Fruitport Community Schools
Superintendent's Office
3255 E. Pontaluna Road
Fruitport, MI 49415
Ph·231·865·4100
Fax·231·865·3393
www.fruitportschools.net

May 13, 2019

Testimony Regarding Student Mental Health in Michigan Schools

Representative Pamela Hornberger, Chairwoman of the House Education Committee

Good Morning,

My name is Bob Szymoniak and I am the superintendent of Fruitport Community Schools. I have been an educator since 1986 with the last 17 years as a school superintendent. I am here this morning to give you an educator's perspective on the magnitude and impact that the mental health of our students is having not just on their learning, but the learning of those around them. To that end, in just the past two to three years, we have seen behaviors from students, particularly our youngest students, like we have never seen before. As I will explain, these behaviors have put a strain on schools both financially and emotionally. I will begin with an incident that happened in my district within the past month.

On the day in question it was reported to the office that a 5th grade boy had tried to hang himself on the playground before school. The student was immediately given a risk assessment by the school counselor who determined that the boy was in a state of emotional crisis and wanted to die. The boy's mother was called and it was recommended to her that she take the boy to the emergency room for a mental health assessment. The mother initially tried to minimize the situation, and refused. Fortunately I employ a special home-based counselor we call our Navigator who offered to go with the mother and the boy for the assessment. With that offer of support, the mother agreed. At the hospital our counselor's assessment was confirmed and the boy was indeed in crisis and wanted to kill himself. At that time arrangements were made and he was sent to a residential treatment center for the care he needed.

Without our Navigator's intervention and support, the mother would have simply taken the boy home, and given the state he was in, may have followed through on his desire to end his life. As such, through our Navigator's intervention, a life may have been saved. Unfortunately, this Navigator position is grant funded and we will lose that resource in the coming months. That will be a profound loss because of work she has done to help many students and families find the resources and treatment they needed to help them deal their mental health issues.

Suicidal ideation is just one mental health issue schools are experiencing with increasing frequency. Other issues range from depression, anxiety, and hyper-sexualization to aggressive behavior, violence, extreme profanity, threats of rape, and self-harm. Just in the past two months I am aware of a 5th grade student holding scissors up to the throat of a classmate threatening to kill her, a 1st grader threatening to rape his teacher, a kindergartner who is verbally abusive dropping the "F" bomb at will, and a high school student transported to the emergency room for suicidal ideation because of his

depression. When I talk to superintendent colleagues from around the state, I am hearing similar stories.

I have spent a great deal of time trying to figure out why we are seeing so many students coming to school with mental health issues. In fact the more I learn about these children, the more it is clear that these children were not born this way, but have experienced multiple examples of what the literature is calling Adverse Childhood Experiences, or "ACEs." Research done by the Centers for Disease Control have identified ACEs to include things like emotional, physical, or sexual abuse, physical or emotional neglect, an incarcerated parent, substance abuse or mental health problems in the home, and divorce. The research shows that the more ACEs a student has, the more likely he/she will have cognitive and behavioral problems. In fact the research has also shown that there are life-long health implications such as obesity, cancer, diabetes, and other health ailments tied to trauma experienced in childhood.

Now think about your average student sitting in a class next to a student from trauma who acts out on nearly a daily basis. Think about the emotional impact inflicted on students who watch a disturbed child bang his head against a wall until he bleeds. Think about the teacher who sees this behavior knowing there is nothing she can do but call for help. And then think about the principal who runs to the classroom to remove the child in question knowing that these children need what a mental health professional could provide while all he can do in reality is provide discipline, and the problem with discipline is that it typically doesn't work on these children. Sadly, the resulting angst that one child can create within a building is profound and often creates yet another type of trauma called residual trauma for those exposed to the behaviors of students from trauma. Now imagine there are 20 of these children in the same building.

While we are beginning to better understand childhood trauma and its implications, schools have neither been designed nor funded to deal with this significant and growing issue. I am fortunate that I have counselors in all of my buildings, but I know most schools don't. Very few schools have nurses anymore, and social workers and psychologists are funded to only work with special education students and their caseloads bigger than they should be. The resources are simply not available to most schools to deal with these children from trauma. The reality is that schools were neither designed, nor are they funded, to deal with this issue.

I have brought with me a brief that I wrote on this issue last fall called "A School District's Response to Childhood Trauma." In the brief you will see more examples of why we need additional resources to address the mental health of our students, and even a few ideas on what can be done to address what appears to be a matter of epidemic proportions. I have also brought the text of an email I sent to Senator Bumstead and also some of you that explains how the findings from the School Finance Research Collaborative can help with this issue. I would welcome the opportunity to discuss all of this further including the concept of resilience and how resilience can address many of the issues traumatized children face. I would also welcome the opportunity to discuss how resilience can be fostered through the creation of trauma informed communities and how things like the faith community can be engaged to help. But again, all of this will mean providing schools with additional resources before any of this work can take place to any sustainable degree, because, again, as it stands today, schools have not been designed, nor are they currently funded to deal with the mounting student mental health concerns we are facing today.

A SCHOOL DISTRICT'S RESPONSE TO CHILDHOOD TRAUMA

Robert Szymoniak, Superintendent

Fruitport Community Schools

October, 2018

This morning the student was being very loud, making screeching noises, and ripping his papers while Mrs. Smith was teaching. He was offered and accepted the break that is part of his behavioral plan. He was very hungry and wanted a snack. He was told break first, then snack. In break he was yelling, trying to knock things off the wall, kicking the wall, screeching. When he finally deescalated he ate a snack. He then completed 3 words of an assignment (while screaming, screeching, yelling), then began breaking pencils and throwing them. He tried to poke me with a pencil. Support was called. He started crawling around the room and grabbing other objects to throw. The school counselor came and he was escorted to the break area in the resource room. He began grabbing the clear plastic wall stabilizers and throwing them at staff member's faces. He was told that if he continued to throw them at people we would have to restrain him because that was not safe. He threw 3 more and when Ms. Love arrived a small child restraint was used. He was held for 4 minutes. During restraint he was yelling that he would hurt us when we let him go and that his parents would hurt us as well. He said he would kick me in the face when we let go of his legs and he was going to claw me with his nails. He did finally say that he would have a safe body so the let go process was followed. After we let go he was still not calm enough to process so his break was continued. He started kicking, head butting and pushing the sides of the wall. He tried to flip his body over using the sides of the wall for arm supports, then swung at me. TCI was called and he was escorted to the office because it was no longer safe for himself or staff to keep him in break in my office. While being escorted, he kicked his legs out repeatedly to trip staff. Once he arrived in the office he was able to sit in a chair until his parents came to take him home.

1. THE PROBLEM -

   I am a school superintendent and what you just read was an actual report written by one of my teachers earlier this fall. The student in question is just one of an increasing number of our youngest students that come to school with behaviors like we have never seen before. These behaviors go beyond simple misconduct to concerns such as suicidal ideation, hyper-sexualization, and threats of rape. And they happen multiple times nearly every day. This alarming trend appears to be a nation-wide epidemic and it requires more than normal school discipline. In fact it requires a complete mind-shift in how schools must function. But before we get to that, let's explore what might be the cause of some, if not most, of these behaviors.

2. RESEARCH REGARDING TRAUMA

Some 30 years ago a physician who performed bariatric surgery on obese female patients observed a strange occurrence. Through his treatment he was able to help most of these women achieve their weight loss goals only to put the weight back on shortly after leaving his care. Curious as to why that occurred, the doctor found that most of these patients who had regained their lost weight had been sexually abused as children. He concluded that the weight gain was intended to keep these women safe from ever experiencing that trauma again.

This led to research done by the Center for Disease Control regarding childhood trauma. The outcomes of that research were profound. The research showed that childhood trauma could lead to lifelong health concerns including an increased incidence of cancer, pulmonary disease, and shortened lifespan. It was found that the more trauma experienced by children, the more likely they would experience health concerns as adults. This research then led to the specific identification of the types of childhood trauma that would lead to adult health problems. This grouping of childhood trauma was called *adverse childhood experiences* or ACEs. They included: emotional, physical, or sexual abuse; physical or emotional neglect; violence in the home/neighborhood; substance abuse or mental illness in the home; divorce; incarcerated household member.

3. ACEs

Over the years additional research has been done on the impact of ACEs to the lives of adults. In fact in Muskegon County, a public mental health agency surveyed 2,000 mostly middle class adults and found that 10% reported having 3+ ACEs, 31% reported 4+ Aces, and 16% reported having more than 6 ACEs. One would think that children from poverty would have more ACEs than those from the middle class or privilege, but the Muskegon study proved that ACEs know no specific demographic. ACEs are everywhere.

When ACEs are at their worst, children begin to live their lives in a constant state of toxic stress. In this elevated state of toxic stress, the body produces more than normal levels of hormones designed to help a body respond to danger. If this condition persists, it is a matter of time before physiological or social/emotional responses to normal stimuli become abnormal, and a multitude of problems emerge such as those seen from the boy at the beginning of this article. In fact it has been shown that ACEs can cause anatomical abnormalities to the brains of children that are potentially permanent and typically result in a child with abnormal behavior and ultimately health concerns later in life

4. RESILIANCE – PROVIDING SUPPORT

Fortunately, the research has shown that when the conditions are right, children can build *resilience* and overcome the anatomical and physiological manifestations brought on by ACEs. These conditions are found in inter-personal relations that focus on the establishment of trust, nurturing, and care. I would imagine that many of us experienced

ACEs earlier in life, but there were adults who were caring, nurturing, and built trust with us through which we gained confidence and composure. Through this we were resilient and overcame the negative manifestations of adverse childhood experiences going on to lead productive lives.

5. IMPACT OF THE HOME

   Unfortunately, the young child at the beginning of this article lives in a situation that fosters his behavior. We know that schools can help students overcome the impact of ACEs, but our challenge is that children are only in school seven hours per day and live most of their lives in the environment creating the trauma. It is likely that we will seldom make progress with these children if their home environment isn't stabilized first. Once that happens, then children have a chance to build resilience through the caring and nurturing relationships that can be fostered at school and through additional home-based supports.

6. SOCIAL DETERMINANTS OF HEALTH

   A way to determine issues at home is through surveying the parents through the lens of Social Determinants of Health (SDH). In doing this, school staff go to the home and interview the parents to determine if there are any of the SDHs that are lacking. The SDHs that are screened for include in some form: economic stability, neighborhood and physical environment, education, food, community/social context, and health.

7. ADDRESSING CHILDREN FROM TRAUMA - SCHOOL-BASED RESOURCE NAVIGATOR

   In my school district, we have hired who we call a School-Based Resource Navigator. She is a licensed counselor with a great deal of home-based service experience. When a student is identified because of extreme behavior, she will typically go to the home and survey the family regarding the SDHs. She then helps the family navigate the "system" to find the supports needed to make for a more healthy family. Once there is stability in the home regarding the SDHs, she then follows up with the family to ensure they are doing what they need to do to sustain a healthy environment for their child. She is also a liaison between the family and the school to ensure that everyone working with this child is on the same page. In closing this loop of care, she then attempts to find mentors so that the student, while at school, interacts with both caring school staff and caring and nurturing adult volunteers to build resilience.

   Here are a few examples of the work our Navigator has done in just the first 40 days of the 2018/19 school year.

- A kindergarten student was destroying his classroom by throwing what he could get his hands on and ripping things from the wall. He was physically aggressive to others and noncompliant with redirection. It turns out this child has an anatomical defect to where

the two hemispheres of his brain are not connected in a normal way. For the first two years of his life he had a neurologist helping him and his mother manage his growth and development. A few years ago the mother felt the neurologist was not helpful and quit attending appointments. Our Navigator was able to work with mom to help her understand the role of the neurologist and the importance of keeping follow-up appointments. As a result, mom scheduled an appointment with a new neurologist. The Navigator also addressed SDHs through connecting mom with a local food pantry, and navigate the health care and mental health systems as stated, and through a connection with Community Mental Health to provide developmental delay supports. The Navigator also got an old mental health assessment that was shared with the special education team at school so programming could be designed to best meet the needs of this student.

- A 4th grade girl previously diagnosed with Autism had not been given her prescription medication for the past seven months because the parents did not make the necessary Medicaid updates to keep her case active. The home was unstructured and unhealthy. There were no supports for this girl and she suffered from extremely poor hygiene which, unfortunately, made her susceptible to bullying. There was also a lack of supervision in the morning as parents left for work leaving the girl to fend for herself in getting fed, dressed, and ready for school. Our Navigator was able to help the family reengage with the Medicaid system so the girl could get her medication, and connected mom with Health West (mental health agency) for home-based autism supports that included bathing, giving structure to the home, and teaching mom how to parent a child with autism. Mom was also connected to clothing and food pantries.

- A high school girl was referred to the Navigator by her assistant principal because he had noticed she had a vision problem. It turns out the girl has partial vision loss due to a condition that was permanent and won't improve. She hadn't been to an eye doctor or specialist in years. The Navigator did a home visit and the girl was thrilled that someone was willing to help her with her vision problem. Mom was working 3rd shift and simply didn't make her daughter's vision problem a priority. The Navigator advocated to mom about the importance of an eye appointment and also worked with teachers and bus transportation so that accommodations for her vision problem could be made allowing this girl to finally feel successful at school. Given the girl's vision problem, she found herself socially isolated with no peer relationships, so the Navigator connected this girl with an agency for disabled students that provided social events designed to fill that void.

- A 4th grade elementary student was living in a home with his mother while his father worked away from home during the week, but was under the influence of drugs and alcohol when home on the weekends. This created toxic stress for the boy and his mother, both of whom also suffered anger issues. His behavior at school was indicative

of his home situation with chronic angry disruptive behavior. The Navigator was providing counseling supports for both the boy and his mother. Mom shared she was thinking of leaving her husband and would need the Navigator to help find housing and related supports. The counseling the Navigator provided was a stopgap measure until more permanent counseling could be established.

- A 7th grade boy lived with his mother and her boyfriend and two young sisters in a tent because their home had burnt down. Because she had unreliable transportation, she lost her employment. The Navigator transported her to various agencies regarding employment, public assistance including housing, food and clothing, and related DHHS supports. The school's Family Resource Center assisted the Navigator in this work which proved to be a productive partnership. This is a work in progress and a very difficult case including the fact that Child Protective Services became involved due to the upcoming colder weather given they were living in a tent. Without our Navigator, this family had no hope.

- A bus driver made a referral of a 6th grade boy to the Navigator. The driver learned that the boy was likely suffering from a mental health issue and was suicidal. She made the referral knowing that a safety plan would need to be established to keep this boy safe in his home. The boy was being raised by his grandparents and had many ACEs prior to his grandparents providing a stable home. The Navigator was able to help establish a safety plan in the home and provide a connection to counseling resources and encouraged pediatric follow-up, along with a referral for the grandparents to join a Grandparents Raising Grandchildren group.

  Thus far early in the school year the Navigator has had 30 referrals and was able to connect and work with 25 families. Of these, 11 have received home visits. Social Determinants of Health addressed through this work included: physical and behavioral health, housing, food, employment, social context, and education. Baseline data for each student served will include attendance, grade profile, and discipline profile at the time of referral. At periodic intervals this data will be reviewed to determine degree of progress these students make.

  The work of our Navigator will not save all of the children we have coming to school with a high number of ACEs. To increase the odds of helping more children with high ACEs scores there needs to be a universal understanding about childhood trauma and a governmental shift of resources in support of schools dealing with this issue. Simply put, we will need many more Navigators along with more counselors if we hope to make a dent in addressing the many troubled youth coming through our school doors.

8. TRAUMA INFORMED
   When looking for a response to trauma, "understanding" is key. For example, if you do a Google search for childhood trauma, you will see many references to the phrase "trauma

informed." Simply put, trauma informed is when one understands what adverse childhood experiences are and how to help suffering children build resilience. It also includes the notion that we should not look at children from trauma by asking, "What's wrong with you?" but instead ask, "What happened to you?" This shift in thinking does not solve the problem, but it sets the stage for resilience through the power of empathy.

Trauma informed comes in many layers and forms. It begins with each individual staff member understanding childhood trauma and how to help these children build resilience (like the bus driver mentioned earlier). From there it goes to trauma informed schools who structure the overall school program to respond to children of trauma through setting clear behavioral expectations with ample opportunities to build resilience. Finally, it reaches out to the overall community to promote understanding and align community resources to help traumatized children build resilience, thus a trauma informed community.

The concept of a trauma informed school seems clear to me. For example, schools implementing the currently popular philosophies and practices of Positive Behavior Interventions and Supports (PBIS) are performing trauma informed practice. Behavioral expectations in every school setting from the classroom, cafeteria, and playground to the bathroom, hallway, and school bus are actively taught. In addition, discipline shifts from punishment to learning opportunities with an emphasis on restorative practice. This gives students the skills to make right what they did wrong instead of assigning arbitrary punitive measures such as detention or suspension. In addition, various interventions and supports are implemented to help improve behavior when necessary. All of this helps students know boundaries and fosters a sense of security and safety which, in turn, fosters resilience.

Looking at the concept of a trauma informed community is a little less clear, likely because it could look so different from community to community. Essentially, trauma informed communities have residents who have been exposed to the concepts of ACEs and resilience through their affiliation with either the school or within their faith community or service organization. In fact anytime a group of community members gather provides an opportunity to teach about childhood trauma and offer residents opportunities to help children build resilience. A church congregation that understands childhood trauma and then organizes a cadre of volunteers to mentor children from trauma giving them the caring and nurturing they need to build resilience would be an example of a trauma informed community practice. In addition, Fruitport is beginning to implement the "Handle with Care" initiative which is all about trauma informed law enforcement.

9. POLICYMAKERS CAN HELP

Earlier I mentioned a governmental shift of resources to address the problem of childhood trauma. It is crucial that our government officials with budgetary power understand that simply putting more counselors in schools will not be the remedy in isolation of addressing the bigger issue which is parenting and the home environment. A balanced approach of in school counseling with home-based efforts to address social determinants of health and parenting education must happen if resilience is to be

sustainable. In addition, the creation of legislative points of leverage holding parents accountable to stop further traumatization of children and create home environments that foster resilience could be a game changer in addressing this looming public health concern of so many children from trauma becoming adults. In fact the CDC has raised the alarm that dealing with the issue of childhood trauma will be as important as the anti-tobacco movement was in addressing lung cancer. There will likely be a drain on the Medicaid system if we don't put resources into play now that address childhood trauma. It is our reality that we will either pay now to help children build resilience and overcome the lifelong manifestations of trauma, or pay later because of sick adults.

I recognize the idea of legislating elements of parenting seems completely un-American and would certainly be controversial. Understand that this is not about Uncle Sam going into the living rooms of America and telling people how to live their lives. But it is about two things legislatively: giving schools avenues to better engage the law enforcement and judicial system in holding parents accountable when they foster trauma in their children, and creating policies that support restorative practices helping parents of traumatized children create circumstances to build resilience in these children. To this point, laws could be beefed up to accelerate court intervention regarding truant children. Children typically aren't truant without some form of dysfunction in the home. I have seen it time and again that truant children suffer from some type of trauma typically in the form of neglect. In this regard, truancy could be a trigger to identifying childhood trauma, and court intervention could mandate that the parents get the educational supports they will need to create a more nurturing, and ultimately resilient environment in the home.

10. CLOSING

I started my career in education some 30+ years ago and remember some of the veterans complaining that, "Kids aren't like they used to be." And so here I am sharing the same sentiment. But I would argue this time is different. We aren't talking about crazy new fashion statements, or really even a breakdown in the moral fabric of our democratic society. We are talking about science. There are things happening to many of today's children that change their anatomy and physiology which impact their psychology and sociology. And these changes can have lifelong impacts on health and can even accelerate death. The magnitude and manifestations of childhood trauma are so impactful that they can no longer be ignored and we must act now to address what the CDC considers a looming epidemic, or pay societal consequences at multiple levels.

I feel fortunate to work in a school district and community that cares deeply for its children. As we work to understand childhood trauma and to build systems that foster resilience, I know that there is no silver bullet or magic cure. But I do believe there is hope if we can stabilize the home environment and ensure there is ample support for traumatized children through counseling, school-wide systems of PBIS, and relationships with caring and nurturing adults. It's at least a start. And I believe there really is no option but to embrace this work. Many of our children are hurting and that hurt will ultimately impact us all if we don't take action now before the problem is too big and the time is too late.

May 2, 2019

Hi Senator Bumstead

,
Thanks again for the yes vote on the snow day legislation.

The incident I mentioned in my text from this morning deals with a 5th grade student who tried to hang himself on the playground before school day this past Tuesday. I saw the surveillance camera footage of what he did and it is truly unnerving. Immediately after the incident one of our staff did a crisis risk assessment of the boy. During that process he revealed that he did indeed want to do self-harm and ultimately wanted to die.

We know this boy to be rather disturbed. He will punch himself in the face until he bleeds, will bang his head against a wall, punch the wall, etc. We have tried to work with this mother since early last year when they first moved to Fruitport, but the mother has been dismissive and minimizes the behavior. She would not get the boy counseling or other medical attention because she said it wouldn't help. We had no leverage short of expulsion to remedy this situation, and I struggled with the idea of expelling an 11 year old child.

This time, however, we were able to get the mother's attention. We told her the boy could not return to school until he had been evaluated by a mental health professional, and that a safety plan had to be put in place to ensure his safety. Again, the mother was reluctant to follow through on this request at first. Fortunately, I employ a person we call a Navigator. She is a counselor that works with families, mostly outside of school, helping them "navigate" the health care and agency systems so that they get the help they need. Our Navigator offered to go with mom to the emergency room for the assessment, and then offered to help ensure the boy had the supports he needs after the assessment. Later that evening I received a text from the Navigator saying that the mother was taking the boy to an in-patient treatment center and that she would follow with the mother the following day to check on things.

As you know, we are definitely seeing an increase in the number of students with mental and behavioral challenges, and it is clear that these behaviors have been spawned by bad parents who don't follow through, or ignore their child's issues all together. Without our Navigator, we had no way to help these children or to hold parents accountable. We are a school, and we weren't designed, nor are we funded, to deal with this stuff. Again, without the Navigator position, we were at a loss as to what to do with these kids.

Unfortunately our Navigator is paid for with grant funds and that grant runs out early next fall. I have no way to continue to afford that very important position.

Here is how this situation relates to the budget.

Not all kids cost the same to educate. For example, some of our special ed kids require ancillary services that our general fund can barely afford such as one-on-one aides, therapists, and social workers. The special education funding we do get covers significantly less than half of the money we need to spend on these students. Therefore, we take money away from general education students to afford these needs.

Now with the increase of mental and behavioral health needs we are seeing in our student population as described above, we will need to divert even more money from general education students to address these issues. Or, as will be the case for us next year, districts will decide not to take away more programming from general ed kids and deal with these behaviors the best we can. Either way, general education students are hurt. They will either lose programming through diversion of funds to address at-risk kids (needs beyond what current at-risk funding covers) or their education will see constant disruptions from mental/behaviorally challenged students.

That is why the research done by the School Finance Research Collaborative makes so much sense. They researched how much it costs to educate a student and then created a weighting system that would provide more money for kids who cost more to educate.

Please know that we appreciate the senate's proposal to increase the foundation allowance, but this proposal falls far short of addressing our needs out here in the field, and is also several hundred thousand dollars short of the Governor's budget proposal for Fruitport.

I encourage you and your staff to delve into the School Finance Research Collaborative and better understand the thinking behind an adequate foundation allowance that is supplemented by weighted formulas to address the needs of more expensive students.

To close, properly funding kids that are more expensive than the typical kid is a big deal. Luckily I had grant funding to help this kid who tried to hang himself on my playground earlier this week. Without that funding, he would have simply been sent home and, based on what he told us, would have likely found a more effective way to end his life.

Thanks for reading this. I continue to appreciate all you are doing to help us back here in West Michigan.