students reporting emotional neglect (feeling unsupported, unloved and/or unprotected).

ACE Exposure by Type of Experience

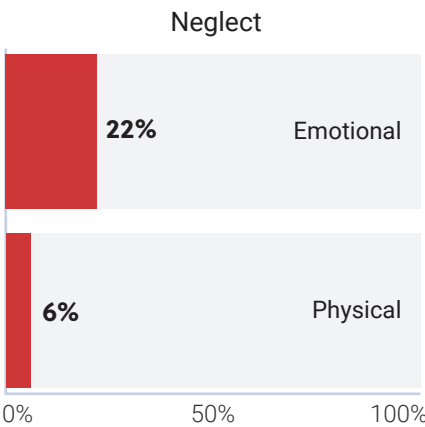
(n = 10,434)



Household member swore at, insulted, humiliated, or put you down in a way that scared you, or acted in a way that made you afraid that you might be physically hurt (Emotional Abuse)	2,063	20%
Someone pushed, grabbed, slapped or threw something at you OR you were hit so hard that you were injured or had marks (Physical Abuse)	1,299	13%
Someone touched your private parts or asked you to touch their private parts in a sexual way that was unwanted, against your will, or made you feel uncomfortable (Sexual Abuse)	785	8%



Saw or heard household members hurt or threaten to hurt each other (Household Member Treated Violently)	2,407	24%
Parents / guardians were separated or divorced (Separation / Divorce)	3,672	36%
You lived with someone who had a problem with drinking or using drugs (Substance Abuse)	1,389	14%
Lived with a household member who was depressed, mentally ill, or attempted suicide (Mental Illness)	1,752	17%
Lived with a household member who served time in jail / prison (Incarcerated Household Member)	1,864	18%



You often felt unsupported, unloved and / or unprotected (Emotional Neglect)	2,269	22%
More than once, you went without food, clothing, a place to live, or had no one to protect you (Physical Neglect)	577	6%

The survey also included the ACE-Q Teen,⁴⁶ a second set of items that augments the original ACEs questionnaire listed to the right. The ACE-Q Teen includes 9 items that assess exposure to additional life stressors relevant to youth, such as experiences related to foster care, bullying, parent / guardian death, separation due to deportation, serious medical condition / procedure, violence in neighborhood, discrimination, youth intimate partner violence, and youth arrest / incarceration.

On this measure, more than 44% of students reported that they had experienced none of the items listed. The most common ACE-Q item endorsed was seeing or hearing violence in a home neighborhood or the school’s neighborhood, which one-third of students reported having experienced. This is consistent with our finding that less than half of students said they felt mostly or very safe outside their school. Additionally, 28% of students reported that they had experienced harassment or bullying in school, and 11% reported the death of a parent or guardian with whom they lived. In general, 56% of students reported that they had experienced at least 1 ACE-Q, while 5% reported having

experienced 4 or more ACE-Qs. Although only 6% of DPSCD students surveyed reported experiencing verbal or physical abuse or threats from a romantic partner, according to the Youth Risk Behavior Survey (YRBS), students in Detroit experienced dating violence at a greater rate than in the US overall.

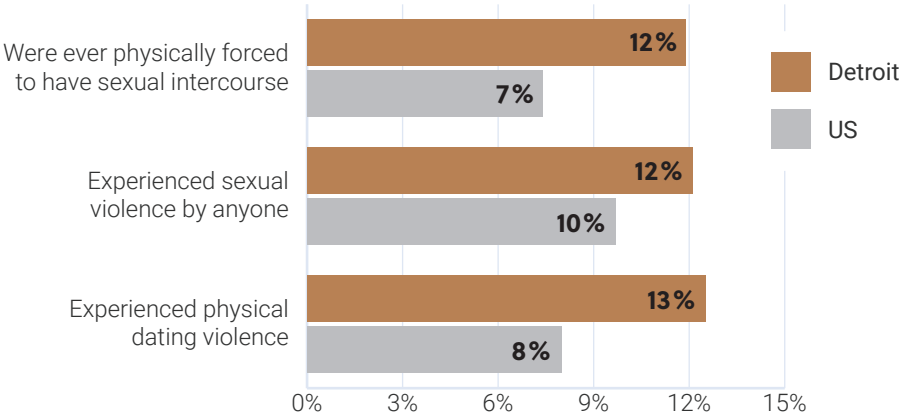
Adverse Childhood Experiences (ACE-Q Teen): Individual Items

(n = 10,072)

	n	%
Have often seen or heard violence in neighborhood or school's neighborhood	3,316	33%
Experienced harassment or bullying at school	2,858	28%
Lived with a parent or guardian who died	1,091	11%
Have often been treated badly because of race, sexual orientation, place of birth, disability, or religion	964	10%
Have experienced verbal or physical abuse or threats from a romantic partner	652	6%
Have had serious medical procedure or life threatening illness	644	6%
Have been detained, arrested, or incarcerated	459	5%
Have been in foster care	408	4%
Have been separated from primary caregiver through deportation or immigration	294	3%
None of these	4,474	44%

Additional Measure of Trauma

Dating Violence Rates: Detroit; US



Source: Centers for Disease Control and Prevention. 2017 Youth Risk Behavior Data. Available at: www.cdc.gov/yrbbs

Findings

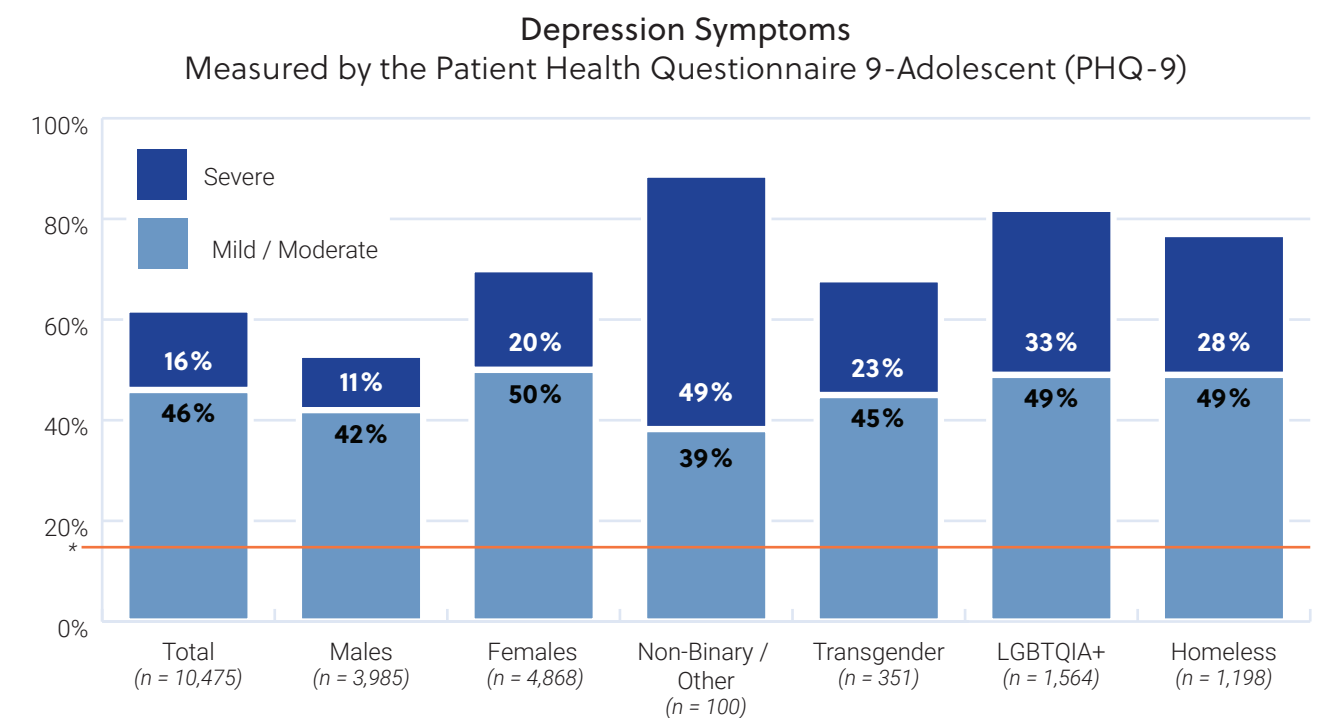
Student Mental Health

Rates of mental health concerns for DPSCD students are considerably higher than national averages.

Compared to national averages, DPSCD students reported substantially higher rates of depression and anxiety, and higher rates of suicidal ideation and behavior. Female students, students who identified as gender non-binary, transgender, LGBTQIA+, and students who have experienced homelessness reported more frequent and more severe symptoms of both illnesses.

Depression

The prevalence of depression among high school students in the United States is approximately 14%.^{47,48}

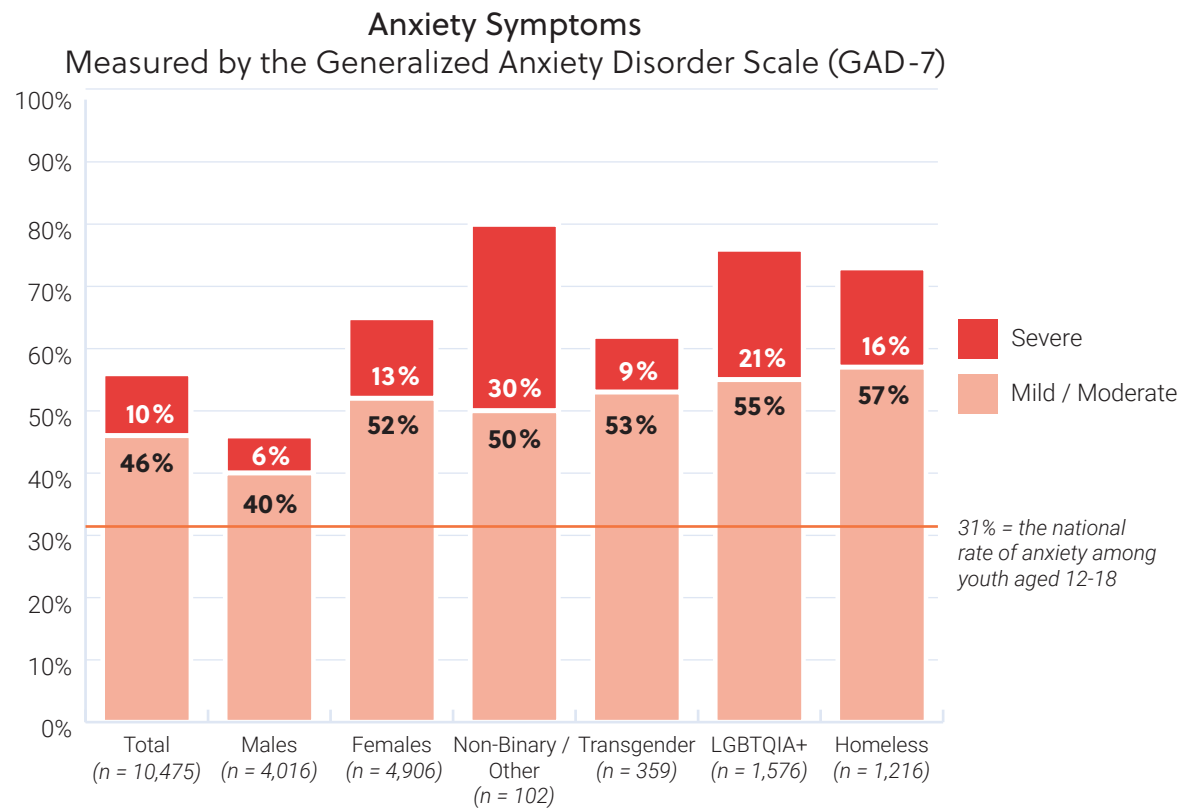


*14% = the national rate of depression among youth aged 12-18

In Detroit, 46% of students reported mild or moderate symptoms of depression and 16% reported severe symptoms. Compared to males, female students reported higher rates of mild and moderate depression (50% of females vs. 42% of males) and severe depression (20% of females vs. 11% of males).

Three groups of students experienced the highest rates of depression: students who identified as gender non-binary / other (40% mild / moderate, 36% severe), students who identified as LGBTQIA+ (49% mild / moderate, 33% severe), and students who experienced homelessness (49% mild / moderate, 28% severe).

Anxiety



The lifetime prevalence of anxiety among high school students in the US is approximately 31%.^{49, 50}
In Detroit, 46% of students reported mild or moderate symptoms of anxiety and an additional 10% reported severe symptoms. Compared to males, female students reported substantially higher rates of mild and moderate anxiety (40% of males vs. 51% of females) and more than twice the rate of severe anxiety (6% of males vs. 13% of females). Students who identified as LGBTQIA+ experienced the highest rates of anxiety (55% mild / moderate and 21% severe). There were no substantial differences in rates of anxiety by race or ethnicity.

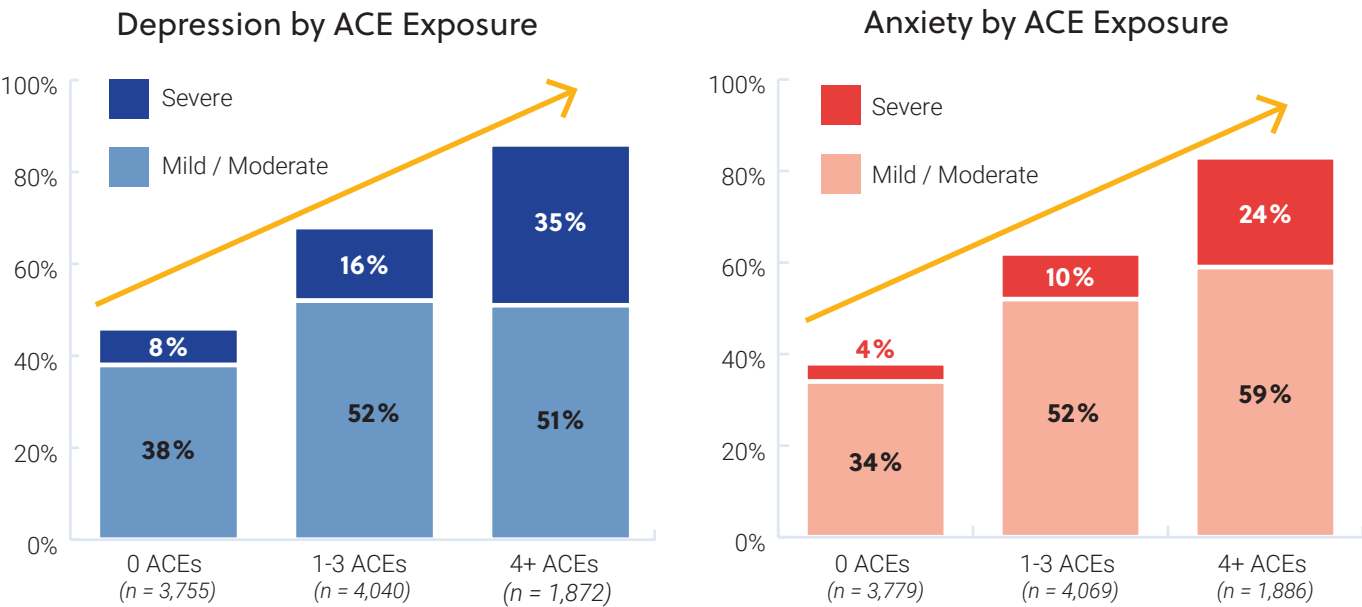


Less than half of all of students reported that symptoms of a mental illness interfere “not at all” with daily activities. 18% reported that anxiety problems and depression symptoms make it “very or extremely difficult to do schoolwork, engage in after school activities, or get along with others.”

47% (n = 740) of LGBTQIA+ students have symptoms of **moderate to severe** anxiety.



Impact of ACEs

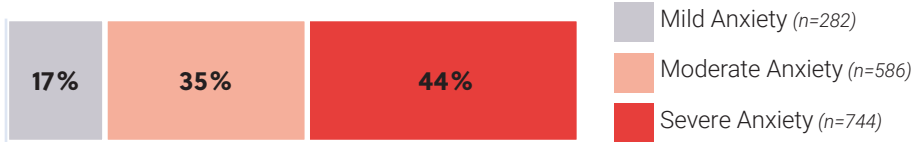


Students who reported exposure to an ACE were more likely to report symptoms of depression and anxiety. Furthermore, as the number of ACEs reported by students increased, the overall rate of depression and anxiety also increased. **Rates of severe depression and anxiety were highest among students who reported a history of 4 or more ACEs.**

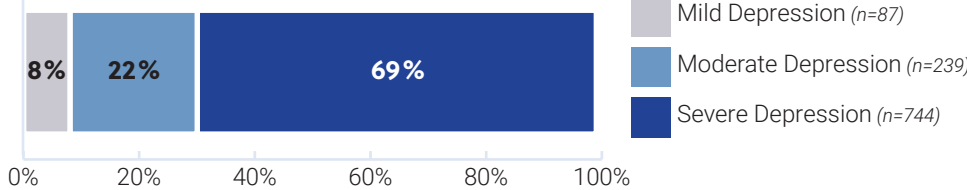
Depression and Anxiety Occur Together

Anxiety and depression in students were highly related. Students with severe symptoms of either illness were more likely to experience both anxiety and depression, rather than experiencing symptoms of only one illness. In particular, **nearly 70% of students with severe anxiety reported they also experienced severe symptoms of depression.**

Anxiety Among Students With Severe Depression (n=1,677)



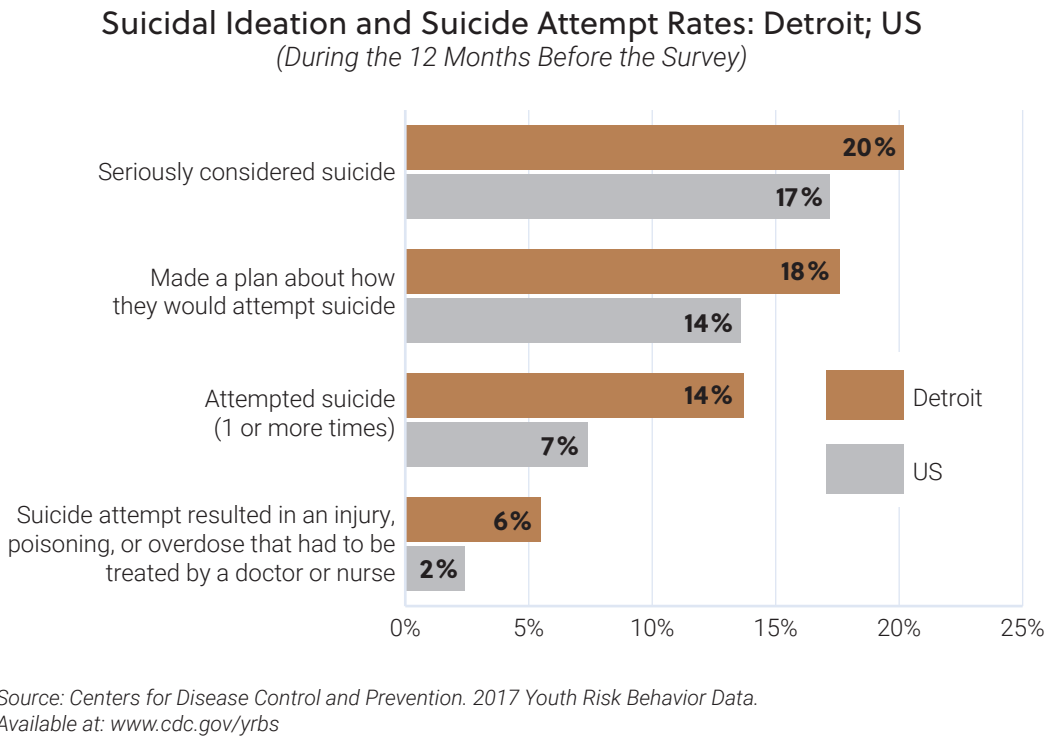
Depression Among Students With Severe Anxiety (n=1,076)



Students who reported 4 or more ACEs experience moderate to severe depression at more than 3 times the rate of those who reported only 1-2 ACEs.

Suicide Risk

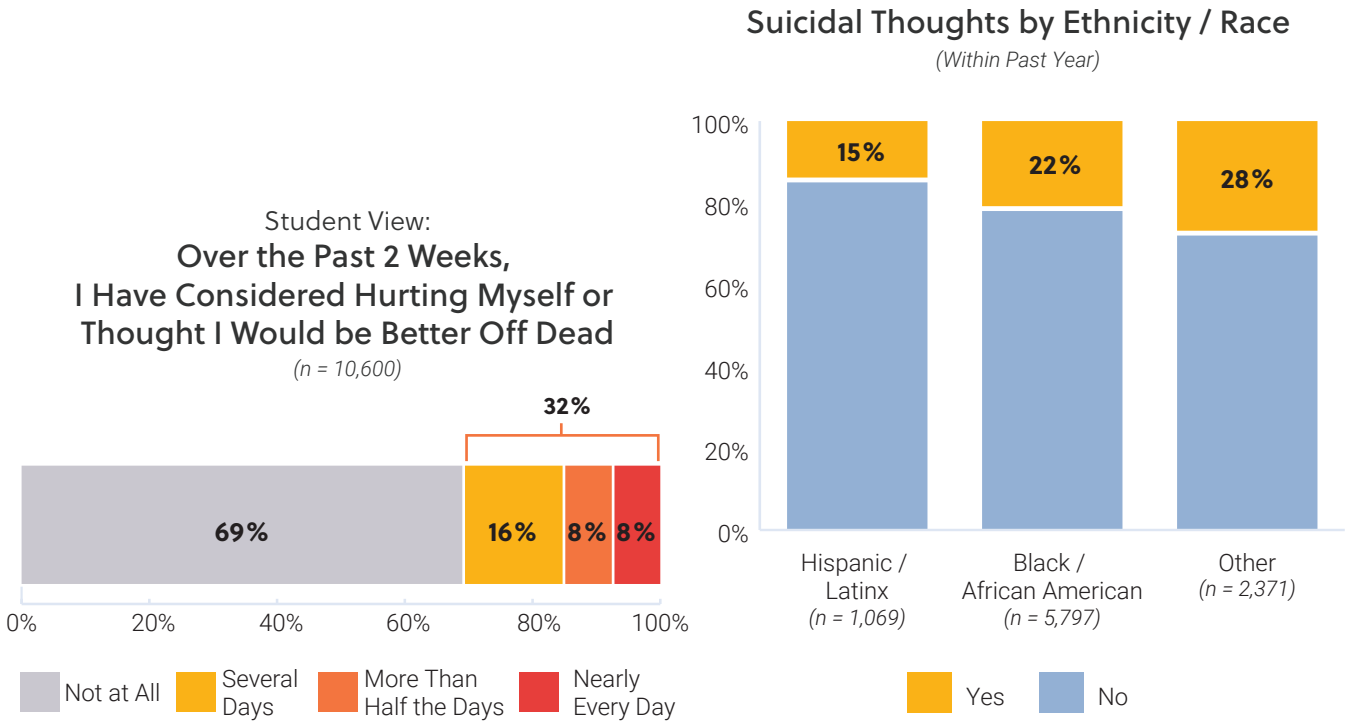
31% of students (n=3,283) reported having been bothered by thoughts of suicide or self-harm in the past 2 weeks, while 23% of students (n=2,407) reported having seriously thought about attempting suicide in the past year. Our survey data about serious suicidal ideation is slightly higher than was found in the 2017 YRBS for Detroit students, which found that 20% of students had seriously considered suicide over the preceding year.



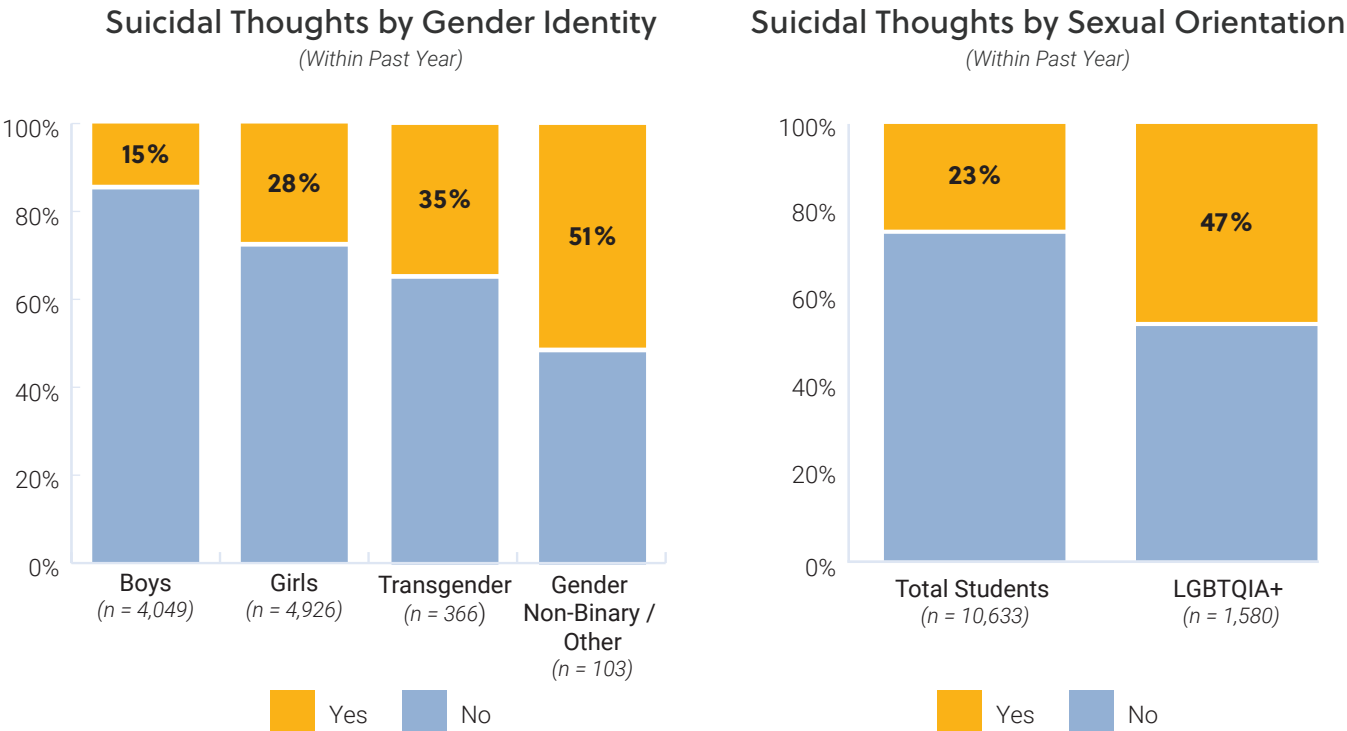
Students who reported more severe symptoms of depression were more likely to report having thought of suicide. Nearly 6 out of 10 students who reported severe symptoms of depression reported having thought about suicide in the last year, while only 1 in 20 students who reported no / minimal symptoms of depression said they had thought about suicide in the last year.



Students impacted by depression are **12 times more likely** to report suicidal ideation than students whose mental health needs are being met.

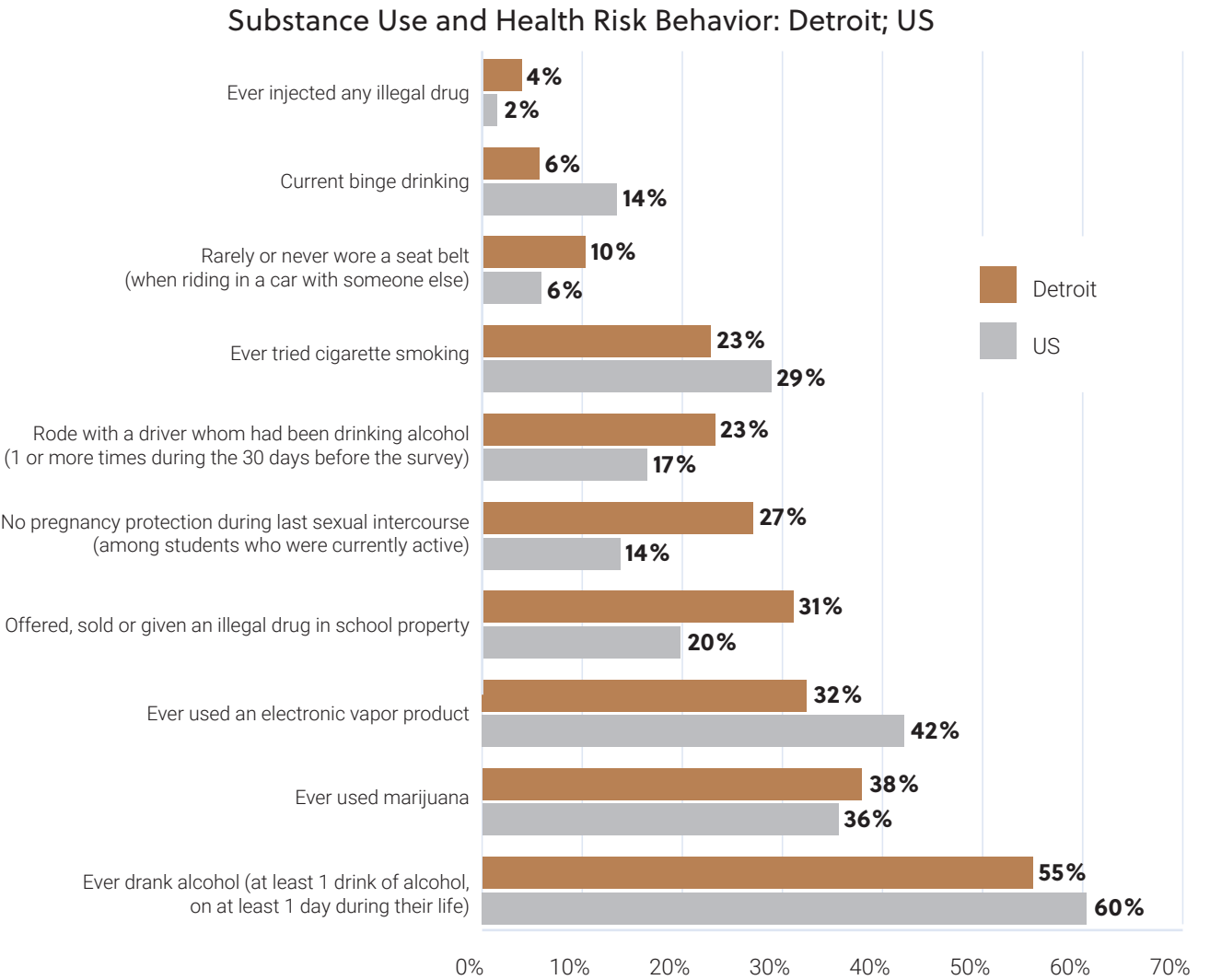


Gender identity and sexual orientation make a substantial difference in rates of suicidal ideation among DPSCD students. Within gender identity, students identifying as gender non-binary/other were more likely to think about attempting suicide in the past year. Additionally, almost half (n = 746, 47%) of LGBTQIA+ students acknowledged thinking about attempting suicide.



Substance Abuse and Health Risk Behavior

Although the relationship is not completely understood, many studies have demonstrated an association between symptoms of mental illnesses and health risk behavior.^{49,50,51,52} Comparing the rates of risk behaviors found in the 2017 YRBS may further explain why we found high rates of severe anxiety and depression.



Source: Centers for Disease Control and Prevention. 2017 Youth Risk Behavior Data. Available at: www.cdc.gov/yrbs

Coping Strategies

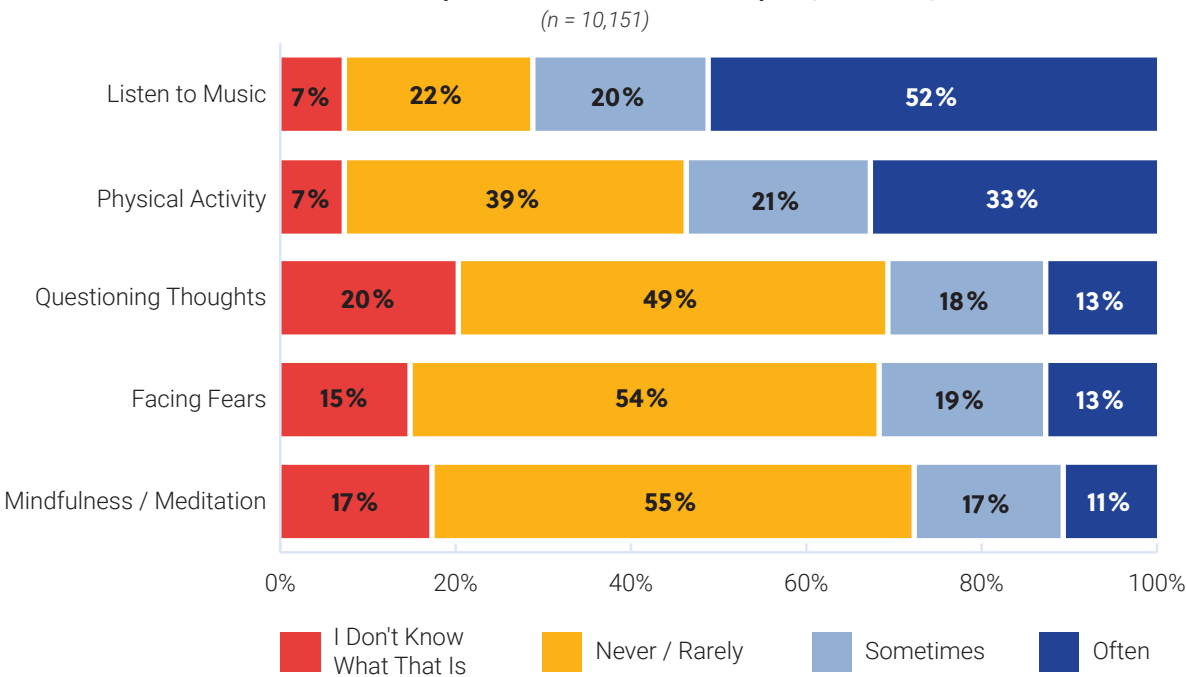
Use of effective coping strategies can help students tolerate and recover from moments of stress, worry, sadness, or disappointment. Regular use of adaptive coping skills can also promote mental health long-term. Detroit students reported using a variety of coping strategies when upset, including several core components of cognitive behavioral therapy (CBT), an evidence-based approach to reducing symptoms of depression and anxiety. **Nearly one-third of students also said they use meditation or mindfulness and more than half said they help themselves feel better by engaging in physical exercise.** While this is encouraging, a majority of students reported either never or rarely using helpful strategies when they are upset.



Relaxation and Mindfulness

Depression and anxiety can both lead to ruminative thoughts and uncomfortable feelings in the body. Relaxation is a skill that helps us to purposefully address these uncomfortable sensations to feel more at ease. Mindfulness is a skill that helps us be more intentional with our attention so that we can focus on relaxing our bodies, changing our thoughts, and choosing more helpful behavior.

Student Self-Reported Use of CBT Coping Strategies



Stressors

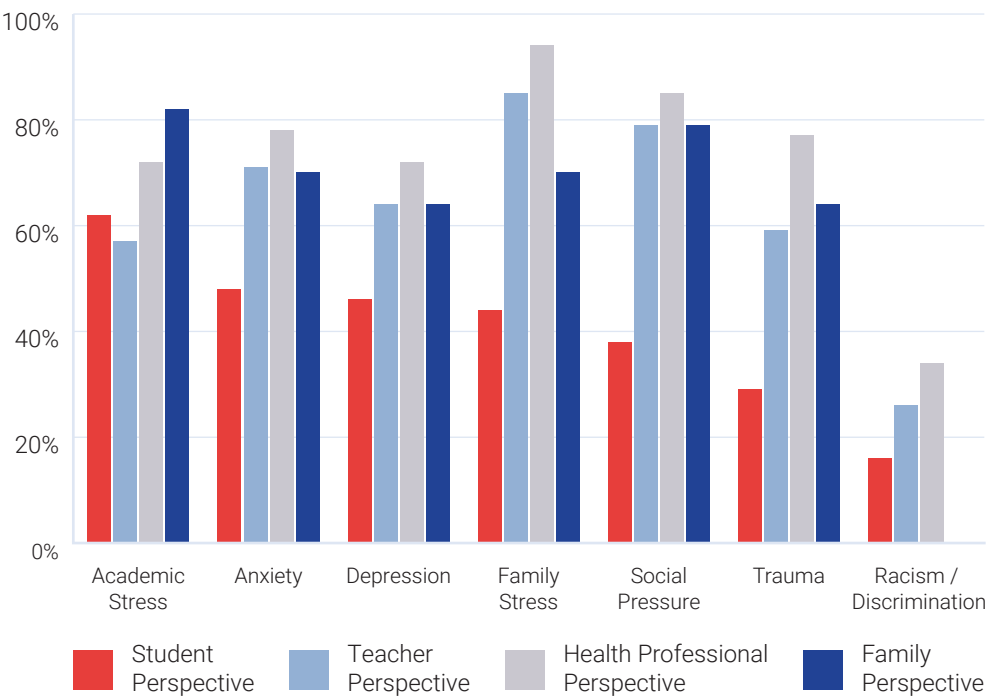
Across all populations surveyed, respondents were asked how much they believed a variety of factors impact the mental health of students. These factors included: academic stress, anxiety, depression, family stress, racism, social pressure, and trauma exposure.

The factor students reported to have the least impact on their mental health was racism / discrimination. In fact, **2 out of 3 students indicated that racism or discrimination had no impact at all on the mental health of students in their schools.** Interestingly, 14% of Black students said racism / discrimination impacted students at their school, compared to 20% of Hispanic / Latinx students and 21% of students of other races or ethnicities.

There are substantial discrepancies between staff and student perceptions of stressors. Among staff, an overwhelming number believed that all items listed, with the exception of racism, had a medium to strong impact on students in their school.

The top 3 problems most frequently endorsed by school staff were family stress, social pressure, and anxiety. While 85% of teachers and 94% of health professionals believed that family stress had a strong impact on students, only 44% of students agreed. Similarly, 79% of teachers and 85% of health professionals thought that social pressures had a strong impact on students compared to only 38% of students themselves. Police officers were more aligned with student perceptions. Among school-based police (n = 12), all items except racism / discrimination were endorsed as having a moderate or strong impact with social pressure and family stress being the most common (92%), followed by depression (83%) and anxiety (75%).

Concerns Impacting Mental Health of Students



	Student	Teacher	Health Professional	Families
Academic stress	n = 6,620 (62%)	n = 1,188 (57%)	n = 120 (63%)	n = 572 (82%)
Anxiety	n = 5,042 (48%)	n = 1,487 (71%)	n = 149 (78%)	n = 470 (70%)
Depression	n = 4,891 (46%)	n = 1,328 (64%)	n = 138 (72%)	n = 432 (64%)
Family stress	n = 4,632 (44%)	n = 1,814 (85%)	n = 181 (94%)	n = 474 (70%)
Social pressure	n = 4,001 (38%)	n = 1,677 (79%)	n = 164 (85%)	n = 541 (79%)
Trauma	n = 3,104 (29%)	n = 1,200 (59%)	n = 147 (77%)	n = 432 (64%)
Racism / Discrimination	n = 1,701 (16%)	n = 534 (26%)	n = 65 (34%)	n/a

Findings

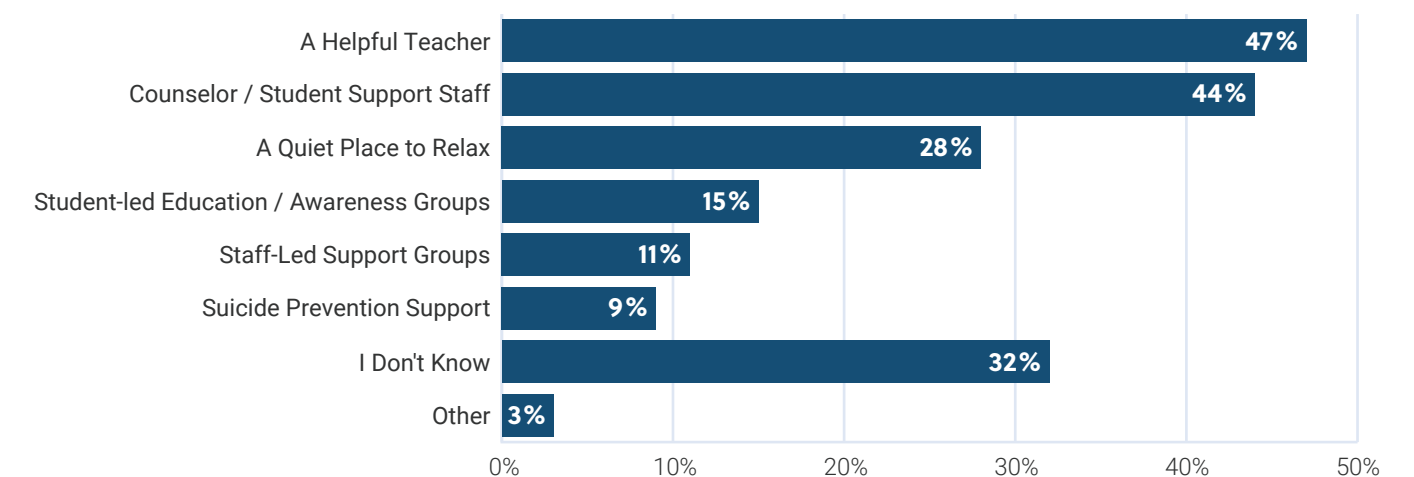
Access to Care



While most school-age youth in the United States who need mental health services do not ever receive treatment, 75% of those who do access care receive those services exclusively in their school.^{5,6}

DPSCD students reported having access to several types of in-school mental health supports or programs, including teachers, counselors, or student support staff for students to talk to; a quiet place in school to relax; staff- or student-led support groups; education and awareness groups; and suicide prevention programming. The table below indicates the percentage of students who reported having access to each support or program in their school.

Student View:
Programs or Services Available at My School
(n = 10,595)



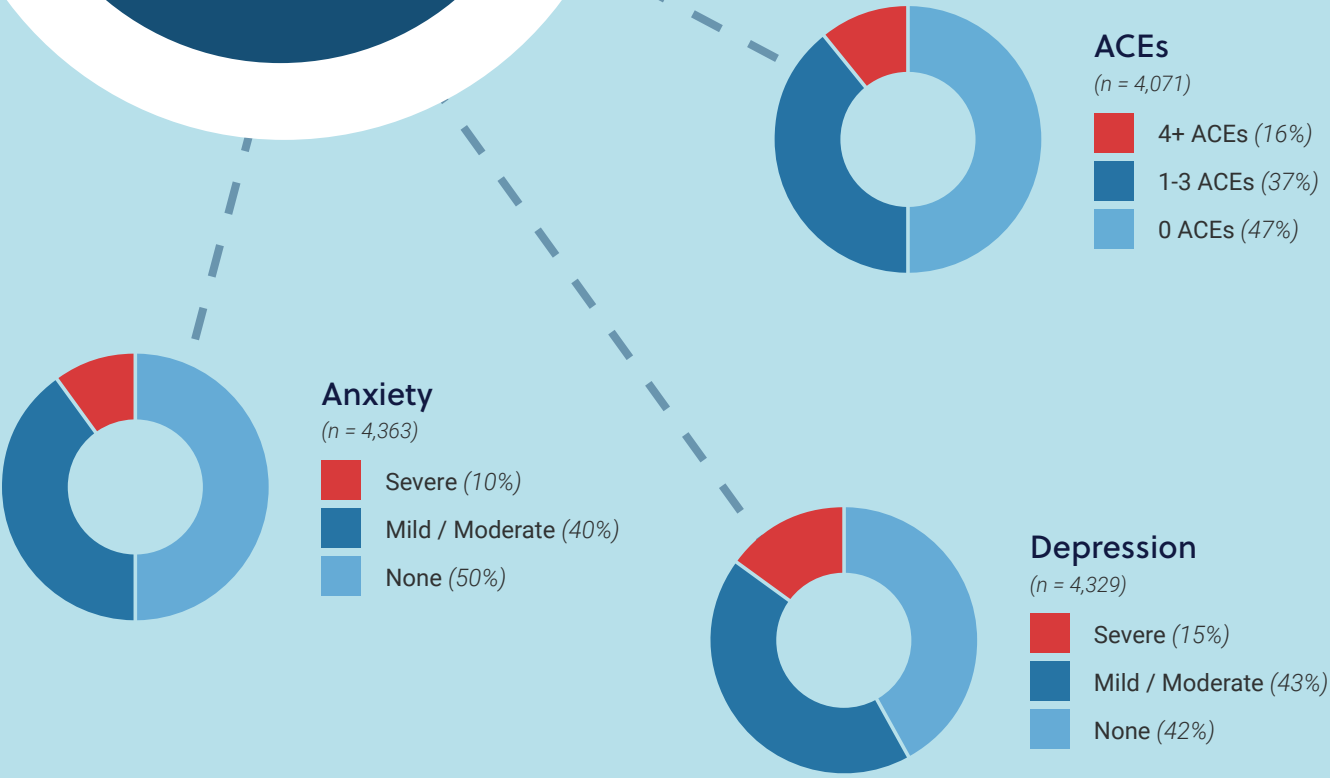
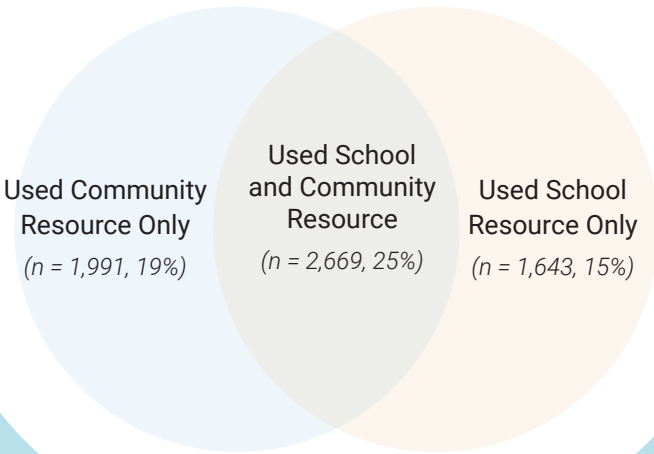
Resources Used

While there are school- and community-based mental health services available to help DPSCD students cope with stress or other mental health concerns, **2 in 5 students reported not having used any school- or community-based mental health resources in the past year.** Students were more likely to use community resources alone than school resources alone.

Students who DID NOT use Resources



Students who used Resources

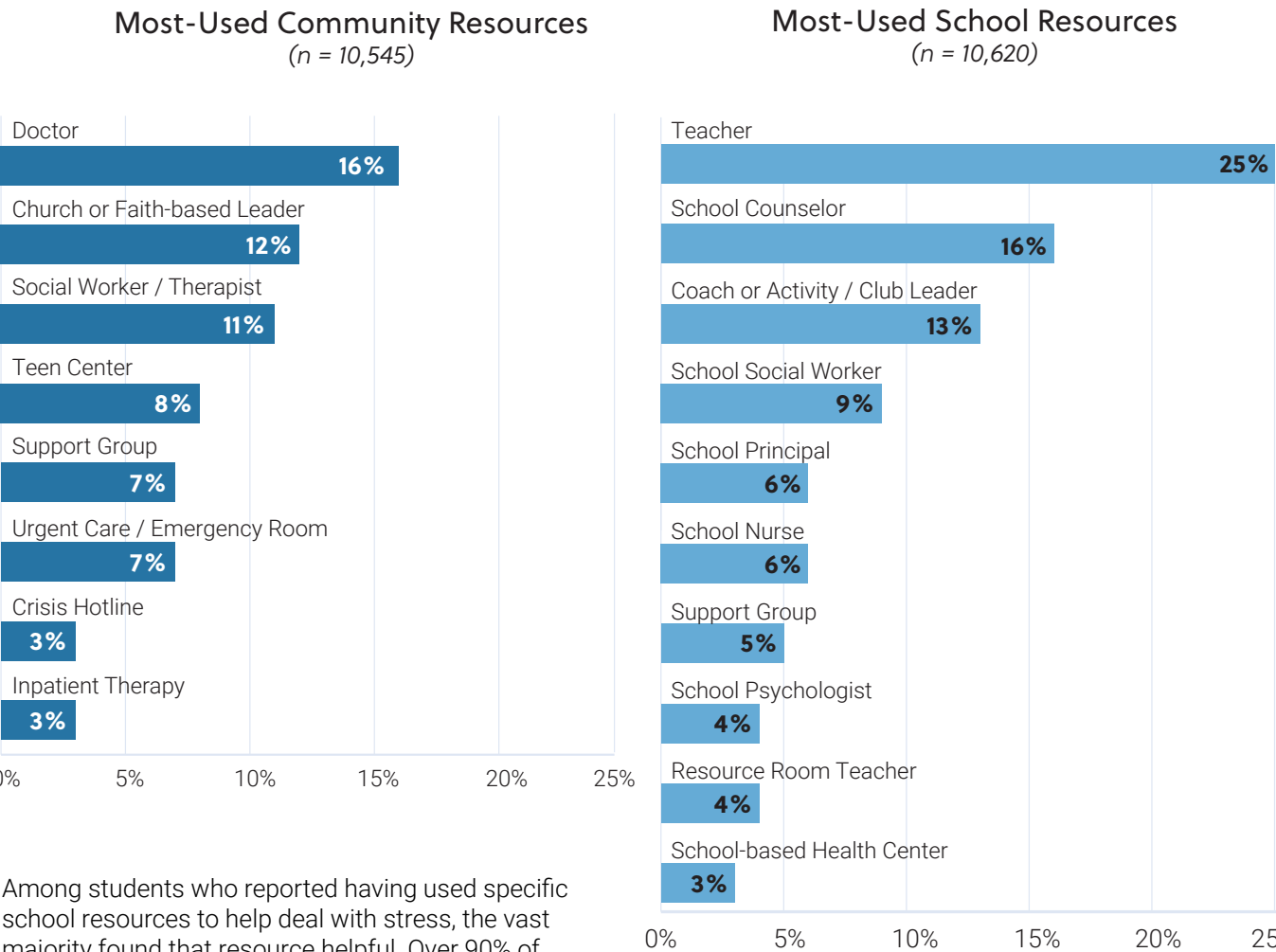


Depression, Anxiety, and ACEs Among Students Who Have Not Accessed Resources

Among students who used neither school- nor community-based mental health supports, 42% had no / minimal depression, 50% had no / minimal anxiety, and 47% had no ACEs.

However, a small but notable share of students who did not seek out mental health resources have a real need for those supports: 15% had severe depression, 10% had severe anxiety, and 16% experienced four or more ACEs.

The most common school and/or community-based mental health resources used by students are ranked below:



Among students who reported having used specific school resources to help deal with stress, the vast majority found that resource helpful. Over 90% of students who reached out to a coach or activity/club leader or a teacher found those resources helpful, and at least 80% of students who used the other resources listed above found them helpful.

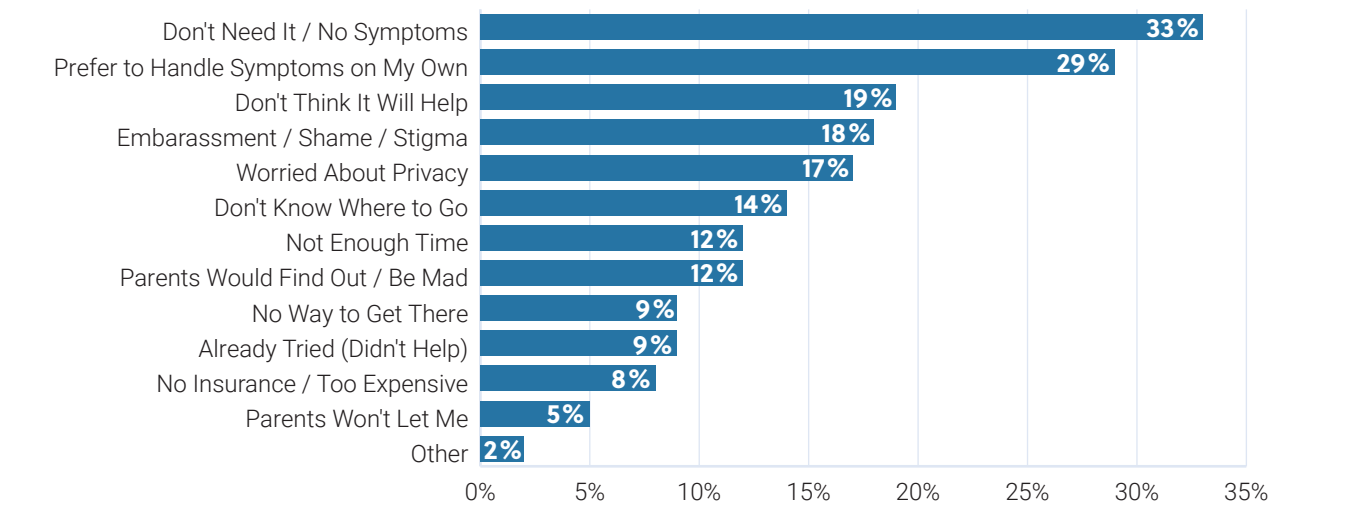
As with school-based resources, a majority of students who used community-based mental health resources found them helpful, ranging from 90% of students who found a church/father-based leader helpful, to 64% of students who found a crisis hotline helpful.

74% of students reported having a primary care or family doctor and 85% of students with an established primary care doctor reported having seen that doctor within the past year.

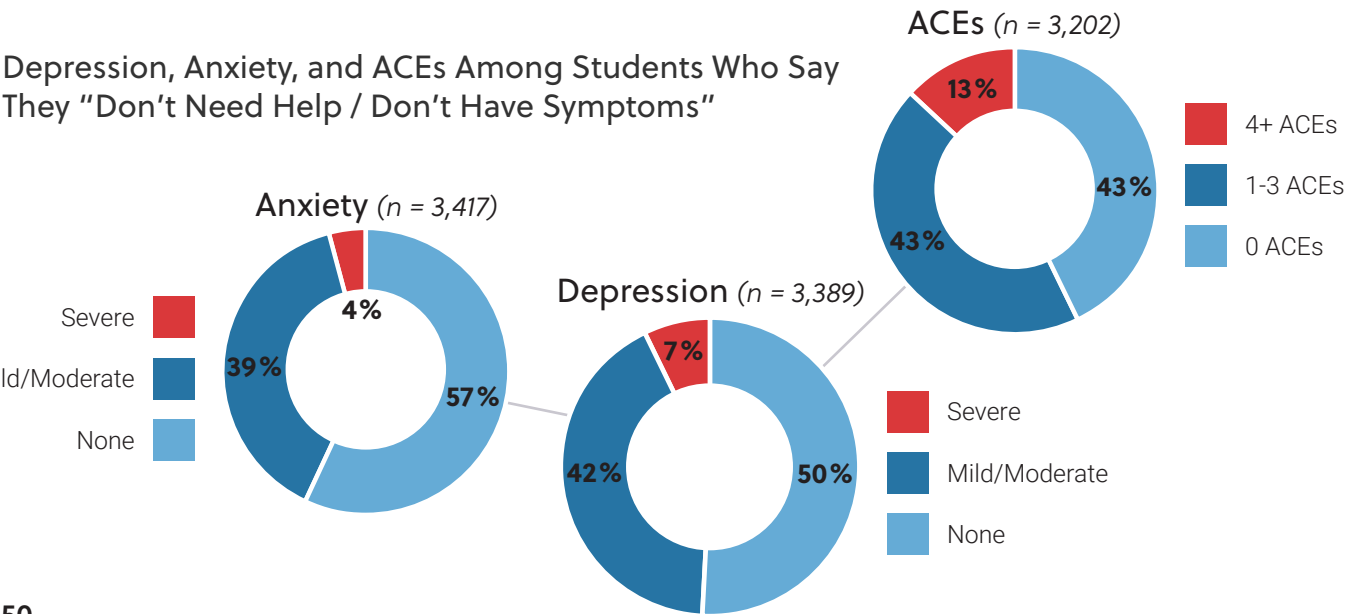
Barriers Identified by Students

DPSCD students were asked to report the barriers they experienced when considering or seeking mental health services of any kind. For many students, the primary barrier to accessing mental health services was a preference for coping with difficulties on their own, or a belief that available services would not be helpful. Nearly 3 in 10 students (29%) indicated they would prefer to handle mental health symptoms on their own. Nearly 1 in 5 students (19%) said they did not think mental health services would help them. Approximately 14% of students said they did not know where to go to receive mental health services.

Student View: Barriers to Seeking Mental Health Services
(n = 10,571)



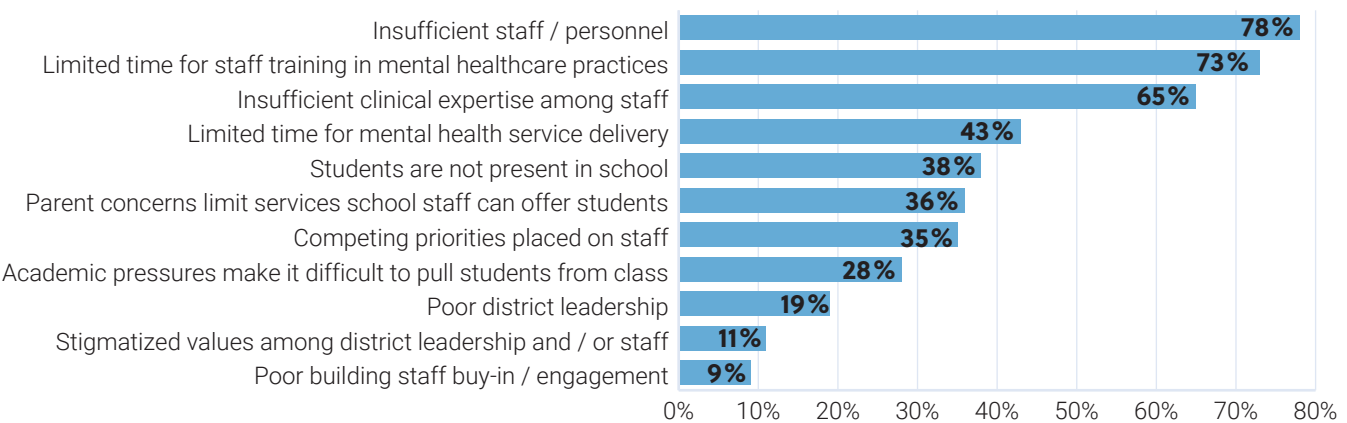
One-third of the students who responded to this survey item indicated that they did not need mental health services or had no symptoms. While many of these students reported no, or minimal, symptoms of depression or anxiety, approximately 40% had endorsed symptoms elsewhere in the survey indicating they were experiencing mild or moderate depression or anxiety. Of these students, 7% reported symptoms consistent with severe depression, 4% reported symptoms consistent with severe anxiety, and 13% experienced 4 or more ACEs.



Barriers Identified by Administrative Leaders

Administrative leaders were asked about barriers to offering mental health programs in their buildings. The most common barriers identified were insufficient staff (78%), limited time for training staff (73%), and insufficient expertise among staff (65%). Staff buy-in was the least common barrier identified (9%), signaling a readiness for, and interest in, mental health programming among staff.

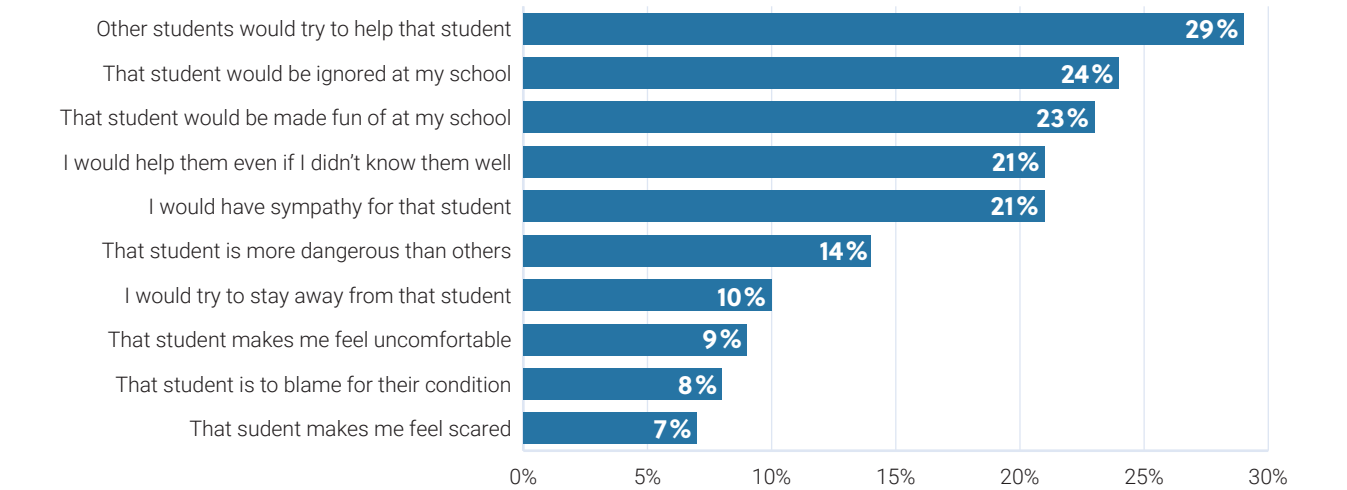
Administrator View: Barriers to Mental Health Programs
(n = 177)



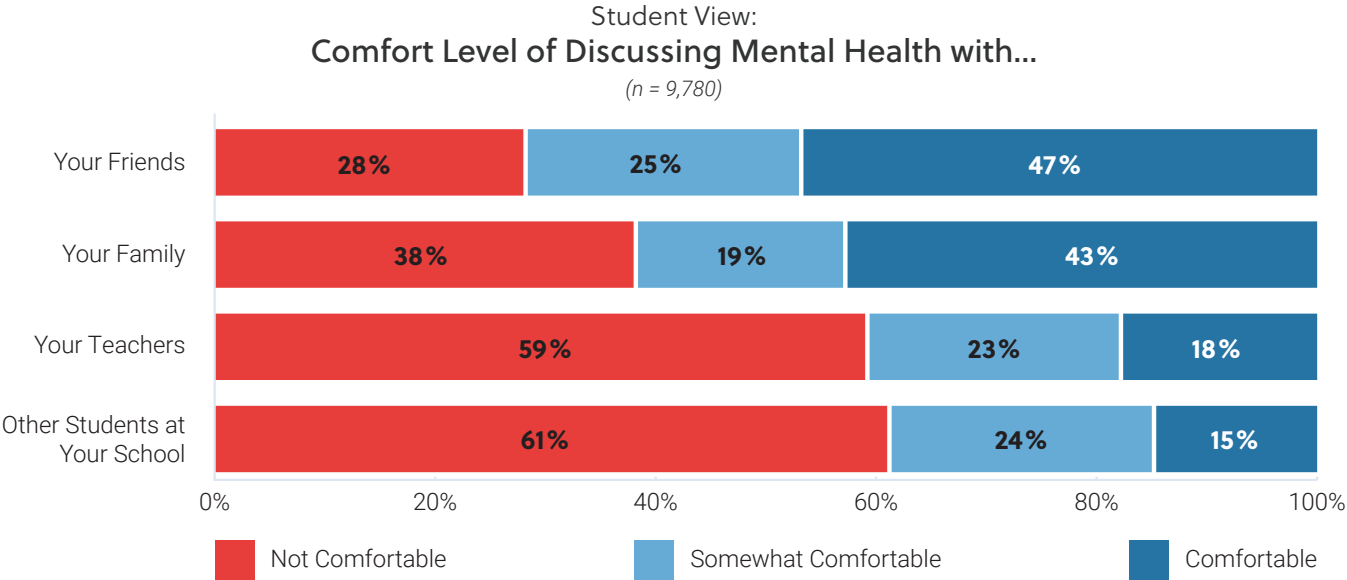
Stigma

Students and staff were asked to respond to a set of survey questions related to beliefs and stigma about mental health. Items queried both the respondent's own perceptions and their beliefs about the perceptions held by others. In general, students tended to rate themselves as having lower levels of mental health stigma than their peers. For example, only 10% of students who responded to this item indicated that they would try to stay away from a student with depression and anxiety, but 24% said that such a student would be ignored at their school.

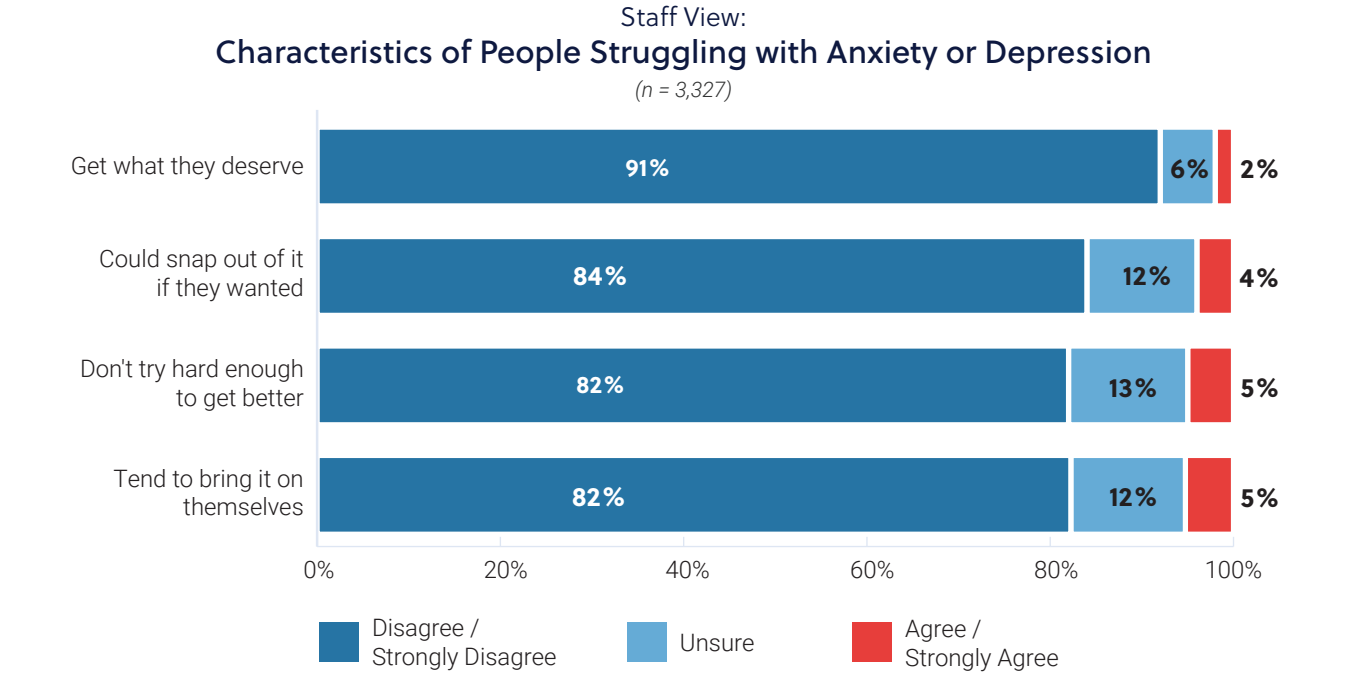
Student View:
Treatment of Peers with Symptoms of Poor Mental Health
(n = 9,900)



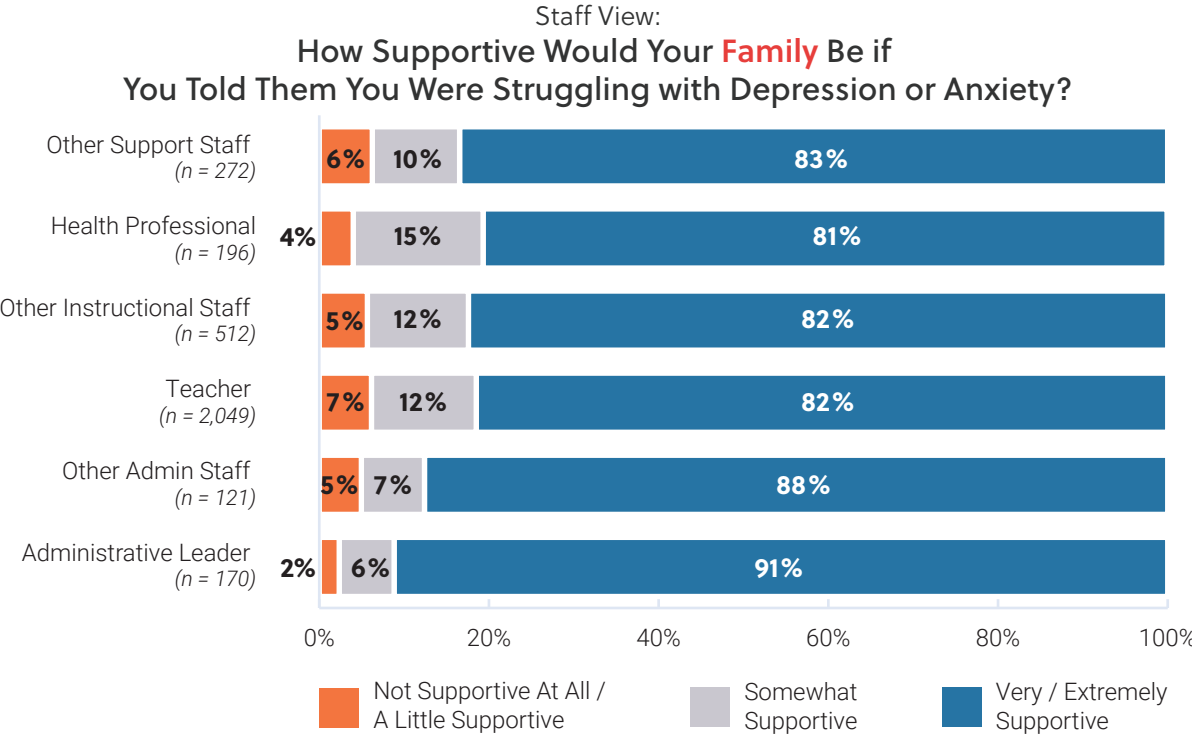
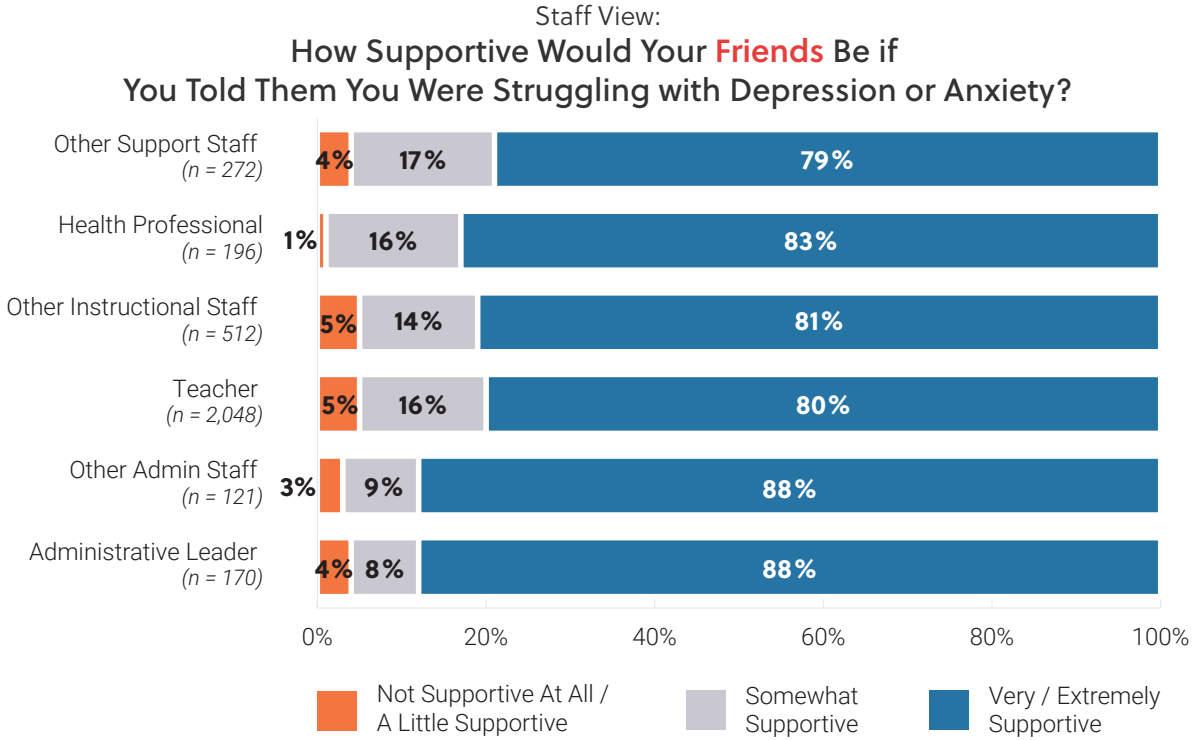
Stigma about mental health may also shape students’ openness to talking about mental illnesses and related symptoms.⁵³ DPSCD students reported the highest levels of comfort talking about mental health issues with friends and family. Conversely, 61% of students said that they would not be comfortable talking about mental health issues with other students in their school, and 59% said they were not comfortable talking with teachers about mental health issues.



A sample of 4 items were selected from the Stigma Evaluation Survey from the Opening Minds Campaign⁵⁴ to gauge beliefs or stereotypes about mental illnesses. In general, more than 80% of all DPSCD staff reported that they do not hold any negative perceptions of people with depression or anxiety. This is particularly true among health professionals. For example, 94% - 96% of health professionals disagree that people with depression or anxiety tend to bring it on themselves, don't try hard enough to get better, could snap out of it if they wanted to, or get what they deserve.

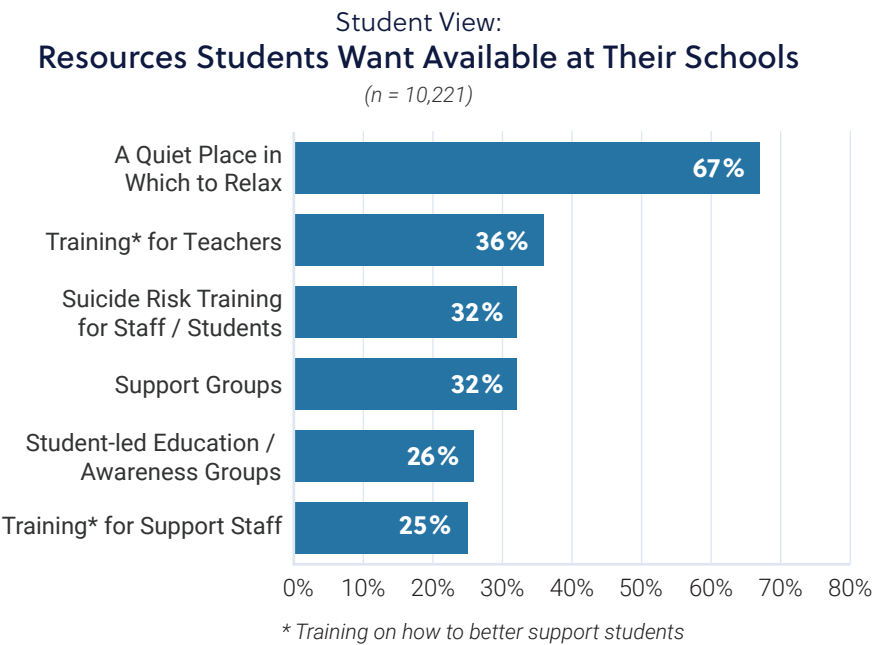


Most staff (90% - 92%) indicated that family and other people in their lives do not see depression or anxiety as a personal weakness. Further, more than 80% believed that family and friends would be very or extremely supportive if they needed help because of their own struggles with depression or anxiety.



Desired Resources

Students were asked which mental health-related programs and services they would like to have available at their school.



A desire for suicide risk training was strongest among students with severe depression, severe anxiety, and 4 or more ACEs, with over 40% of students in these categories indicating that they wanted this type of programming in their school.

School Leadership and Evidence-Based Mental Health Programming

Readiness to adopt evidence-based mental health programming is essential for incorporating new practices into schools. In particular, it's important for building leaders to be supportive of innovation and adoption of new programs and protocols, so that adequate time and resources may be protected. We define evidence-based practices broadly as services that have been tested through clinical research and shown to be effective, including therapeutic approaches like cognitive behavioral therapy and adaptive strategies like mindfulness. School support staff were surveyed about the extent to which they thought their school building was ready to implement evidence-based programming.

While nearly 8 in 10 administrative leaders said that they were supportive of evidence-based programming in their schools to a great- or very-great extent, only about half as many (42%) school health professionals agreed. School administrative leaders and health professionals were more closely aligned in their assessment of administrative leader proactivity in bringing evidence-based mental health programs to their schools. Interestingly, school health professionals reported that administrative leaders were more proactive than administrative leaders self-assessed. Nearly two-thirds of administrative leaders (64%) said they were not at all or only slightly proactive while only 46% of health professionals expressed the same perception. Approximately 60% of health professionals reported that their administrative leaders were knowledgeable of evidence-based practices to at least a moderate extent.

Leadership and Evidence-Based Mental Health Practices



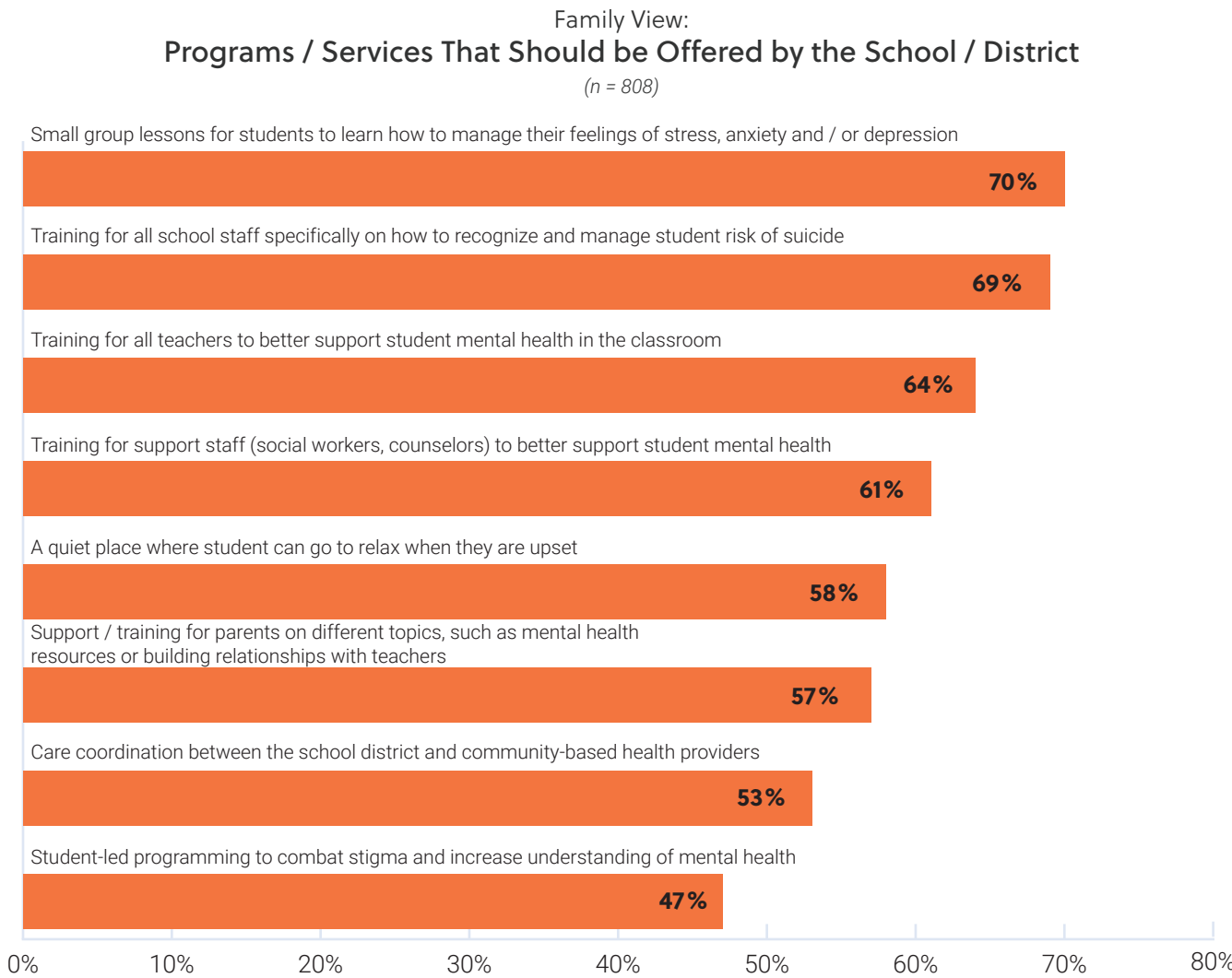
Family and Community Perceptions and Experiences

Mental health is a priority for most Detroiters. According to the 2018 Community Health Assessment from the Detroit Health Department, every district in the city ranks mental health as a priority in improving community health.³⁰ In District 1, the northwest corner of the city, mental health was the community's number 1 priority. In order to gain a more complete picture of issues and perceptions specific to student mental health in Detroit, we surveyed DPSCD families about their experiences with accessing mental health care for their child, their perceptions of their children's mental health stressors, and mental health-related programming they would like to have in their child's school.

92% of DPSCD families surveyed believe that schools should play a part in supporting the mental health or emotional well-being of students.

Families Would Use School Services if They Needed Them

The majority of families mentioned that they want students to learn how to manage their feelings of stress, anxiety, and depression in school. In alignment with the majority of both teachers and students, families also indicated that they would like training for school staff on how to recognize and manage student risk of suicide as well as training for teachers in how to better support student mental health in the classroom.

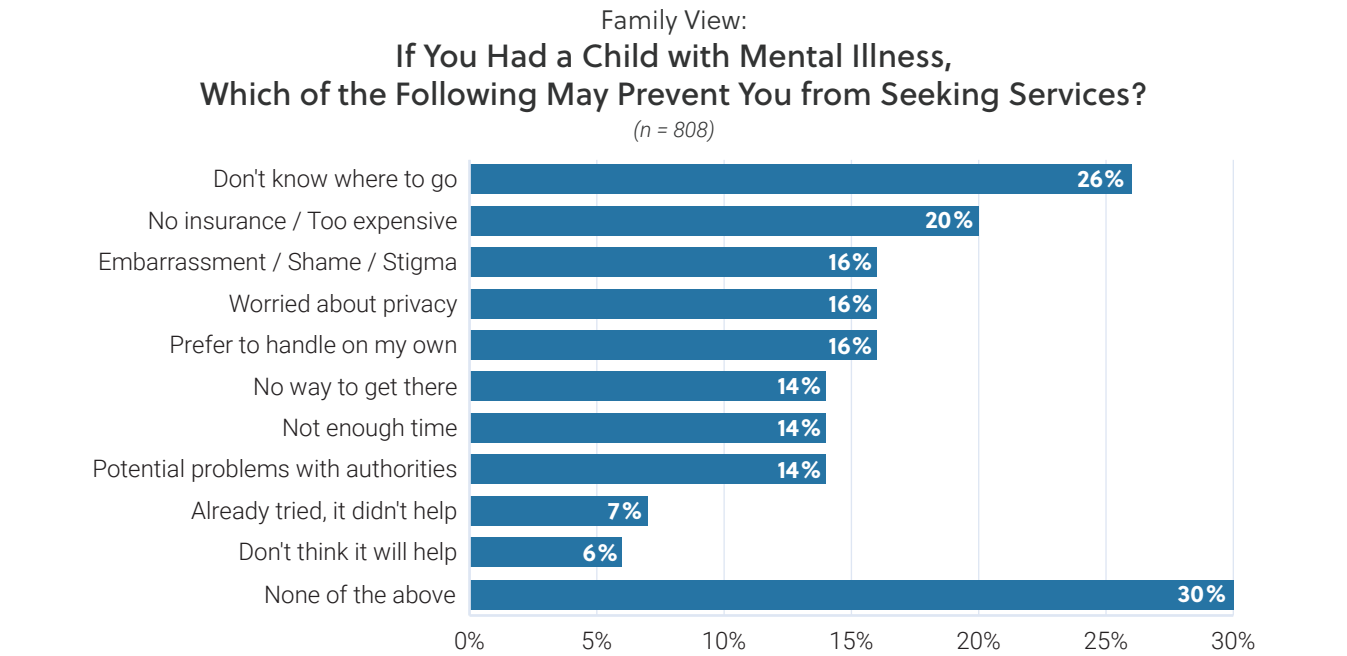


The vast majority of families **84%** said they would be interested in having a school mental health professional provide counseling or support services to their child during the school day.



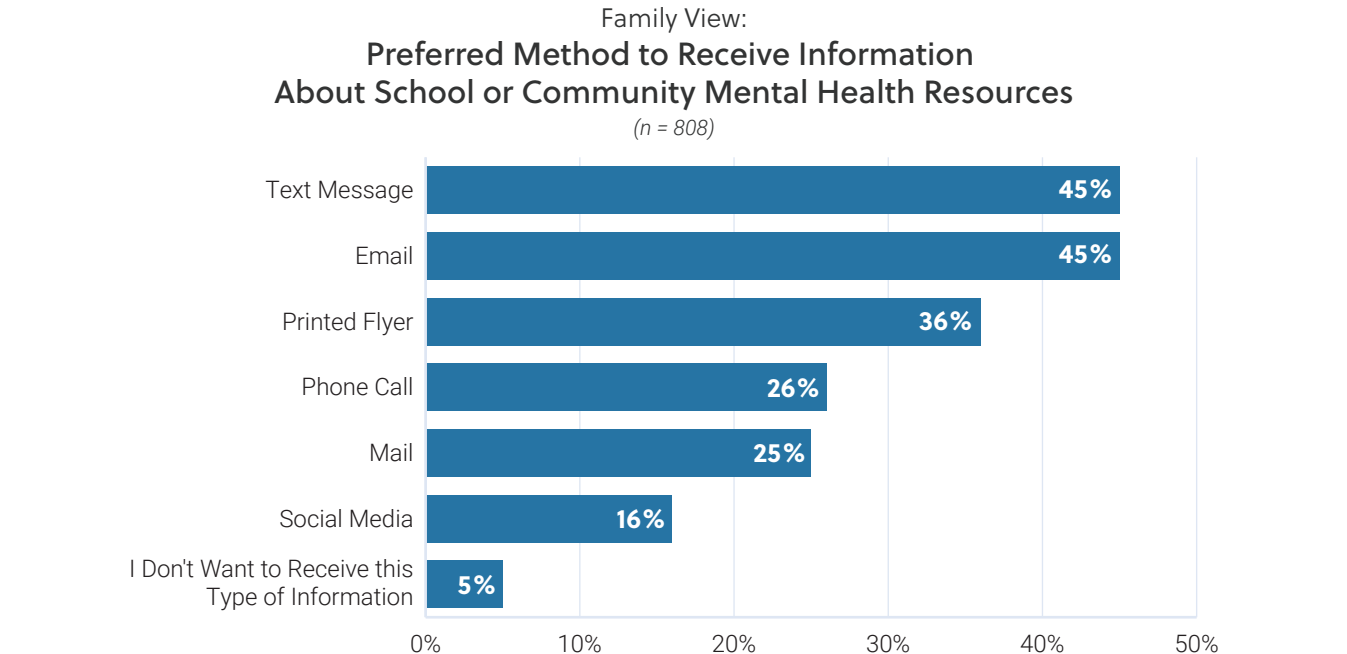
Barriers to seeking mental health services

While 30% of family survey respondents did not select any of the barriers to accessing mental health services, those who did indicated that the biggest barrier is not knowing where to go (26%). The cost of accessing mental health services was also among the top barriers for families.



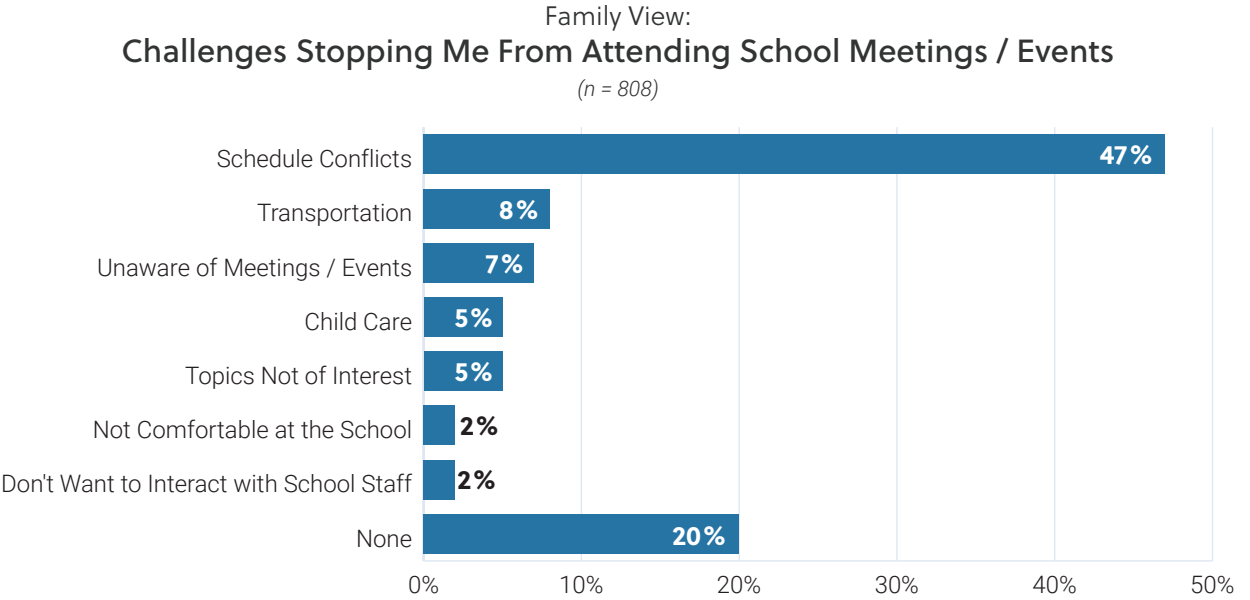
Family preferences about receiving mental health information

The ability to share information with families about mental health services is an important part of increasing access to resources. About 45% of families said that text message or email was their preferred method of communication from the school, and 36% said they like printed flyers sent home with their child.



Family Barriers to Attending School Events

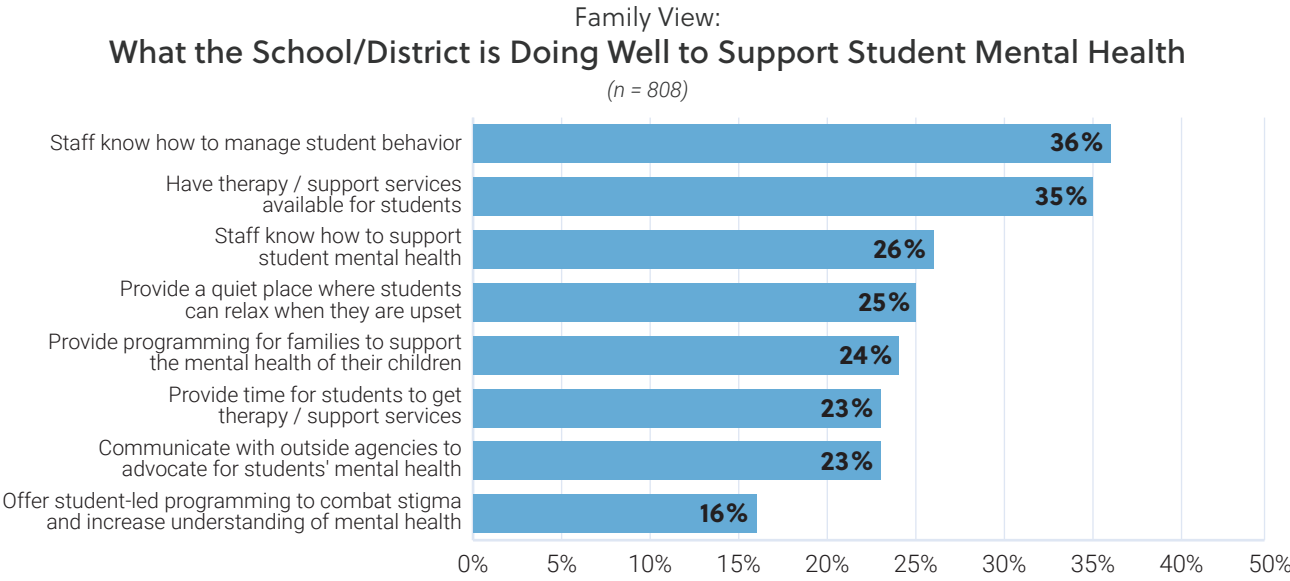
Nearly half of family survey respondents (47%) said that scheduling is the biggest barrier to attending meetings or events at their child’s school—by far the most common answer.



Concerns Impacting Students

School / District Efforts Supporting Student Mental Health

Respondents to the family survey were generally positive about the school staff and services as they relate to student mental health.

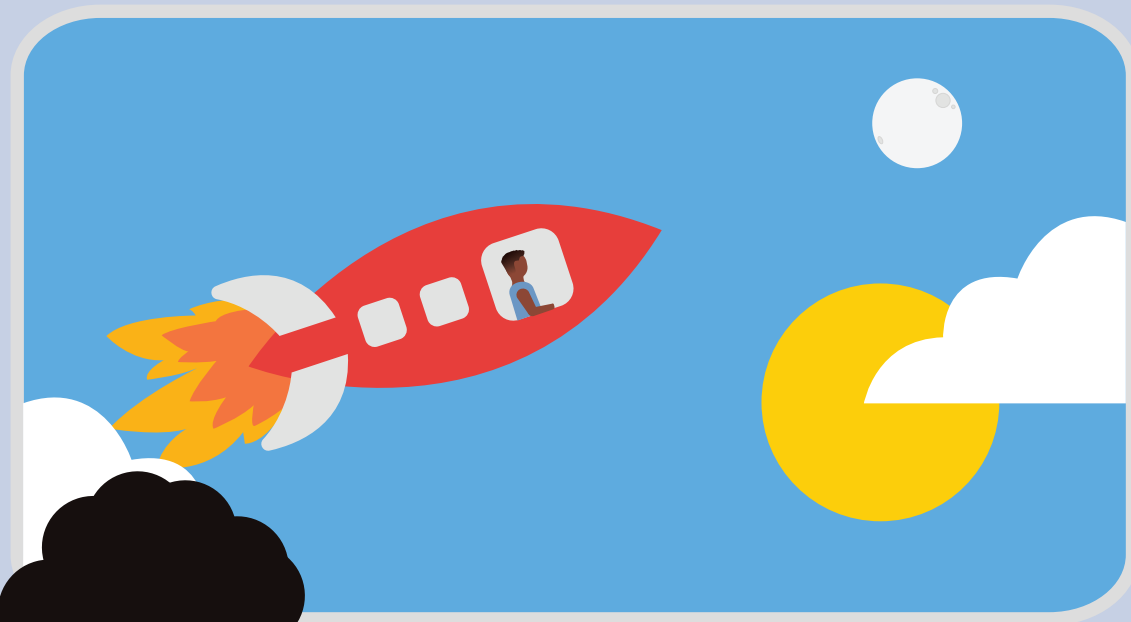


“Students are dealing with PTSD from situations arising from their family life and come to school and have to interact with teachers who are also dealing with PTSD from their daily interactions. I believe training should be offered/required of teachers to deal with the emotional behavior that students are suffering through. There should also be ‘mandatory’ self care workshops [and] decompression times set aside for the teachers. Teachers cannot help students if they are struggling themselves.”

- Family Survey Participant

Findings

School Engagement

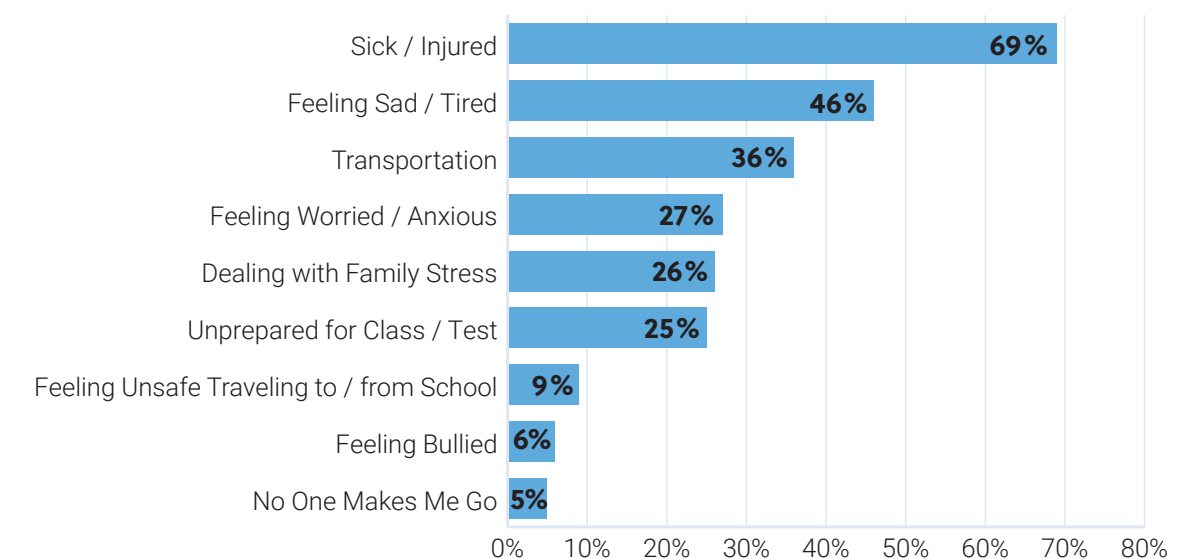


Student mental health is associated with absenteeism, academic engagement, and school behavior.

Chronic absenteeism is a key concern for district administrators in DPSCD. Chronic absenteeism is generally defined as missing 10% or more school days, thus being absent 9 or more days would qualify as chronically absent for that semester. **13% of students reported being absent from school on 10 or more days of the last semester of the last school year and an additional 11% reported that they missed 7-9 school days in the last semester of the last year.**

This number may under-estimate the number of students who were chronically absent, since chronically absent students were less likely to be in school on the day that the survey was made available. Further, students might poorly recall or under-report their absences from the prior school year or semester.⁵⁵

Student View:
Reasons for Missing School
(Among Those Who Missed 10+ Days) (n = 1,252)



Mental health connection to absenteeism

Mental health seemed to play a role in student absenteeism. Of those missing 10 or more days, 46% said they had missed school because they were feeling sad or tired, 27% said they missed school because they were feeling worried or anxious, and 26% said they had missed some school because they were dealing with family stress.

Importantly, only 9% of the 3,472 students who had no or minimal depression reported missing school more than 10 times, while 22% of the 1,523 students with severe depression said they had missed school more than 10 times during the past year. The patterns are similar for students who exhibit high levels of anxiety and those who report 4 or more ACEs.

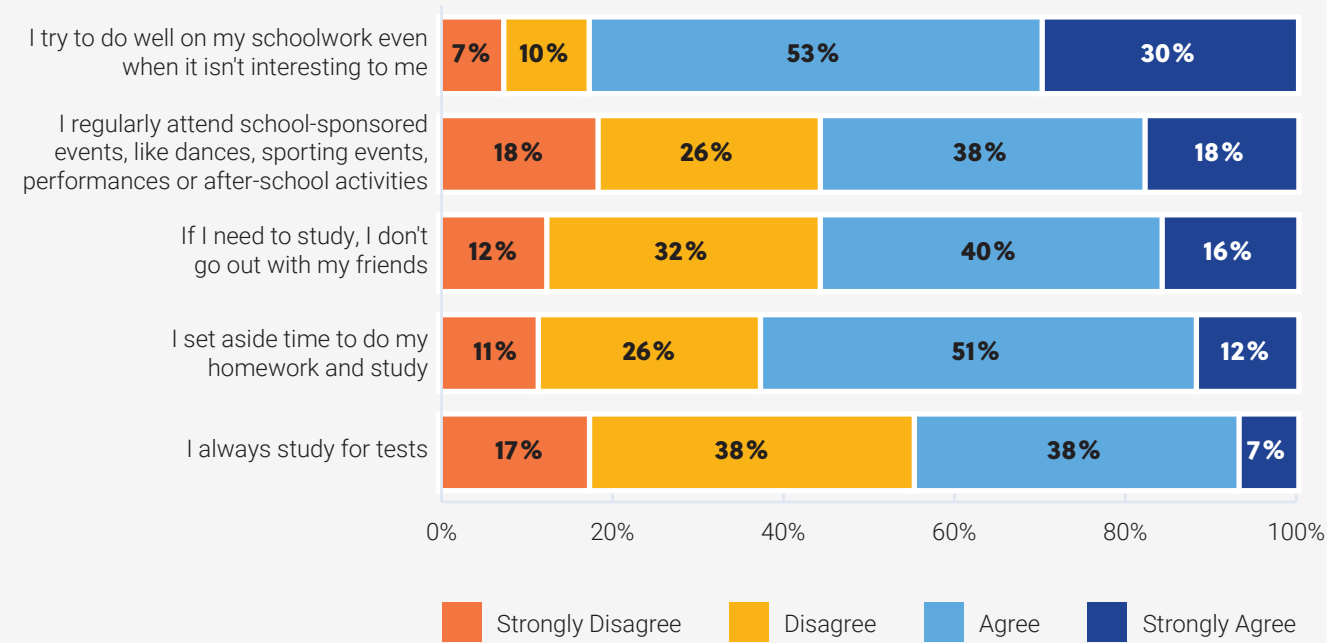


Students with depression were more likely to report chronic absenteeism.

Academic Engagement

Detroit students reported moderate engagement in school.⁵⁶ While most (83%) said they try to do well on schoolwork even when it isn't interesting and 63% said they set aside time to do homework, only 46% always study for tests. More than half regularly attend school-sponsored events.

Student View:
Academic Engagement
(n = 9,892)



Mental health connection to school engagement

Academic stress is a major stressor for DPSCD students, and students who attend schools with rigorous coursework requirements exhibit higher levels of depression and anxiety (a topic also discussed later in this report). Among students, 61% indicated that symptoms of depression have made it at least somewhat difficult to do schoolwork, participate in chores or after school activities, or get along with other people. Further, 18% indicated that symptoms of depression have made it very or extremely difficult to do these things.

Among students with no or minimal depression, 53% always study for tests, while only 37% of those with severe depression symptoms indicated the same. Students with severe depression were also less likely to attend school-sponsored events than their peers with no or minimal depression, 49% vs. 59%, respectively.



Students with depression were more likely to report difficulties completing schoolwork, engaging in after school activities, and studying for tests.



Disciplinary Actions

It is not uncommon for students in DPSCD to have interactions with the school disciplinary system. Nearly half of students (45%) reported getting in trouble at least once for not following school rules; 1 in 5 students reported having been suspended, and more than 1 in 10 students said they transferred to another school for disciplinary reasons.

Mental health connection to discipline

Survey responses show that students who exhibit signs of depression or anxiety or who have experienced 4 or more ACEs are more likely than their peers to have disciplinary problems. For example, only 37% of students who reported no or minimal symptoms of depression, said they had ever gotten in trouble for not following school rules, while 50% of those with severe depression reported the same. As shown in the figure to the right, students who experienced high levels of depression or who reported 4 or more ACEs were also more likely to report having been suspended or transferred schools for disciplinary reasons.

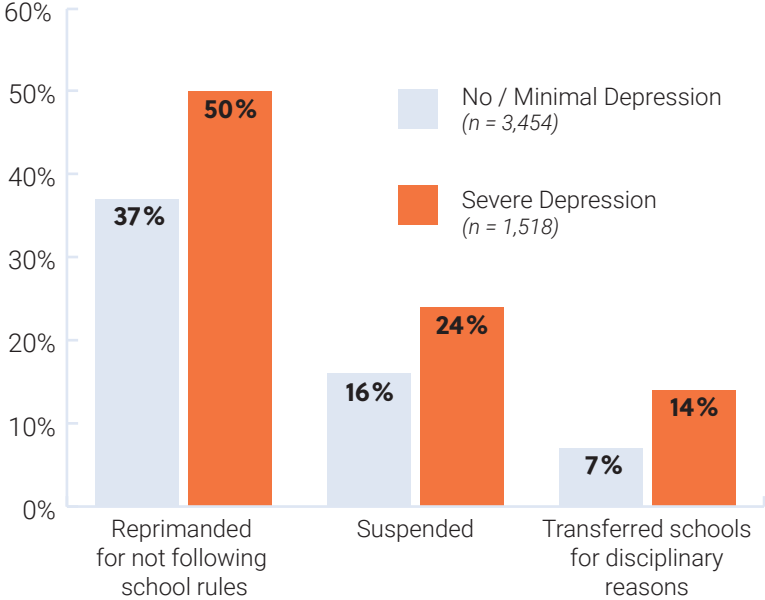


Students with depression were more likely to report having been suspended from school.

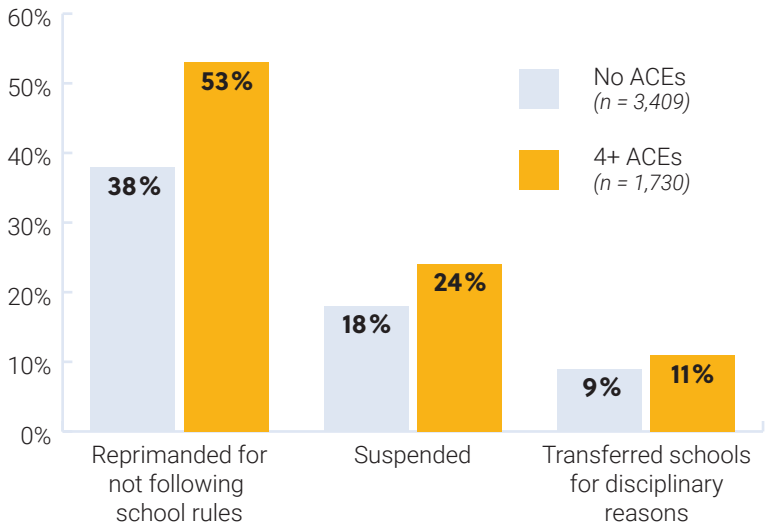
DETENTION



Relationship Between Mental Health / Trauma and School Discipline - Depression



Relationship Between Mental Health / Trauma and School Discipline - ACEs





Findings

School-to-School Differences

There are several types of schools in DPSCD, including application schools, examination schools, and neighborhood schools.

Combined, students attending application and exam schools comprise just over half of our analytical sample. Because these schools have unique academic requirements, application and exam school students may face different stressors than students in neighborhood schools. In this section, we explore differences in key indicators of student mental health and mental health care access across these three types of schools.

Our survey gathered responses from 5 exam schools, all of which were high schools: Cass Technical High School, Martin Luther King Jr. Senior High School, Renaissance High School, Southeastern High School, and the School at Marygrove. **Approximately 37% of student survey respondents attended 1 of these 5 exam schools.** Approximately 16% of student survey respondents attended an application school.

Exam and Application Schools

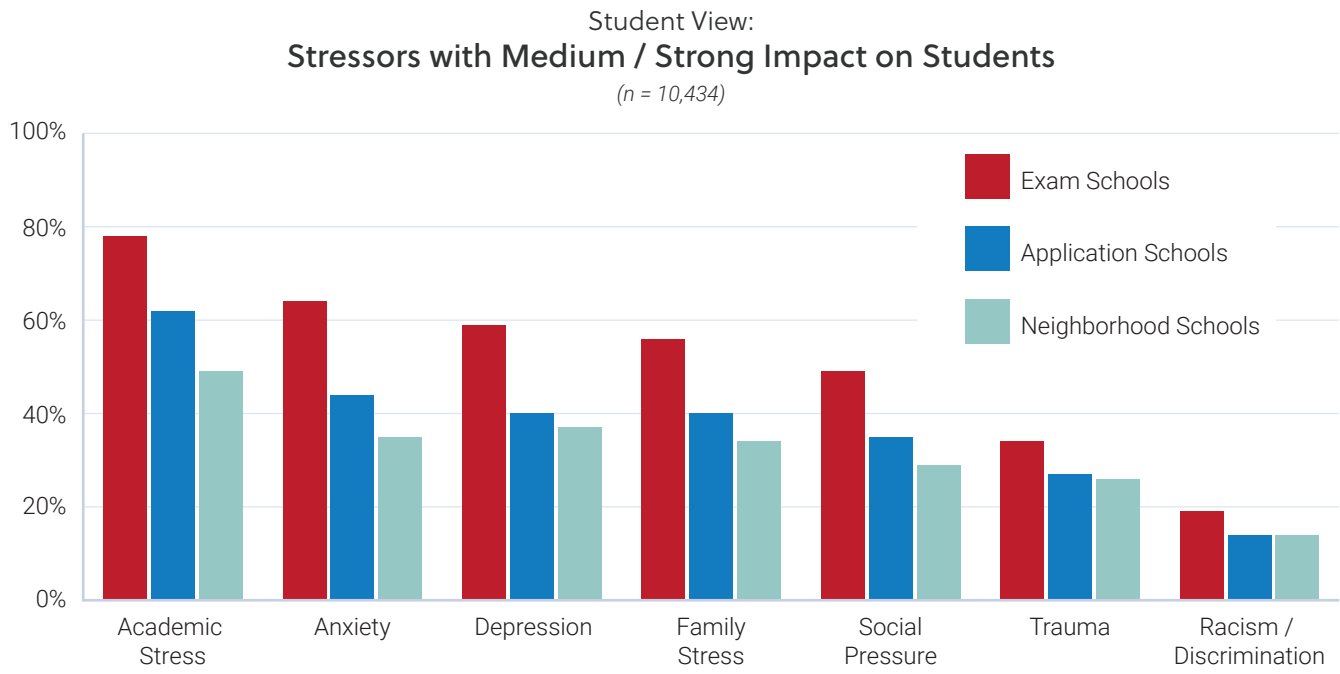


Exam schools have selective admission requirements and require applicants to complete an admission exam in order to enroll.

Application schools offer specialized programs (e.g., gifted and talented, foreign language immersion, performing arts) that require an application and minimum standards for admission.

Students were asked to evaluate whether a variety of mental health challenges (e.g., depression, anxiety, academic stress, family stress) affected students at their school. **Across all schools, academic stress was the number 1 issue students reported impacting student mental health.**

Academic stress seems particularly acute in application and exam schools where 62% and almost 80% of students reported academics to be more than a mild stressor, respectively. Approximately one-half of students in exam schools also felt that depression, anxiety, and family stress were impacting students in their school.

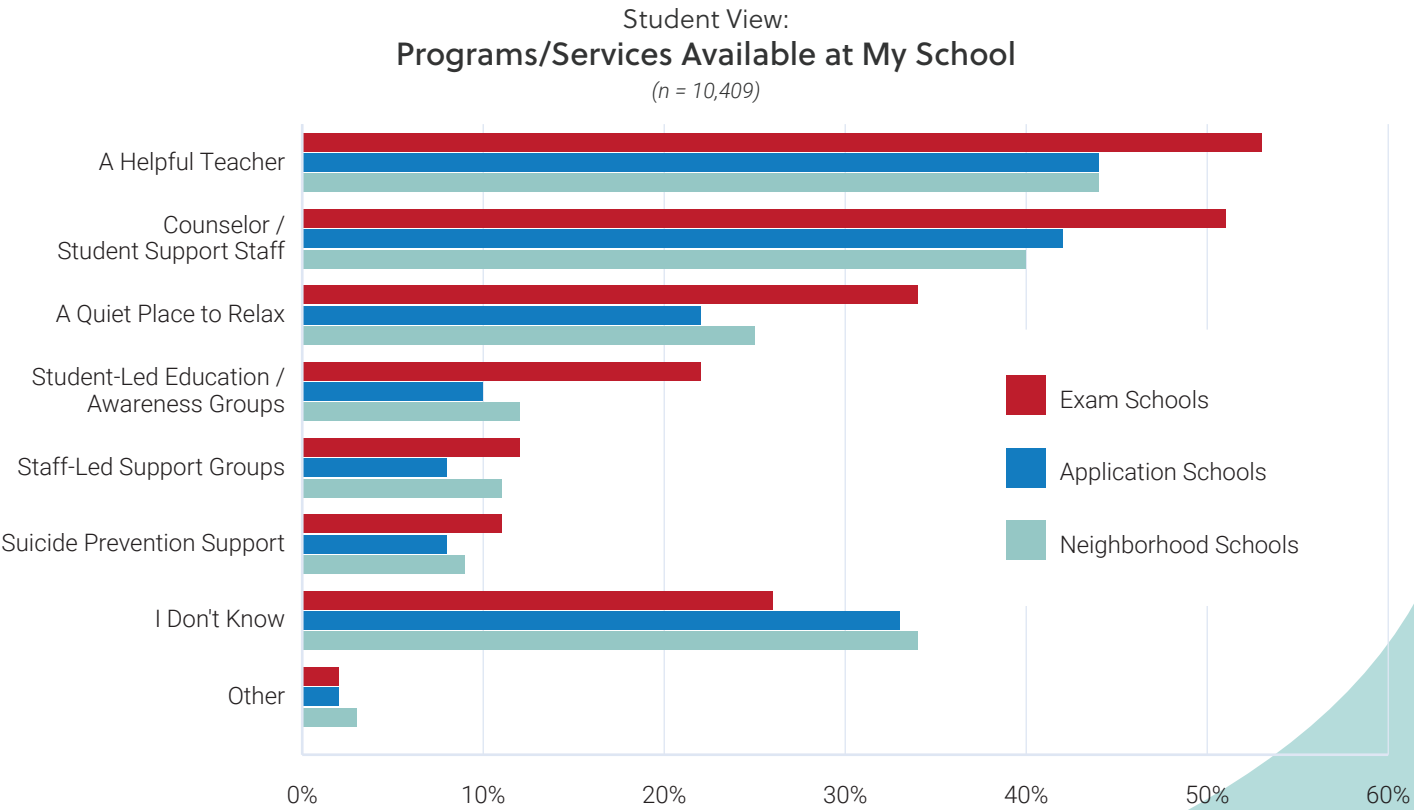


Patterns of ACE exposure, depression, and anxiety are similar across different types of schools. However, students at exam schools and, to a lesser extent application schools, indicate slightly higher ACE exposure and more markers of severe anxiety and depression.

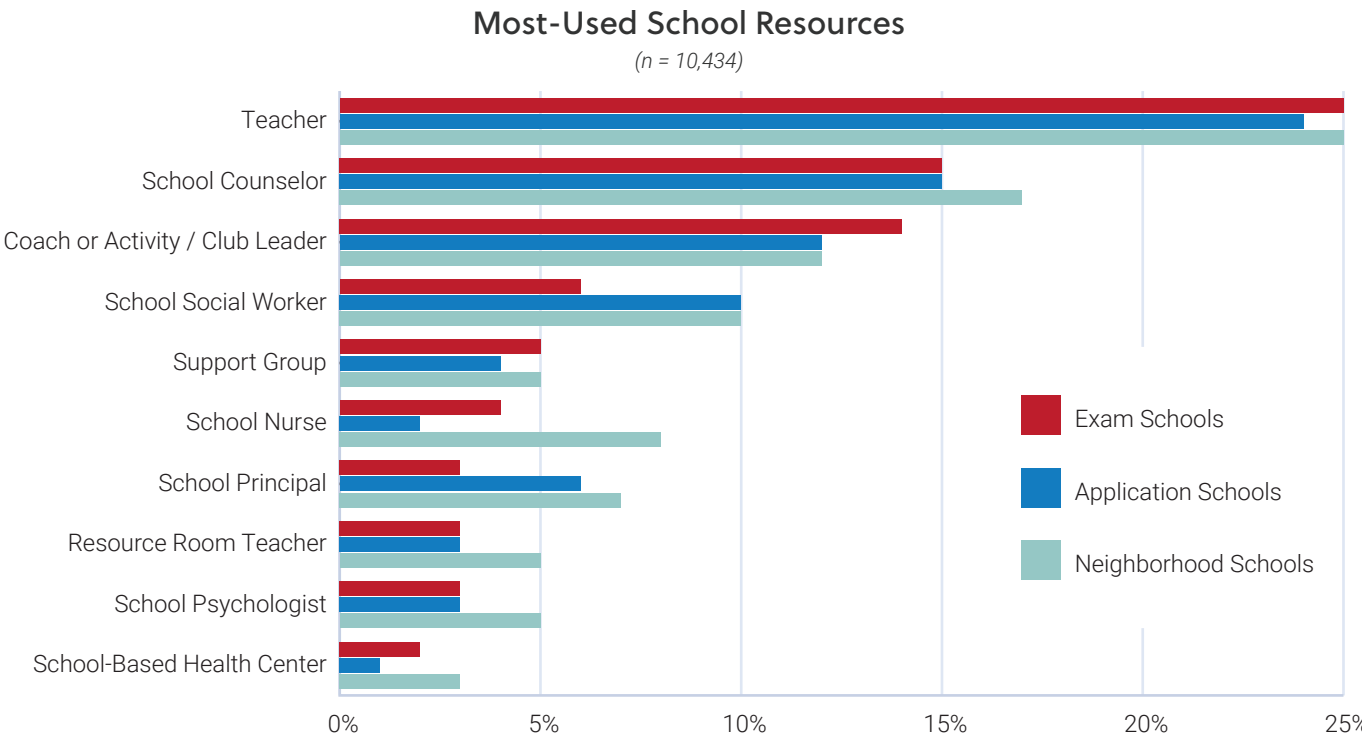
	Exam Schools	Application Schools	All Other Schools
ACEs (n=9,827)	n=3,722	n=1,511	n=4,594
0-1	55%	59%	64%
2-3	24%	20%	19%
4+	22%	21%	17%
Depression (n=10,434)	n=3,913	n=1,636	n=4,885
No/Minimal Depression	33%	37%	42%
Mild Depression	30%	28%	26%
Moderate Depression	19%	19%	18%
Severe Depression	18%	16%	15%
Anxiety (n=10,506)	n=3,928	n=1,640	n=4,938
No/Minimal Anxiety	41%	44%	46%
Mild Anxiety	30%	28%	28%
Moderate Anxiety	17%	17%	17%
Severe Anxiety	12%	10%	9%

School Mental Health in DPSCD

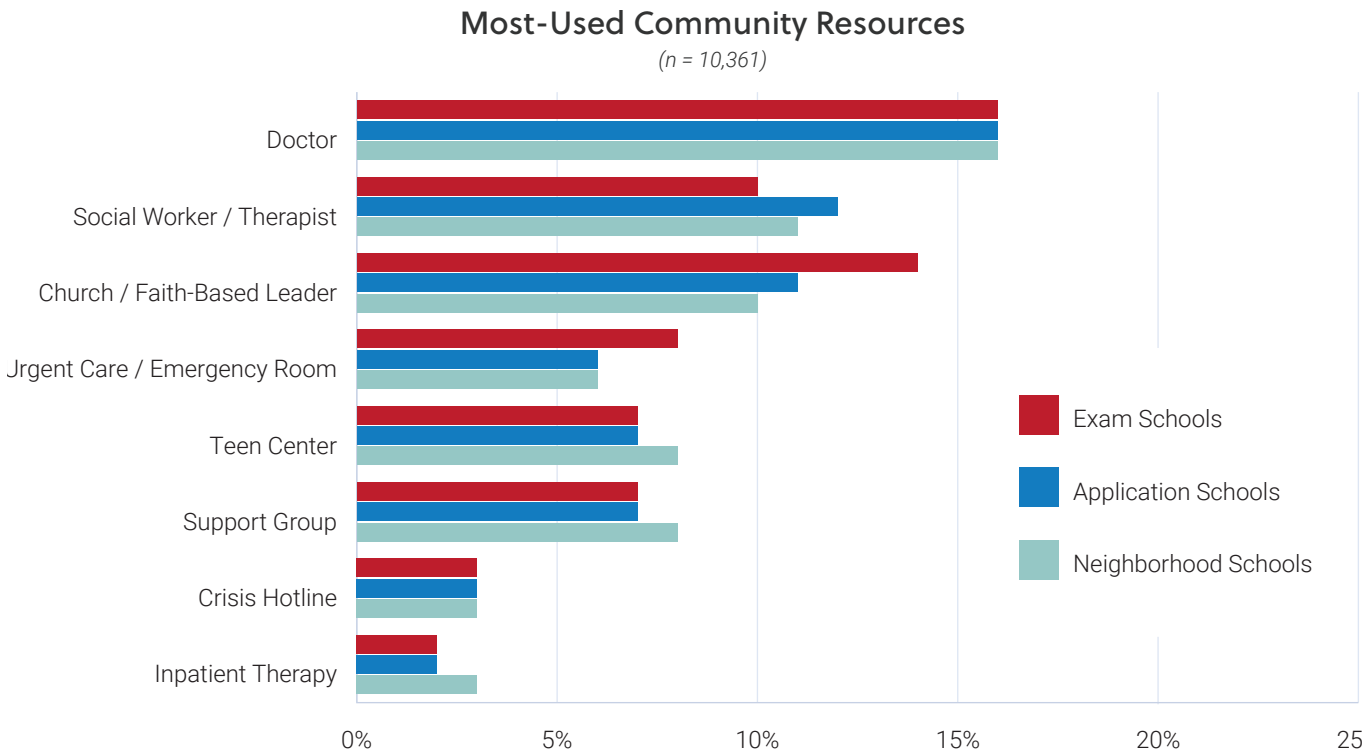
Students were asked to indicate whether their school had specific mental health resources available and whether they had used selected school- and community-based mental health resources within the past year. Answers varied based on school type. In general, students at exam schools were more likely to indicate that their school had such resources available: only 26% of exam school students said they did not know which resources were available, or that their school had no resources available, compared to approximately 33% of application school and 34% of neighborhood school students.



Findings // School-to-School Differences



Compared to neighborhood schools, application and exam school students reported similar use of school-based mental health supports: 42% of students in application and exam schools and 46% of students in neighborhood schools reported that they used school-based mental health supports. Among students who did report using school-based resources, patterns were similar across schools. The top 4 most-commonly used school resources, regardless of school type, were teachers, school counselors, coaches or activity / club leaders, and social workers.



Nearly 6 in 10 students, regardless of school type, reported that they did not use any of the listed community-based mental health resources within the past year. Across all 3 school types, the top 3 most commonly accessed community resources were doctors, social workers, and church or faith-based leaders.



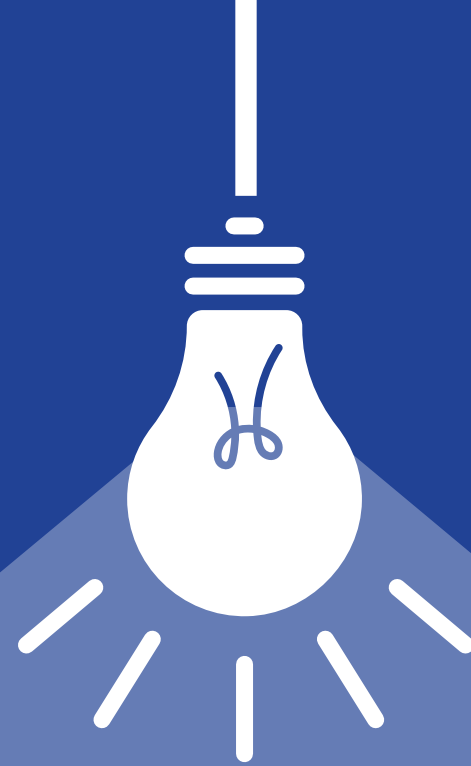
03

Conclusion

Recognizing strengths and identifying gaps within the District will enable DPSCD leadership to determine the best, most relevant training and programming.

Throughout the process of designing, building, and implementing surveys to complete this needs assessment, TRAILS and the Lab marveled at the incredible partners they found within the DPSCD leadership. While tireless in their efforts to support students every day, the many DPSCD partners that made this needs assessment possible went above and beyond to enable this data to shine a light on the needs of students and staff across the District.

Many students across the District were found to be struggling with symptoms of anxiety, depression, and/or have experienced significant traumas in their young lives. Furthermore, several groups of students were identified as being at particularly high risk for experiencing these difficulties. Yet, our assessment also revealed a dedicated and experienced workforce — one that wants to be supported to deliver the best services and programming to their students.



Conclusion

Recommendations



TRAILS works to improve social, emotional, and academic outcomes for students by improving their access to effective mental health care across 3 tiers of programming.

In alignment with best-practices for educational settings, TRAILS recommends coordinating school mental health programming around a 3-tiered framework: universal programming for all students, early intervention for students experiencing mental health difficulties, and crisis management for students at risk of serious self-injury or suicide. Below are TRAILS's key recommendations for DPSCD. Future discussion with District leadership and stakeholders will inform additional recommendations and next steps.



"If our district seeks higher student achievement, we need to invest in mental health services to support kids."

– DPSCD Administrator

TRAILS Core Features: A 3-Tiered Approach

Tier 3: Suicide Risk Management

Tier 2: Early Intervention

Tier 1: Universal Education and Awareness

Tier 1: Universal Prevention for the Whole School Community

Recommendation 1: Implement districtwide social emotional learning (SEL) in the classroom

SEL is the process by which students develop skills for identifying and managing their emotions, develop an awareness of others, and learn practical skills for interacting with people effectively and sensitively. SEL instruction is associated with improvements in a variety of educational and health outcomes, including improved social and emotional skills, attitudes and behavior; reduced emotional distress and substance use; and significantly improved academic performance.^{57,58} Districtwide implementation of social and emotional learning programming in classrooms is strongly recommended.

To support this recommendation, TRAILS offers training and implementation support for integration of a comprehensive SEL curriculum into the classroom setting. The TRAILS SEL curriculum provides all materials needed to enable teachers to deliver lessons that foster student development of the five SEL core competencies established by the Collaborative for Academic, Social, and Emotional Learning (CASEL). These competencies include self-awareness, self-

management, social awareness, relationship skills, and responsible decision-making, and were recently adopted by the Michigan Department of Education as statewide SEL competencies. Educators trained to deliver the TRAILS SEL curriculum will be able to recognize the signs and symptoms of mental illness in students more accurately, make appropriate referrals to building resources more quickly, and lead classroom-appropriate lessons on student self-care strategies and interpersonal skills. Students who participate in SEL lessons are anticipated to demonstrate increased self-awareness including a broader understanding of thoughts and feelings and their impact on behavior; improved self-management and decision-making, including the ability to regulate impulses and choose helpful coping strategies; and greater social awareness and relationship skills, such as appreciating differences and choosing and maintaining healthy relationships.

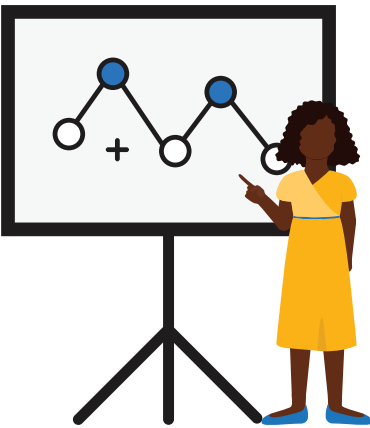
Recommendation 2: Provide universal support for student mental health during times of community stress and uncertainty

When staff and students face unusual and large-scale stressors, mental health supports should be responsive and tailored to the local circumstances. At present, COVID-19-related stressors and the concurrent global spotlight on persisting violence against Black, Indigenous, and people of color, systemic racism, and racial inequities present a uniquely challenging and unprecedented community environment in Detroit. TRAILS recommends ongoing professional development for staff in best practices for supporting all students during this turbulent and difficult time.

TRAILS recommends and offers professional development in up-to-date and responsive practices designed to help students navigate and cope with current stressors. Trainings and materials would focus on a new TRAILS manual and associated professional development and resources for providing evidence-based individual or group social-emotional support to students, either virtually or in-person. This manual complements resources traditionally offered to students experiencing depression or anxiety, but is recommended for use during the 2020-21 school year for any student who could benefit from strengthened coping skills to build resilience and effective self-care techniques.

Recommendation 3: Provide training and resources for family and community engagement teams

TRAILS recommends universal prevention and awareness training and accompanying resources for the DPSCD Family and Community Engagement team (FACE) to ensure this team is well-equipped to talk with families and community members about mental illnesses and evidence-based mental health practices. TRAILS has already initiated work with the FACE director to determine which training topics should take priority and the most appropriate training delivery strategies. FACE staff may also be trained to offer caregiver workshops and supplied with materials to distribute to parents and families. Finally, TRAILS may also prepare materials (e.g. informational packets, phone scripts) for the FACE team, as needed.



Recommendation 4: Provide training for all staff in effective self-care strategies

Educators and school staff face a number of stressors that impact their mental health and ability to perform, including high job demands, insufficient time and resources, and large student caseloads or class sizes with many students struggling with complex trauma and unmet needs. High-stress work environments can negatively impact employee wellness and productivity across industry settings. In schools, workplace stress can lead to teacher burnout, exhaustion, and compassion fatigue; resulting in both reduced effectiveness of instructional practices and high rates of turnover. Emotional exhaustion in teachers also negatively impacts the quality of their relationships with students, while greater teacher well-being is associated with better student well-being and fewer student psychological difficulties.⁵⁹

A significant number of DPSCD teachers, staff, and administrative leaders reported work exhaustion or burnout and an interest in learning effective strategies to manage their own self-care. Training in effective self-care techniques is therefore recommended for all school staff to help build resiliency for managing and overcoming stress, improve work performance, and benefit the whole-school climate and culture.

To support this recommendation, TRAILS is able to provide training in self-care that includes recognizing signs of burnout among school staff and evidence-based strategies for supporting one's own mental and emotional wellness, while promoting a culture of resilience and support throughout DPSCD.

Recommendation 5: Implement programming to improve awareness and understanding of mental illnesses among students

Despite the benefits of early identification and treatment of mental illnesses, stigma and lack of understanding are top reasons that prevent students from seeking help for mental health issues even when services are available. Peer-based programming can be successful in increasing knowledge, decreasing stigma, and increasing help-seeking, while also providing student participants with opportunities for pro-social engagement and school connection, both protective factors for mental health. One award winning example of this is the Peer-to-Peer Depression Awareness Program, an evidence-based program that educates middle and high school students about mental illnesses and supports them in finding creative ways to convey this knowledge to their peers.

Given the unique needs of DPSCD students, it is important that programming capitalize on the District’s youth voices and engage students directly in program design and implementation, while adhering to evidence-based practices. Therefore, introduction of

a peer-based, student-driven/adult-guided education and stigma reduction program to improve the school climate around mental health, direct students to resources, and encourage help-seeking behavior is recommended.

To support this recommendation, TRAILS is able to provide access to its training content and support to aid the adaptation and implementation of the U-M Depression Center’s Peer-to-Peer Depression Awareness Program, in order to equip student teams with the knowledge and skills needed to create safe and effective mental health awareness campaigns. Through this partnership, TRAILS can better support common language around mental health for all those involved in the school community.

Tier 2: Early Intervention for Students Who Are Struggling

Recommendation 6: Build school mental health professional expertise in evidence-based mental health care approaches

Access to evidence-based mental health care including CBT and mindfulness has been demonstrated to improve a range of health outcomes for students impacted by mental illness, including a reduction in high-risk behaviors, self-harm, or behaviors leading to school disciplinary action; and improved management of symptoms of mental illnesses, such as depression or anxiety.^{60, 61, 62} Additionally, access to these evidence-based practices helps students impacted by mental illness build resilience, more effectively control reactive impulses, and utilize adaptive coping strategies for managing difficult emotions. Improving access to evidence-based practices among students impacted by stress, trauma exposure, or mental illness is strongly recommended. To improve student access to these services, implementation of staff-led CBT- and mindfulness-based skills groups for students is recommended.

Additional training for school mental health professionals (e.g., school counselors, school social workers, psychologists) to deliver these skills groups is crucial for successfully expanding access to evidence-based services. However, typical professional development and clinical training opportunities are often unsuccessful because they lack adequate implementation support.^{64, 65, 66, 67} Therefore, TRAILS recommends clinical training for school mental health staff in CBT and mindfulness, followed by additional implementation and fidelity supports, including access to high quality clinical resources, technical support, and personalized skill-building opportunities.

To support these recommendations, TRAILS offers clinical training and implementation support assistance to build competency among school mental health professionals in evidence-based mental health techniques, including CBT and mindfulness. Following a full-day training in core concepts of CBT and mindfulness, school mental health professionals would have access to the following TRAILS implementation supports:

- **Clinical resources:** To support implementation of evidence-based practices with students, TRAILS has developed comprehensive skills-based student group manuals as well as stand-alone resources on effective ways to manage symptoms of depression, anxiety, and stress. All group manuals and accompanying resources are available on the TRAILS website. Additional resources include handouts, worksheets, activity guides, and videos that support student skill learning and practice.
- **Coaching:** To continue strengthening their clinical skills, school mental health professionals are paired with a CBT expert from their community who has been trained to support the application, practice, and sustainment of new clinical skills through live coaching. Coaching is typically delivered in the schools during co-delivery of the recommended student skills groups, so as to maximize efficiency and provide personalized training in a naturalistic setting, but may be delivered virtually during COVID-19 school closures.

- **Technical support:** Mental health professionals at partner schools have access to a TRAILS clinical expert who can answer questions about best-practice delivery of student mental health supports, particularly using TRAILS materials, during weekly office hours. They also receive regular newsletters highlighting key concepts, updates to materials, and advanced practice trainings, as needed.



Due to COVID-19, implementation of CBT groups with live coaching are recommended to begin during the school year of 2021-22. Delivery of wellness support groups to students using the new TRAILS manual referenced under Tier 1 recommendations is encouraged instead, as the need for mental health support is anticipated to be significant districtwide.

Recommendation 7: Promote timely and accurate identification of mental health concerns in students

Identification of mental health concerns in students remains a challenge in the classroom setting. While educators are often the first to observe students who may be struggling, they typically receive little to no training in recognizing symptoms of unhealthy stress or mental illness. DPSCD staff reported witnessing and experiencing challenging student behaviors, many of which can be manifestations of student trauma exposure, stress, anxiety, or depression. Therefore, training for staff, especially classroom instructional staff, in recognizing mental health concerns in students and applying trauma-informed classroom practices is recommended.

To support this recommendation, TRAILS offers training for school staff and teams designed to build knowledge of how untreated mental health concerns can present in a school setting, as well as how staff can best respond to those concerns to support optimal student engagement and performance.

Tier 3: Suicide Risk Management

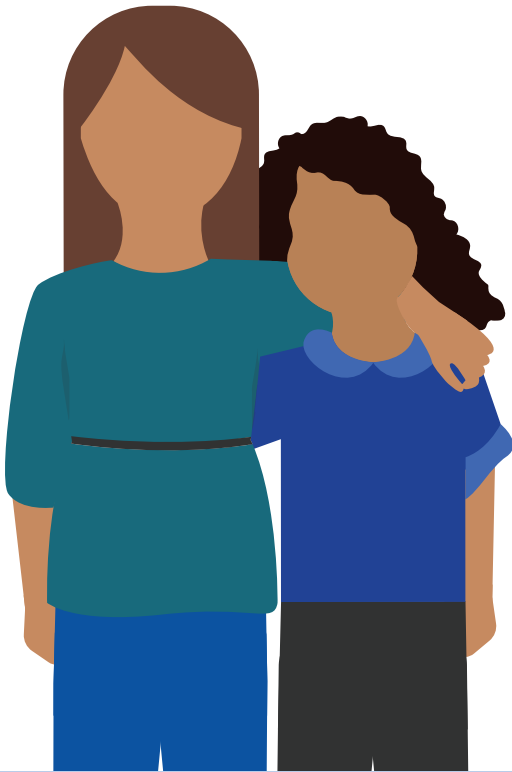
Recommendation 8: Improve student suicide risk identification and referral

A primary advantage of school-delivered mental health services is that staff can readily observe students and recognize quickly when a student needs additional support. However, a lack of available staff training or adequate resources to support proper identification of students at highest risk limits the effectiveness of many student risk management protocols.

TRAILS offers a number of strategies to support accurate and timely identification and management of students at risk of suicide:

- **TRAILS Student Risk Referral and Communication Tool:** The TRAILS Student Risk Referral and Communication Tool is a standardized referral form that outlines the specifics of a student’s risk of suicide, including the presence of suicidal ideation, plans, and intent. Completion of the tool is paired with administration of the Columbia Suicide Severity Rating Scale,⁶⁸ a validated suicide risk screening measure, as well as parent or caregiver release of information documentation, and the form may be subsequently shared with treatment providers outside of the school setting (such as in an emergency room or inpatient setting). The tool also facilitates communication of individualized recommendations back to the school after external providers have assessed and/or treated the student.

- **Gatekeeper training:** SafeTalk, Applied Suicide Intervention Skills Training (ASIST), and similar suicide awareness and prevention trainings teach staff to notice suicide risk and respond effectively. SafeTalk provides detailed information appropriate for any staff member in a school system, within the scope of a half-day training. ASIST is an in-depth training geared towards school mental health professionals. Over the course of 2 days, ASIST provides hands-on learning focused on acknowledging suicide risk and safety planning in the context of a supportive and engaged interaction.



Monitoring and Data Collection

Recommendation 9: Engage in ongoing program evaluation

TRAILS recommends routine data collection in order to understand the needs of staff, administrators, families, and students; and to evaluate the implementation, fidelity, and effectiveness of programming and staff professional development. In some cases, sampling may be used to collect representative data across the District while minimizing school burden. To support data collection and rigorous program evaluation, TRAILS offers the combined expertise of their own clinical and research staff as well as the expertise of the Youth Policy Lab – an established partner of both TRAILS and DPSCD, with additional experience in the use of data to inform and advocate for policy changes that benefit schools and communities.

With ongoing data collection and program evaluation, TRAILS, the Lab, and DPSCD can continuously monitor the impact of their partnership and can revise and improve plans as needed to ensure optimal and timely programming that is appropriate and responsive to the most pressing community needs.



Conclusion

Meeting the needs of students struggling with mental health challenges is not impossible. Community schools can provide tiered services to intervene at any stage of a mental health struggle or illness. School staff can be equipped with knowledge and skills based in evidence and can provide effective supports to their students academically, socially, and emotionally. Students can learn foundational and helpful skills that can prevent the onset or progression of mental illness and will benefit them throughout their lifetime. It is imperative that schools and staff receive the support they need to lift their students up and help them not only succeed, but also thrive.

TRAILS, the Lab, and DPSCD will continue to work collaboratively to build the District’s capacity to provide school-based mental health supports that are responsive to the needs identified in this report. This next chapter of work would not be possible without the generous financial support of our partner foundations and sponsors who are committed to improving the lives of youth in Detroit; and so to them, and to all of the DPSCD community, we offer our most sincere appreciation and gratitude.

Appendix

Methodology

Survey Instrument

TRAILS and the Lab worked together to develop a number of survey instruments including surveys for students, administrative leaders, teachers, and support staff in DPSCD schools, as well as families and members of the DPSCD police department. Each survey varied in number of questions ranging from about 50-75 and was predominantly organized by topic. Some questions overlapped across staff surveys and others were population specific. In general, topics for staff surveys included: perception of students’ needs; current state of student mental health and factors impacting mental health in schools; school programming availability and perspectives; self-reported burnout/ exhaustion; beliefs (stigma) about mental health; school climate measures; professional development needs, barriers, and motivators; and demographic information.

The student survey also included questions about perception of students’ needs; current state of mental health and factors impacting mental health in schools; school programming availability and perspectives; and beliefs about mental health. The student survey also included commonly used screener questions for depression (PHQ-9) and anxiety (GAD-7), as well as questions about adverse childhood experiences (ACEs), suicidal ideation, and mental health coping skills. Finally, the student survey included items related to student engagement in school.

Data Collection

Staff Surveys

A survey of nearly all school staff in DPSCD was conducted between June 7 and June 28, 2019. Links to the web-based survey were sent by the DPSCD superintendent’s office to approximately 5,000 school administrative, support, and instructional staff identified by the District. Staff who completed the survey were sent a \$10 gift card and were entered into a raffle for a chance to win 1 of 5 \$100 gift cards. All surveys were voluntary and anonymous. When the survey closed, there were 3,908 responses, of which 331 took the school administrator survey, 2,797 took the instructional staff survey, and 780 took the support staff survey.

Surveys came from 79 schools in the District in addition to some responses from central office staff. Our overall number of completed surveys corresponds to approximately a 79% response rate among all eligible staff in the District. Surveys that were less than 50% completed were dropped from analysis. Our analytical sample of 3,480 staff survey equates to approximately a 66% response rate among all eligible staff in the District.

Student Surveys

A survey of students in grade 8 and above was conducted between October 7 and December 20, 2019, the last day of classes before the District’s winter break. Parents and guardians were provided the opportunity to opt their students out of the survey prior to October 7th. These opt-outs and the other technical aspects of survey administration were managed by school staff with support from DPSCD central office staff. District personnel coordinated the survey effort with building assessment coordinators. Schools were encouraged to administer the survey to all eligible students by central office leadership. In addition, TRAILS established five \$2,000 prizes for schools with the highest response rates.

Response rates for each school were calculated using the number of students who were broadly eligible to take the survey (in 8th grade and above), the number of opt-outs reported to the District by each building level coordinator, and the number of surveys received from that school based on student reports within the survey itself.

When the survey closed, there were 12,794 responses to the survey of which 2,047 were less than 50% completed and dropped from analysis. Our final analytical sample of 10,747 survey responses equates to a 64% response rate among eligible DPSCD students. Approximately 90% of eligible school buildings (schools with at least an 8th grade class) participated in the student survey.

Family Survey

A survey of family members of DPSCD students was conducted from January 8, 2020 to January 31, 2020. Families were invited to fill out a brief, anonymous online survey. Respondents were entered into a drawing for a \$100 gift card. A total of 808 family members completed the survey. The survey was distributed by DPSCD, and families were told about the survey through several channels, including emails, phone calls, and text messages.

Police Survey

Our initial staff survey was intended to capture the opinions of school police and security personnel. However, 2 issues arose. First, very few building security staff responded to the survey. Second, school police were not included in District email lists to which the survey was sent. To address this, the TRAILS team developed a stand-alone survey for school-based police personnel. The survey was shared by the DPSCD Police Department Chief of Police Ralph Godbee with all police in his agency, including 78 police officers who patrol schools and 43 campus police officers as well as investigators, the executive command team, and security officers.

During the 3-week window that the survey was open, from February 10, 2020 – March 6, 2020, 42 officers responded to the survey. Of those who responded, 29% (n=12) were stationed in schools. Of those 12, 9 were campus-based police officers.

Analysis

Quantitative Analysis

The majority of survey items were analyzed using Stata by staff at the the Lab. Exceptions to this include the open-ended text field at the end of each survey (see section on Qualitative Analysis) and the family surveys. Due to the immense amount of information collected and project priorities, the bulk of the analysis for this report has focused on descriptive analysis and bivariate analysis. Future analysis will include more complex analyses into specific questions raised by DPSCD or that emerge from these analyses.⁶⁹

Where possible, the survey used already validated measures and survey items from other national studies.

Qualitative Analysis

The questionnaires included an open-ended text field providing DPSCD staff, students, and families to respond to the prompt, “What comes to mind when you think about the mental health of students in your school?” A large majority of staff (82%) chose to respond to this question — a demonstration of the importance of the topics of mental health within DPSCD. For the student population the number was somewhat lower, with 892 (8%) entries in the open-ended text field. Over half of respondents on the family survey chose to answer this question, with 409 text entries, representing 51% of total respondents.

The thematic analysis of the qualitative data involved a careful reading of 10% of the narrative data with the goal of identifying text sharing the same ideas. Through this in-depth reading and collaboration between team members, a coding rubric was developed that depicted various codes accompanied by detailed descriptions, as well as inclusion and exclusion rules. Team members received training on the application of the coding rubric that entailed a discussion and examples of narrative data. Confidence in using the rubric as intended was further created by a reliability test/assignment that included a coding of another 10% of the narrative data that was finally compared to the master code developed by the team leaders.

Interrater agreement of 75% or higher was achieved before the coders could move on with coding the

This included measures related to perceptions of leadership orientation borrowed from the medical field (Implementation Leadership Scale), mental health screeners (the General Anxiety Disorder-7, Patient Health Questionnaire), measures used by the US Department of Education on the Education Longitudinal Study of 2002, measures of stigmatized views of mental health issues (Opening Minds Campaign/Mental Health Commission Canada),⁷⁰ school climate items from the University of Chicago Consortium on School Research,⁵⁸ measures of Adverse Childhood Events,⁴⁵ and measures of staff burnout (Oldenburg Burnout Inventory).^{71,72}

remaining data. Excel was used for the final coding of the narrative data that took place from August 2019 to February 2020. Other coding of open-ended question options (e.g., responses to “Other, please specify” questions) was conducted primarily in Stata, with some additional coding conducted in Excel.

Finally, the voices of the DPSCD staff depicted a variety of themes predominantly including: mental health is problematic in schools; the need for support for students, families, and staff; the lack, or need of, resources; students’ needs for training and or coping skills; insufficient staff; behavior issues; the negative impact on academic achievement; stigma; that mental health needs prioritization; and more.

Similarly, students and families frequently stressed mental health concerns in general; academic pressure; stress; depression; and anxiety, in particular. Students also voiced the feeling that adults or the school do not care about them, that they need more support or resources, and that mental health is stigmatized.

Throughout this report, we report percentages based on the number of individuals that responded to a given item on the survey. In some cases, the n indicates the maximum number of respondents to a multi-question survey construct. In some cases, percentages do not add up to 100% due to rounding.

Limitations

Student Surveys

- Data collection was interrupted after gathering 935 survey responses due to a front-end code in the online survey that triggered security measures created to meet standards of the Children’s Internet Protection Act. The problem was noticed after a substantial number of surveys stopped at a specific point within the survey. The interruption likely created duplicates, however, identification of those duplicates was not possible because of the anonymous nature of the survey.⁷³
- Reading level was made as low as possible while keeping validated measures intact. However, many students in the District read below grade level,⁷⁴ and some items, especially longer items, may have been challenging for students.
- Students with the lowest reading levels, or who are not independent readers, may have been completely unable to engage with the survey independently. Research suggests these populations may be among some of the most in need of mental health support services. Given technical, temporal, and financial constraints, these important voices were likely left out of the survey.
- Chronic absenteeism is a problem in DPSCD. We also know that chronic absenteeism is, in part, a consequence of higher ACE scores, depression, anxiety, and suicidality. As a result, our survey may not have accurately captured the extent to which students in DPSCD are facing mental health issues, because chronically absent students may have been absent on days the survey was conducted. Thus, our survey results may indicate lower scores for ACEs, PHQ-9, and GAD-7 than actually experienced in the wider Detroit student population.

All Other Surveys

- There was no precise way for identifying or removing duplicate responses in any of the surveys.
- Because of confidentiality, we did not ask administrative staff to report the school at which they work since we thought this might discourage leadership, in particular, from responding.

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16. Demographic questions were included as the last section of the survey and as many as 14% of students may not have made it through to the end of the survey to answer these questions.

17. LGBTQIA+ here includes all respondents who selected any of the following: "gay or lesbian" (n=300), "bisexual" (n=769), "pansexual" (n=148), "asexual"(n=103), "queer"(n=33), or "questioning or unsure" (n=243).

18. Multiracial includes any respondent who selected more than two of the above categories, who wrote in that they were multiracial in the "other" field, or who typed in multiple responses to the "other field."

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