Achieving Lifelong Payoffs for Displaced Children through Investments in School Health Services

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Children's Defense Fund
NEW YORK

CDF Mission Statement

The Children's Defense Fund Leave No Child Behind® mission is to ensure every child a *Healthy Start, a Head Start, a Fair Start, a Safe Start, and a Moral Start* in life and successful passage to adulthood with the help of caring families and communities.

CDF provides a strong, effective and independent voice for all the children of America who cannot vote, lobby or speak for themselves. We pay particular attention to the needs of poor and minority children and those with disabilities. CDF educates the nation about the needs of children and encourages preventive investments before they get sick, drop out of school, get into trouble or suffer family breakdown.

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Executive Summary

New York City's (NYC) ability to maintain its economic viability and stature will depend on the success of future generations. Policy makers must ensure that children who learn and grow-up in NYC and remain there as adults are able to meet future workforce demands. To that end, policy makers should focus on raising the ground floor by supporting the needs of children living in NYC who are most at risk of failing in school.

Some of the most at-risk children in NYC are children who have been displaced from their homes or families due to homelessness or resettlement as unaccompanied immigrant children. While homeless and unaccompanied immigrant children have been displaced from their homes or families for different reasons, both groups of children often have remarkably similar experiences and needs. For example, studies have consistently found that homeless and immigrant children have greater health needs and poorer health outcomes than their peers.

Addressing the health needs of displaced children will improve their health outcomes and likelihood of success in school and life. Moreover, the payoff does not end there. New economic research has found that improving health outcomes improves economic output. One study noted that improving life expectancy by a single year increases gross domestic product (GDP) by as much as 4 percent. Accordingly, improving health outcomes for displaced children in NYC will also improve economic outcomes in NYC.

A review of current research and NYC school administrator survey responses collected by the Children's Defense Fund – New York (CDFNY) identified gaps in key services that benefit displaced children. For example, 84 percent of school administers who responded to the survey indicated that they continue to refer students with disruptive behaviors to the emergency room. This indicates that preventative mental and behavioral health services in the school setting may still be lacking. In order to address these gaps and others, CDFNY recommends the following policy changes to improve health, school, and lifelong outcomes for displaced children:

- Expand school-based health centers (SBHCs) in medically underserved areas;
- Allow SBHCs to serve as health homes in the Medicaid and Child Health Plus programs;
- Increase support for teachers to implement PBIS in the highest need school districts; and
- Expand access to after-school and weekend meal services in the highest need school districts.

Introduction

Investing in At-risk Children

New York City (NYC) is one of the most economically powerful cities in the world. The United Nations City Prosperity Initiative (CPI) produces an annual report that consistently notes NYC ranks near the top when it comes to economic output per capita—ahead of the most prosperous world class cities.[1] NYC's economic prowess contributes to its reputation as a financial, media, and cultural mecca. NYC's ability to maintain its economic viability and stature will depend on the success of future generations.

In the coming years, cities across the United States will face economic and demographic challenges as baby boomers continue to age. A measure referred to as "old age dependency" calculates the ratio of retirement age individuals to working age individuals. The measure is intended to indicate the economic pressure an aging population exerts on working age individuals. While old age dependency is rising across the US, NYC is better positioned than other cities to relieve some of the demand by relying upon the scores of young working age domestic and international migrants that come to the city every year.[2]

However, reliance on in migration alone is unlikely to be enough, as a closer look at the data reveals that NYC faces net migration losses.[3] This means that investing in the success of children is not only a moral imperative, but is also necessary to remain economically competitive. Policy makers must ensure that children who learn and grow-up in NYC and remain there as adults are able to meet future workforce demands. To that end, policy makers should focus on raising the ground floor by supporting the needs of children living in NYC who are most at risk of failing in school.

Displaced Children in NYC

A variety of risk factors play a role in shaping a child's academic and lifelong outcomes. While not determinative, these factors can create obstacles or trajectories that make it more difficult for children to succeed. Risk factors include economic hardship, residential mobility, residing in a household without English speakers, and immigration status.[4]

Some of the most at-risk children in NYC are children who have experienced homelessness and unaccompanied immigrant children. While homeless and unaccompanied immigrant children have been displaced from their homes or families for different reasons, both groups of children often have remarkably similar experiences and needs. For example, many of these children have lived in

[1] The New School, 2030 Agenda and New York City – Draft Report: Measuring New York's Performance on UN Habitat's City Prosperity Index. 2017. Available from: http://cpi.unhabitat.org/sites/default/files/resources/NYC%20CPI%20Final%20Report_TNS_2017.pdf.

[2] The New School.

[3] NYC Planning. Who Migrates to and From NYC? 2017. Available at: https://nycplanning.github.io/labs-migration-viz/#age.

[4] Child Trends. High School Dropout Rates: Indicators of Child and Youth Well-Being. 2015. Available at: https://www.childtrends.org/wp-content/uploads/2015/11/01_Dropout_Rates.pdf; and National Center for Children in Poverty. Young Children at Risk: National and State Prevalence of Risk Factors. 2012. Available at: http://www.nccp.org/publications/pdf/text_1073.pdf.

impoverished conditions,[5] are sick more often than their peers,[6] are more likely to have suffered abuse than their peers,[7] and are more likely to have witnessed violence than their peers.[8]

Moreover, studies have consistently found that homeless and immigrant children have greater health needs and poorer health outcomes than their peers.[9] Meeting the health needs of homeless and immigrant children is often complicated by lower health insurance coverage rates and poorer access to health care and related services.[10] The lack of health coverage and access to care and services often creates barriers to learning that inhibit later success.[11] Accordingly, if the needs of these children remain unmet, these children will be more likely to struggle academically and later in life.

The number of children in NYC displaced due to either homelessness or resettlement as unaccompanied immigrant children has grown in recent years. The Institute for Children, Poverty & Homelessness found that nearly 140,000 NYC students in school year 2015-16 were homeless, and that if trends continue 1 in 7 children will be homeless at some point during elementary school.[12] With regard to unaccompanied immigrant children, data from the Office of Refugee Resettlement show that around 6,000 unaccompanied immigrant children have settled in NYC since October 2013.[13]

Improving Outcomes for Displaced Children

While the challenges of displaced children in NYC may be severe, many policy solutions can improve the odds of lifelong success for these children. For example, children with access to health care have better school attendance,[14] perform better in school,[15] have higher graduation rates,[16] are more likely to

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[5] Council on Community Pediatrics. Providing Care for Children and Adolescents Facing Homelessness and Housing Insecurity. Pediatrics 2013; 131; 1206. Available at: http://pediatrics.aappublications.org/content/pediatrics/131/6/1206.full.pdf; and Fordham University School of Law and Vera Institute of Justice. Unaccompanied Immigrant Youth in New York: Struggle for Identity and Inclusion—A Participatory Action Research Study. 2015. Available at: https://www.fordham.edu/download/downloads/id/2416/unaccompanied_immigrant_youth_in_new_york_august_2015.pdf.

[6] Council on Community Pediatrics; and Fordham University School of Law and Vera Institute of Justice.

[7] Council on Community Pediatrics; and Fordham University School of Law and Vera Institute of Justice.

[8] Council on Community Pediatrics; and Fordham University School of Law and Vera Institute of Justice.

[9] Council on Community Pediatrics; and Fordham University School of Law and Vera Institute of Justice.

[10] Council on Community Pediatrics; and Fordham University School of Law and Vera Institute of Justice.

[11] Child Trends. Health Insurance Coverage Improves Child Well-Being. 2017. Available at: https://childtrends-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/2017-22HealthInsurance_finalupdate.pdf.

[12] Institute for Children, Poverty & Homelessness. On the Map: Atlas of Student Homelessness in New York City 2017. Available at: *http://www.icphusa.org/new_york_city/map-atlas-student-homelessness-new-york-city-2017/*

[13] U.S. Department of Health & Human Services, Office of the Administration for Children & Families, Office of Refugee Resettlement. Unaccompanied children released to sponsors by state. Available at: http://www.acf.hhs.gov/programs/orr/programs/ucs/state-bystate-uc-placed-sponsors.

[14] Keeton et al. School-Based Health Centers in an Era of Health Care Reform: Building on History. *Current Problems in Pediatric and Adolescent Health Care*, *42*(6), 132–158. 2012. Available at: http://doi.org/10.1016/j.cppeds.2012.03.002.

[15] Keeton et al.

[16] National Bureau of Economic Research. The Effect of Child Health Insurance Access on Schooling: Evidence from Public Insurance Expansions. 2014. Available at: http://www.nber.org/papers/w20178.pdf.

attend college,[17] are less likely to need public assistance,[18] and are more likely to have greater lifetime earnings than their peers.[19] Accordingly, improving access to health care and related services for homeless children and unaccompanied immigrant children will increase the likelihood of their success in school and ability to meet future workforce demands.

The purpose of this report is to identify policy recommendations that will help meet the health needs of displaced children and improve their lifelong outcomes. To accomplish this goal, the report will examine how providing health care and related services in schools can help overcome disparities in access to care in the community, and meet the needs of displaced children. The report will also identify some of the current programs and services available in NYC schools that address the needs of displaced students. To help evaluate whether available programs and services are sufficient, the report will analyze the results of a school health services survey delivered to NYC school administrators at schools located in high need districts. After reviewing the survey results, the report will make policy recommendations to improve upon existing infrastructure in NYC schools.

Key Terms and Definitions

This report will focus on the needs of and services for displaced children because of their growing numbers in NYC. Children may be displaced from their homes or families for a variety of reasons including divorce, eviction, foster care placements, immigration, lack of affordable housing, or natural disasters. The term "displaced children" as used in this report refers to children who are homeless due to a lack of household income—as indicated by living at or below the federal poverty level— and unaccompanied immigrant children.

The term "health" as used in this report refers to physical health, mental health, and behavioral health, unless otherwise specified.

Background

Focusing on Health

Health is about more than the absence of disease. Health is a resource that helps children develop the capacity to become successful in school and contributes to their economic success later in life. Healthier children and adults have more energy, better concentration,[20] and greater productivity than their peers.[21] Countries with the best health outcomes typically have greater wealth and less income inequality than countries with poorer health outcomes.[22] Formative research on the impact of health on economic

[17] National Bureau of Economic Research. 2014.
[18] National Bureau of Economic Research. Medicaid as an Investment in Children: What Is the Long-Term Impact on Tax Receipts? 2015. Available at: http://www.nber.org/papers/w20835.pdf.
[19] National Bureau of Economic Research. 2015.
[20] The Commonwealth Fund. Health and Productivity among US Workers. 2005. Available at: http://www.commonwealthfund.org/usr_doc/856_Davis_hlt_productivity_USworkers.pdf.
[21] Bloom et al. The Effect of Health on Economic Growth: A Production Function Approach. 2004. Available at: http://www.bvsde.paho.org/bvsacd/cd46/effect.pdf.
[22] Center on the Developing Child at Harvard University. The Foundations of Lifelong Health Are Built in Early Childhood. 2010. Available at: http://www.developingchild.harvard.edu.

growth found that improved health outcomes yield economic growth. Specifically, studies have found that an increase in life expectancy by one year could increase GDP by 4 percent.[23] To put this in context, the US economy has not produced a 4 percent annual increase in GDP since the year 2000.[24]

Specific Health Needs of Displaced Children

Improving the health of displaced children requires more than ensuring basic needs such as health coverage and access to care are met. Available care and services should address the specific health needs of displaced children. The following subsections will outline some of these needs.

Health Needs of Homeless Children

Homeless children are more likely to develop certain health conditions and have poorer health outcomes than their housed peers. For example, homeless children are at increased risk for numerous diseases, including asthma[25] and gastrointestinal disorders.[26] Homeless children are twice as likely to experience hunger[27] and more likely to have dental caries.[28] Although homeless children have greater health needs, they are less likely to have a regular health care provider and more likely to use an emergency department for care.[29]

The mental and behavioral health needs of homeless children are also well documented. Homeless children report higher rates of depression, anxiety, and substance use.[30] Homeless children are also 50 percent more likely to have a psychiatric disorder,[31] and homeless adolescents are at significant risk for suicide and suicidal ideation.[32] Many of the mental and behavioral health needs of homeless children are a result of increased stress from the lack of a stable home environment. Stressors may include unsafe or unsanitary sleeping conditions, lack of regular meals, exposure to violence, and suffering sexual or physical abuse. By middle school, "83 [percent] of homeless children have witnessed serious violence

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[23] Bloom et al.

[24] World Bank. GDP Growth (annual %): United States. 2017. Available at: https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=US.

[25] Hwang et al. Interventions to Improve the Health of the Homeless. Am. J. Pre. Med. 2005; 29(4): 311-319. Available at: http://homelesshub.ca/sites/default/files/Systematic_Review_(AJPM).pdf.

[26] University of Minnesota Extension. Risk and Resilience in Homeless Children. 2013. Available at: http://www.extension.umn.edu/family/cyfc/our-programs/ereview/docs/April2013ereview.pdf.

[27] University of Minnesota Extension.

[28] Council on Community Pediatrics.

[29] United States Interagency Council on Homelessness. Ending Family Homelessness, Improving Outcomes for Children. 2016. Available at: https://www.usich.gov/resources/uploads/asset_library/Impact_of_Family_Homelessness_on_Children_2016.pdf.

[30] Edidin et al. The Mental and Physical Health of Homeless Youth: A Literature Review. 2012 Jun; 43(3): 354-75; and Rhode et al. Depression, Suicidal Ideation and STD-related Risk in Homeless Older Adolescents. J. Adolesc. 2001 Aug; 24(4): 447-60.

[31] University of Minnesota Extension.

[32] Yoder, Longley, Whitbeck, and Hoyt. A Dimensional Model of Psychopathology among Homeless Adolescents: Suicidality, Internalizing, and Externalizing Disorders. J Abnormal Child Psych. 2008. 36(1): 95-104. 2008; and Yoder, Whitbeck, and Hoyt. Dimensionality of Thoughts of Death and Suicide: Evidence from a Study of Homeless Adolescents. Social Indicators Research. 2008. 86: 83-100.

and 25 [percent] have witnessed intimate partner violence."[33] Homeless children are also more likely to have an incarcerated parent.[34] Many of these factors are considered adverse childhood experiences that may increase the likelihood of poor physical health outcomes in adulthood.[35] Finally, increased stress from the lack of a stable home environment can result in homeless children acting out in disruptive behavior that impacts relationships with teachers and other students.[36]

Health Needs of Unaccompanied Immigrant Children

Unaccompanied immigrant children are often fleeing the worst conditions in their home countries. These conditions may include poverty, extreme violence, abuse, and exploitation.[37] Unaccompanied children are more likely to have experienced more trauma than children accompanied by parents or caregivers. The trauma may have occurred both in their home country and on their journey to the United States. Children who travel alone are at greater risk of physical and sexual abuse.[38] Once in the United States, some children are settled with family members who may not be experienced or suitable caregivers. The lack of a supportive home environment for some children can exacerbate their underlying health needs as well as create new ones.[39]

As a result, considerable attention has been given to the mental health needs of unaccompanied immigrant children in an effort study levels of post-traumatic stress, anxiety and depressive symptoms linked to experiences of trauma. Research has shown that unaccompanied children face an elevated risk of post-traumatic stress symptoms and that self-reports of psychological distress are significantly higher than for accompanied refugee children living with family members and even higher than for normative populations.[40] Just like homeless children, unaccompanied immigrant children frequently have significant adverse childhood experiences, which research indicates are correlated with chronic physical and mental health conditions, including depression, substance abuse, diabetes, and heart disease.[41]

Lack of Access to Care

There are often a multitude of barriers that prevent displaced children from receiving adequate health care.[42] Many of these barriers are logistical, financial, and personal.[43] First, providers may be in parts of

[33] University of Minnesota Extension.
[34] University of Minnesota Extension.
[35] Felitti et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. Am J Prev Med. 1998; 14(4).
[36] National Center for Homeless Education. Supporting Homeless Children and Youth through Proactive and Positive Behavior Management and Intervention Practices. 2014. Available at: http://www.serve.org/nche.
[37] Fordham University School of Law and Vera Institute of Justice.
[38] Fordham University School of Law and Vera Institute of Justice.
[39] Fordham University School of Law and Vera Institute of Justice.
[40] Hodes et al. Risk and Resilience for Psychological Distress amongst Unaccompanied Asylum Seeking Adolescents. J Child Psychol Psychiatry. 2008 Jul; 49(7): 723-32.
[41] Hodes et al.
[42] Sulkowski and Michael. Meeting the Mental Health Needs of Homeless Students in Schools: A Multi-Tiered System of Support Framework. Children and Youth Services Review. 2014; 44: 145-51.
[43] Sulkowski and Michael.

NYC that are difficult to reach. In addition, because displaced children tend to live in families that are transient, going to the same clinic to receive services consistently may not be feasible. It may also be difficult to pay for transportation to these vital services.

Displaced children in NYC are also more likely to live in medically underserved parts of the city. School districts in NYC with the highest rates of poverty and the highest rates of English language learners (ELL) often overlap with medically underserved areas (MUAs) or areas with medically underserved populations (MUPs). In fact, the 10 school districts in NYC with the highest rates of poverty all have MUAs or areas with MUPs within their boundaries.[44] These same ten school districts also contain primary care shortage areas.[45] Moreover, nine out of the ten school districts in NYC with the highest ELL rates have MUAs or MUPs within their boundaries, and all ten districts contain primary care shortage areas.

MUAs and MUPs are defined by the Health Resource & Services Administration (HRSA), and are used to allocate federal funding to combat health workforce shortages.[46] MUAs "have a shortage of primary care health services for residents within a geographic area."[47] In New York City, the geographic area consists of a group of urban census tracts. MUPs, on the other hand, "are specific sub-groups of people living in a defined geographic area with a shortage of primary care health services."[48] The groups often include those who "face economic, cultural, or linguistic barriers to health care."[49] HRSA defines individuals who are homeless as a MUP.[50] Both MUAs and MUPs are determined based on "the population to provider ratio[,] the percent of the population below the federal poverty level[,] the percent of the population over the age of 65[,] and the infant mortality rate."[51] Despite decades of efforts to address shortages in MUAs and MUPs, the designations remain in numerous locations throughout New York City and the United States. Primary care shortage areas are similar to MUAs and are also defined by HRSA. Primary care shortage areas are areas where the population-to-provider ratio is at least 3,500 to 1.[52]

This means children living and attending school in the school districts with the highest poverty and ELL rates are less likely than their peers to have their health needs met in the community, outside of school.

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[44] Analysis of Health Resources & Services Administration. Data Warehouse, MUA Find. 2017. Available at: https://datawarehouse.hrsa.gov/tools/analyzers/muafind.aspx; and NYC Department of Education. Demographic Snapshot. 2017. Available at: http://schools.nyc.gov/Accountability/data/default.htm.

[45] Analysis of Health Resources & Services Administration. Data Warehouse, HPSA Find. 2017. Available at: https://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx; and NYC Department of Education. Demographic Snapshot. 2017. Available at: http://schools.nyc.gov/Accountability/data/default.htm.

[46] Health Resources & Services Administration. What Is a Shortage Designation? 2017. Available at: https://bhw.hrsa.gov/shortage-designation/what-is-shortage-designation.

[47] Health Resources & Services Administration. What Is a Shortage Designation?

[48] Health Resources & Services Administration. What Is a Shortage Designation?

[49] Health Resources & Services Administration. What Is a Shortage Designation?

[50] Health Resources & Services Administration. What Is a Shortage Designation?

[51] Health Resources & Services Administration. What Is a Shortage Designation?

[52] Kaiser Family Foundation. Primary Care Health Professional Shortage Areas. 2016. Available at: https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Further, poverty rates can serve as a proxy for homelessness as it typically correlates with homelessness and accounts for children at-risk of becoming homeless due to a lack of household income. Similarly, ELL rates can serve as a proxy for unaccompanied immigrant children because data on unaccompanied immigrant children are unavailable at the NYC school district level. Accordingly, children living in the districts with the highest rates of children likely to be or become homeless and the districts most likely to serve unaccompanied immigrant children are less likely than their peers to have their health needs met in the community, outside of school.

Schools Provide Optimal Settings for Health Services

Schools provide an optimal setting to overcoming the multitude of barriers that exist to accessing care for all students—not just homeless children and unaccompanied immigrant children.[53] Providing health services in schools allows children to meet their needs directly on the school campus, where they spent most of their time during the school year. School based services are particularly helpful for homeless children, who may be moving around a lot outside of the school day. Many students are also more likely to obtain services at school than off-campus. For example, research has shown that 96 percent of individuals who were referred for school-based counseling followed through, compared to only 13 percent of individuals referred for counseling in the community.[54] Additionally, the availability of mental health services in schools has also been linked to increased classroom participation, significant decline in disciplinary referrals, increased positive peer associations, and improved grades.[55] Better outcomes are not limited to mental and behavioral health services, children with access to school-based care for their physical health needs also have better school attendance and perform better in school.[56]

Services Available in NYC Schools

A multitude of services that have demonstrated favorable impacts on displaced children already exist at some level in NYC schools. The following subsections describe some of these services.

Positive Behavior Intervention and Supports (PBIS)

Stable, supportive school environments help homeless children develop self-control and self-regulation skills necessary to succeed in school and life. These skills facilitate strong relationships with their peers and teachers, and promote healthy behaviors beyond school walls. [57] Positive Behavioral Interventions and Supports (PBIS) is an evidence-based practice that provides the stable and supportive environments necessary to help homeless children succeed. According to the National Center for Homeless

[53] Keeton et al.

[54] Catron et al. Posttreatment Results after 2 Years of Services in the Vanderbilt School-Based Counseling Project. 1998. In M.H. Epstein et al. (Eds.) *Outcomes for Children and Youth with Emotional and Behavioral Disorders and Their Familes: Programs and Evaluation Best Practices*. 653-56. Austin, TX: PRO-ED, Inc.

[55] Citizens' Committee for Children of New York. A Prescription for Expanding School-Based Mental Health Services In New York City Public Elementary Schools. 2013. Available at: https://www.cccnewyork.org/data-and-reports/publications/a-prescription-for-expanding-school-based-mental-health-services-in-new-york-city-public-elementary-schools/.

[56] Keeton et al.

[57] National Center for Homeless Education. 2014.

Education's 2014 Research Summary, "PBIS incorporates four key components: (a) clearly defined desired outcomes, (b) proven research-based practices, (c) data-driven decision making for the selection, implementation, and monitoring of evidence based behavioral strategies, and (d) systems that support fidelity to implementation."[58] Accordingly, PBIS is not an intervention program, but rather a classroom-wide or school-wide framework.

The PBIS framework is designed to provide clear behavioral expectations, "positive and consistent classroom management practices, and frequent positive interactions with teachers."[59] While PBIS benefits all children, the framework can be particularly beneficial to homeless children who may have greater need for the approach. As a framework, PBIS can be used with a variety of other evidence-based programs and interventions that are consistent with the framework such as various social-emotional learning curriculums, and behavioral intervention and support models like Response to Interventions (RTI).[60]

Research demonstrates that the success of school-wide implementation of PBIS depends primarily on school leadership. School support for initial training, ongoing professional development, and data-driven decision making is paramount. While the New York State Department of Education has encouraged statewide implementation of PBIS, not all schools in NYC have implemented the framework.[61]

School Meal Services

NYC schools offer a variety of school meal services to meet the food and nutrition needs of their students. These services are particularly important for homeless children who are more likely to experience hunger. Apart from universal school lunch, which is being implemented for the first time in the 2017-18 school year, school meal services vary greatly at each school. School meal services other than school lunch may include breakfast, after-school meals, Saturday meals, and summer meals.[62]

Bridging the Gap Social Worker Services

NYC Department of Education provides funding for 43 social workers to work with homeless students. The social workers schools offer counseling services and connect students to academic support services and other social services in the community. These services are critical to combat chronic absenteeism and improve child outcomes.

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[58] National Center for Homeless Education. 2014.

[59] National Center for Homeless Education. 2014.

[60] National Center for Homeless Education. 2014.

[61] New York City PBIS Technical Assistance Center Update: Adaptation, Alignment and Integration. National PBIS Leadership Forum. Oct 2011. Available at: www.pbis.org/common/cms/documents/Forum11.../E7_Moorthy.ppt.

[62] New York City Food Policy Center. The Public Plate in New York City. 2013. Available at: http://www.nycfoodpolicy.org/wp-content/uploads/2013/05/PUBLICPLATEREPORT.pdf.

NYC DOE Mental Health Services

Over the past several decades the DOE has undertaken efforts to infuse mental health services into the NYC public school system, even though large gaps remain. And most recently, ThriveNYC was launched in November 2015 to address the insufficient mental health services in NYC's public schools. It includes the expansion of community schools and the use of mental health consultants to provide training and referrals for the 900 school campuses that do not have any mental health resources. NYC also engages 219 school-based mental health centers (SBMHCs), 130 community schools, some mobile crisis teams and 23 mental health consultants to work with 210 schools.[63]

NYC School-Based Health Centers (SBHCs)

SBHCs are licensed medical facilities that provide primary care medical services, first aid services, and emergency services. Many SBHCs also provide other health services including mental health, dental, and vision services. NYC has approximately 145 SBHCs serving 345 schools, spread across all 5 boroughs. SBHCs are operated by sponsoring organizations in collaboration with the schools they serve. Sponsoring organizations are often hospitals, federally qualified health centers, or community based organizations. SBHCs are funded primarily through insurance reimbursement, federal, state and local grant funds, and private donations.[64]

Methodology

This project began with a literature review to gather background information regarding evidence-based health interventions that benefit displaced children. Upon completion of the literature review, CDFNY drafted a survey for school administrators in New York City (NYC). The survey solicited information regarding school-based health services for displaced children, as well as services available to the entire school.

To increase the likelihood of gaining survey data specific to health services available for displaced children, CDFNY chose to target delivery of the survey to school administrators in NYC school districts with the highest poverty and ELL rates. CDFNY chose to use poverty and ELL rates as a proxy for displaced children. School districts with higher poverty rates are more likely to have more children who are homeless or who are at risk of becoming homeless. School districts with higher ELL rates tend to have more immigrant communities, and are therefore more likely to be areas where unaccompanied immigration children are settled with other immigrant family members.

Accordingly, CDFNY identified the ten NYC school districts with the highest poverty rates and the ten NYC school districts with the highest ELL rates for school year 2016-17 by using the NYC Department

[63] NYC Department of Education. Available at: http://schools.nyc.gov/default.htm; and NYC Office of the Mayor. Available at: http://www1.nyc.gov/office-of-the-mayor/.

[64] NYC Department of Education. School-based health centers. http://schools.nyc.gov/Offices/Health/SBHC/SBHC.htm

of Education's Demographic Snapshot.[65] The analysis identified 16 total school districts, with four among those with the 10 highest poverty rates and the 10 highest ELL rates. Throughout this report, these sixteen NYC school districts will be referred to as "high need school districts."

Districts with Highest Poverty Rates		
District	**Neighborhoods and Borough**	**Poverty Rate**
12	Belmont, East Tremont, and Van Nest in the Bronx	93%
9	Grand Concourse, Morrisania, and Tremont in the Bronx	92%
7	South Bronx	92%
23	Ocean Hill, Brownsville, and parts of East New York in Brooklyn	91%
32	Bushwick and northern Bedford-Stuyvesant in Brooklyn	91%
8	Hunts Point, Throgs Neck, and Soundview in the Bronx	90%
4	East Harlem in Manhattan	89%
19	East New York in Brooklyn	89%
6	Northern Harlem, Washington Heights, and Inwood in Manhattan	87%
16	Bedford-Stuyvesant in Brooklyn	86%

Districts with Highest ELL Rate		
District	**Neighborhoods and Borough**	**ELL Rate**
6	Northern Harlem, Washington Heights, and Inwood in Manhattan	28%
20	Borough Park, Bay Ridge, Dyker Heights, and Fort Hamilton in Brooklyn	24%
9	Grand Concourse, Morrisania, and Tremont in the Bronx	23%
24	Corona, Ridgewood, Elmhurst, Maspeth, and Middle Village in Queens	22%
10	Riverdale, Wave Hill, Fordham, and Kingsbridge in the Bronx	20%
12	Belmont, East Tremont, and Van Nest in the Bronx	20%
32	Bushwick and northern Bedford-Stuyvesant in Brooklyn	19%
25	Flushing, College Point, and Whitestone in Queens	18%
30	Astoria, Jackson Heights, Long Island City, and Sunnyside in Queens	17%
21	Coney Island, Brighton Beach, and Bensonhurst in Brooklyn	17%

CDFNY delivered the survey by e-mail to school principals and community school directors in the 16 school districts. Periodically, CDFNY sent follow-up e-mails to the school administrators. School administrators responded to the survey anonymously. CDFNY analyzed demographic data from the

[65] NYC Department of Education. Demographic Snapshot. 2017. available at http://schools.nyc.gov/Accountability/data/default.htm.

responses to ensure duplicate responses were not submitted by a principal and community school director from the same school.

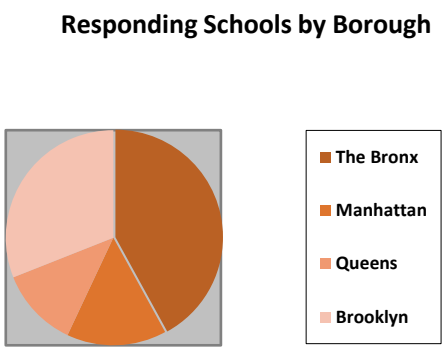
While the sample size in this study was not large enough to be statistically representative, the findings in this report are reflective of the experiences of the responding school administrators in high need NYC school districts. Accordingly, the survey responses are a useful way to analyze the available services in these schools, and whether the school administrators identified additional services that are needed.

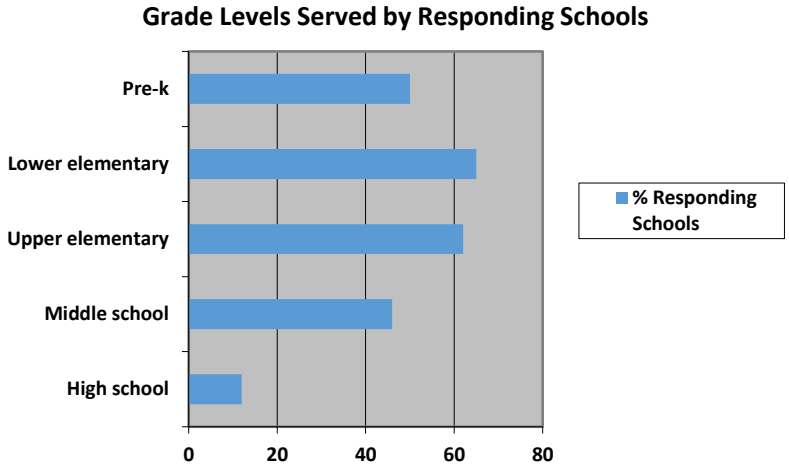
Findings

The school administrator survey covered a wide array of school health services addressing the needs of students in a holistic manner. The results demonstrate broad interest in expanding school meal services; increasing the number of school guidance counselors, psychologists, and social workers; and adding or expanding medical, behavioral, or dental services. The results also indicate additional support is needed to appropriately implement and support behavioral change models, particularly for teachers on the frontlines of implementation.

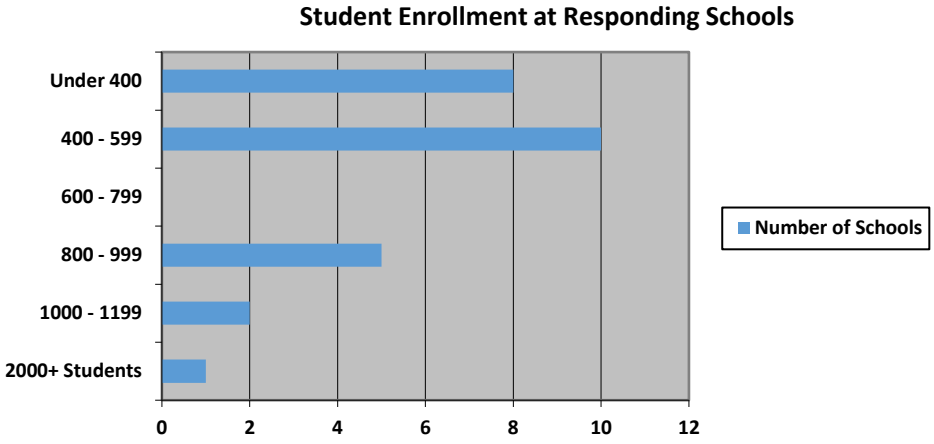
About the Schools

Administrators from 26 schools responded to the survey. CDFNY collected complete responses from 24 schools. Of the 26 responding schools, 4 were located in Manhattan, 11 in the Bronx, 3 in Queens, and 8 in Brooklyn. Seventeen responding schools served upper or lower elementary students (excluding pre-kindergarten), while 13 served pre-kindergarten students. Twelve responding schools served middle school students, while only 3 served high school students.



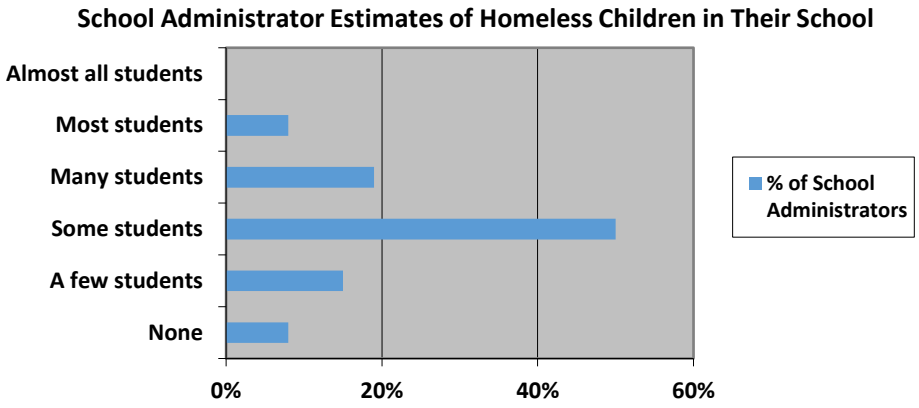


The size of the responding schools varied widely. The smallest school reported having 240 students, while the largest school had 4400 students. The median school size was 478 students. The median average class size was 27 students, while the averages reported ranged from 20 to 34 students.

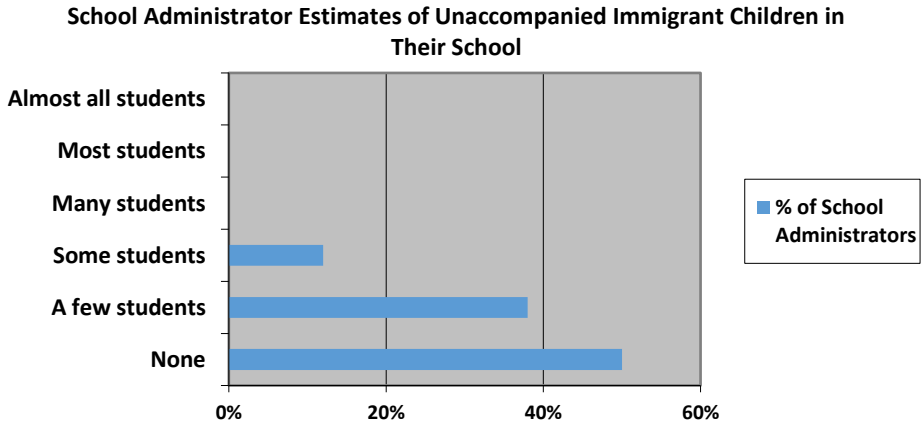


Respondents were asked to estimate the number of students who were homeless within the past 12 months. Ninety-two percent of respondents estimated that at least a few students in their school had been homeless in the past 12 months, and 77 percent estimated that more than a few of their students had been homeless. Alarmingly, 8 percent of respondents estimated that most of their students had experienced homelessness in the past 12 months. These results indicate that nearly all of the administrators at the responding schools are aware of at least several students in their school who had experienced homelessness in the past year.

Eighty-eight percent of the responding administrators also indicated that their schools had strategies to help them identify homeless students. The strategies ranged from relying on students and parents to self-report their housing status to administering parent surveys. Most of the responses appear to be consistent with NYC DOE Chancellor's Regulation A-101. A small number of respondents did not identify strategies, which suggests some administrators may benefit from continuing education related to homeless students.



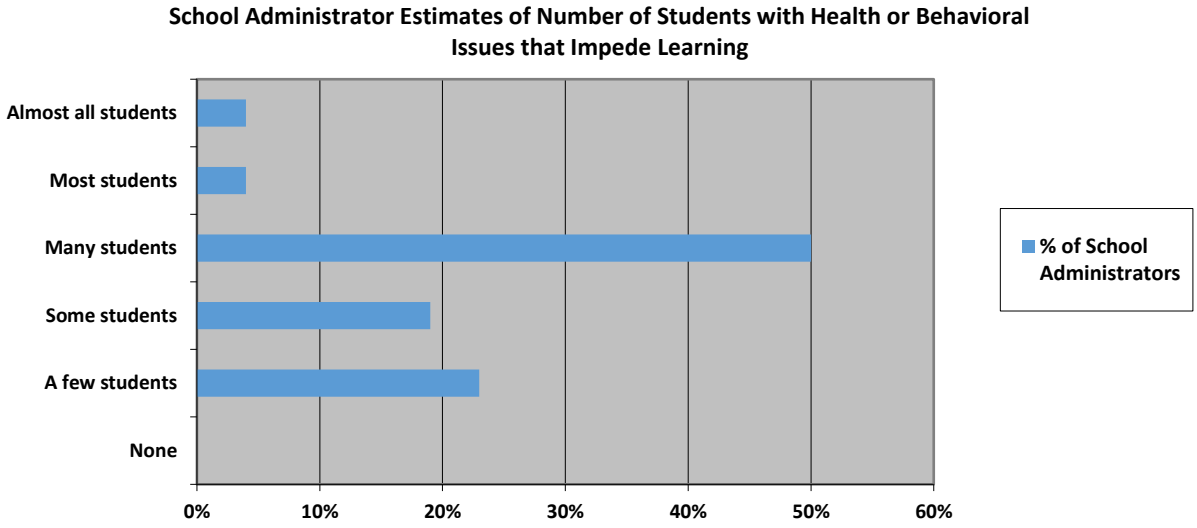
Respondents were asked to estimate the number of students who were unaccompanied immigrant children. Half of all respondents estimated that their schools did not have any unaccompanied immigrant children, while half said they had at least a few. The overwhelming majority of schools with reported unaccompanied immigrant children only reported having a few. These results are not surprising given: (1) the number of known unaccompanied immigrant children in New York City is only around 6,000 and the total number of children in the school districts surveyed is nearly 500,000,[66] and (2) immigrant families often do not share their immigration status freely. Only 8 percent of respondents indicated their schools had strategies to identify unaccompanied immigrant children. These responses are unsurprising as the information may be difficult for schools to track. Schools who did monitor this information relied on self-reports and immigration paperwork.



[66] Analysis of NYC Department of Education. Demographic Snapshot. 2017. available at http://schools.nyc.gov/Accountability/data/default.htm.

Mental and Behavioral Health Needs and Services Findings

More than 75 percent of respondents indicated that more than a few students in their school have mental health or behavioral issues that impede their own learning or the learning of others. In fact, 50 percent indicated that many students have mental health or behavioral issues that impede their own learning or the learning of others, and 4 percent described the level as "most students" and 4 percent described the level as "almost all students." Accordingly, the mental health needs in the responding schools appear to be significant. The needs in these schools are so severe that 84 percent of respondents stated that they had to refer at least a few students to the emergency department because of mental health or behavioral issues. These responses are a clear indication that the services available at the schools are insufficient to address the needs of several students at each school.



PBIS Findings

Ninety-two percent of respondents indicated that their school used a behavioral change or restorative practices program. Forty-seven percent of respondents indicated that their schools either utilized PBIS or were in the process of implementing PBIS. Of those respondents utilizing or implementing PBIS, a slight majority were using only PBIS, while the remainder were using PBIS along with other restorative practices like social emotional learning or peer mediation. A small number of respondents were using non-evidence based practices that did not appear to be restorative practices.

While nearly half of respondents indicated their schools had adopted PBIS, respondents indicated incomplete implementation of PBIS across the whole school. First, only 67 percent of those with PBIS had trained at least three-quarters of the teachers on PBIS. The training rate dropped to a dismal 25 percent when administrators were included with teachers in the question.

Further, only 8 percent of the respondents using PBIS had teachers review behavior data to guide action planning at least twice per month, while 36 percent had teachers review behavior data to guide action

planning monthly. The lack of school-wide training and regular monthly or semi-monthly use of data raises concerns regarding the level of support provided by the administration and DOE to implement PBIS. This is particularly concerning given that the survey was only distributed in high risk school districts.

Mental and Behavioral Health Services Findings

Responding school administrators indicated a strikingly low rate of coordination amongst staff related to the behavioral needs of their students, particularly amongst those with school based mental health centers and school based health centers. Less than half of respondents indicated that their teachers met once a month or more frequently to discuss the mental or behavioral health needs of their students. Only 36 percent of schools with a school based mental health center meet regularly with a representative from the center to discuss the mental or behavioral health needs of the students. Twenty-one percent of schools with a school based mental health center never meet with the school to discuss the mental or behavioral health needs of students. The results are similar for school based health centers. Accordingly, greater coordination between the schools and the centers appears to be needed. School social workers can provide this critical link. Seventy-five percent of responding school administrators indicated that they needed additional social workers in their school.

School Meal Service Findings

Nearly 80 percent of respondents provided universal school breakfast for students. A similar, but smaller amount, provided universal school lunch. About half of all respondents served after-school meals, and about two-thirds provided after-school snacks. Roughly 60 percent of respondents provide summer breakfast, and nearly the same number provide summer lunch. Less than 10 percent of respondents provide Saturday meals.

Despite many of the respondents offering relatively robust school meal services prior to the passage of universal school lunch across NYC, half of all respondents expressed a desire to provide additional meal services for their students. Of the respondents who indicated they wanted to provide additional meal services, 58 percent want to provide Saturday meals, and 42 percent want to provide after-school meals. This indicates a strong level of concern among many responding administrators that additional school meal services are needed in the evenings and on weekends for their students.

SBHC and Related Services Findings

Respondents indicated their schools had fairly robust school-based health services available to their students. Thirty-one percent of respondents indicated their schools had a school-based health center, while 54 percent of respondents indicated their school had a school-based mental health clinic. Thirty-five percent of respondents indicated their school had dental services available.

While increased investments in school-based health services have been made in recent years, the survey data suggests additional investments are needed. A substantial portion of respondents indicated interest

in expanding all types of school based health and related services. Their interest ranged from expansion of the number of school social workers to expansion of school based health centers.

The greatest level of interest was in expanding school based mental health clinics. Seventy-nine percent of respondents expressed interest in expanding school based mental health clinic services. Forty-six percent of respondents expressed interest in expanding school based health center services, and 50 percent of respondents expressed interest in expanding dental services. The level of interest in expanding school based mental health clinics likely indicates unmet mental health service needs in the responding schools. The lower level of interest in expanding other services likely still indicates unmet health needs in those schools. However, it may also indicate that respondents may be unaware of the value of school based health clinics and dental services for their students.

Recommendations

The evidence base for school based services for displaced children is overwhelming. Displaced children have greater instability where they reside, and often live in families that are unable to ensure their nutrition, mental health, and physical health needs are met. Additionally, many displaced children in NYC reside in medically underserved areas or are part of medically underserved populations. Accordingly, school based services—which reach the students where they are during the day—present a convenient, and effective option to meet the needs of these students.

Based upon the literature review and the school administrator survey responses regarding school based health services and needs, CDFNY recommends the following:

1. Expand school-based health services in the highest need school districts and allow school-based health centers to serve as health homes in the Medicaid and Child Health Plus programs;
2. Increase support for teachers and other staff to implement PBIS in the highest need school districts; and
3. Expand access to after-school and weekend meal services in the highest need school districts.

Expand SBHCs and Fund Health Home Services.

Expand SBHCs in Medically Underserved Areas.

School based health services offer an effective way to provide access to much needed health services for children living in medically underserved communities.[67] Nearly all of the schools surveyed by CDFNY are in medically underserved areas. Additionally, a substantial portion of the responding school administrators indicated need for additional mental and physical health services. The greatest level of need, as indicated by the interest in expanding services, is for mental health services. The level of interest in expanding mental health services is underscored by the rate of respondents who indicated they had to refer at least a few students to the emergency department because of mental health or

[67] Keeton et al.

behavioral issues. Again, 84 percent of respondents indicated they had made such referrals for at least a few students.

In 2015, the NYC Department of Education issued Chancellor's Regulation A-411 to reduce the number of calls to 911 for assistance with disruptive student behavior. The regulation requires schools to intervene and de-escalate disruptive student behavior prior to making calling 911. The regulation requires schools to employ a variety of de-escalation strategies, including obtaining support from "a member of the school's Crisis Intervention Team, a member of the Building Response Team, a guidance counselor, School-Based Mental Health Clinic (SBMH) or a School-Based Health Center with mental health services (SBHC) if there is one on-site, or the Children's Mobile Crisis Team if available in the borough."[68] Given that 84 percent of respondents from the schools surveyed by CDFNY continue to refer at least a few students to the emergency room each year, it appears that some schools may lack sufficient mental health personnel to successfully de-escalate disruptive student behavior. If schools lack sufficient mental health personnel for these crisis interventions, then it is probable that they lack sufficient personnel to address the regular mental health needs of displaced students.

We also know that homeless children are also more likely to suffer from a variety of physical health needs, ranging from asthma to gastrointestinal conditions. Making dental services available to homeless children is a proven way to turn around poor dental health. Accordingly, CDFNY recommends expansion of school based health services by targeting schools with known service needs, or in communities that are in primary care, mental health, or dental shortage areas. Additional resources for school social workers should be provided to facilitate better coordination of school, SBHC, and community services, for children that do not have access to a health home.

Fund Health Home Services

CDFNY recommends expansion of health home services in Medicaid and Child Health Plus by utilizing school-based health centers as health home case management providers. Health homes, which are also known as medical homes, provide a team of health and related service professionals that work together to coordinate care and social services for individuals.[69]

Children on Medicaid in New York are eligible for health home services if they have a serious emotional disturbance (SED) or complex trauma.[70] All homeless children and unaccompanied immigrant children likely have experiences that meet the requirements for complex trauma. This determination must be made by certain practitioners[71] using the Complex Trauma Exposure Screen

[68] Regulation of the Chancellor of the New York City Department of Education, NYCRR § A-411.

[69] Keeton et al.

[70] New York State Department of Health. Health Home Chronic Conditions. Available at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_home_chronic_conditions.htm.

[71] NYS Department of Health. Qualified practitioners include Licensed Masters Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Psychiatric Nurse Practitioner (LPNP), Licensed Marriage and Family Therapist (LMFT), Licensed Mental Health Counselor (LMHC), Psychologist, Psychiatrist, or a Pediatrician, Family Physician or Internist with a specialization in Behavioral Health.

(CTES).[72] If a child has experienced two or more traumas identified on the CTES, or has experienced at least one trauma identified on the CTES for more than six months, then the child qualifies for Medicaid health home services. Displacement is listed as a trauma type on the CTES. Moreover, homelessness, living with someone other than a parent or caregiver, living on the street, or living in a car are all qualifying conditions under the criteria to indicate displacement. Many other traumas disproportionately experienced by homeless children and unaccompanied immigrant children are also listed on the CTES. These traumas include physical abuse, sexual abuse, domestic violence, and chronic community violence.

By becoming health home providers, SBHCs will be able to access additional revenue streams and, in some cases, provide a new or higher quality service for their students. New York's Medicaid program reimburses health home providers on a per member per month rate for comprehensive care management services. Health home rates vary by the acuity of the child, and in Downstate New York range from $240 to $799 per child per month. Reimbursement is also available for outreach and assessment.[73]

Medicaid Health Home Rates for Children

Tier	**Per Member Per Month Health Home Care Management Rates**	
Acuity	Upstate	Downstate
High	$750	$799
Medium	$450	$479
Low	$225	$240
Outreach	$135	$135
Assessment	$185	$185

At this time, a limited number of providers are designated to serve as child health homes.[74] NYS DOH has only designated six child health home providers in New York City, and none of them are school-based health centers.[75] In order to expand availability and access to health home services, NYS DOH should allow SBHCs that meet the newly announced National Committee for Quality Assurance

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/trauma/complex_trauma_fact_sheet.htm

[72] See Appendix 1.

[73] New York State Department of Health. Health Home Rates for Children. Available at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_hml_rate_for_children.pdf

[74] New York State Department of Health. Health Homes Serving Children – Designated May 2017. Available at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/hh_children_designations_by_county.htm

[75] New York State Department of Health. Health Homes Serving Children – Designated May 2017.

(NCQA) School Based Medical Home (SBMH) standards[76] to provide health home case management services to qualifying children in Medicaid. Requiring NCQA standards are met will ensure a high level of quality of services are provided. Additionally, NYS DOH should expand the health home program to include children with insurance funded by Child Health Plus. Expanding health homes to Child Health Plus will ensure all unaccompanied immigrant children also have access to health home services, as Child Health Plus covers children regardless of immigration status.

These policy changes will improve access to care for displaced children and ensure that the health needs of displaced children are met.

Increase Support for Teachers to Implement PBIS

Given the substantial trauma and instability many homeless children and unaccompanied immigrant children have experienced, PBIS presents a particularly useful tool in creating a stable and supportive environment. More stable and supportive environments will foster stronger relationships in the lives of children and healthier lifelong behaviors. To recap, successful implementation of PBIS requires administrative support by way of professional development and facilitation of data driven decision making. Numerous sources indicate that this type of administrative support for PBIS is paramount to its success.[77]

Our survey results indicate that a low percentage of responding schools trained all teachers in PBIS. The survey results also indicate infrequent availability of data for data driven decision making. Less than half of respondents using PBIS made data available to teachers to guide action planning at least once per month. Available resources on PBIS implementation and quality indicators state that data should be made available to teachers monthly, and to those assisting with more individualized interventions on a more frequent basis.[78]

Accordingly, it appears additional administrative support for teachers through training and opportunities to integrate data driven decision making is needed. CDFNY recommends additional evaluation of the implementation of PBIS, particularly in high need schools, to determine how extensively teachers are trained and how frequently data for guided decision making is made available, among other key measures. If gaps in training and the use of behavioral data are confirmed, or if other gaps that suggest a lack of administrative support for PBIS implementation are discovered, then CDFNY recommends further study to determine how full implementation of PBIS in high need schools can be achieved.

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[76] NCQA. Announcing the Nation's First School-Based Medical Home Recognition Program. Press release. http://www.ncqa.org/newsroom/details/announcing-the-nation%E2%80%99s-first-school-based-medical-home-recognition-program?ArtMID=11280&ArticleID=102&tabid=2659

[77] Kennedy et al. Data-based decision making in high schools: Informed implementation of school-wide positive behavior support. 2009. In Flannery and Sugai (Eds.), SWPBS implementation in high schools: Current practice and future directions. 81-114. University of Oregon.

[78] Kennedy et al.

Expand Access to After-school and Weekend Meals

Displaced children often have unmet nutritional needs. School meal services have long been one of the best ways to ensure children with unmet nutritional needs have consistent access to meals. According to our survey results, a substantial percentage of responding school administrators indicated interest in expanding school meal services in the evenings and on the weekends. While the focus of our recommendations is on after-school and weekend meals due to the survey results, schools that have high numbers of displaced students and a lack other meal services should also explore other opportunities to expand school meal services.

Assist Families with Supplemental Nutritional Assistance Program (SNAP) Applications

Various strategies could help NYC schools facilitate expanded access to after-school and weekend meals. First, improving access to meals outside of school hours and outside of the school building can be accomplished by ensuring eligible families are enrolled in the Supplemental Nutritional Assistance Program (SNAP).[79] SNAP uptake is relatively low in NYC compared to the rest of the country. Roughly 25 percent of eligible households are not enrolled in SNAP.[80] NYC schools can help facilitate improved SNAP uptake by providing additional funding for social workers or case managers in SBHCs, or social workers in schools. Additional social workers or case managers in SBHCs would increase the SBHCs ability to assist with SNAP outreach and applications. Additional assistance with outreach and applications should improve uptake and help meet the nutritional needs of displaced children.

Coordinate with Child and Adult Care Food Program (CACFP) Providers

The CACFP provides meals for eligible children served by many different organizations in the community. Organizations that provide meals through the CACFP include after-school programs, child care providers, and homeless shelters.[81] Again, additional funding for social workers or case managers in SBHCs, or social workers in schools would increase the number of professionals available to work with families to identify appropriate programs in the community that utilize CACFP to provide meals after school.

Partner with Community Organizations to Provide After-School and Weekend Meals

NYC DOE should establish after-school or weekend programs that serve after-school or weekend meals. Additional funding should be allocated to the NYC DOE Office of Community Schools for the express purpose of developing after-school or weekend programs that serve meals. NYC DOE could utilize federal CACFP funding to cover the costs of meals.[82] Food banks, grocery stores, famers' markets, and

[79] National Center for Homeless Education. Best Practices in Interagency Collaboration, Access to Food for Homeless and Highly Mobile Students. 2012. Available at: http://nche.ed.gov/downloads/briefs/nutrition.pdf
[80] Robin Hood, Spotlight on SNAP, Going Hungry: Which New Yorkers Are Leaving Food on the Table? 2017. Available at: https://robinhoodorg-production.s3.amazonaws.com/uploads/2017/11/robin-hood-poverty-tracker-snap-spolight.pdf
[81] National Center for Homeless Education. 2012.
[82] United States Department of Agriculture, Food and Nutrition Service, Child and Adult Food Program. Afterschool Meals. 2017. Available at: https://www.fns.usda.gov/cacfp/afterschool-meals.

restaurants may also be helpful in providing meals.[83] NYC DOE should also consider leveraging its efforts and resources in the Office of Strategic Partnerships, or by working with the Fund for Public Schools, to collaborate with the Office of Community Schools to provide programs that serve after-school and weekend meals.

Conclusion

The health needs of homeless children and unaccompanied immigrant children are significant and require special policy considerations. A substantial body of research emphasizes the importance of addressing the behavioral needs, nutritional needs, and physical health needs arising from complex trauma of displaced children. Based on our research and survey of NYC school administrators, we suggest a variety policy changes to address the needs expressed by the school administrators in relation to the behavioral needs, nutritional needs, and health needs of displaced children.

[83] National Center for Homeless Education. 2012.