A Framework for Safe and Successful Schools

AMERICAN SCHOOL COUNSELOR ASSOCIATION

NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

School Social Work Association of America

NASRO National Association of School Resource Officers

naesp National Association of Elementary School Principals

nassp national association of secondary school principals

Mental Health Assistance Allocation
SB 7026

Mental Health Assistance Allocation in SB 7026 (s. 1011.62(16), F.S.)

(16) MENTAL HEALTH ASSISTANCE ALLOCATION.— The mental health assistance allocation is created to provide funding to assist school districts in establishing or expanding school-based mental health care. These funds shall be allocated annually in the General Appropriations Act or other law to each eligible school district. Each school district shall receive a minimum of $100,000 with the remaining balance allocated based on each school district's proportionate share of the state's total unweighted full-time equivalent student enrollment. Eligible charter schools are entitled to a proportionate share of district funding. At least 90 percent of a district's allocation must be expended on the elements specified in subparagraphs (b)1. and 2. The allocated funds may not supplant funds that are provided for this purpose from other operating funds and may not be used to increase salaries or provide bonuses. School districts are encouraged to maximize third party health insurance benefits and Medicaid claiming for services, where appropriate.

(a) Before the distribution of the allocation:

1. The school district must develop and submit a detailed plan outlining the local program and planned expenditures to the district school board for approval.

2. A charter school must develop and submit a detailed plan outlining the local program and planned expenditures to its governing body for approval. After the plan is approved by the governing body, it must be provided to the charter school's sponsor.

(b) The plans required under paragraph (a) must be focused on delivering evidence-based mental health care treatment to children and include the following elements:

1. Provision of mental health assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and students at high risk of such diagnoses.

2. Coordination of such services with a student's primary care provider and with other mental health providers involved in the student's care.

3. Direct employment of such service providers, or a contract-based collaborative effort or partnership with one or more local community mental health programs, agencies, or providers.

(c) School districts shall submit approved plans, including approved plans of each charter school in the district, to the commissioner by August 1 of each fiscal year.

(d) Beginning September 30, 2019, and annually by September 30 thereafter, each school district shall submit to the Department of Education a report on its program outcomes and expenditures for the previous fiscal year that, at a minimum, must include the number of each of the following:

1. Students who receive screenings or assessments.

2. Students who are referred for services or assistance.

3. Students who receive services or assistance.

4. Direct employment service providers employed by each school district.

5. Contract-based collaborative efforts or partnerships with community mental health programs, agencies, or providers.

TAB # 1

AN OVERVIEW OF SCHOOL-BASED MENTAL HEALTH SERVICES

Why is mental health important to education?

Mental health is directly related to children's learning and development. It encompasses or intersects with interpersonal relationships, social-emotional skills, behavior, learning, academic motivation, certain disabilities, mental illness (e.g., depression or bipolar disorder), crisis prevention and response, school safety and substance abuse. Each of these issues affects not only the success and well-being of the individual student but also the school climate and outcomes for all students.

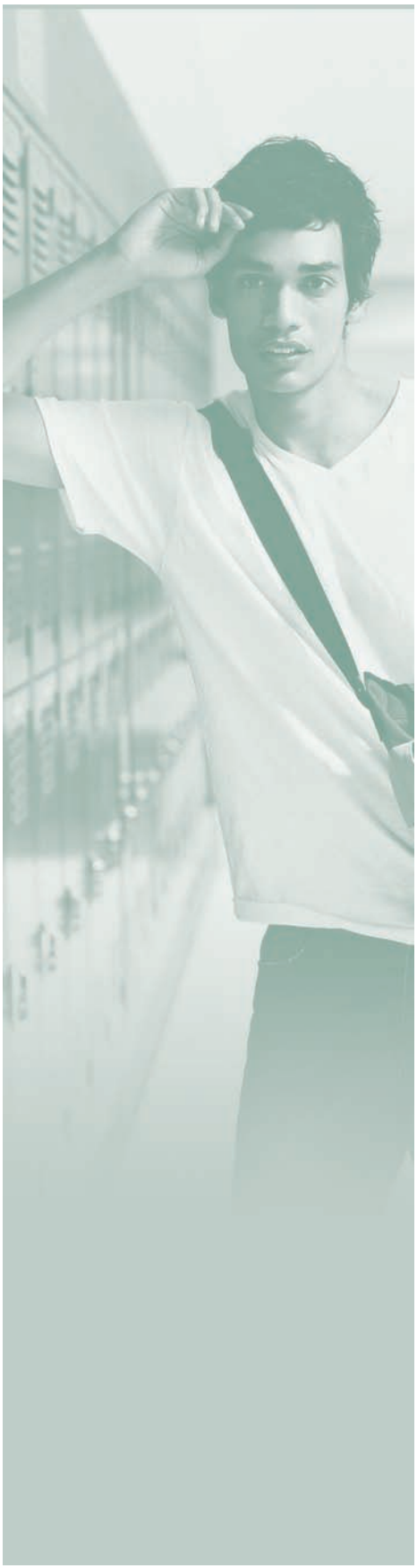
What are school-based mental health services?

School-based mental health services include a broad spectrum of assessment, prevention, intervention, postvention, counseling, consultation, and referral activities and services. These services are essential to a school's ability to ensure a safe and healthy learning environment for all students, address classroom behavior and discipline, promote students' academic success, prevent and respond to crisis, support students' social-emotional needs, identify and respond to a serious mental health problem, and support and partner with at-risk families. Ideally, school-based services dovetail with community-based services so that children and youth receive the support they need in a seamless, coordinated, and comprehensive system of care.

Who are school-based mental health providers?

School-employed professionals. The vast majority of school-based services are provided by school-employed school counselors, psychologists and social workers. They are specially trained in school system functioning and learning, as well as mental health, and focus on how students' behavior and mental health impacts their ability to learn and be successful in school. In most states, the certification or licensure for practice in the schools is typically issued by the state's Department of Education. To earn this certification or licensure, a practitioner generally needs a comprehensive master's degree and knowledge of child development, school systems, and service provision. This includes but is not limited to the ability to demonstrate broad knowledge of school systems' functioning, educational law, curriculum and instruction, classroom and behavior management, models for working with diverse populations including people with disabilities, and models for consultation and school-based practice. Additionally, all of these professionals are required to have practiced these skills successfully in school settings with supervision prior to being eligible for practice (usually between 500 and 1700 hours is required depending upon the discipline). Best practice recognizes the master's degree as the preferred entry level credential for provision of services in schools.

Community-employed professionals. In selected school districts across the country, community mental health providers working in the schools through inter-agency agreements provide some school-based mental health services. Community-employed mental health providers tend to focus their work on a student's global mental health and how it impacts family, community, work, and school functioning. In some communities, these agreements set up "School-Based Health Clinics" where students and their families can come to the school for all medical, social-emotional, and/or behavioral health services. These clinics provide a valuable service, particularly in communities without other easily accessible mental health services. In these settings, the interagency agreement should articulate the purpose and scope of the services being provided by the public school practitioners and the community practitioners. Community-employed mental health providers vary in their level of experience and training related to schools. Some community mental health providers hold masters and doctorate degrees, while other



community mental health providers have minimal graduate coursework in education or their training is specific to a particular mental health or behavioral health need (i.e. substance abuse).

What are the necessary qualifications of school-based mental health providers?

Variations in the qualifications (training and experience) of school-based mental health providers pose challenges to ensuring the quality of school-based services. It is essential that all school-based mental health providers, whether they are school employees or community employees working in schools, meet the "highly qualified" standards for practice in the schools. Specifically, school-based mental health providers need to have graduate training and experience working with children, knowledge of child and adolescent development, an understanding of school systems, prevention and intervention skills and strategies appropriate for school settings, an awareness of how mental health and academic achievement interplay, and a working knowledge of state and federal educational law, regulations, and practices. Further, all school mental health providers should only practice within the scope of their training, qualifications and experience, adhere to the professional code of ethics for their discipline, and hold the appropriate state licensure credential.

Who receives services from school-based mental health providers?

There has been an increased demand for school-based mental health services across all segments of the student population in the past decade. This is due both to the increased mental health needs of students and their families and to an improved understanding of the role mental health plays in children's functioning. Additionally, the growing emphasis on prevention and early intervention (a public health approach) encompasses universal services that target all students. Historically, many school counselors spent much of their time responding to the needs of a small percentage of students, typically those who were high achievers or who were at-risk. Today school counselors provide services to all students. As times have changed so has the focus of school-based services. For example, school psychology research indicates that by the mid 1990s, 68% of school psychologists reported providing services to students with disabilities at least 20% of their day, and by the year 2000, 79% of school psychologists reported providing services at least 20% of the time to students without disabilities. The percentage continues to rise as the number of students and families seeking mental health support increases. In the past, school social workers were hired primarily to assist in the assessment of and provision of services to students with special education needs and their families. Currently, their role is quickly evolving to include all students, with emphasis on those in crisis and those with disabilities. According to the 1999 Surgeon General's Report on Mental Health, 70% of children with a diagnosis and impaired functioning received mental health services from the schools.

How are school-based mental health services accessed?

There are two primary ways to initially access school-based mental health services: a) through referral by an adult in the student's life (parent, teacher, or administrator); or b) if the student is of consenting age and ability, by self-referral. When there is a suspected need or concern, parents should call their child's school to determine the appropriate professional to contact and the breadth of services and supports available.

For more information, contact:

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5999 Stevenson Avenue
Alexandria, VA 22304
800-347-6647
www.counseling.org

American School Counselor Association
1101 King Street, Suite 625
Alexandria VA 22314
800-306-4722
www.schoolcounselor.org/

National Association of School Psychologists
4340 East West Highway, Suite 402
Bethesda, MD 20814
301-657-0270
http://www.nasponline.org/

School Social Work Association of America
P.O. Box 2072
Northlake IL 60164
847-289-4527
www.sswaa.org/

NASP
NATIONAL ASSOCIATION OF School Psychologists

School-Based Mental Health Services

Improving Student Learning and Well-Being

Mentally healthy children are more successful in school and life. Good mental health is critical to children's success in school and life. Research demonstrates that students who receive social–emotional and mental health support achieve better academically. School climate, classroom behavior, on-task learning, and students' sense of connectedness and well-being all improve as well. Mental health is not simply the absence of mental illness but also encompasses social, emotional, and behavioral health and the ability to cope with life's challenges. Left unmet, mental health problems are linked to costly negative outcomes such as academic and behavior problems, dropping out, and delinquency.

There is a growing and unmet need for mental health services for children and youth. According the U.S. Department of Health and Human Services, one in five children and adolescents experience a mental health problem during their school years. Examples include stress, anxiety, bullying, family problems, depression, a learning disability, and alcohol and substance abuse. Serious mental health problems, such as self-injurious behaviors and suicide, are on the rise, particularly among youth. Unfortunately, estimates of up to 60% of students do not receive the treatment they need due to stigma and lack of access to services. Of those who do get help, nearly two thirds do so only in school.

Schools are an ideal place to provide mental health services to children and youth. Virtually every community has a school and most children spend at least 6 hours a day there. Schools offer an ideal context for prevention, intervention, positive development, and regular communication between school and families. School-employed professionals like school psychologists, school counselors, school social workers, and school nurses know the students, parents, and other staff, which contributes to accessibility of services. In fact, research has shown that students are more likely to seek counseling when services are available in schools. In some cases, such as rural areas, schools provide the *only* mental health services in the community.

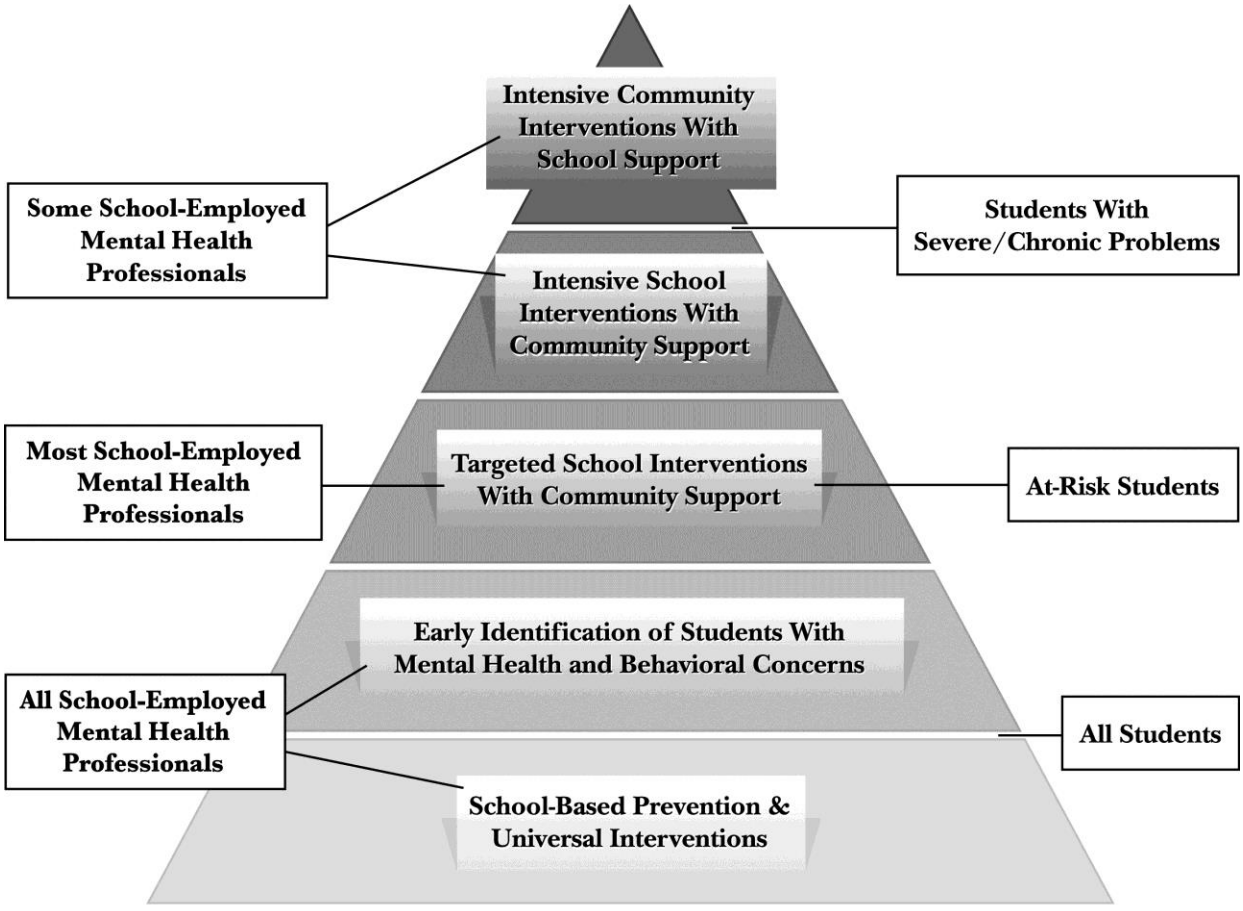
School mental health services support the mission and purpose of schools: learning. All services provided in schools should be appropriate to the learning environment; those that are not risk being ineffective or even counterproductive. Just as children are not simply small adults, schools are not merely private clinics with chalk boards. Being trained to work within this culture is essential to being effective (and cost-effective).

School-employed mental health professionals are specially trained to provide services in the learning context. School counselors, school psychologists and school social-workers provide the vast majority of school-based services. They are specially trained in school system functioning and learning, as well as how students' behavior and mental health impacts their ability to be successful in school. Areas of expertise include but are not limited to: education law, curriculum and instruction, classroom and behavior management, individual and group counseling, learning disabilities, school safety and crisis response, effective discipline, cultural competence, and consultation with educators, families and community providers.

School mental health services are essential to creating and sustaining safe schools. Increased access to mental health services and supports in schools is vital to improving the physical and psychological safety of our students and schools, as well as academic performance and problem-solving skills. School mental health supports that encompass social–emotional learning, mental wellness, resilience, and positive connections between students and adults are essential to creating a school culture in which students feel safe and empowered to report safety concerns, which is proven to be among the most effective school safety strategies. Additionally, in the aftermath of a crisis, school-employed mental health professionals provide supports that facilitate a return to normalcy, are sustainable, and can help to identify and work with students with more intense or ongoing needs.

Providing a continuum of school mental health services is critical to effectively addressing the breadth of students' needs. Comprehensive mental health services are most effective when provided through a multitiered system of supports (MTSS) but school-employed mental health professionals. MTSS encompasses the continuum of need, enabling schools to promote mental wellness for all students, identify and address problems before they escalate or become chronic, and provide increasingly intensive, data-driven services for individual students as needed. Access to adequate staffing of school-employed mental health professionals is essential to the quality and effectiveness of these services.

School-community collaboration is critical to providing the full continuum of mental health services. Meeting the full continuum of student needs is also dependent on collaboration between schools and community mental health providers. Typically, community providers offer supplementary or intensive services that go beyond school capacities. An MTSS approach facilitates effective collaboration while ensuring that services provided in school are appropriate to the learning context and those that are provided after school hours are appropriately linked to and supported in the school setting. Partnerships are most effective when coordinated by school-employed mental professionals, are defined by clear memoranda of understanding, and reinforce an appreciation for the unique contribution each group makes to creating more seamless and comprehensive service delivery. This not only reduces gaps, redundancy, and conflict, it also reduces stress on families and supports their roles as primary caregivers and decision-makers regarding their child's development.



The Continuum of School Mental Health Services

Adapted from "Communication Planning and Message Development: Promoting School-Based Mental Health Services" in *Communiqué*, Vol. 35, No. 1. National Association of School Psychologists, 2006.

IssueBRIEF

NITT-TA
NOW IS THE TIME
TECHNICAL ASSISTANCE CENTER

Mental Health and Academic Achievement

All educators, and especially school leaders, take pride in knowing the strengths and needs of the young people they serve. Educators are accustomed to thinking about a variety of factors known to affect young people's school-related outcomes, such as whether they come from historically underserved groups, whether they are learning English as a second language, and/or whether they are experiencing poverty. One important contributor to school outcomes that school leaders may not regularly consider is the mental health of the young people they serve.

What is mental health?

Mental health is best thought of as the way a young person's thoughts, feelings, and behaviors affect his or her life. Mental health is a spectrum. In the same way that every individual experiences physical health as a continuum from 'well' to 'ill', every individual has a mental health experience. As with physical health, mental health changes at different points in individuals' lives based on both biological and environmental factors. Many young people enjoy **mental wellness**, meaning that they have positive regard for themselves, enjoy positive relationships with the people who are important to them, and are generally resilient when faced with challenges in their lives at home and school.[1] When mental health deteriorates substantially, mental illness may be involved. A **mental illness** is a condition that impacts a young person's thinking, emotions, and mood such that it interferes with his or her daily functioning at home and school.[2]

What is the prevalence of mental illness among young people?

Approximately **one in six school-aged youth** experiences impairments in life functioning due to a mental illness, and the number of young people experiencing mental illness increases as young people grow older.[3]

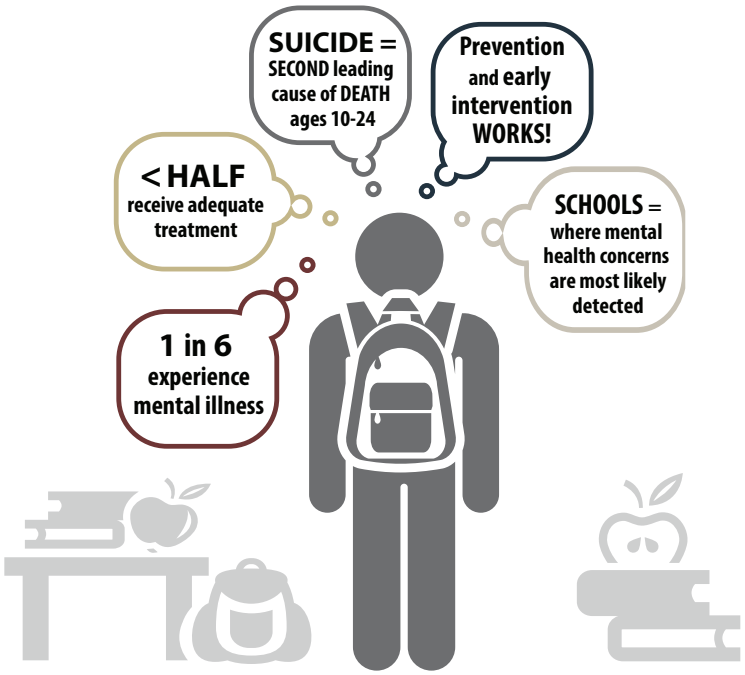
The most prevalent mental illnesses in school-aged young people include attention deficit hyperactivity disorder (ADHD), behavioral or conduct problems, anxiety, and depression.[3] Half of mental illnesses emerge during or before adolescence, and three-quarters emerge before the age of 25, meaning that mental illness places a disproportionate burden on young people, yet **fewer than half of young people with mental illness receive adequate treatment**.[4]

What is the impact of mental illness?

When left untreated or undertreated, coping with the pain of mental illness can contribute to self-harm, including thoughts of **suicide**, which is now t**he second leading cause of death for young people ages 10-24**.[5]

Fortunately, **the earlier mental health concerns are detected and addressed, the more likely the young person is to avoid the onset and/or progression of a mental illness**.[6] Many times signs of deteriorating mental health are noticeable in young people well before a mental illness emerges.

What is the school's role in addressing mental illness? Outside of the young person's home, **schools are the most likely place where mental health concerns will be detected**. Young people spend most of their day at school interacting with several adults and peers, all of whom can be empowered to help connect those suffering from mental health concerns to early intervention and treatment supports.



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4) Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustun TB. (2007). Age of onset of mental disorders: A review of recent literature. *Current opinion in psychiatry*, 20, 359-364.
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6) Baskin, T. W., Slaten, C. D., Sorenson, C., Glover-Russell, J., & Merson, D. N. (2010). Does youth psychotherapy improve academically related outcomes? A meta-analysis. *Journal of Counseling Psychology*, 57, 290–296. doi:10.1037/a0019652

You Need to Know: Mental Health Matters

In an average school of 600 students, approximately **100 students** are **coping with a mental illness**.

More than **1 in 20 young people** ages 12 and over **report current depression**, which among school-aged youth is linked to reduced academic achievement and increased school suspensions.[7]

Mental illness is associated with **school absences**, causing the **loss of critical school funding sources**.[8]

$$$

Young people with **attention-deficit/ hyperactivity disorder (ADHD)** often feel **isolated** at school due to **social problems** associated with their illness.[9]

Having a mental illness is associated with being pushed out of school through **suspension**, **expulsion**, and **credit deficiency**.[10, 11, 12]

17% considered **SUICIDE**

8% attempted **SUICIDE**

Among students in grades 9-12 in the U.S. during 2013-2014[13]: 17.0% of students seriously considered attempting suicide, and 8.0% of students attempted suicide one or more times in the previous 12 months.

Only **one third** of adolescents with mental illness **go on to postsecondary education**.[14]

1/3

Early detection of mental health concerns leads to **improved academic achievement** and **reduced disruptions at school.**[15]

Where to Begin? Get to Know Project AWARE

The NITT-Project AWARE (NITT-PA) grant program, supported by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), seeks to intervene with the sequelae leading to school failure for young people with undertreated or untreated mental illness through mental health promotion, mental illness prevention, and early intervention. Project AWARE grantees are seeking to build the capacity of educators, in partnership with other youth-serving sectors, to address the mental health needs of the young people they serve by improving awareness of mental health indicators; providing training in how to properly identify and respond to mental health concerns; and by improving service systems that connect young people and their families to affordable, developmentally aligned, and culturally and linguistically-appropriate resources and services in their communities.

Your Community's Project AWARE Coordinator is: _____

Your Project AWARE Coordinator can be reached at: _____

7) Centers for Disease Control and Prevention (CDC, 2016). Retrieved April 2016 from: http://www.cdc.gov/mentalhealth/basics/mental-illness/depression.htm
8) Wood, J. J., Lynne-Landsman, S. D., Langer, D. A., Wood, P. A., Clark, S. L., Eddy, J. M., & Ialongo, N. (2012). School attendance problems and youth psychopathology: Structural cross-lagged regression models in three longitudinal data sets. *Child Development*, 83, 351–366. doi: 10.1111/j.1467-8624.2011.01677.x
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10) Kang-Yi CD, Mandell DS, Hadley T. (2013). School-based mental health program evaluation: children's school outcomes and acute mental health service use. *Journal of School Health*, 83, 463-472.
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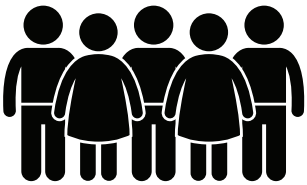
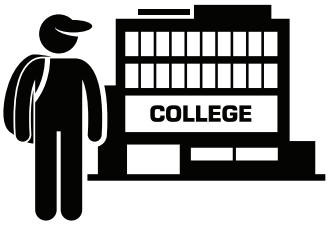
How can we detect mental illness in schools?

Coping with mental health concerns negatively impacts young people's ability to meet the many demands of school, including cognitive demands for learning; social and emotional demands for making friends and behaving according to school rules, norms, and expectations; and physical demands for being active throughout the school day. Described below are many of the ways that mental health concerns impact young people at school.

School-Related Effects of Mental Health Concerns on Young People			
 **Learning and Academic Achievement**	 **Friendships and Behavior**	 **School Completion**	 **Postsecondary Academic Pursuits**
Coping with the impact of mental illness through the developmental transitions of childhood and adolescence can interfere with the cognitive processes required for classroom learning. Over time, these cognitive processes can affect academic achievement.	The behavior of young people experiencing mental health concerns may interfere with learning and making friends at school.	Over time, as young people experience the progression of untreated or undertreated mental health concerns, barriers to school completion become more difficult to surmount.	The transition from adolescence to young adulthood requires social skills and executive functioning skills that can be reduced or impaired when young people are coping with mental health concerns.
Below are some of the ways that undertreated or untreated mental health concerns can impact young people at school.[16]			
• Difficulty controlling attention during learning tasks • Trouble persevering during challenging academic tasks • Trouble recalling academic information • Slowed problem solving • Trouble completing homework • Reductions in standardized achievement test scores • Lower end-of-course grades	• Frequent absences from school due to illness and school avoidance • Trouble making and/or maintaining friendships • Low energy for physical activities, including sports and other recreation • Difficulty following school routines and norms, resulting in suspension and expulsion	• Course credit deficiencies over time • Reduced high school graduation rates • Interference with attainment of General Equivalency Degree (GED) and technical education certifications	• Difficulty completing postsecondary coursework • Difficulty managing independent life demands in college • Interference with college attendance and college completion

16) The constellation of experience is different for every individual, meaning that not every young person with mental health concerns will experience one or more of the school-related effects described here.

Supporting The Mental Health of Young People: The School's Role

When school leaders commit time and resources to address the mental health of young people they serve, the entire school community benefits. In addition to enjoying a healthier student body that is more engaged in school life, young people who receive appropriate mental health supports have improved academic achievement, are more likely to graduate, and are more likely to attend and successfully complete college.[17,18,19] Of course, these are outcomes in which all educators are invested because **when young people thrive, school communities thrive**.

Academic, social, and emotional outcomes of young people are improved in schools with positive school climates; adequate mental and behavioral health supports, including a workforce that is trained in supporting mental and emotional wellness; and coordinated systems for identifying, referring, and addressing mental health needs.[20,21] In reflection of the growing acknowledgement of the links between mental health and school outcomes, the ***Every Student Succeeds Act***[22] **placed an unprecedented priority on wraparound supports** for young people struggling with barriers to learning, including programs that address mental health, school climate, violence prevention, and trauma.

Project AWARE supports several key strategies for addressing mental health in schools: (1) promoting mental wellness and combating stigma, (2) building awareness of indicators of mental health concerns, and (3) intervening early with coordinated supports.

1. Promote Mental Wellness and Combat Stigma

- *Provide supports for mental wellness in the general education setting.* Encourage school staff, including instructional staff and school support staff, to implement evidence-based and developmentally-matched prevention curricula in the general education setting, including social-emotional learning and mental health literacy curricula.
- *Host school-wide mental wellness campaigns.* Encourage mental wellness and improve awareness of mental health concerns among school adults, peers, and family members by hosting regular social marketing campaigns.

2. Build Awareness of Indicators of Mental Health Concerns

- Promote the mental health literacy of community members through Youth Mental Health First Aid (YMHFA). YMHFA is designed to reduce stigma associated with mental illness; to enhance the ability of educators to appropriately identify young people in need of mental health supports; and to improve help-seeking and referrals by young people and their families.

What are some of the signs of mental health concerns in young people?

- Withdrawing from others
- Having very low energy
- Appearing disheveled
- Losing interest in hobbies and other activities
- Trouble concentrating
- Becoming easily irritated or angered
- Changing eating or sleeping patterns
- Crying a lot

3. Intervene Early with Coordinated Supports

- *Improve school mental health referral systems* to ensure that concerned school adults, family members, and peers can efficiently and effectively refer their students, friends, and children for mental health supports.
- *Improve the coordination of mental health supports across general education and special education.* Special education and general education must work in a coordinated manner to provide prevention and early intervention opportunities—such as those underscored in *Every Student Succeeds Act*—aligned with a public health model for mental health.
- *Build codified relationships with local mental health service providers* in order to connect young people and their families to affordable, developmentally aligned, and culturally and linguistically-appropriate resources and services.
- Coordinate your school-community mental health partnerships with other supportive, youth-serving sectors, including law enforcement, juvenile justice, and health care.

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19) Baskin, T. W., Slaten, C. D., Sorenson, C., Glover-Russell, J., & Merson, D. N. (2010). Does youth psychotherapy improve academically related outcomes? A meta-analysis. *Journal of Counseling Psychology*, 57, 290–296. doi:10.1037/a0019652
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22) Every Student Succeeds Act S 1177 (2015)

The Now Is The Time
Technical Assistance (NITT-TA) Center

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Email: NITT-TA@cars-rp.org
Website: www.samhsa.gov/NITT-TA

Florida AWARE
Advancing Wellness and Resiliency in Education

Florida AWARE Program Model

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Florida AWARE is a State Education Agency "Now is the Time" Program, awarded by the Substance Abuse and Mental Health Services Administration to the Florida Department of Education's Bureau of Exceptional Education and Student Services with a subagreement to the University of South Florida and the three partnering districts (Duval, Pinellas, and Polk).

What is the Florida AWARE program?

The purpose of the Florida AWARE program is to build state capacity to support districts in promoting mental wellness, and ensuring that Florida youth who experience mental health problems have timely access to effective and coordinated supports and services. The program focus is on long-term systems change for integrating school and community-based mental health supports within a multi-tiered service delivery framework based on a shared youth, family, school, and community vision. The program also provides training to youth serving adults using the Youth Mental Health First Aid program. At the state level, partners from multiple youth serving systems and organizations serve on a State Management Team that provides oversight and leadership. At the local level, three Florida AWARE districts (Duval, Pinellas, Polk) are developing and implementing a multi-tiered system of mental health supports that will serve as a model for future scale up.

Florida AWARE Goals

Goal 1

Increase youth access to mental health services and supports within a multi-tiered framework *(e.g., Interconnected Systems Framework; Barrett, Eber, & Weist, 2013)*

Goal 2

Increase implementation of evidence-based, culturally responsive mental health practices

Goal 3

Increase awareness of mental health issues within our youth, families, schools and communities

Florida AWARE Program Priorities are to Support Implementation of:

- A multi-tiered framework of mental health supports across a variety of organizations and providers
- A streamlined cross-organizational data system to inform mental health supports and services
- Procedures for identifying, accessing, and/or maximizing existing resources to support mental health outcomes
- A streamlined efficient and effective system for youth and families to access mental health supports and services
- Awareness of mental health issues by youth, families, community members and school personnel
- Tested and proven to be effective mental health practices designed to meet the needs of diverse populations
- Professional development to increase knowledge and skills to provide effective mental health supports and services

FLORIDA AWARE PROGRAM MODEL

Florida AWARE State Management Team Partners

- Office of Independent Education and School Choice/Charter Schools, Florida Department of Education (FLDOE)
- Bureau of Exceptional Education and Student Services, FLDOE
- Bureau of Family and Community Outreach, Office of Safe Schools, FLDOE
- Bureau of School Improvement, FLDOE
- Bureau of Standards and Instructional Support, FLDOE
- Department of Children and Families
- Department of Juvenile Justice
- Florida Diagnostic & Learning Resource System (FDLRS)
- Florida Department of Health
- Governor's Office of Adoption and Child Protection
- Healthy Schools, Bureau of Standards and Instructional Support
- NITT-Healthy Transitions, Central Florida Behavioral Health Network, Inc.
- The Multiagency Network for Students with Emotional/Behavioral Disabilities (SEDNET)
- Florida's Positive Behavior Interventions and Supports Project: A Multi-Tiered Support System
- Florida's Problem Solving & Response to Intervention Project

Florida AWARE Local Educational Agencies & Community Partners

Duval

- Federation of Families of Northeast Florida
- Partnership for Child Health

Pinellas

- Personal Enrichment through Mental Health Services
- National Alliance on Mental Illness (NAMI)

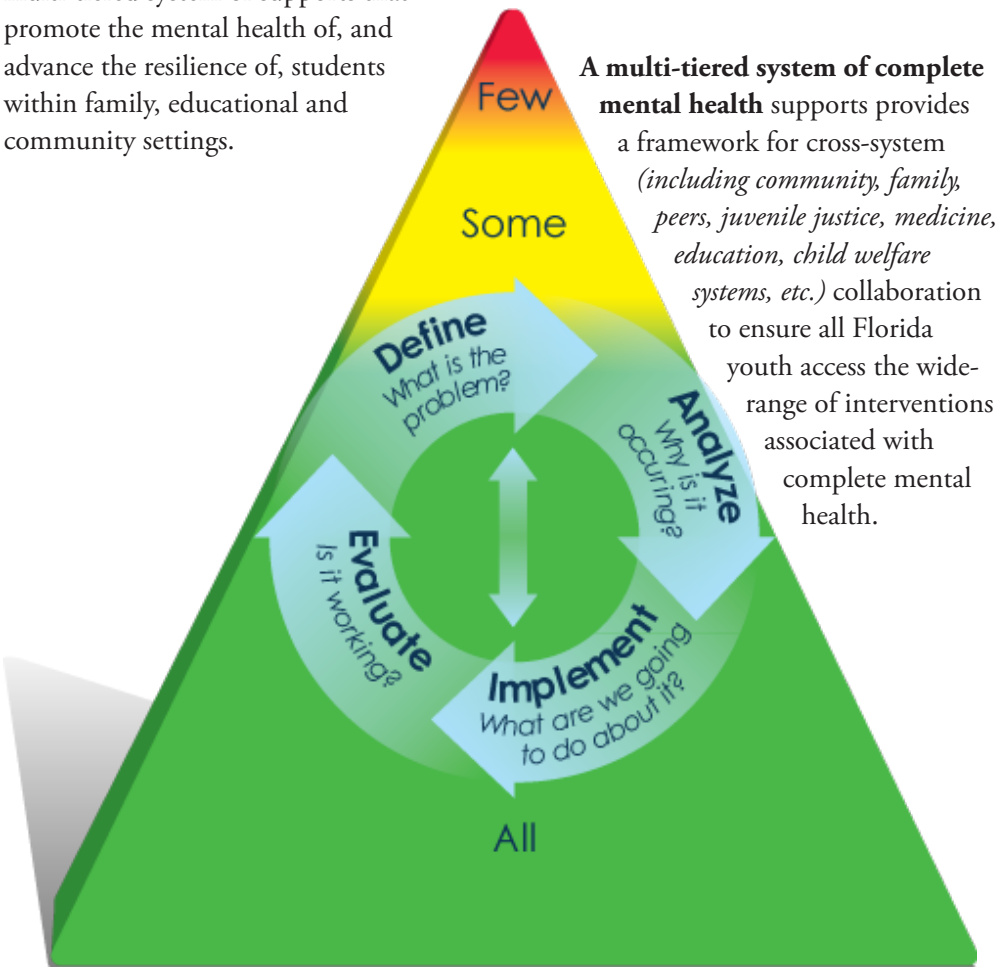
Polk

- Heartland for Children
- Polk County Indigent Healthcare, Polk County BoCC

Florida AWARE
Advancing Wellness and Resiliency in Education

Florida AWARE Vision

Florida will develop and sustain integrated, multi-tiered system of supports that promote the mental health of, and advance the resilience of, students within family, educational and community settings.



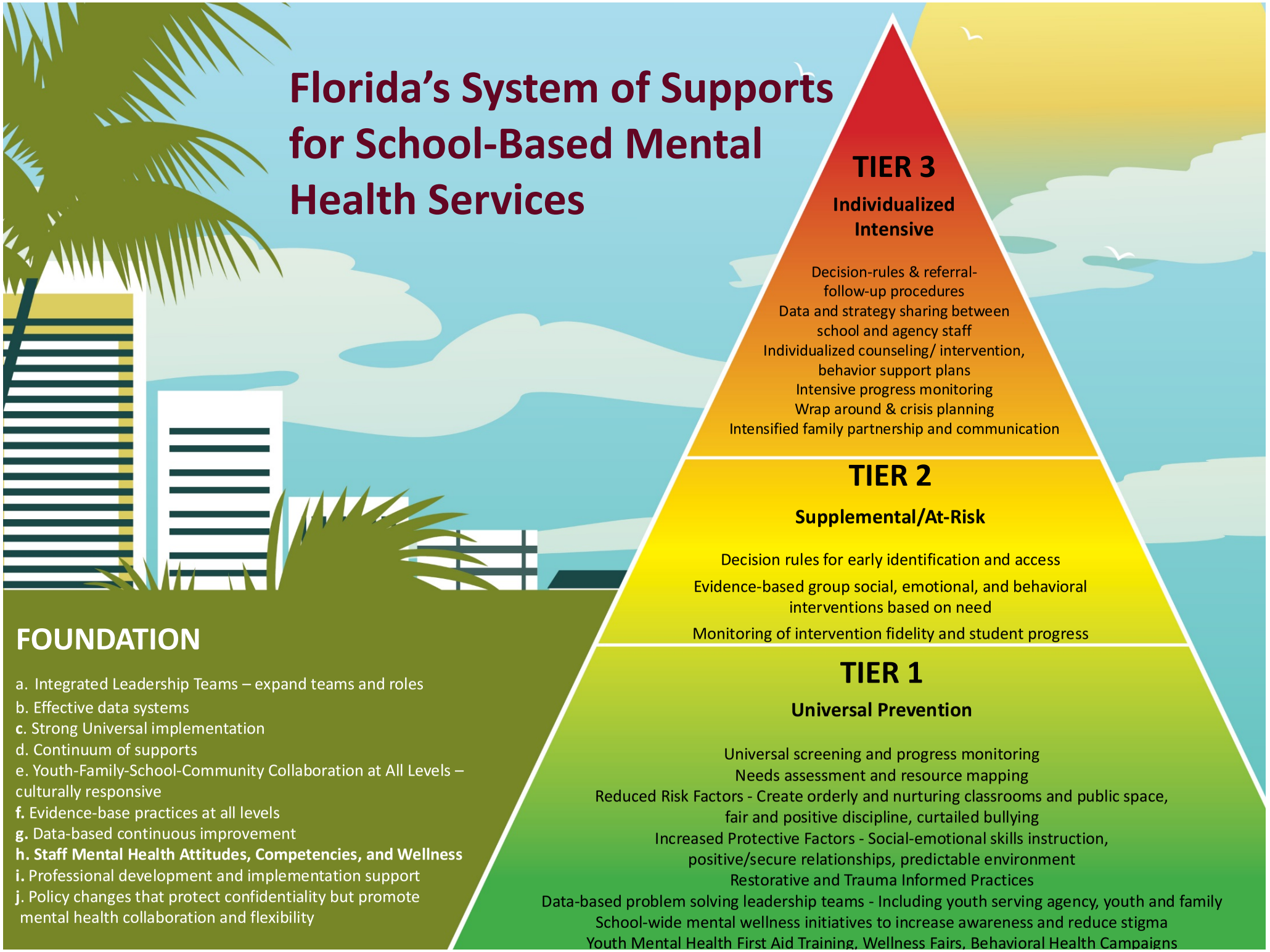
A multi-tiered system of complete mental health supports provides a framework for cross-system *(including community, family, peers, juvenile justice, medicine, education, child welfare systems, etc.)* collaboration to ensure all Florida youth access the wide-range of interventions associated with complete mental health.

Six Evidence Based Components

Florida AWARE's integrated multi-tiered system of mental health supports builds upon six critical evidence-based components:

- **District and state level leadership** to prioritize the Florida AWARE vision and mission, oversee implementation, and allocate resources
- **Capacity building and infrastructure development** including workforce development through training and ongoing systems and practice level coaching
- **Interdisciplinary collaboration and communication** guided by youth and family voice
- **Data-based problem solving processes** for a broad range of complete mental health outcomes for youth
- **Data evaluation systems** for comprehensive screening and progress monitoring for effectiveness and fidelity
- **Multiple tiers of evidence-based, culturally responsive practices and programs** to support complete mental health

Florida's System of Supports for School-Based Mental Health Services



FOUNDATION

a. Integrated Leadership Teams – expand teams and roles
b. Effective data systems
c. Strong Universal implementation
d. Continuum of supports
e. Youth-Family-School-Community Collaboration at All Levels – culturally responsive
f. Evidence-base practices at all levels
g. Data-based continuous improvement
h. Staff Mental Health Attitudes, Competencies, and Wellness
i. Professional development and implementation support
j. Policy changes that protect confidentiality but promote mental health collaboration and flexibility

TAB # 2

A Framework for Safe and Successful Schools

AMERICAN SCHOOL COUNSELOR ASSOCIATION

NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

School Social Work Association of America

NASRO National Association of School Resource Officers

naesp National Association of Elementary School Principals

nassp national association of secondary school principals

Executive Summary

This joint statement provides a framework supported by educators for improving school safety and increasing access to mental health supports for children and youth. Efforts to improve school climate, safety, and learning are not separate endeavors. They must be designed, funded, and implemented as a comprehensive school-wide approach that facilitates interdisciplinary collaboration and builds on a multitiered system of supports. We caution against seemingly quick and potentially harmful solutions, such as arming school personnel, and urge policy leaders to support the following guidance to enact policies that will equip America's schools to educate and safeguard our children over the long term.

POLICY RECOMMENDATIONS TO SUPPORT EFFECTIVE SCHOOL SAFETY

1. Allow for blended, flexible use of funding streams in education and mental health services;
2. Improve staffing ratios to allow for the delivery of a full range of services and effective school–community partnerships;
3. Develop evidence-based standards for district-level policies to promote effective school discipline and positive behavior;
4. Fund continuous and sustainable crisis and emergency preparedness, response, and recovery planning and training that uses evidence-based models;
5. Provide incentives for intra- and interagency collaboration; and
6. Support multitiered systems of support (MTSS).

BEST PRACTICES FOR CREATING SAFE AND SUCCESSFUL SCHOOLS

1. Fully integrate learning supports (e.g., behavioral, mental health, and social services), instruction, and school management within a comprehensive, cohesive approach that facilitates multidisciplinary collaboration.
2. Implement multitiered systems of support (MTSS) that encompass prevention, wellness promotion, and interventions that increase with intensity based on student need, and that promote close school–community collaboration.
3. Improve access to school-based mental health supports by ensuring adequate staffing levels in terms of school-employed mental health professionals who are trained to infuse prevention and intervention services into the learning process and to help integrate services provided through school–community partnerships into existing school initiatives.
4. Integrate ongoing positive climate and safety efforts with crisis prevention, preparedness, response, and recovery to ensure that crisis training and plans: (a) are relevant to the school context, (b) reinforce learning, (c) make maximum use of existing staff resources, (d) facilitate effective threat assessment, and (e) are consistently reviewed and practiced.
5. Balance physical and psychological safety to avoid overly restrictive measures (e.g., armed guards and metal detectors) that can undermine the learning environment and instead combine reasonable physical security measures (e.g., locked doors and monitored public spaces) with efforts to enhance school climate, build trusting relationships, and encourage students and adults to report potential threats. If a school determines the need for armed security, properly trained school resource officers (SROs) are the only school personnel of any type who should be armed.
6. Employ effective, positive school discipline that: (a) functions in concert with efforts to address school safety and climate; (b) is not simply punitive (e.g., zero tolerance); (c) is clear, consistent, and equitable; and (d) reinforces positive behaviors. Using security personnel or SROs primarily as a substitute for effective discipline policies does not contribute to school safety and can perpetuate the school-to-prison pipeline.
7. Consider the context of each school and district and provide services that are most needed, appropriate, and culturally sensitive to a school's unique student populations and learning communities.
8. Acknowledge that sustainable and effective change takes time, and that individual schools will vary in their readiness to implement improvements and should be afforded the time and resources to sustain change over time.

Creating safe, orderly, and welcoming learning environments is critical to educating and preparing all of our children and youth to achieve their highest potential and contribute to society. We all share this responsibility and look forward to working with the Administration, Congress, and state and local policy makers to shape policies based on these best practices in school safety and climate, student mental health, instructional leadership, teaching, and learning.

A Framework for Safe and Successful Schools

The author organizations and cosigners of this joint statement applaud President Obama and Congress for acknowledging that additional actions must be taken to prevent violence in America's schools and communities. We represent the educators who work day in and day out to keep our children safe, ensure their well-being, and promote learning. This joint statement provides a framework supported by educators for improving school safety and increasing access to mental health supports for children and youth.

We created these policy and practice recommendations to help provide further guidance to the Administration, Congress, and state and local agencies as they reflect upon evidence for best practices in school safety and climate, student mental health and well-being, instructional leadership, teaching, and learning. Further, the partnership between our organizations seeks to reinforce the interdisciplinary, collaborative, and cohesive approach that is required to create and sustain genuinely safe, supportive schools that meet the needs of the whole child. Efforts to improve school climate, safety, and learning are not separate endeavors and must be designed, funded, and implemented as a comprehensive school-wide approach. Ensuring that mental health and safety programming and services are appropriately integrated into the overall multitiered system of supports is essential for successful and sustainable improvements in school safety and academic achievement.

Specifically, effective school safety efforts:

- Begin with proactive principal leadership.
- Allow school leaders to deploy human and financial resources in a manner that best meets the needs of their school and community.
- Provide a team-based framework to facilitate effective coordination of services and interventions.
- Balance the needs for physical and psychological safety.
- Employ the necessary and appropriately trained school-employed mental health and safety personnel.
- Provide relevant and ongoing professional development for all staff.
- Integrate a continuum of mental health supports within a multitiered system of supports.
- Engage families and community providers as meaningful partners.
- Remain grounded in the mission and purpose of schools: teaching and learning.

Although the focus of this document is on policies and practices that schools can use to ensure safety, we must acknowledge the importance of policies and practices that make our communities safer as well. This includes increased access to mental health services, improved interagency collaboration, and reduced exposure of children to community violence. Additionally, our organizations support efforts designed to reduce youth access to firearms. Finally, many local school districts and state boards of education are considering policies that would allow school staff to carry a weapon. Our organizations believe that arming educators would cause more harm than good, and we advise decision makers to approach these policies with extreme caution.

We urge policy leaders to support the following guidance to promote safe and supportive schools. We look forward to working with the Administration, Congress, and state and local agencies to shape and enact meaningful policies that will genuinely equip America's schools to educate and safeguard our children over the long term.

POLICY RECOMMENDATIONS TO SUPPORT EFFECTIVE SCHOOL SAFETY

1. **Allow for blended, flexible use of funding streams.** The Department of Education should work with the Department of Health and Human Services and Congress to release guidance that gives schools access to various funding streams (e.g., SAMHSA and Title I) to ensure adequate and sustained funding dedicated to improving school safety. One-time grants are beneficial in some circumstances; however, one-time allotments of money for schools are insufficient for sustained change to occur. Similarly, district superintendents must be able to anticipate the availability of future funding in order to collaborate with school principals to effectively plan for and implement meaningful changes that will result in positive, sustainable outcomes for students.
2. **Strive to improve staffing ratios to allow for the delivery of a full range of services, including school–community partnerships, and set standards that will help schools effectively and accurately assess their needs.** This will require providing additional funding for key personnel such as school counselors, school psychologists, school social workers, and school nurses.
3. **Outline standards for district-level policies to promote effective school discipline and positive behavior.** Although it has been briefly discussed in this document, we urge the Department to release guidance regarding effective school discipline policies. Far too many schools continue to use punitive discipline measures, such as zero-tolerance policies, that result in negative outcomes for students and contribute to the school-to-prison pipeline.
4. **Provide funding for continuous and sustainable crisis and emergency preparedness, response, and recovery planning and training (utilizing evidence-based models).** The minimum standards include:
   a. establishment of a school safety and crisis team that includes the principal, school-employed mental health professionals, school security personnel, and appropriate community first responders;
   b. a balanced focus on promoting and protecting both physical and psychological safety;
   c. a crisis team and plan based on the Department of Homeland Security's Incident Command System;
   d. ongoing professional development for all school employees to help identify key indicators of students' mental health problems as well as employees' specific roles in implementation of crisis response plans;
   e. professional development for school-employed mental health professionals and other relevant staff (e.g., key administrators, school resource officers) on how to implement effective crisis prevention, intervention, and postvention strategies, including the critical mental health components of recovery.
5. **Provide incentives for intra- and interagency collaboration.** All levels of government need to take preemptive measures to strengthen the ability of schools to provide coordinated services to address mental health and school safety. We urge the federal government to set the standard and issue guidance on how various government, law enforcement, and community agencies can work together to provide services to students and families. At all levels, we must remove the barriers between education and health service agencies. Schools serve as the ideal "hub" for service delivery; however, schools must be adequately staffed with school counselors, school psychologists, school social workers, and school nurses who can provide the proper services in the school setting, connect students and families to the appropriate services in the community, and work collaboratively with external agencies to ensure streamlined service delivery and avoid redundancy.

6. **Support multitiered systems of supports.** A full continuum of services ranging from building-level supports for all students to more intensive student-level services is necessary to effectively address school safety and student mental health.

BEST PRACTICES FOR CREATING SAFE AND SUCCESSFUL SCHOOLS

School safety and positive school climate are not achieved by singular actions like purchasing a designated program or piece of equipment but rather by effective comprehensive and collaborative efforts requiring the dedication and commitment of all school staff and relevant community members. Schools require consistent and effective approaches to prevent violence and promote learning, sufficient time to implement these approaches, and ongoing evaluation.

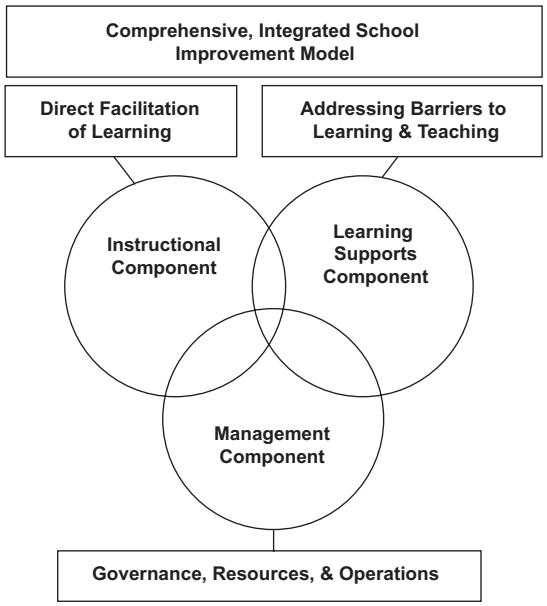
1. Integrate Services Through Collaboration

Safe and successful learning environments are fostered through collaboration among school staff and community-based service providers while also integrating existing initiatives in the school. Effective schools and learning environments provide equivalent resources to support instructional components (e.g., teacher quality, high academic standards, curriculum), organizational/management components (e.g., shared governance, accountability, budget decisions), and learning supports (e.g., mental health services; see Figure 1). Rather than viewing school safety as a targeted outcome for a single, stand-alone program or plan developed by the school building principal alone, this model seeks to integrate all services for students and families by framing the necessary behavioral, mental health, and social services within the context of school culture and learning. Integrated services lead to more sustainable and comprehensive school improvement, reduce duplicative efforts and redundancy, and require leadership by the principal and a commitment from the entire staff (See Roles of School Principals, page 8.).

2. Implement Multitiered Systems of Supports (MTSS)

The most effective way to implement integrated services that support school safety and student learning is through a school-wide multitiered system of supports (MTSS). MTSS encompasses (a) prevention and wellness promotion; (b) universal screening for academic, behavioral, and emotional barriers to learning; (c) implementation of evidence-based interventions that increase in intensity as needed; (d) monitoring of ongoing student progress in response to implemented

Figure 1.



Note. Adapted from UCLA Center for Mental Health in Schools and the National Association of School Psychologists. (2010). *Enhancing the Blueprint for School Improvement in the ESEA Reauthorization: Moving From a Two- to a Three-Component Approach* [Advocacy statement]. Adapted with permission.

interventions; and (e) engagement in systematic data-based decision making about services needed for students based on specific outcomes. In a growing number of schools across the country, response to intervention (RTI) and positive behavior interventions and supports (PBIS) constitute the primary methods for implementing an MTSS framework. Ideally though, MTSS is implemented more holistically to integrate efforts targeting academic, behavioral, social, emotional, physical, and mental health concerns. This framework is more effective with coordination of school-employed and community-based service providers to ensure integration and coordination of services among the school, home, and community.

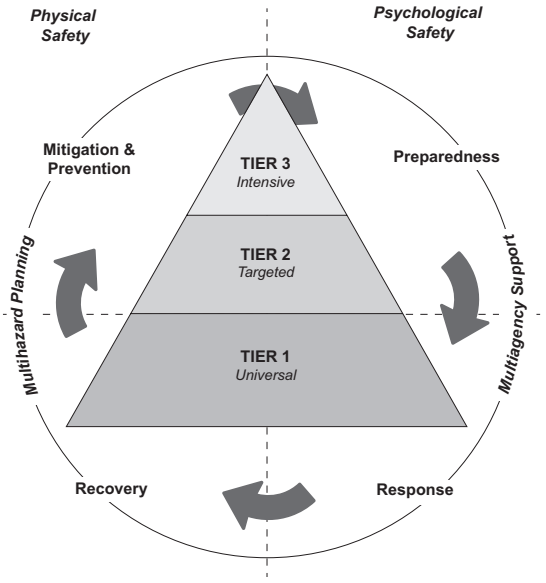
Effective MTSS requires:

- adequate access to school-employed specialized instructional support personnel (e.g., school counselors, school psychologists, school social workers, and school nurses) and community-based services;
- collaboration and integration of services, including integration of mental health, behavioral, and academic supports, as well integration of school-based and community services;
- adequate staff time for planning and problem solving;
- effective collection, evaluation, interpretation, and use of data; and
- patience, commitment, and strong leadership.

One approach to integrating school safety and crisis management into an MTSS framework is the M-PHAT model (see Figure 2). M-PHAT stands for:

- ***M***ulti-***P***hase (prevention, preparedness, response, and recovery)
- Multi-***H***azard (accidental death, school violence, natural disasters, terrorism)
- Multi-***A***gency (school, police, fire, EMS, mental health)
- Multi-***T***iered (an MTSS framework)

Figure 2. Comprehensive Safe Learning Environment: The M-PHAT Approach



Note. From *Comprehensive Planning for Safe Learning Environments: A School Professional's Guide to Integrating Physical and Psychological Safety – Prevention Through Recovery,* by M. A. Reeves, L. M. Kanan, & A. E. Plog, 2010, New York, NY: Routledge. Reprinted with permission.

3. Improve Access to School-Based Mental Health Supports

Mental health is developed early in life and educators play a significant role in ensuring that students' experiences throughout their school careers contribute to their positive mental health. Access to school-based mental health services and supports directly improves students' physical and psychological safety, academic performance, and social–emotional learning. This requires adequate staffing levels in terms of school-employed mental health professionals (school counselors, school psychologists, school social workers, and in some cases, school nurses) to ensure that services are high quality, effective, and appropriate to the school context. Access to school mental health services cannot be sporadic or disconnected from the learning process. Just as children are not simply small adults, schools are not simply community clinics with blackboards. School-employed mental health professionals are specially trained in the interconnectivity among school law, school system functioning, learning, mental health, and family systems. This training ensures that mental health services are properly and effectively infused into the learning environment, supporting both instructional leaders and teachers' abilities to provide a safe school setting and the optimum conditions for teaching and learning. No other professionals have this unique training background.

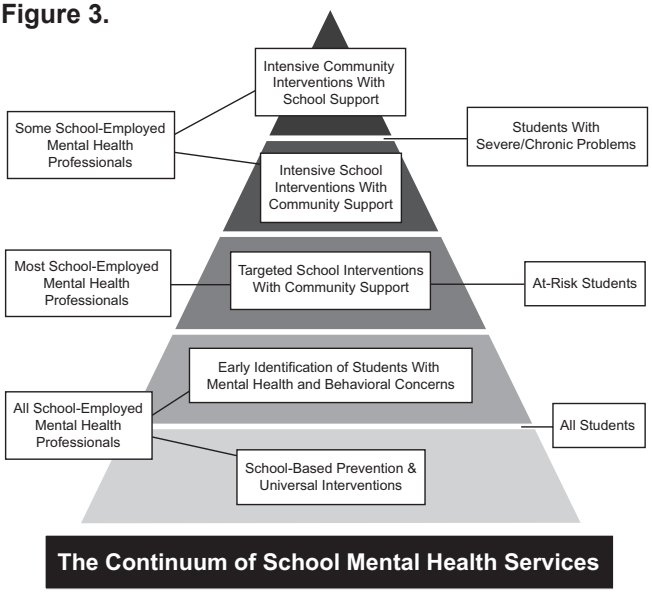
Having these professionals as integrated members of the school staff empowers principals to more efficiently and effectively deploy resources, ensure coordination of services, evaluate their effectiveness, and adjust supports to meet the dynamic needs of their student populations. Improving access also allows for enhanced collaboration with community providers to meet the more intense or clinical needs of students (see Figure 3).

School counselors, school psychologists, and school social workers all offer unique individual skills that complement one another in such a way that the sum is greater than the parts (See Roles of School-Employed Mental Health Professionals, page 9.) When given the opportunity to work collectively, they are ready and capable of providing an even wider range of services, such as:

- collecting, analyzing, and interpreting school-level data to improve availability and effectiveness of mental services;
- designing and implementing interventions to meet the behavioral and mental health needs of students;
- promoting early intervention services;
- providing individual and group counseling;
- providing staff development related to positive discipline, behavior, and mental health (including mental health first aid);
- providing risk and threat assessments;
- supporting teachers through consultation and collaboration;
- coordinating with community service providers and integrating intensive interventions into the schooling process.

Addressing Shortages: Fully providing effective, integrated, and comprehensive services requires schools to maintain appropriate staffing levels for their school-employed mental health professionals. Every district and school must

Figure 3.



Note. Adapted from "Communication Planning and Message Development: Promoting School-Based Mental Health Services," by the National Association of School Psychologists, 2006, *Communiqué*, *35*(1), p. 27. Copyright 2006 by the National Association of School Psychologists. Adapted with permission.

be supported to improve staffing ratios. Unfortunately, significant budget cuts, combined with widespread personnel shortages, have resulted in reduced access to school-employed mental health professionals in many schools and districts. In these districts, school counselors, school psychologists, school social workers, and school nurses often have inappropriately high student-to-professional ratios that far exceed the recommendations provided by their respective professional organizations. Poor ratios restrict the ability of these professionals to devote time to important initiatives, including school-wide preventive services (e.g., bullying, violence, and dropout prevention), safety promotion, and sustained school improvement. Many districts go without prevention and early intervention services that effectively link mental health, school climate, school safety, and academic instruction. Partnerships with community providers or school-based health centers can provide important resources for individual students. However, community providers sometimes lack familiarity with specific processes in teaching and learning and with systemic aspects of schooling. Successful school–community partnerships integrate community supports into existing school initiatives utilizing a collaborative approach between school and community providers that enhances effectiveness and sustainability. Many schools have limited access to community supports making overreliance on community partners as primary providers of mental health services potentially problematic.

District-wide policies must support principals and school safety teams to provide services in school-based settings and strengthen the ability of schools to respond to student and family needs directly. While working to improve ratios, districts can begin to move toward more effective and sustainable services by:

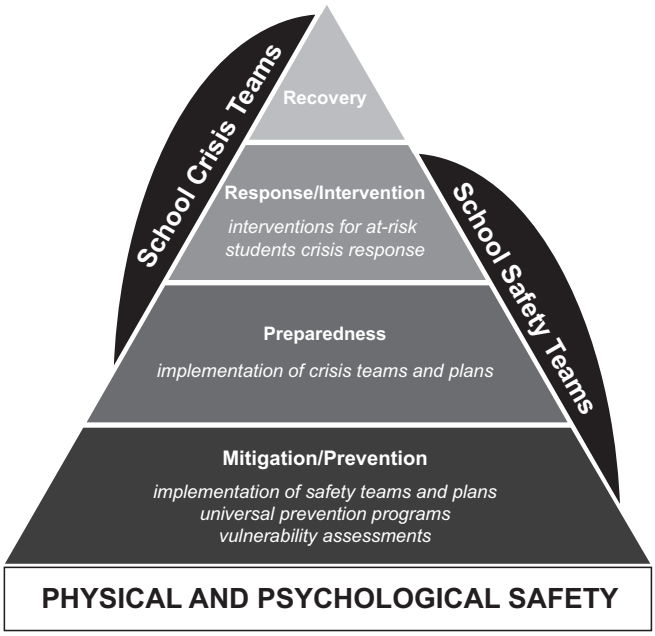
- Assigning a school psychologist, school counselor, or school social worker to coordinate school-based services with those provided by community providers.
- Ensuring that the school data being collected and resulting strategies are addressing the most urgent areas of need with regard to safety and climate.
- Providing training that targets the specific needs of individual schools, their staffs, and their students.
- Reviewing current use of mental health staff and identifying critical shifts in their responsibilities to bolster prevention efforts.

4. Integrate School Safety and Crisis/Emergency Prevention, Preparedness, Response, and Recovery

Schools must be supported to develop an active school safety team that focuses on overall school climate as well as crisis and emergency preparedness, response, and recovery (see Figure 4). School safety and crisis response occur on a continuum, and crisis planning, response, and recovery should build upon ongoing school safety and mental health services. School crisis and emergency preparedness training should encompass prevention/mitigation, early intervention (which is part of ongoing school safety), immediate response/intervention, and long-term recovery. These four phases are clearly articulated by the Departments of Education and Homeland Security.

Training and planning must be relevant to the learning context and make maximum use of existing staff resources. The safety and crisis team should, at a minimum, include principals, school mental health professionals, school security personnel, appropriate community stakeholders (such as representatives from local law enforcement and emergency personnel), and other school staff or district liaisons to help sustain efforts over time. Additionally, crisis and emergency preparedness plans must be consistently reviewed and practiced, which is more easily facilitated by an actively engaged team that links the school to the broader community. Active engagement of the team is often directly linked to appropriate staffing levels that allow time for collaboration and planning. Effective, engaged teams and plans:

Figure 4.



Note. Adapted from Cherry Creek School District. (2008). *Emergency response and crisis management guide*. Greenwood Village, CO: Author. Adapted with permission.

- Contribute to ongoing school safety and improved school climate by supporting a school-wide, evidence-based framework that is appropriate to the unique school culture and context.
- Balance efforts to promote and protect physical and psychological safety.
- Minimize unsafe behaviors such as bullying, fighting, and risk-taking by providing quality prevention programming.
- Improve early identification and support for students at risk of harming themselves or others (e.g., threat assessment).
- Model collaborative problem solving.
- Provide for consistent, ongoing training of all school staff.
- Address the range of crises that schools can face with a focus on what is most likely to occur (e.g., death of a student or staff member, school violence, natural disaster).
- Improve response to crises when the unpreventable occurs.
- Ensure an organized plan that has appropriately assessed risks to the school and the learning environment and has been adopted by the school safety team to promote a return to normalcy following a crisis or emergency.
- Promote efforts for ongoing learning and long-term emotional recovery for every student and family.

5. Balance Physical and Psychological Safety

Any effort to address school safety should balance building security/physical safety with psychological safety. Relying on highly restrictive physical safety measures alone, such as increasing armed security or imposing metal detectors, typically does not objectively improve school safety. In fact, such measures may cause students to feel *less safe* and more fearful at school, and could undermine the learning environment. In contrast, combining reasonable physical security measures with efforts to enhance school climate more fully promotes overall school safety. Effectively balancing physical and psychological safety entails:

- Assessing the physical security features of the campus, such as access points to the school grounds, parking lots and buildings, and the lighting and adult supervision in lobbies, hallways, parking lots, and open spaces.
- Employing environmental design techniques, such as ensuring that playgrounds and sports fields are surrounded by fences or other natural barriers, to limit visual and physical access by non-school personnel.
- Evaluating policies and practices to ensure that students are well monitored, school guests are appropriately identified and escorted, and potential risks and threats are addressed quickly.
- Building trusting, respectful relationships among students, staff, and families.
- Providing access to school mental health services and educating students and staff on how and when to seek help.
- Providing a confidential way for students and other members of the school community to report potential threats, because educating students on "breaking the code of silence" is one of our most effective safety measures.

Schools also should carefully weigh the unique needs of their communities when determining the need to hire additional security personnel or school resource officers (SROs). It is important to recognize that SROs differ from other school security personnel or armed guards. SROs are commissioned law enforcement officers who are specially trained to work within the school community to help implement school safety initiatives as part of the school safety leadership team. They should be integral participants in school life and student learning. Additionally, if a school determines that it needs to have an armed professional on school grounds, SROs are the only school personnel of any type who should be armed. (See Roles of School Resource Officers, page 9.)

6. Employ Effective, Positive School Discipline

School discipline policies are ultimately the responsibility of the school principal; however, all school staff play a role in their effective development and implementation. Discipline practices should function in concert with efforts to address school safety/climate. When positive discipline is incorporated into the overall MTSS, students feel respected and supported, positive behavior is continually reinforced, and school climate improves. Additionally, this structure allows for the use of restorative practices that seek to build positive relationships within the school community. In contrast, overly harsh and punitive measures, such as zero tolerance policies, lead to reduced safety, connectedness, and feelings of belonging, and have historically been unsuccessful at improving student behavior or the overall school climate. Additionally, utilizing SROs or other security personnel primarily as a substitute for effective discipline policies is inappropriate, does not contribute to school safety or students' perceptions of being safe, and can perpetuate the school-to-prison pipeline. Effective school discipline:

- is viewed within the context of a learning opportunity and seeks to teach and reinforce positive behaviors to replace negative behaviors;
- is clear, consistent, and equitably applied to all students;
- employs culturally competent practices;
- safeguards the well-being of all students and staff;
- keeps students in school and out of the juvenile justice system; and
- incorporates family involvement.

7. Allow for the Consideration of Context

There is no one-size-fits-all approach to creating safe and successful schools. To be most effective, schools should assess the structures and resources already in place and determine what additional resources are needed. Schools should provide universal, secondary, and tertiary interventions that are most appropriate and culturally sensitive to their unique student populations and learning communities. Additionally, decisions regarding appropriate security measures, including the use of SROs, should be determined by each school's leadership team and not via universal mandate.

8. Acknowledge That Sustainable and Effective Improvement Takes Patience and Commitment

School districts will vary considerably in their readiness to change and in their ability to accept the suggestions included within this document. Recognizing that sustainable change takes time both to improve acceptability and allow for full implementation will help set districts up for success rather than setting unrealistic goals. Efforts for change should not be abandoned if goals are not immediately met, as frequent programmatic changes lead to more resistance to change among school personnel in the future.

ROLES OF KEY LEADERSHIP PERSONNEL REGARDING SCHOOL SAFETY AND CLIMATE

Role of School Principals

Effective principals and assistant principals recognize the potential they have to create a school environment where teachers thrive and students achieve their greatest potential in a safe and nurturing school setting. As instructional leaders, principals maintain a constant presence in the school and in classrooms, listening to and observing what is taking place, assessing needs, and getting to know teachers and students. Principals set high expectations and standards for the academic, social, emotional, and physical development of all students. They bring together a wide range of stakeholders within the school community, take into account the aspirations, and work to create a vision that reflects the full range and value of a school's mission. Principals encourage the development of the whole child by supporting the physical and mental health of children, as well as their social and emotional well-being, which is reinforced by a sense of safety and self-confidence. High-quality early childhood education and learning experiences are crucial to an elementary level principal's shared vision to shape the school culture and instructional leadership. School leaders must mobilize the staff, students, parents, and community around the mission and shared values, as well as school improvement goals and set the parameters of high expectations for the school. Effective practice requires:

- building consensus on a vision that reflects the core values of the school community to support student safety and well-being;
- valuing and using diversity to enhance the learning of the entire school community;
- broadening the framework for child development beyond academics; and
- developing a learning culture that is adaptive, collaborative, innovative, and supportive by taking into account the contributions of every member of the school staff.

Roles of School-Employed Mental Health Professionals

Many professionals within a school help to support students' positive mental health. This includes school counselors, school psychologists, school social workers, school nurses, and other specialized instructional support personnel. For the purposes of these recommendations, however, we are focusing on the mental health professionals who should serve in critical leadership roles in terms of school safety, positive school climate, and providing school-based mental health services: school counselors, school psychologists, and school social workers. Their training and expertise help link mental health, behavior, environmental factors (e.g., family, classroom, school, community), instruction, and learning. Each of these professionals helps to create school environments that are safe, supportive, and conducive to learning. Each may deliver similar services such as counseling, social–emotional skill instruction, and consultation with families and teachers; however, each profession has its own unique focus based upon its specializations, which result in different, albeit interrelated, services. The specific services and expertise of individual practitioners may vary, but the following describes the core competencies and specialized instructional services of each profession.

School counselors. Have a minimum of a master's degree in school counseling. School counselors are generally the first school-employed mental health professional to interact with students as they commonly are involved in the provision of universal learning supports to the whole school population. School counselors have specialized knowledge of curriculum and instruction and help screen students for the basic skills needed for successful transition from cradle to college and career. School counselors focus on helping students' address their academic, personal/social, and career development goals and needs by designing, implementing, and evaluating a comprehensive school counseling program that promotes and enhances student success. School counselors work to promote safe learning environments for all members of the school community and regularly monitor and respond to behavior issues that impact school climate, such as bullying, student interpersonal struggles, and student–teacher conflicts. Effective school counseling programs are a collaborative effort between the school counselor, teachers, families, and other educators to create an environment promoting student achievement, active engagement, equitable access to educational opportunities, and a rigorous curriculum for all students.

School psychologists. Have a minimum of a specialist-level degree (60 graduate semester hour minimum) in school psychology, which combines the disciplines of psychology and education. They typically have extensive knowledge of learning, motivation, behavior, childhood disabilities, assessment, evaluation, and school law. School psychologists specialize in analyzing complex student and school problems and selecting and implementing appropriate evidence-based interventions to improve outcomes at home and school. School psychologists consult with teachers and parents to provide coordinated services and supports for students struggling with learning disabilities, emotional and behavioral problems, and those experiencing anxiety, depression, emotional trauma, grief, and loss. They are regular members of school crisis teams and collaborate with school administrators and other educators to prevent and respond to crises. They have specialized training in conducting risk and threat assessments designed to identify students at-risk for harming themselves or others. School psychologists' training in evaluation, data collection, and interpretation can help ensure that decisions made about students, the school system, and related programs and learning supports are based on appropriate evidence.

School social workers. Have master's degrees in social work. They have special expertise in understanding family and community systems and linking students and their families with the community services that are essential for promoting student success. School social workers' training includes specialized preparation in cultural diversity, systems theory, social justice, risk assessment and intervention, consultation and collaboration, and clinical intervention strategies to address the mental health needs of students. They work to remedy barriers to learning created as a result of poverty, inadequate health care, and neighborhood violence. School social workers often focus on providing supports to vulnerable populations of students that have a high risk for truancy and dropping out of school, such as homeless and foster children, migrant populations, students transitioning between school and treatment programs or the juvenile justice system, or students experiencing domestic violence. They work closely with teachers, administrators, parents, and other educators to provide coordinated interventions and consultation designed to keep students in school and help their families access the supports needed to promote student success.

Roles of School Resource Officers

The presence of school resource officers in schools has become an important part of the duty to protect students and staff on campus. Families and school officials in communities around the country benefit from a more effective relationship with local police as part of a school safety plan. Specialized knowledge

of the law, local and national crime trends and safety threats, people and places in the community, and the local juvenile justice system combine to make SROs critical members of schools' policy-making teams when it comes to environmental safety planning and facilities management, school safety policy, and emergency response preparedness.

In order to fully realize the benefits of the presence of local police, the SROs must be trained properly. Officers' law-enforcement knowledge and skill combine with specialized SRO training for their duties in the education setting. This training focuses on the special nature of school campuses, student needs and characteristics, and the educational and custodial interests of school personnel. SROs, as a result, possess a skill set unique among both law enforcement and education personnel that enables SROs to protect the community and the campus while supporting schools' educational mission. In addition to traditional law enforcement tasks, such as investigating whether drugs have been brought onto campus, SROs' daily activities cover a wide range of supportive activities and programs depending upon the type of school to which an SRO is assigned. This can include conducting law-related education sessions in the classroom, meeting with the school safety team, conducting safety assessments of the campus, and problem solving with students or faculty. Trained and committed SROs are well suited to effectively protect and serve the school community. They contribute to the safe-schools team by ensuring a safe and secure campus, educating students about law-related topics, and mentoring students as informal counselors and role models.

Actions Principals Can Take Now to Promote Safe and Successful Schools

Policies and funding that support comprehensive school safety and mental health efforts are critical to ensuring universal and long-term sustainability. However, school leaders can work toward more effective approaches now by taking the following actions.

- Establish a school leadership team that includes key personnel: principals, teachers, school-employed mental health professionals, instruction/curriculum professionals, school resource/safety officer, and a staff member skilled in data collection and analysis.
- Assess and identify needs, strengths, and gaps in existing services and supports (e.g., availability of school and community resources, unmet student mental health needs) that address the physical and psychological safety of the school community.
- Evaluate the safety of the school building and school grounds by examining the physical security features of the campus.
- Review how current resources are being applied, for example:
    - Are school employed mental health professionals providing training to teachers and support staff regarding resiliency and risk factors?
    - Do mental health staff participate in grade-level team meetings and provide ideas on how to effectively meet students' needs?
    - Is there redundancy in service delivery?
    - Are multiple overlapping initiatives occurring in different parts of the school or being applied to different sets of students?
- Implement an integrated approach that connects behavioral and mental health services and academic instruction and learning (e.g., are mental health interventions being integrated into an effective discipline or classroom management plan?).
- Provide adequate time for staff planning and problem solving via regular team meetings and professional learning communities. Identify existing and potential community partners, develop memoranda of understanding to clarify roles and responsibilities, and assign appropriate school staff to guide these partnerships, such as school-employed mental health professionals and principals.
- Provide professional development for school staff and community partners addressing school climate and safety, positive behavior, and crisis prevention, preparedness, and response.
- Engage students and families as partners in developing and implementing policies and practices that create and maintain a safe school environment.

SUMMARY

Modern-day schools are highly complex and unique organizations that operate with an urgent imperative: Educate and prepare all children and youth to achieve their highest potential and contribute to society, no matter their socioeconomic background or geographic location. Creating safe, orderly, warm, and inviting school environments is critical to ensuring that all of our schools meet this goal. In order to create this type of environment, schools must work towards integrating services (academic, behavioral, social, emotional, and mental health) through collaboration using a multitiered system of support. Schools should strive to increase access to mental health services, increase the number of school employed mental health staff, and ensure that measures to improve school safety balance physical safety with psychological safety. To further support student safety, schools must develop effective emergency preparedness and crisis prevention, intervention, and response plans that are coordinated with local first responders. We look forward to working with the Administration, Congress, and state and local policy makers to help ensure that all schools are safe, supportive, and conducive to learning.

GUIDELINES FOR EFFECTIVE PRACTICE

ASCA: http://www.ascanationalmodel.org/

- *ASCA National Model, 2008*

NAESP: http://www.naesp.org/resources/1/Pdfs/LLC2-ES.pdf

- *Leading Learning Communities: Standards for What Principals Should Know and Be Able to Do*, 2008

NASP Professional Standards: http://www.nasponline.org/standards/2010standards.aspx

- *Model for Comprehensive and Integrated School Psychological Services*, 2010

NASRO: http://www.nasro.org/sites/default/files/pdf_files/NASRO_Protect_and_Educate.pdf

- *To Protect and Educate: The School Resource Officer and the Prevention of Violence in Schools*, 2012

NASSP: http://www.nassp.org/school-improvement

- *Breaking Ranks: The Comprehensive Framework for School Improvement*, 2011

SSWAA: http://sswaa.org/associations/13190/files/naswschoolsocialworkstandards.pdf

- *NASW School Social Work Standards*, 2012

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National Association of School Psychologists (NASP): www.nasponline.org

National Association of School Resource Officers (NASRO): www.nasro.org

National Association of Secondary School Principals (NASSP): www.nassp.org

School Social Work Association of America (SSWAA): www.sswaa.org

ENDORSING ORGANIZATIONS*

National Organizations

Alberti Center for Bullying Abuse Prevention
American Association of School Administrators
American Camp Association, Inc.
American Council for School Social Work
American Dance Therapy Association
American School Health Association
Born This Way Foundation
Character Education Partnership
Child Mind Institute
Coalition for Community Schools
Collaborative for Academic, Social, and Emotional Learning
Committee for Children
Council for Children with Behavioral Disorders
Council for Exceptional Children
Division 16, American Psychological Association
Gay, Lesbian & Straight Education Network
High Hope Educational Research Foundation
International School Psychology Association
Learning Disabilities Association of America
Mental Health America
Midwest Symposium for Leadership in Behavior Disorders
National Association of School Nurses
National Association of School Safety and Law Enforcement Officials

National Association of Social Workers
National Association of State Directors of Special Education
National Center for School Engagement
National Education Association
National Federation of Families for Children's Mental Health
National Network of Safe and Drug-Free Schools
National Organizations for Youth Safety
Pride Surveys
Safe and Civil Schools
Trainers of School Psychology
The Trevor Project

State Associations

Alabama School Counselor Association
Alaska School Counselor Association
Arizona School Counselors Association
Association of School Psychologists of Pennsylvania
California Association of School Counselors
California Association of School Social Workers
Colorado School Counselor Association
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Nebraska School Psychology Association
New Jersey Association of School Social Workers
New Jersey School Counselor Association
New Mexico School Counselor Association
New York Association of School Psychologists
New York State School Counselor Association
North Dakota School Counselor Association
Ohio School Psychologist Association
Oklahoma School Counselors Association
Oregon School Psychologists Association
Pennsylvania School Counselors Association
Rhode Island School Counselor Association
School Social Work Association of Arizona
School Social Workers Association of Missouri
School Social Workers in Arkansas
School Social Workers in Maryland
South Carolina Association of School Psychologists
South Carolina Association of School Social Workers
South Carolina School Counselor Association
South Dakota School Counselor Association
Tennessee School Counselor Association
Utah School Counselor Association
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Virginia Academy of School Psychology
Virginia Association of Visiting Teachers/School Social Workers
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*As of April 12, 2013. For an updated list, visit www.nasponline.org/schoolsafetyframework

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AVAILABLE ONLINE AT WWW.NASPONLINE.ORG/SCHOOLSAFETYFRAMEWORK.

Policy Recommendations for Implementing the Framework for Safe and Successful Schools

Implementing the Framework for Safe and Successful Schools[1] requires policies and practices that support ongoing efforts to establish comprehensive school safety programming. Following are policy and practice recommendations to consider when developing your action plan. Some recommendations may appear in multiple sections.

Integration of Services and Initiatives

- Provide ongoing, high quality, relevant, and job embedded professional development to all school staff.
- Encourage the use of professional learning communities or other structured avenues to foster collaboration among school staff.
- Ensure that district and school building teams have representation of diverse stakeholders, including principals, teachers (general and special education), parents, school security professionals and school resource officers (SROs), school-employed mental health professionals (e.g., school psychologists), and other specialized instructional support personnel.
- Engage in resource mapping to better understand available resources and how they are utilized through the school or district to support:
  - Instruction
  - Organization and management
  - Learning supports (e.g., mental and behavioral health services)
- Develop a process for regular examination of school initiatives to improve student outcomes.
  - Are any initiatives redundant?
  - Are all initiatives directly related to the school improvement plan?
  - Do you have staff buy-in?
- Effectively engage parents and families in school improvement and school safety efforts.

Related Resources

- Assessing School Level and District Level Needs
- Ready to Learn, Empowered to Teach: Guiding Principles for Effective Schools & Successful Students
- Ensuring High-Quality, Comprehensive and Integrated Student Supports (NASP Position Statement)
- NASSP Position Statement on Safe Schools
- NASP Online Learning Center
- NASP PREPaRE Training Curriculum
- Leading Success Module on Safe and Healthy School Environments

[1] Cowan, K. C., Vaillancourt, K., Rossen, E., & Pollitt, K. (2013). A framework for safe and successful schools [Brief]. Bethesda, MD: National Association of School Psychologists.

Implementation of Integrated Multitiered Systems of Support (MTSS)

- Establish a process for universal screening for academic, behavioral, and emotional barriers to learning.
- Implement high-quality, rigorous curricula that address core academic competencies, social–emotional learning principles, mental and behavioral wellness, and positive behavior.
- Establish a process for regularly reviewing student data (both behavioral and academic).
  - Require a multidisciplinary, data-based decision-making team comprised of diverse stakeholders, including principals/administrators, teachers (general and special education), parents, school-employed mental health professionals (e.g., school psychologists) and other specialized instructional support personnel.
- Ensure access to a range of high-quality, evidence-based interventions to address the comprehensive needs of students.
- Build upon existing district and state initiatives related to MTSS (e.g., response to intervention and positive behavioral interventions and supports).
- Embed time for planning and problem solving into the staff master schedule.
- Explicitly include MTSS efforts in the school improvement plan.
- Braid available funding streams to scale up existing efforts.
- Embed MTSS principles into all relevant professional development.
- Leverage existing technical assistance available from state, regional, and national centers.

Related Resources

- Leveraging Essential School Practices, ESSA, MTSS, and the NASP Practice Model: A Crosswalk to Help Every School and Student Succeed
- Integrated Model of Academic and Behavior Supports (NASP Position Statement)
- The School Counselor and MTSS
- ESSA and Multitiered Systems of Support
- ASCA specialist trainings/PD opportunities

Access to School-Based Mental Health Supports

- Examine existing ratios of school psychologists, school social workers, and school counselors.
  - Work with district and state leaders to develop a long-term plan to achieve recommended ratios of *each profession.*
- Develop and implement a process for parents, teachers, and students to refer themselves or others for mental health support.
- Provide annual (or biannual) professional development to all school staff in mental health first aid, the appropriate referral process, suicide prevention, and other relevant mental and behavioral health topics.
  - Utilize existing school-employed mental health professionals in the development and delivery of this professional development.
  - Provide additional professional development to school-employed mental health professionals on current evidence-based practices.
- Develop policies and procedures for conducting suicide risk and threat assessments.

    - Require involvement of the school counselor, school psychologist, or school social worker.
- Conduct a needs assessment to evaluate existing and needed supports.
    - Examine availability of services in all tiers (prevention/early intervention, targeted support, intensive support).
- Implement universal screening for mental and behavioral health concerns.
- Ensure availability of evidence-based mental health supports for students identified as being 'at-risk' in universal screening measures and other referral processes.
- If your school or district maintains formal partnerships with community agencies who provide mental and behavioral health, establish clear expectations for communication and collaboration among school-employed mental health professionals and community-employed providers.
- Braid available funding streams to scale up existing efforts.

Related Resources

- NASP Practice Model Implementation Guide
- Mental and Behavioral Health Services for Children and Adolescents (NASP Position Statement)
- Shortages in School Psychology Resource Guide
- School Psychologists: Qualified Health Professionals Providing Child and Adolescent Mental and Behavioral Health Services (NASP White Paper)
- NASSP Position Statement on Mental Health
- The School Counselor and Student Mental Health
- Community Schools White Paper
- School–Community Alliances Enhance Mental Health Services

Integration of School Safety and Crisis Preparedness Efforts

- Require establishment of a dedicated safety/crisis response team that includes, at a minimum, school principals/administrators, school employed mental health professionals, school security professional/SROs, community stakeholders, parents, and other school staff as appropriate. Convene this team on a regular basis.
- Develop a memorandum of understanding (MOU) with school security agency/local police department with clear articulation of specific roles and responsibilities of school security personnel or the school resource officer.
- Examine existing ratios of school psychologists, school social workers, and school counselors.
    - Work with district and state leaders to develop a long-term plan to achieve recommended ratios of *each profession.*
- Develop an emergency response plan with procedures for regular review.
- Provide ongoing staff development on the school safety and crisis plan that includes regularly scheduled practice and coordination with community responders.

Related Resources

- Model School District Policy on Suicide Prevention
- School Violence Prevention (NASP Position Statement)
- NASP PREPaRE Training Curriculum
- NASP Online Learning Center

Balance of Physical and Psychological Safety

- Ensure annual (at least) collection and review of school-wide climate and school safety data.
  - Data collection should include teacher, parent, and student perception of school climate and safety.
- Include explicit goals related to school climate and school safety in the school/district level improvement plan.
- Regularly examine the use and effectiveness of extreme physical security measures (e.g., metal detectors, armed security).
  - Examine the use of these measures in conjunction with student perception of school safety.
- Develop and implement procedures (including anonymous reporting) for students, staff, and families to report potential threats or other concerning behaviors.
- Promote mentoring programs and other efforts to ensure that all students have a positive relationship with at least one adult.
- Develop and implement a process for parents, teachers, and students to refer themselves or others for mental health support.
- Provide annual (or biannual) professional development to all school staff—and students as appropriate—in mental health first aid, the appropriate referral process, suicide prevention, and other relevant mental and behavioral health topics.
- Ensure availability of evidence-based mental health supports for students identified as being 'at-risk' in universal screening measures and other referral processes.

Related Resources

- School Security Measures and Their Impacts on Students (NASP Research Summary)
- ESSA and School Climate
- Best Practice Considerations for Active Shooter and Armed Assailant Drills
- School Safety: What Really Works

Use of Effective Discipline Practices

- Create and communicate clear behavioral expectations for staff and students.
- Clearly articulate, and consistently enforce, consequences for inappropriate behavior.
- Routinely teach students appropriate behavior, and make sure that staff model appropriate behavior.
  - Reinforce the display of appropriate behavior.
- Establish a process for regularly reviewing student discipline data (in conjunction with other available data sources).
  - Require a multidisciplinary, data-based decision-making team comprised of diverse stakeholders, including principals, teachers (general and special education), parents, school-employed mental health professionals (e.g., school psychologists) and other specialized instructional support personnel.
- Prohibit the use of zero tolerance policies.
- Establish enumerated antibullying and harassment policies.
- Establish procedures for responding to all reports of bullying and harassment.

Related Resources

- Bullying Prevention and Intervention in Schools (NASP Position Statement)
- Corporal Punishment (NASP Position Statement)
- NASSP Position Statement on Corporal Punishment
- NASSP Position Statement on School Discipline
- A Framework for School-Wide Bullying Prevention and Safety
- Effective School-Wide Discipline

Please cite as: NASP (2017). Policy recommendations for implementing the *framework for safe and successful schools* [Brief]. Bethesda, MD: National Association of School Psychologists.

Available online at *www.nasponline.org/schoolsafetyframework*.

Assessing the Safety of the School Environment Using the *Framework for Safe and Successful Schools*

Implementing the *Framework for Safe and Successful Schools*[1] necessitates ongoing assessment of the current school environment. This tool will help assess the policies and practices represented in the framework, identify effective systems that need sustained effort, and components in need of change to better support school and student physical and psychological safety.

This assessment should be utilized collaboratively by the school safety team and school administration to guide efforts and identify needs within the unique context of each school community. Consider using this assessment and the attached result analysis and action planning tool in conjunction with the *Policy Recommendations for Implementation the Framework for Safe and Successful Schools.* Data from this assessment is not a valid method of comparing schools or measuring progress; it is intended *only* to guide discussion, planning, goal setting, and decision making.

Definitions:

Multitiered systems of support (MTSS) represents a framework for a continuum of system-wide interventions of increasing intensity depending on need. MTSS emphasizes wellness promotion, prevention, and early intervention, helping to minimize redundancies and gaps in services.

Physical safety includes reasonable physical security measures such as locked doors, lighted hallways, and visitor check-in systems.

Psychological safety includes a positive school climate and trust among staff, students, and families where students feel connected and part of a close-knit and caring community, and where students are empowered to report any safety concerns.

School-employed mental health professionals are permanent, salaried professionals employed by the school district, such as school counselors, school psychologists, or school social workers.

[1] Cowan, K. C., Vaillancourt, K., Rossen, E., & Pollitt, K. (2013). A framework for safe and successful schools [Brief]. Bethesda, MD: National Association of School Psychologists.

Assessment of Comprehensive School Safety Practices

Prior to completing this assessment, we encourage review of the Framework for Safe and Successful Schools.

Please indicate the degree to which your school or district engages in each of the actions outlined below as they relate to the best practices of: (a) Integration of Services, (b) Implementation of Multitiered Systems of Support, (c) Access to School-Employed Mental Health Professionals, (d) Integration of School Safety and Crisis Preparedness Efforts, (e) Balance of Physical and Psychological Safety, and (f) Use of Effective Discipline Practices.

In completing the assessment, refer to the Best Practices for Creating Safe and Successful Schools section within the Framework for Safe and Successful Schools for more details on each item. *School teams can have team members complete the tool individually and then compare results, or they can complete it together as a team.* Consider any available data or evidence you may have that can inform responses to each item.

Description of Rated Actions

Willingness: Openness to engage in efforts to address or improve practices

Level of implementation: Degree to which each item is embedded within current school-wide practices and polices

Effectiveness: Perception or evidence of positive outcomes associated with item

Responsiveness: Responsiveness to unique cultural and contextual factors of the school community

1 = Very Low
2 = Low
3 = Neutral/Split/Undecided
4 = High
5 = Very High

	Very Low	Low	Neutral	High	Very High
1a. Integration of services and initiatives (i.e., avoiding numerous stand-alone or redundant programs)					
Willingness	1	2	3	4	5
Level of implementation	1	2	3	4	5
Effectiveness	1	2	3	4	5
Responsiveness	1	2	3	4	5
1b. Collaboration among school staff					
Willingness	1	2	3	4	5
Level of implementation	1	2	3	4	5
Effectiveness	1	2	3	4	5
Responsiveness	1	2	3	4	5

	Very Low	Low	Neutral	High	Very High
1c. Collaboration with families and community					
Willingness	1	2	3	4	5
Level of implementation	1	2	3	4	5
Effectiveness	1	2	3	4	5
Responsiveness	1	2	3	4	5

Notes:

2. Integrated multitiered systems of support across academic, behavioral, social, emotional, physical, and mental health concerns					
Willingness	1	2	3	4	5
Level of implementation	1	2	3	4	5
Effectiveness	1	2	3	4	5
Responsiveness	1	2	3	4	5

Notes:

3a. All students have access to comprehensive school mental health supports and services					
Willingness	1	2	3	4	5
Level of implementation	1	2	3	4	5
Effectiveness	1	2	3	4	5
Responsiveness	1	2	3	4	5
3b. School-employed mental health professionals (e.g., school psychologists, school social workers, school counselors) are integrally involved in the delivery of comprehensive school mental health services					
Willingness	1	2	3	4	5
Level of implementation	1	2	3	4	5
Effectiveness	1	2	3	4	5
Responsiveness	1	2	3	4	5
3c. Established procedures for collaboration in school–community partnerships for school mental health services					
Willingness	1	2	3	4	5
Level of implementation	1	2	3	4	5
Effectiveness	1	2	3	4	5
Responsiveness	1	2	3	4	5

Notes:

	Very Low	Low	Neutral	High	Very High
4. Integrated plans and processes for school safety and crisis/emergency prevention preparedness, response, and recovery					
Willingness	1	2	3	4	5
Level of implementation	1	2	3	4	5
Effectiveness	1	2	3	4	5
Responsiveness	1	2	3	4	5

Notes:

5a. Reasonable efforts utilized to address physical safety					
Willingness	1	2	3	4	5
Level of implementation	1	2	3	4	5
Effectiveness	1	2	3	4	5
Responsiveness	1	2	3	4	5
5b. Reasonable efforts utilized to address psychological safety					
Willingness	1	2	3	4	5
Level of implementation	1	2	3	4	5
Effectiveness	1	2	3	4	5
Responsiveness	1	2	3	4	5
5c. Balance of physical and psychological safety efforts					
Willingness	1	2	3	4	5
Level of implementation	1	2	3	4	5
Effectiveness	1	2	3	4	5
Responsiveness	1	2	3	4	5

Notes:

6. Use of effective positive school disciplinary practices					
Willingness	1	2	3	4	5
Level of implementation	1	2	3	4	5
Effectiveness	1	2	3	4	5
Responsiveness	1	2	3	4	5

Notes:

Result Analysis and Action Planning

As a team, review the ratings on the Assessment of Practices to identify areas of strength that need sustained effort to maintain and areas for improvement or growth. Develop a plan of action using the worksheet below. Consider reasonable short and long term changes to policy and practice (See Policy Recommendations for Implementing the Framework for Safe and Successful Schools for suggestions).

1. Which areas, indicated by high ratings across all four descriptors (willingness, level of implementation, and responsiveness), are identified as specific areas of strength? What is needed to sustain those efforts?

2. Which areas, indicated by inconsistent ratings across all four descriptors, are identified as areas for possible improvement?

3. Which areas, indicated by low ratings across all four descriptors, are identified as areas that need to be addressed?

Please cite as: NASP (2017). Assessing the safety of school environments using a *framework for safe and successful schools* [Brief]. Bethesda, MD: National Association of School Psychologists.

Available online at *www.nasponline.org/schoolsafetyframework*.

Action Planning Guide

Areas of Strength

Consider short and long term plans to sustain current efforts and progress.

Area of Strength	Short-Term Actions	Resources Needed	Long-Term Actions	Resources Needed

Areas in Need of Improvement

Area of Strength	Short-Term Actions	Resources Needed	Long-Term Actions	Resources Needed

TAB # 3

AIR®
American Institutes for Research®

Mental Health Needs of Children and Youth

THE BENEFITS OF HAVING SCHOOLS ASSESS AVAILABLE PROGRAMS AND SERVICES

SEPTEMBER 2017

There has been a steady rise in the number of children and youth needing programs and services that promote positive mental health and provide early intervention and treatment. How are schools responding to this challenge?

Increasingly, school systems are joining forces with community health, mental health, and social service agencies to promote student well-being and to prevent and treat mental health disorders. Through these collaborations, schools and local agencies are working together to address the growing health, behavioral, and mental health needs of students (Atladottir et al., 2015; Olfson, Druss, & Marcus, 2015).

School mental health programs must evaluate their capacity to respond to the growing needs of their students if they are to effectively connect them to the mental health programs and services that address their needs. American Institutes for Research (AIR) has worked with a number of large school districts to help prepare them to conduct such assessments.

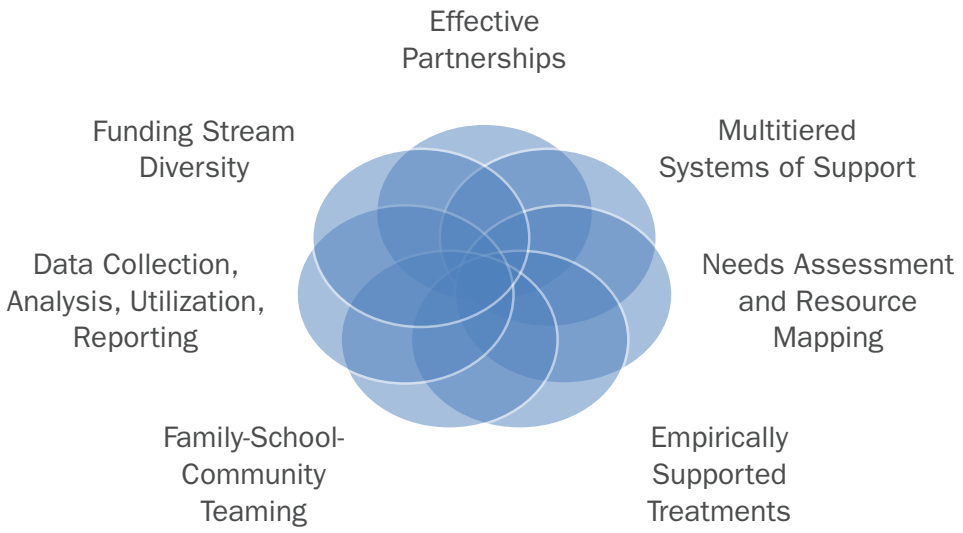
This issue brief explores how continuous evaluation and assessment of a school's mental health programming (e.g., classroom programs, interventions, services, parental involvement, etc.) can benefit students, families, schools, and communities. Further, the brief describes how the Mental Health Parity Act, the new Mental Health Reform Act (embedded within the 21st Century Cures Act), and Medicaid provide ways for schools and communities to offer services for those in greatest need.

Introduction

Comprehensive school mental health programs include mental health promotion and prevention programming for *all* students as well as screening, assessment, and effective prevention and treatment interventions and services for those students with more intensive needs. Partnerships between schools and community mental/behavioral health professionals offer students and families an extended network of services that are easily accessible. When programs are able to identify and address student mental and behavioral challenges early, students are more likely to gain resiliency skills and be successful in school and life while the threat of later harm is reduced (Conley, Shapiro, Kirsch, & Durlak, 2017; Csillag et al., 2016; Dekovic et al., 2011; McLaughlin et al., 2010; Stockings et al., 2016; Weeks, Hill, & Owen, 2017).

These collaborative partners in the fields of education and mental health have evolved to incorporate best practices for comprehensive school mental health as illustrated in Figure 1. It is important that schools and communities collaborate, united by a theory of action that offers students and families a comprehensive set of services.

Figure 1: Best Practices in Comprehensive School Mental Health



Center for School Mental Health, 2014

Comprehensive school mental health programs offer three tiers of supports: **universal** mental health promotion activities for all students, **selective** prevention services for students identified as at risk for a mental health problem, and **indicated** services for students who already show signs of a mental health problem. These programs, built over time, rely on partnerships between schools and community systems, such as community mental health centers, hospitals, and universities.

An important first step in developing a school mental health program is to conduct a thorough assessment of the nature and type of student and family behavioral and mental health needs and the capacity of current school and community resources across the promotion-through-treatment continuum to meet them. Asset mapping can reveal gaps in programs and services and provide important information for planning, building, and implementing specific components of such programs.

How common are behavioral and mental health disorders in children and youth in Grades K–12? Why conduct an assessment?

Research shows that our nation's school children have significant unidentified mental health needs, and many receive no treatment for the mental health challenges they face (Brown, Green, Desai, Weitzman, & Rosenthal, 2014; Kataoka, Zhang, & Wells, 2002). Poverty is a major contributing factor to children and youth's mental health problems, and it has direct and indirect effects on the development and maintenance of emotional, behavioral, and psychiatric problems (Bassuk, Richard, & Tsertsvadze, 2015; Bradley & Corwyn, 2002; Jones et al., 2016; Murali & Oyebode, 2004). Children living in persistent poverty experience long-term effects on their ability to learn in school as well as increased exposure to stressors and trauma that can permanently

affect their brain development and emotional functioning (Evans & English, 2002; Luby et al., 2013; Odgers, 2015; Osher, Cantor, Berg, Steyer, & Rose, 2017; Yoshikawa, Aber, & Beardslee, 2012).

Every year in the United States, up to 20% of children and youth experience a mental, emotional, or behavioral disorder (Centers for Disease Control and Prevention, 2015; Perou et al., 2013). However, nearly half of all children with emotional or behavioral difficulties receive no mental health services (Simon, Pastor, Reuben, Huang, & Goldstrom, 2015). Only 7.4% of young people report any mental health visits in the past year (Merikangas et al., 2010).

Among the relatively few children and youth who do receive mental health services, most do so at school (Substance Abuse and Mental Health Services Administration, 2017a). Schools sometimes serve as the de facto mental health system for children in the United States. The most prevalent mental health disorder in children and youth is attention deficient hyperactivity disorder (ADHD), followed by depression, behavioral or conduct problems, anxiety, substance use disorders, Autism spectrum disorders, and Tourette syndrome (Perou et al., 2013). Often these conditions occur together, which can complicate identification and treatment of mental health disorders. Because children and youth spend a great deal more time in schools than in community mental health centers, it is critical that schools provide or link students and families to mental health services. For children and youth living in poverty in particular, it is imperative that schools develop multilevel, evidence-based interventions to enhance students' emotional wellness and serve and reduce their mental health needs (New York University & McSilver Institute for Poverty Policy and Research, 2017).

Mental health problems in children and youth that are not addressed early in life can inflict a high cost on young people themselves as well as their families and society (Perou et al., 2013). The consequences of mental health problems can be painful and can include serious difficulties at home, with peers, and in school; a higher risk for dropping out; and increased risk of engaging in substance use, criminal behavior, and other risk-taking behaviors (Substance Abuse and Mental Health Services Administration, 2014; Vos et al., 2012). But the financial cost is also high. Mental health hospitalizations for teens cost $2.6 billion in 2012. The total annual cost for care associated with mental disorders for persons under age 24 is estimated to be $247 billion annually. This estimate includes costs related to health care, special education, juvenile justice, and decreased productivity (Perou et al., 2013).

Examining your state and local prevalence data will help you understand the mental health problems and needs of your school and community. These data highlight the need for schools and communities to work together to provide sufficient mental health services. Your school and community can collect prevalence data to build a solid foundation to plan, develop, and implement comprehensive mental health programs and services through strong school–community partnerships. National and state data show the number and types (prevalence) of behavioral and mental disorders for school-age children and youth. There are many sources that schools can consult. Examples of resources include KIDS COUNT, YRBSS, CDC, CDC-CMH, School Climate Survey, NIMH, NAMI, SAMHSA Behavioral Health Barometer Report by State, Healthy People 2020 state data, County Health Rankings, City-Data, diversitydatakids.org (data for states, metropolitan areas, counties, cities,

and school districts), state departments of education, school districts, community mental health data, and juvenile justice, among others.

What are the steps to conduct an assessment of current mental health services and resources for children, youth, and families?

In addition to the national and state data described earlier, schools may also need to conduct local focus groups (e.g., with parents, students, and teachers) and administer brief surveys to document and understand the mental health needs of their student population. Such surveys can be administered to a variety of school staff, students, parents, and community service providers to identify the full spectrum of current mental health needs. Some schools include community mental health or social work agencies to gain an understanding of the patterns of need that they experience as well as the available resources, services, and gaps.

Some schools use a proactive approach and administer a mental health survey to all students with parental permission. These free surveys are available to the public, are easily administered, and address a wide variety of issues. Some examples are the Strengths and Difficulties Questionnaire, the Achenbach System of Empirically Based Assessment (ASEBA), the Generalized Anxiety Disorder (GAD) 7-item scale, the Revised Children's Anxiety and Depression Scale, the Child and Adolescent Disruptive Behavior Inventory, and surveys on substance use and suicide screening and assessment. Additional mental health surveys and screening tools are available from SAMHSA. Often school systems begin their assessment in targeted middle and high schools where staff are concerned about the behaviors that students exhibit.

Steps to develop a brief assessment of student mental health services include the following:

1. **Identify key questions first:** Craft survey questions based on the various respondent groups participating in the assessment process. These might include school staff (administrators, teachers), students, parents, and mental health agency professionals. When considering students and parents, attention should be given to the different income groups, literacy levels, cultures, and languages spoken when formulating the survey questions.

    - ***Questions for school staff:*** What are the most prevalent mental health problems that students experience? Does this vary for students in the poorest neighborhoods? New immigrants? Non-English-speaking families? What types of programs and services are currently provided in the school—by school-employed staff? By community mental health staff? What access do they have? What types of mental and behavioral health interventions are provided in the school? Who provides the interventions? Who provides mental health programs and/or services? How are these programs and services funded?

Examples of Schools and Communities That Have Conducted Assessments

- **New York City (NYC),** state, and community leaders worked with AIR and Westat to create a comprehensive set of surveys to identify student mental health needs. The surveys include all student population groups (racial/multiethnic populations [56%], foreign-born persons [37.2%], and those under the federal poverty level [20.6%]). The purpose of the surveys was to understand current mental health problems and interventions provided and identify service and resource gaps. The surveys were administered to school and community professionals in 1,051 NYC schools and 140 mental and behavioral health care clinics. Westat and AIR implemented the survey and analyzed and reported the results. The surveys resulted in a redesign and maximization of resources to address students' mental health needs. It also led to the development of short- and long-term strategic plans for increasing programs and services, revisions to existing policies to make them more effective, and a financing redesign, realignment, and restructuring of current fiscal resources.

- In **Nevada,** three school districts—**Lyon, Nye,** and **Washoe**—began a partial assessment process early in the 2016 school year through their suicide prevention programs. These districts sought to understand the mental health needs of middle and high school students—specifically students experiencing depression, anxiety, or suicidal thoughts. Assessments in all three districts led to the identification of students in need of mental health services. One district's assessment—Washoe—found 63% of screened students were identified as needing further assessment and obtained mental health services in the school or in the community. School-employed counselors and school-linked mental health professionals from the community provided the interventions and follow-up services.

  As a result of each school district's partial assessment process, the school and community agencies worked together to develop a more comprehensive assessment. The deeper assessment identified current resources and services provided in the school and community agencies and gaps in services and resources that needed to be addressed. Washoe County School District also added a new policy requiring all middle schools to provide the assessment of students' mental health needs at the beginning of each school year. Routine assessment provides the opportunity for early identification of students in need of mental health services. Continuing the assessments on a yearly basis provides valuable information about the changing mental health needs of all students.

  > "The collaboration of our Lyon County Community Team has been highly beneficial to our work. Our joint development of assessment and identification protocols for students with mental health needs was highly beneficial to our collaborative work in schools. We have also braided our collective resources and funding streams together to provide mental health resources and services for our students. We now have a shared vision to prioritize positive mental health of our students and families through a multitiered services approach from prevention, early intervention, and treatment."
  >
  > *Deborah Loesch Griffin, PhD, Turning Point, Inc.*
  > *Lyon County, Nevada*

- In **Methuen, MA,** the district's school mental health team sought to fully understand student mental health needs by assessing all 900 students after gaining parental consent. The goal was to identify students in need of services. The team initially used validated instruments, such as the Child Behavior Checklist, the Strengths and Difficulties Questionnaire, the Worry Questionnaire, the Children's Anxiety and Depression Scale, and the CRAFFT behavioral health screening tool. Findings indicated that 180 (20%) students scored in the moderate to severe range for mental health problems in need of services. The team had to quickly determine resources in the school and/or community that could provide mental health services for the identified students. School support staff then developed individual intervention plans for these students and provided interventions for the students who scored in the moderate range. Students scoring in the severe range were referred to and obtained appropriate community mental health services. The assessment process increased the Methuen school district's ability to identify students who required mental health services and supports and assisted the school team in determining the most appropriate interventions across a multitiered system of mental health services and supports, both in the school and in the community.

- ***Questions for parents:*** What are the emotional and behavioral problems that your child experiences at school? What are your concerns for your child related to their behavior or emotions? What types of services are provided and/or offered at school for your child? Who provides the services? Are there additional services that need to be provided at school for your child that are not currently available? Do you have difficulty obtaining mental health services for your child at school? In the community? If yes, what are the reasons that you cannot obtain services? Is funding a concern for you?

2. **Identify useful assessment tools:** Some of the following free tools may help schools and communities to develop surveys to fit their local needs:

   - Center for School Mental Health—School Health Assessment and Performance Evaluation System (SHAPE). School and community teams use this system to assess their current mental health programs via seven quality performance domains and five sustainability performance domains.
     - Quality domains include: teaming, needs assessment and resource mapping, screening, evidence-based supports and services, evidence-based implementation, student outcomes and data systems, and data-driven decision making.
     - Sustainability domains include: funding and resources, resource utilization, system quality, documentation and reporting of impact, and system marketing and promotion.
   - Mental Health Planning and Evaluation Template (MHPET) (Mental Health Planning and Evaluation Template, n.d.). The School-Based Health Alliance, in partnership with the Center for School Mental Health, developed a 34-indicator measure that operates as an eight-dimension assessment tool to target areas of strength and needed improvement in school-based mental health quality.
   - Community Tool Box, Section 8. Identifying Community Assets and Resources. This system enables school and community teams to identify mental and behavioral health resources in their communities.

3. **Identify existing data:**
   - ***Questions:*** What data can you obtain from existing instruments, such as school or community surveys? Do you need to customize a survey instrument to obtain information and answer your specific questions? Do you need to host specific stakeholder focus groups to understand the current mental health needs of different groups of students or families? Do you need to disaggregate data for particular audiences such as children and families living in extreme poverty; lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth; non-English speaking families, etc.? Do you need to develop stakeholder focus groups to learn about available services in the community and the ability of those services to be culturally and linguistically competent?

4. **Develop protocols and methods to collect data and identify existing mental health resources within the community that may benefit children, youth, and families:** Determine what services and resources you want to know more about (e.g., mental/behavioral health, youth programs, recreational programs, and so forth). Determine who would be the best person(s) to lead this task. Determine who to interview for the information (e.g., clinic directors, program managers). Access for marginalized groups is a particularly important issue to address. Identification of existing programs and services should include the following:

    - ***Various levels of interventions (universal, selective, indicated):*** What are the existing programs and services for each level of intervention? What services are available in the schools for all students? What services are available for students with an emerging need? What services are available for students experiencing a serious mental health problem? Are these services available and accessible, especially for the poorest families? How are these services funded?

    - ***Types of mental health programs and child/youth services in the community:*** These include outpatient clinics, support groups, mentoring programs, and/or youth recreation programs. What types of mental and behavioral interventions are provided in the community? Who provides these programs and services? To what audiences? With what outreach? How are they funded?

    - ***Community workforce:*** What types of mental health professionals work in your school? In your community? What interventions do these clinical professionals provide? What skills do these clinical professionals possess? Do the mental health professionals in the school and/or community have language skills to address the school population? Are translation services available or adequate? Do the mental health professionals in the school and/or community understand and have the ability to address the cultural needs of the student population? Do these skills address the identified needs of students and families?

5. **Analyze the data and findings from your assessment and service/resource identification process with school and community stakeholders and identify strengths and gaps:** Some important questions to consider in your analysis include the following:

    - Are there disparities in access to services? Or disparities in service experience and/or outcomes among groups of students (e.g., age/grade level, gender, socioeconomic status, ethnicity/culture, sexual orientation)?

    - What are the financing and resource gaps? What are the obstacles or hurdles in the school or community that affect the students' access to services? Is there a lack of resources in the community (e.g., financial, clinical professionals, etc.)? What are the financial obstacles for families? Does the community have resources that are unknown to families and/or schools? What additional financial and community resources need to be developed? Has your assessment and resource mapping process identified financing opportunities that could be used to develop school mental health programs and services or provide support for services for individual students and families (e.g. Medicaid)?

    - What types of professionals provide the mental and behavioral health programs and services? Are there gaps in the number and type of professionals that provide a particular service? Are there providers who understand and speak the languages of families in the community?

- Do community agencies have the capacity to address the mental health needs of students and families? In schools? In the community? Are there gaps in agency resources? Is there sufficient professional development and education for school and community staff to obtain the skills needed to provide specific mental and behavioral health interventions and services? Is there a shortage of professionals in the community to provide the needed services? Are there recruitment resources in place with mechanisms to find and reach potential candidates? Is there a shortage of available school space to provide mental health services for students and families?

AIR Resource

For more information and training about implementing the assessment process and identifying resources in your school mental health program, check out this free online training module: http://www.healthysafechildren.org/learning-module-series/mental-health-module-series.

From the National Resource Center for Mental Health Promotion and Youth Violence Prevention, School Mental Health module series, this module, "Module 2: Preparing to Implement a Comprehensive School Mental Health Program," discusses engaging staff, families, youth, and a community mental health partner in your program; identifying programs and services, reviewing needs and planning services; managing referrals and intake; and developing an advisory group for your program.

6. **Determine strategies with school and community stakeholders to develop a comprehensive school-based mental health program:** This should include a short-term plan for implementation; a long-term plan to build the program over 3 to 5 years; and a long-range financial plan to sustain the program. Ideally, thinking through measurable outcomes for each phase can keep efforts on track.

Is there specific legislation to assist districts, schools, and communities in building school mental health programs?

Listed below are some opportunities for schools and districts to realign current funding and obtain new dollars to support assessment, planning, and development of school mental health programs and services:

1. The federal Every Student Succeeds Act (ESSA) has implications for schools and communities that want to increase mental health resources. ESSA allows for new flexibility in the use of all Title I, II, and IV funding for schools. ESSA expands allowable uses of all Title I, II, and IV funds for school-wide purposes in order to best serve the mental health needs of students. This includes integrated services, counseling, school-based mental health programs, mentoring, partnerships with community providers, and other strategies that can help improve students' skills beyond academics.

2. Designated block grants are available in every state to develop programs and services to address the mental health needs of children and adolescents. Many former discretionary grants that schools have used through the federal and state departments of education have been combined in ESSA through a state block grant.

3. Medicaid is the largest funder of mental health care in schools and communities across the United States, providing services for 33 million children. Mental health professionals provide intensive mental health interventions for students in schools through a variety of approved providers (public and private community health, mental and behavioral health providers, hospitals, community clinics, etc.).

Here are some resources (Freeman, 2011; Freeman, Grabill, Rider, and Wells, 2014) to learn more about financing and sustaining your school mental health program.

4. The Substance Abuse and Mental Health Services Administration (SAMHSA) offers multiple grants to address school and community mental health initiatives (Substance Abuse and Mental Health Services Administration, 2017b).

5. The Mental Health Reform Act embedded in the 21st Century Cures Act includes funding to promote integrated physical and mental health care; early intervention programs; suicide prevention; assisted outpatient and assertive community treatment programs; and fellowships for minority students in mental health training. The act also strengthens enforcement of the Mental Health Parity and Addiction Equity Act (Center for Consumer Information and Insurance Oversight, n.d.), state block grant funding, and more. The legislation also provides funding for proven evidence-based strategies to address mental health and substance use disorders.

6. The American Recovery and Reinvestment Act, extended through 2017, provides education benefits for higher education students obtaining additional education related to mental health. These funds could be used by school and/or community professionals to support student mental health programs and services through internships with a college or university. These interns could also assist in the assessment and resource mapping processes.

These links will provide you with more information on each funding resource. It is important to investigate all types of funding that could benefit you in building your comprehensive school mental health program. An integrated system of financial supports from the community, school, and state is the most sustainable over time as you build cross-system resources to fund your school mental health program and services.

What can be learned from assessing school mental health programs and services?

Many school districts and communities gain invaluable information from a thorough assessment of available mental health programs and services in their schools and communities. A few direct benefits for schools and communities include: new insights into their community's mental health programs and services; data on the types of mental health services and resources students need most; the ability to build stronger relationships between all stakeholders and connections to community providers; the identification of service and resource gaps; reduced duplication of services; delineation of specific services best provided as school-based and/or as a school-linked service; cost-effective use of current resources; realignment of school and community funding resources to better support school mental health programs; increased prevention and early intervention services for students with evolving mental health needs; saving on high-cost care such as inpatient treatment,

hospital admissions/treatment, out-of-home placements, and so forth; and new or improved communication systems that allow school and community mental health professionals to share essential information in a confidential and timely manner.

"The assessment process helped us identify students proactively. Now we can determine the most appropriate interventions across a multitiered system, in the school and community. Progress monitoring allows us to assess efficacy of these interventions and improves our accountability. Our collaboration has greatly decreased high-cost services associated with school and community funding. We continue to gather data to reinforce the idea that mental health services and supports improve student's academic, social, and emotional functioning."

John Crocker, Director of Guidance at Methuen Schools, MA, on the benefits of the process over the past two school years

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TAB #4

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NOW IS THE TIME
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School Mental Health Referral Pathways (SMHRP) Toolkit

September 2015

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NOW IS THE TIME
TECHNICAL ASSISTANCE CENTER

School Mental Health Referral Pathways (SMHRP) Toolkit

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INTRODUCTION

INTRODUCTION

The *School Mental Health Referral Pathways (SMHRP) Toolkit* was funded by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to help state and local education agencies and their partners develop effective systems to refer youth to mental health service providers and related supports.

The SMHRP Toolkit provides best-practice guidance and practical tools and strategies to improve coordination and collaboration both within schools and between schools and other youth-serving agencies. The SMHRP Toolkit supports the cultivation of systems that improve the well-being of young people by providing targeted mental health supports at the earliest sign that a need is present. In particular, the SMHRP Toolkit delves deeply into the topic of *referral pathways*, which are defined as the series of actions or steps taken after identifying a youth with a potential mental health issue.

Mental Health Referral Pathway: the series of actions or steps taken after identifying a youth with a potential mental health issue.

Referral pathways vary from community to community based on cultural and linguistic considerations and the resources available, including the public and private organizations providing services to school aged youth. School and community-based mental health providers must understand their local community in order to ensure the seamless provision of mental health supports to youth and their families. While mental health referral pathways may involve different partners depending on the community, all effective referral pathways share similar characteristics:

- They define the roles and responsibilities of all partners in a system.
- They have clearly articulated procedures for managing referrals within and between partners.
- They share information across partners in an efficient manner.
- They monitor the effectiveness of evidence-based interventions provided by all partners within a system.
- They make intervention decisions collaboratively with a priority on what is best for young people and their families.

The SMHRP Toolkit provides guidance to support the critical, challenging work of building effective mental health referral pathways in diverse communities throughout the United States.

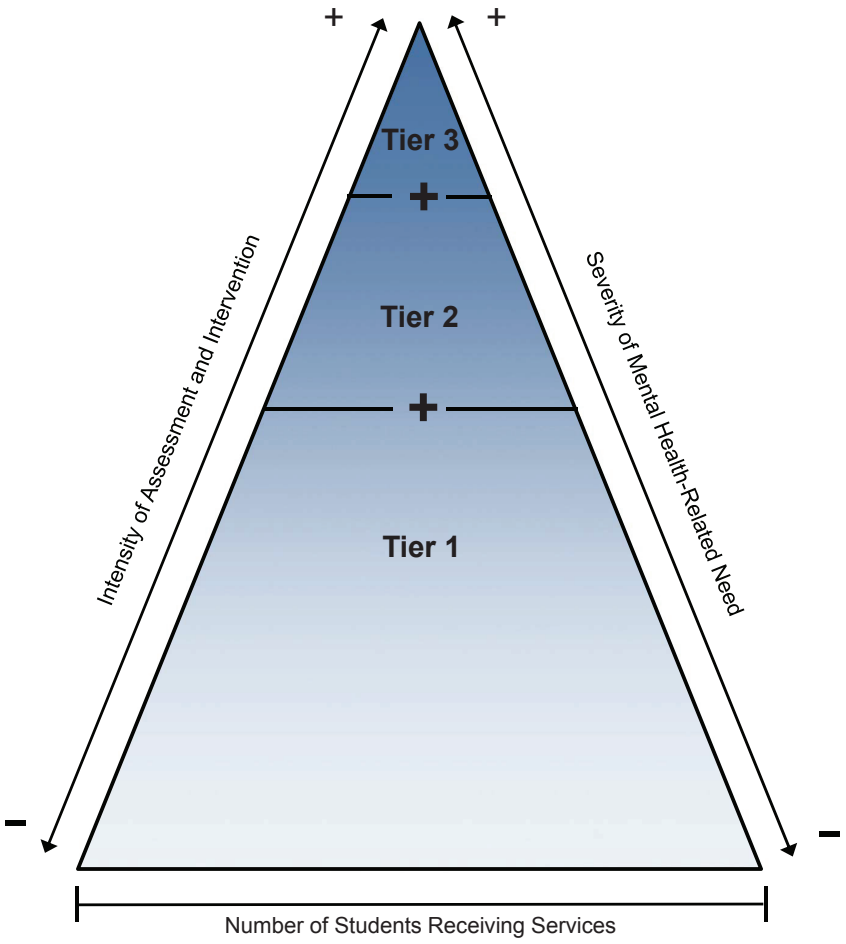
Multitiered System of Supports: A Conceptual Framework

The multitiered system of support (MTSS) framework is the guiding conceptual model used throughout the SMHRP Toolkit. The MTSS framework is widely used among educators and mental health practitioners, providing a common language for all SMHRP Toolkit topics. Attesting to its broad appeal as a model for organizing mental health and other student supports, federal agencies, including SAMHSA, have incorporated the MTSS framework into grant opportunities and related guidance documents for state and local education agencies.

As applied to mental health needs, MTSS supports are best thought of as a continuum of supports defined by (a) the precision and intensity of assessment involved in assigning students to intervention conditions, (b) the dosage of intervention provided to match the presenting mental health need, and (c) the number of students targeted by the intervention (Figure I.1). Based on these defining characteristics, the MTSS framework is organized into three tiers:

- **Tier 1** supports are typically implemented for prevention, are designed to reach all students in a school, and are delivered within the scope of the general education curriculum. For example, delivering an evidence-based social and emotional learning program in all classrooms is a universal prevention strategy.
- **Tier 2** interventions are intended for students with mild or emerging mental health needs (i.e., social, emotional, or behavioral). Tier 2 interventions require effective problem-solving approaches, including the strategic use of data to identify targeted students and match their needs to appropriate, evidence-based treatments. Tier 2 interventions are typically delivered in small group settings and are time-limited in duration. An example of a Tier 2 intervention is a school-based mental health clinician delivering an evidence-based mindfulness curriculum over the course of ten weekly half-hour sessions to a small group of eight to ten students identified as having mild to moderate challenges with anxiety.
- **Tier 3** interventions are meant for students with more advanced mental health needs (i.e., social, emotional, or behavioral) who require more intensive intervention. Typically, Tier 3 interventions are individualized and delivered by trained mental health clinicians, often in one-to-one settings. As with Tier 2 interventions, Tier 3 interventions use problem-solving strategies that accurately match students' presenting needs to evidence-based treatments. Tier 3 interventions are distinguished from Tier 2 interventions by their intensity and duration. An example of a Tier 3 intervention is a year-long intervention wherein a mental health clinician meets weekly with a young person to treat his symptoms of depression using an evidence-based therapeutic approach.

Figure I.1. **The Multitiered System of Support Model for Mental Health Supports in Schools**[1]



MTSS supports are designed to be cumulative: a student who receives Tier 3 supports should also receive the Tier 2 supports that align with their needs as well as the Tier 1 supports provided to all students.

In addition to mapping the resources available to address student mental health needs at each tier of the MTSS framework, school personnel and their partners must consider how young people are identified for additional Tier 2 and Tier 3 mental health supports and how to gauge the impact interventions on participating students. The SMHRP Toolkit provides tools to assist school based professionals and their partners with these tasks.

1 Renshaw, T. L., & O'Malley, M. D. (2015). *A new take on the old triangle: Illustrating the key characteristics of a multitiered system of supports for efficiently organizing problem-solving in schools*. Self-published illustration. doi:10.13140/RG.2.1.4633.5204

Organization of the School Mental Health Referral Pathways Toolkit

The SMHRP Toolkit is divided into four chapters meant to provide best-practice guidance to facilitate referrals both within schools and between schools and their community partners. The SMHRP Toolkit describes several strategies for defining interventions within the MTSS model and matching young people to the interventions that are most appropriate for their needs. Chapters are meant to be practical and user friendly; they are divided into sections by sub-topics, and important resources are regularly highlighted in toolboxes. Each chapter of the SMHRP Toolkit provides several relevant and practical techniques and tools related to the following topics:

Chapter 1, *Laying the Foundation: Assessing Your Current Referral Management Approach*, provides a process for determining what mental health resources and partnerships exist for a school and how to link students with mental health needs to appropriate school- or community-based services. Chapter 1 provides tools and techniques for:

- establishing referral management systems,
- establishing a problem-solving team, and
- mapping school- and community-based mental health resources across MTSS tiers.

Chapter 2, *Building Effective Partnerships*, describes strategies for collaborating with external partners to develop robust prevention and intervention supports at all three MTSS levels. Chapter 2 addresses:

- models for effective collaboration across sectors,
- understanding cross-sector roles for supporting the mental health of youth,
- tracking mental health referrals and monitoring intervention progress across youth-serving systems,
- legal considerations for sharing mental health information within and across youth-serving systems, and planning for transitions across youth-serving systems.

Chapter 3, *School-Based Problem-Solving to Promote the Mental Health of Young People*, gives an in-depth description of the problem-solving process that school-based teams can use to create individualized intervention plans for young people whose social, emotional, and behavioral needs extend beyond the universal, Tier 1 supports provided in the general classroom environment. Topics detailed in Chapter 3 include:

- establishing a problem-solving process,
- applying a problem-solving model to customize mental health interventions for individuals, and
- monitoring mental health intervention effectiveness for individuals.

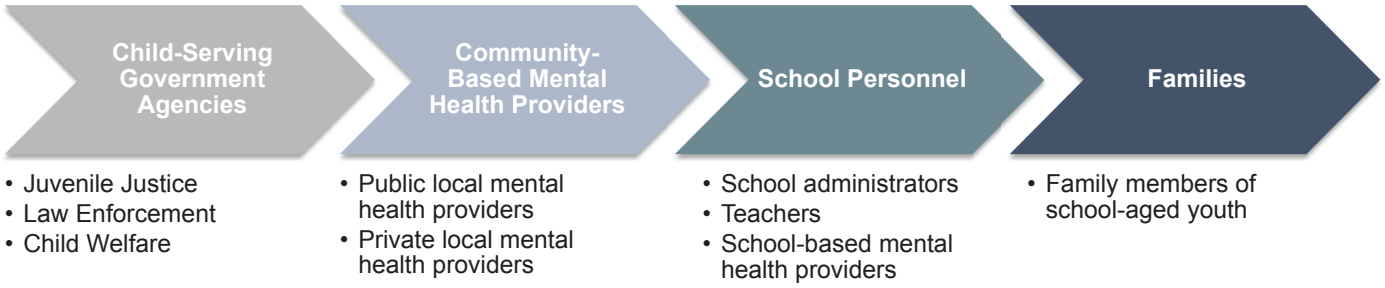
Chapter 4, *Cultural and Linguistic Considerations*, provides an overview of cultural and linguistic considerations for building effective referral pathways. Topics detailed in Chapter 4 include:

- understanding disparities in mental health services for culturally and linguistically diverse students,
- effective strategies for referring culturally and linguistically diverse students to appropriate mental health supports at school and in the community, and
- identifying and supporting culturally and linguistically competent practice among school mental health personnel and community partners.

Using the School Mental Health Referral Pathways Toolkit

Who can use the SMHRP Toolkit? Families, caregivers, community members, educators, school administrators, mental health providers in school and community settings, and persons affiliated with child-serving agencies that intersect with school mental health are encouraged to use the SMHRP Toolkit. Because of the anticipated interest from various groups, the SMHRP Toolkit provides best-practice guidance and related tools intended for all audiences, including those with varying degrees of background knowledge in school and community-based mental health services for school-aged youth.

While each of these groups will find parts of the SMHRP Toolkit useful for informing their own work, it is designed to be used collaboratively by teams of school personnel and their community-based partners to improve mental health supports for school-aged youth.



How should the SMHRP Toolkit be used? The SMHRP Toolkit can be used as a single, comprehensive resource to guide all steps involved in building effective mental health referral pathways, or individual chapters can be referenced to answer specific questions. In order to provide a common point of reference, users are encouraged to distribute the SMHRP Toolkit to their state and local partners.

Addressing the Mental Health Needs of School-Aged Youth: A Shared Priority

Embracing the need for effective mental health referral pathways within schools and between schools and community service providers requires a thorough understanding of the scope of the mental health challenges faced by school-aged young people in the United States today. This Now Is The Time Factsheet provides up-to-date information about the nature of the mental health challenge; the links between mental health and key educational and economic outcomes; and key characteristics of effective school-community mental health partnerships.

The Status of Mental Health Among School-Aged Young People

Many youths are suffering due to mental health challenges that impair their interpersonal and academic functioning, leading to short- and long-term consequences at home, at school, and in their communities.

- Approximately one in six school-aged children experiences impairments in his or her life functioning due to a diagnosable mental health disorder[1] and an estimated 70% of children have experienced some type of physical or emotional trauma.[2]
- The majority of mental illnesses emerge in childhood[3], yet fewer than half of children who suffer from mental illness receive treatment.[4]
- Young people with mental illness are frequently absent from school and many experience reductions in academic achievement.[5]
- Among students with disabling conditions, young people with mental illness are the most likely to drop out of school.[6]
- Only one third of young people with mental illness advance to postsecondary education.[7]
- More than 60% of children in juvenile detention have a diagnosable mental illness.[8]

These data point to an urgent need for educators and their partners in diverse private and public sectors to dramatically reduce the impact of mental illness on young people in their communities by prioritizing collaborative prevention and intervention efforts.

Supports for Mental Health in Schools: The Current Landscape

The prevailing pattern of mental health service delivery to young people suggests a need for communities to invest in school-based supports. This is due in large part to the fact that schools are easily accessible to most children and youth, and the reality that several barriers to access exist for community-based settings (e.g., stigma, cultural beliefs, limited availability of providers, confusion about how to initiate services).

- In any given year, 11-12% of school-aged young people access mental health services through the education sector, whereas only 7% and 4% are served through specialty mental health (community-based) and general medical settings, respectively.[9]
- Young people are more likely to seek mental health supports when they are available on their school's campus.[10]
- Preliminary evidence suggests that school-based mental health care is less expensive than private and community-based mental health services.[11]
- Early intervention in school is critical given that the indirect costs (e.g., lost earnings, emergency medical care) of treating adult mental illness in the United States are estimated at over $300 billion per year.[12]

Despite the fact that schools are the most accessible context for the provision of mental health services to young people, they have not historically been organized for the delivery of mental health services. There exist both perceived and real structural, programmatic, and financial barriers that must be overcome to provide quality mental health services in school settings:

- The overall average ratio of students to qualified mental health services staff in schools across the U.S. is 500 to 1.[13]
- The activities assigned to school staff with mental health expertise compete for time that might otherwise be
- spent working on prevention and early intervention efforts. For instance, over 50% of school psychologists' time is spent conducting psychoeducational assessments to identify students for special education.[14] The assessment process is reserved for students who appear to require intensive, individualized, and resource-intensive intervention.
- Administrators may struggle with requirements to provide mental health services for students with mental, emotional and behavioral disorders because the services themselves are perceived as time consuming, costly, and hard to integrate into the existing school schedule.[15]

Advances in School-Based Mental Health: Partnerships That Work

Despite the fact that schools are not traditionally organized to provide mental health education or service delivery, school-based mental health innovations are on the rise. The attention to this matter is encouraged by legislation (e.g., No Child Left Behind Act of 2001 and Individuals with Disabilities Education Improvement Act of 2004) that emphasizes the role of schools in supporting childhood cognitive, behavioral, and social-emotional development, particularly for those with identified mental health disabilities. Below are key characteristics of effective school mental health partnerships:

- Integrated mental health services involve merging resources across sectors, including combined school and medical, school and community mental health, and school and home-based services.
- The ideal integrated system represents the full continuum of care: from behavioral health promotion and pro-social development to prevention, early intervention, treatment, and crisis management.[16]
- Planning for school mental health should take into account avenues toward the promotion of healthy families, the enhancement of childhood resilience and protective factors, strategies to reduce systemic issues in schools that impact healthy development and learning, and the promotion of partnerships between the school and community that improve access to health and mental health services.[17]
- Selection of services (e.g., psychotherapy, case management, prevention education, medication management) depends on the needs and preferences of the youth and family, the nature of the mental health needs, the diagnosis, the severity of the problem, and the cultural and linguistic needs of the family. Services provided also depend on the strengths and natural supports inherent in the child and the context in which he or she lives.
- Providers are able to reduce barriers to access by meeting with youth and their families within community locations, schools, and in homes. Providers also acknowledge the value that other positive, informal supports have for mental health and well-being, such as faith-based organizations, non-profit agencies, friends and neighbors, and youth organizations.

Now Is The Time to Support the Mental Health of Young People in Your Community

Communities throughout the United States are called upon to build systems that improve the well-being of young people by providing effective mental health supports at the earliest sign that a need is present. Meeting the highest standards of mental health care will require coordinated partnerships between schools and other youth-serving organizations, as well as cooperation with partners in public and private sectors. By using a systematic approach to working together, communities can make substantial improvements in the lives of young people.

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CHAPTER 1

Laying the Foundation: Assessing Your Current Referral Management Approach

CHAPTER 1

LAYING THE FOUNDATION: ASSESSING YOUR CURRENT REFERRAL MANAGEMENT APPROACH

Key Questions

1. How can schools build effective systems for matching students referred for social, emotional, or behavioral concerns with high-quality interventions that meet their needs?
2. How can schools build effective problem-solving teams?
3. How can problem-solving teams self-assess their effectiveness to continuously improve?

The Challenge: Building Referral Systems that Work

Identifying, tracking, and referring young people with social, emotional, or behavioral concerns involves multiple steps and processes. Because of the complexity of the challenge, schools must develop and implement an effective referral pathway and tracking system. This referral system facilitates objectively and systematically gathering and analyzing information in order to plan for students' behavioral, social, emotional, and academic development. An effective referral system relies on multidisciplinary problem-solving teams that match students' needs with appropriate types or levels of evidence-basedof support within a systems that has multiple tiers of support (i.e., multitiered system of support (MTSS) framework; Figure 1.1; see SMHRP Toolkit Introduction for detailed description). The team is tasked with determining whether referred students' needs may be best matched by promotion and prevention services, early intervention services, or more intensive and individualized interventions provided by school- or community-based personnel.

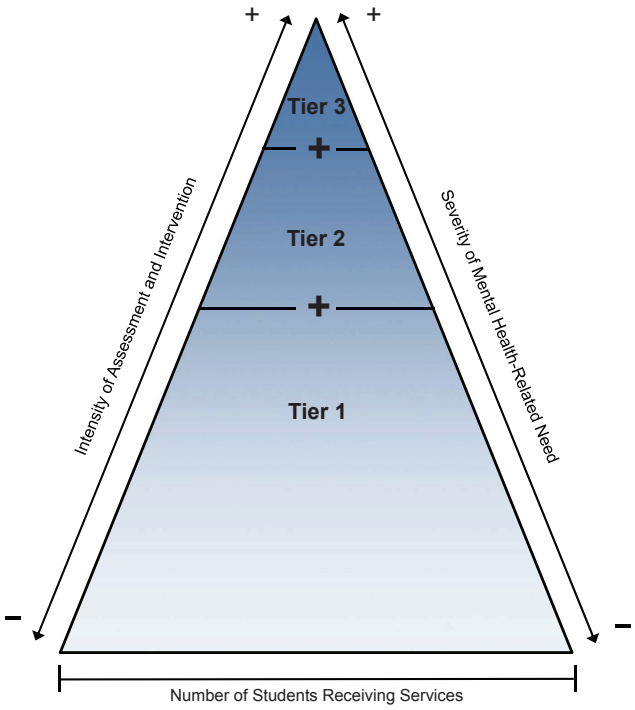
Systematic and effective referral pathways take advantage on the fact that school have separate but complementary roles and functions within the system and are organized to improve the well-being of young people. School professionals, in collaboration with community partners, work together to identify students needing extra support and link them to appropriate services.

The remainder of this SMHRP Toolkit chapter describes a process intended to help schools reflect upon and improve their referral pathways by assessing the infrastructure (i.e., processes, resources, procedures) and service capacity currently in place to support students at all levels of the MTSS framework. A thorough self-assessment of infrastructure and service capacity will provide insight into the opportunities for improvement to best serve students' mental health needs at each MTSS level.

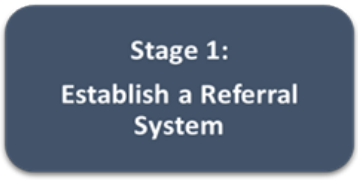
Four Stages of Referral Pathway Self-Assessment

Self-assessment of the quality of your school's referral pathway system occurs across four stages (Figure 1.2): Stage 1 evaluates the system for managing referral concerns, Stage 2 evaluates the process of managing referral flow, Stage 3 examines existing resources and procedures for matching needs to interventions, and Stage 4 involves evaluating the effectiveness of prescribed interventions. Tools and techniques for each of these stages are provided throughout the remainder of this SMHRP Toolkit chapter.

Figure 1.1. ***The Multitiered System of Support Model for Mental Health Supports in Schools***



Adapted from: Renshaw & O'Malley (2015)

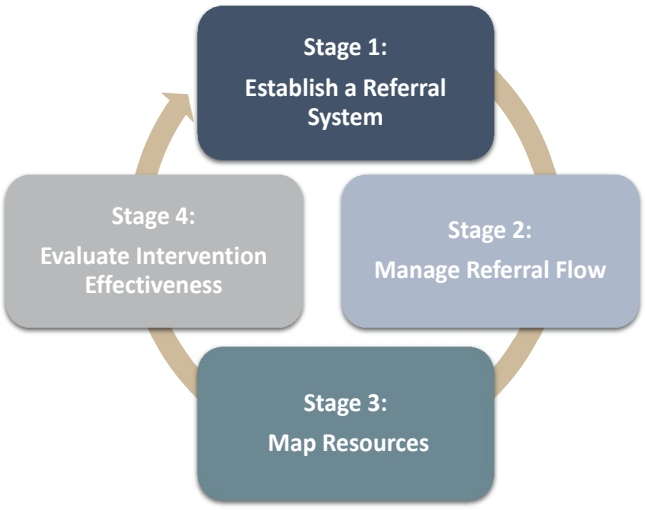


Stage 1: Establish a Referral System

The initial stage of a referral pathway self-assessment process examines how the school identifies student need. Schools must consider several things when examining their referral processes:

- ***Are systems in place to manage all types of referral concerns?*** Referral concerns may include a constellation of problems within one or more of the following domains: academic, emotional, behavioral, social, or physical. High-quality referral systems can effectively manage all types of referral concerns.
- ***Are referral systems formalized?*** Formalized referral systems provide structured and clearly defined procedures specifically for linking students to appropriate and effective services or supports. Procedures for accessing formal referral systems are easy to follow; for referral systems to be effective, school professionals, caregivers, and young people need to be willing to use them. Universal screening systems may be a part of formalized referral systems when they are used to accurately identify young people for whom subsequent intervention is appropriate.
- ***Does a collaborative structure exist to manage referrals?*** Using a team approach for identifying and addressing students' presenting problems is essential (Burns, Kanive, & Karich, 2015). Effective problem-solving teams (also referred to as student care teams, student success teams, or student study teams) are multidisciplinary, have a set of decision-making protocols that guide their work, and make decisions based on credible information and data. Problem-solving team effectiveness is described in detail later in this chapter.
- ***Are all individuals who might make a referral aware of the referral process?*** Because behaviors that may lead to a referral are diverse in nature, they may noticed by a variety of adults or peers that interact with a student. In order for referral systems to have maximum impact, each of these groups must understand the referral system and how to use it.

Figure 1.2. ***Four Stages of Referral Pathway Self-Assessment***



- ***Are referral systems sensitive to developmental, cultural, and linguistic diversity?*** Effective referral systems take into account the developmentally, culturally, and linguistically relevant factors to support diverse individuals making or receiving referrals. Chapter 4 of the SMHRP Toolkit describes this topic in detail.

Steps for Establishing a Problem-Solving Team

Establishing a problem-solving team is fundamental for ensuring that students with social, emotional, and behavioral needs are matched to interventions that will effectively meet their needs. Below are several steps to follow if your school does not yet have a problem-solving team:

1. **Assess Existing Teams.** Avoid redundancy by assessing existing campus teams that focus on student support. Consider which current groups might be natural fits for the task of managing referrals. Examples of existing teams include (Lachini, Anderson-Butcher, & Mellin, 2013):

    - school climate teams,
    - wellness teams,
    - transition teams,
    - grade-level teams,
    - crisis intervention teams,
    - wraparound teams,
    - multidisciplinary individualized educational plan (IEP) teams, and
    - Positive Behavior Interventions and Supports (PBIS) teams.

2. **Identify Team Members.** Multidisciplinary teams should include physical health, general education, special education, law enforcement, and mental and behavioral health personnel. Although some schools may have fewer personnel to participate on a problem-solving team than others, it should never be the case that a single individual is responsible for managing all tasks. If an effective referral system is a priority, then schools should bring together several people to do this work collaboratively. Consider inviting the following individuals to become members of your problem-solving team:

    - administrators
    - school resource officers
    - school psychologists
    - school counselors
    - school social workers
    - teachers
    - school nurses
    - family representatives
    - PTA representatives
    - member of community organizations
        - mental health providers
        - health care professionals
        - police
        - child protective services
        - social services

    Include Family Members and Caregivers. When teams meet to discuss students who are struggling, invite families to participate. Welcoming families to be a part of the discussion and to help identify solutions to the presenting problem often supports student and family access services and ensures follow-through.

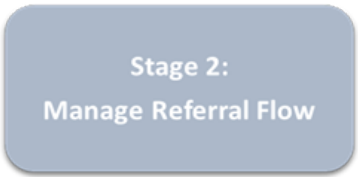
3. **Articulate Team Purpose and Clarify Roles.** All members of the team should be able to articulate the common purpose for the group as well as the roles and responsibilities of individual team members for meeting that common purpose. Problem-solving teams work best when:

- One person is identified as the team leader. Team leaders are responsible for the critical tasks that keep the team running, including delegating housekeeping tasks (e.g., sending meeting notices, obtaining meeting space, keeping notes) and management tasks (e.g., setting agendas, ensuring participation of key team members, ensuring team objectives get met).
- They clearly articulate the types of student concerns they manage (e.g., academic, behavioral, social, emotional, physical) as well as the environments from which these concerns are expected to arise (e.g., school, home, community).
- Team members bring specialized skills to the team. Team members should adequately represent the following domains:
    - student assessment,
    - individual support services,
    - school discipline and behavior management,
    - family engagement,
    - academic instruction,
    - community collaboration, and
    - school policy and governance.

4. **Establish Routines.** Establishing a routine for team meetings will help reduce the burden on team members by allowing them to focus their time on addressing student concerns. Teams should utilize an agenda, meet at regular intervals, and act within a set time frame. Agendas do not need to be lengthy but should include opportunities to discuss the following topics, each of which is described in more detail later in this chapter:

    - a progress review of previously referred students,
    - an examination of new referrals, and
    - a review of team members' responsibilities for next steps.

5. **Reassess Team Structure and Functioning.** After a problem-solving team is established and has met for several months, it will almost always be the case that the team's structure and functioning will need to be revaluated and perhaps modified to better meet its aims. Toolbox 1.1 provides key questions to consider when assessing the structure and functioning of a problem-solving team.



Stage 2: Manage Referral Flow

Once the problem-solving team is in place, their first order of business is to determine how to manage referral flow. *Referral flow* refers to the series of steps that occur after a young person comes to the problem-solving team's attention and before the team matches his or her needs with an appropriate intervention. Below are four questions to ask to effectively assess referral flow:

1. ***Does the problem solving team effectively collect initial referrals?*** First, problem-solving teams need to establish a procedure for receiving referrals. Referral forms are often used for this purpose, and the first task of the problem-solving team is to adopt a referral form or set of referral forms that suit their needs. In addition to the types of referral forms the team wishes to use, they will need to determine what languages the referral forms need to be translated into in order to ensure that linguistically diverse students, family members, and community members can make referrals as needed. Tool 1.1 provides three examples of referral forms: school adult, parent, and self or peer.

    After creating referral forms, the problem-solving team must determine how they will be used:

    - Will blank referral forms be available in paper, electronic format, or both?
    - Where can referral forms be found?
    - Where can referral forms be submitted? Will electronic submissions be accepted?

- Who will review referral forms? Will the problem-solving team review all submitted forms or will a delegated individual review the forms and submit them to the problem-solving team?
- How will procedures for submitting referral forms be communicated with school professionals, parents, and community members?

2. ***Does the problem-solving team effectively expand on initial referrals?*** Once the initial referral has been received, the problem-solving team should gather additional information in order to better understand the scope of the problem. The process of understanding the focus of a referral's concern using school-based problem-solving methods is discussed at length in Chapter 3 of the SMHRP Toolkit. A few key methods for expanding the problem-solving team's understanding of the referral's concern are offered below:

    - ***Collect Background Information.*** Collecting background information is essential to understand the context of the student's presenting problem(s) described within the referral document. In order to understand the history of the child and provide context for the key issues, the problem-solving team may wish to conduct a review of records or interview the student's caregiver(s). Teams may consider tasking a single team member, such as the school psychologist, with collecting and summarizing any psychological or educational history (e.g., previous evaluations or reports) relevant to the presenting problem. Teachers or learning specialists may also be able to collect and report on relevant academic or instructional information relevant to the referral's concern. Information gleaned from this thorough examination of background information should be organized, summarized, and presented to the team to guide intervention decisions.

Toolbox 1.1. ***Questions to Consider When Assessing Problem-Solving Team Structure and Functioning***

Communication, Collaboration, and Leadership

- Are there regularly scheduled meetings or are they only as needed?
- Is sufficient time provided for team meetings?
- Are all people who have a role to play invited to participate in the team?
- Do team members communicate regularly outside of planned meeting dates?
- Do team members know what skills they and others bring to the team?
- Is there a clear team leader?
- Does the leader use an effective leadership style?
- Does the team engage in ongoing self-reflection and improvement efforts?

Relationships with School Staff, Families, and Community Partners

- Do school personnel know who members of the team are?
- Do members of the team enjoy positive relationships with school personnel?
- Has the team met with community partners to introduce the team's purpose and to invite community partners to participate?
- Have family members been asked to inform the team's processes?
- Do family members play a meaningful role on the team?
- Do school personnel, community members, and families know when the team meets and how to get in touch with team members if needed?

Adapted from Wisconsin Department of Public Instruction's (2008) "Collaborative and Comprehensive Pupil Services' Self-Assessment."

Schools may consider formalizing the collection of background information by requiring reports or forms be completed by members of the problem-solving team. These reports or forms may contain the following questions:

- Is this the first time this concern has been brought to the school's attention? If not, what initiated the previous referrals?
- Is there background information that may influence the problem behavior, such as a medical diagnosis or history of trauma experiences?
- What has already been done to address the current problem (pre-referral interventions)?
- Is the student seeing a professional about this problem within or outside of the school?
- What interventions have been implemented in the past for similar problems?

- Have past interventions been partially effective, fully effective, or not effective at all?
- Are there explanations for why interventions have or have not been effective?

Of course, confidentiality needs to be maintained, and information (e.g., a parental report of infidelity) that is not relevant to the presenting concern should not be discussed by the team.

- ***Conduct Observations.*** Observation of the student can provide valuable insight into the context of the referral concern(s).
  - Does the problem-solving team follow a formal observation protocol?
  - Is parental consent considered when conducting observations?
  - Are there specific team members who are most qualified to conduct observations?
  - How are observation records used in combination with other sources of data related to the referral?

- ***Interview Teacher(s) and Other School Adults.*** Problem-solving teams may also choose to interview school staff who frequently interact with the student in order to address specific questions about the presenting problem and understand how the student functions in a variety of school settings.
  - Does the problem-solving team follow a formal interview protocol?
  - Are there specific team members who are most qualified to conduct interviews?
  - How are interview records used in combination with other sources of data related to the referral?

- ***Interview Community Partners.*** In addition to interviewing school personnel, the problem-solving team may learn that the student frequently interacts with partners in the community, such as afterschool youth-development staff, law enforcement, or a mental health provider. If these individuals do not sit on the problem-solving team themselves, they may need to be interviewed to obtain their insights into the student's presenting concern. The team should be considerate about sharing student information with school personnel outside of the team; furthermore, the problem-solving team will need to consider whether the child's parent or guardian has given signed consent for information about the child to be shared across partner agencies. All sensitive information should be carefully managed and student and family rights to confidentiality honored.

3. ***Does the problem-solving team have defined decision rules?*** Once the team has conducted a thorough assessment of the referral concern, a meeting should be held to review the collected information, synthesize it, and discuss next steps. Advancing all students to Tier 2 or Tier 3 intervention may not be necessary; in some cases, an informal plan to monitor the child's progress may be sufficient. Before moving forward in the referral pathway, teams should examine the rules to follow when making recommendations for interventions. The team must consider:

   - how they know when a student needs a Tier 2 intervention,
   - how they know when a student needs a Tier 3 intervention,
   - how they know when intervention ends or can be terminated, and
   - how they know when an intervention should be discontinued because it is not working.

4. ***Does the problem-solving team have a record-management system?*** The process of managing referrals will generate documents such as referral forms, record reviews, and observation and interview reports. The problem-solving team must have a system for retaining these materials. Teams must:

   - store records in a secure location,
   - use a secure electronic filing system, and
   - determine if all members of the problem-solving team have access to the team's documents or if different levels of permission are appropriate.

Stage 3: Map Resources

If the problem-solving team decides to move forward with intervention after thoroughly reviewing the referral concern, then they will need to ensure that a clear link exists between the presenting problem and the type of intervention selected. Matched interventions may include social, emotional, or behavioral consultation between (a) the student's teacher(s) and member(s) of the problem-solving team; (b) a targeted, evidence-based intervention delivered in a small group or individually; or (c) a referral for additional services to community-based agencies. In order to match students to the intervention that will best meet their needs, the problem-solving team will need to establish an up-to-date map of available resources and engage in a vetting procedure to ensure that all resources are evidence based and of high quality. Below are three self-assessment topics that should be addressed when mapping resources:

1. ***Has the team identified all school and community resources available to them?*** The problem-solving team will need to create a database of all existing and potential resources, interventions, and partnerships. To obtain information for the database, the team may wish to ask community partners to submit information about their organization (Toolbox 1.2) that will then be used to populate a resource database (for example, see Tool 1.2). To optimize utility of the resource database, the team may wish to describe the MTSS tiers each resource fits into. Toolbox 1.3 displays a sample database of resources and partners (e.g., providers, services, programs) both within and outside of school, categorized by tier.

2. ***Has the team examined the breadth and quality of interventions provided at school?*** After thoroughly mapping resources available within the school, the problem-solving team will need to judge the quality and breadth of resources in order to answer the following questions:

    - Are any interventions not supported by research and therefore appropriate for disqualification?
    - Are there sufficient types of Tier 2 and Tier 3 interventions to match diverse student needs?
    - Are there enough spaces in Tier 2 and Tier 3 interventions to adequately serve all students who may need them?

3. ***Has the team examined issues related to access to community-based resources?*** Below are several questions that could be used to guide the problem-solving team's relationship with community partners. Additional strategies for building effective partnerships are covered at length in Chapter 2 of the SMHRP Toolkit.

    - Whose responsibility is it to facilitate contact between the student's family and the community partner?
    - Is there a structured relationship between the school and the community partner?
    - Is there a written agreement between the community partner and the school?
    - Are data shared between the partner agency and the school? Is there a memorandum of understanding (MOU) in place to codify data sharing?
    - Whose role is it to track a referral after it has gone from the school to the community partner?
    - Is the student's family experiencing any barriers to accessing services offered by the community partner? (e.g., transportation, concerns about confidentiality, cultural or linguistic barriers)
    - Are there any barriers to accessing services by community partners that the school may be able to address, such as school policies that prevent collaboration?

Toolbox 1.2. ***Community Resource Recruitment Form***

Name of Organization and Website	
Date Updated	
Responsible School-Based Team Member	
Services Provided	☐ Individual Counseling ☐ Substance Abuse Counseling ☐ Group Counseling ☐ Family Sessions ☐ Behavioral Approaches ☐ Home Visits ☐ Other_____
Organization Type	
Vetting and Licensure	Names of agencies that have approved the service: Licensure of service providers:
Operating Days/Hours	
Contact Person at Community Resource	
Specific Providers	
Telephone/Email	
Location/Transportation Concerns	
Cost: Insurance, Sliding Fee Scale, etc.	

How Is Progress Monitored at the Community Site?	☐ Checklists ☐ Clinical Judgment ☐ Progress Monitoring Forms ☐ Other_____
Languages	☐ Spanish ☐ Chinese ☐ Korean ☐ Other_____
Age Population	☐ Early childhood ☐ Elementary ☐ Adolescents ☐ Adults
Other Notes	

Toolbox 1.3. ***Sample List of Resources and Partners within the MTSS Framework***

NAME	WITHIN/ OUTSIDE	TIER(S)	TYPE	SUMMARY
Social Emotional Learning (SEL) Curriculum	W	1	Program	School counselor facilitates in classrooms
After School Clubs	W	1	Program	Variety of club opportunities focused on academics or social activities
Parent Teacher Association	W	1, 2	Volunteers	Utilizing families to provide connections, volunteers for reading interventions, or career day
Positive Behavioral Interventions Supports	W	1, 2, 3	Program	Tiered approach to rewarding positive behaviors
Group Counseling	W	2	Service Provider	Group counseling, short term, focusing on at-risk students, developing specific skills
Check and Connect	W	2	Service/ Program	Home-school liaison facilitates
Functional Behavioral Assessment and Behavior Intervention Plan	W	2, 3	Service	School psychologists and multidisciplinary team implement
Individual Mental Health Services	W	3	Licensed Mental Health Clinicians, School Based	School-based individualized mental health services

Individual Mental Health Services	O	3	Licensed Mental Health Clinicians, Community Based	Community-based individualized mental health services
Chamber of Commerce	O	1	Private Partnerships	Grant opportunities
Boys and Girls Club	O	1, 2	Program	Private organization
Faith-based Organization	O	1, 2	Non-Profit Organization	After school programs, faith-based supports
Child Protective Services	O/W	2, 3	Government Agency	Provides support for safety of children
Person in Need of Supervision (PINS) Diversion Program	O	3	Government Agency	Family specialists work with families to address non-violent offenses
Hospitals	O	3	Medical	Mental health crisis response

Note: The first column represents an example type of resource. The next column, labeled, “Within/Out,” indicates if the resource is located within (W) the school or outside (O) of the school. The third column indicates the type of organization, such as a formal program or an individual service provider. The last column is a short description of each resource/partner.

Stage 4: Evaluate Intervention Effectiveness

The final set of procedures that the problem-solving team must self-assess are the ones they use to monitor the effectiveness of the interventions they've prescribed. This stage is critical for ensuring that the problem-solving team can speak with confidence when they say they are improving the social, emotional, and behavioral well-being of young people. In addition to the detailed steps articulated in Chapter 3 of the SMHRP Toolkit, the problem-solving team will need to answer the following questions:

1. ***What will it look like when this student no longer experiences the problem for which he or she was referred?*** The team must answer this question in as observable and quantifiable a way as possible so that students' responses to intervention can be measured.
2. ***Does the problem-solving team collect process data?*** Process data help the team monitor whether the intervention is happening as planned. Process data include the number of sessions provided and the duration of sessions.
3. ***Does the problem-solving team collect outcome data?*** Outcome data help the team determine if the interventions they selected are reducing the problem for which the student was referred. Outcome data might include improved school attendance, improved grades, or fewer fights with peers.
4. ***Does the problem-solving team monitor intervention progress?*** The team will want to know before an intervention concludes whether or not the intervention is working. For this reason, the team may request to monitor progress by asking for reports on process and outcome indicators at regular intervals during the course of the intervention. For example, if a student is assigned to a Tier 3 intervention meant to occur once per week for fifteen weeks, the team might request reports on progress indicators at weeks five and ten.
5. ***Does the problem-solving team request intervention effectiveness information from community partners?*** Sometimes problem-solving teams request different information from school-based practitioners than they do from community partners. Typically this is due to the fact that community partners are not employees of the school district and cannot be required to provide data. Most community partners will gladly provide requested information if provided an efficient and lawful route to do so. See Chapter 2 of the SMHRP Toolkit for more information about sharing data across agencies.
6. ***Does the problem-solving team request feedback from the student or his or her family about the intervention experience?*** A valuable source of process data can be obtained by asking the student and his or her family how they felt about the intervention. Did the student feel the experience was useful? Did he or she feel connected to the person providing the intervention? Did the student's family perceive any positive changes as a result of the intervention?
7. ***Has the problem-solving team adopted systems for tracking response to intervention?*** Problem-solving teams should consider adopting software systems to electronically track intervention process and evaluation data. Toolbox 1.4 displays several software systems that may be used for tracking intervention data.

Toolbox 1.4. ***Software Systems for Tracking Intervention Data***[1]

Name of Data System	Developer	Description
Early Warning System betterhighschools.org/ews.asp	The National High School Center	A downloadable electronic tool that "helps schools and districts systematically: 1) identify students who are showing signs that they are at risk of dropping out of high school; 2) match these students to interventions to get them back on track for graduation; and 3) monitor students' progress in those interventions." *Source: The National High School Center, American Institutes for Research*
Hero herok12.com	Hero K12, LLC	"An in–browser web app and a mobile app to allow K–12 schools to capture a record of anything that happens on their campus." *Source: HeroK12*
Maxient Maxient.com	Maxient	A web-based information system designed to coordinate "student discipline, academic integrity, care and concern records, Title IX matters, or just an "FYI"...an integral component of many schools overall early alert efforts, helping to identify students in distress and coordinate the efforts of various departments to provide follow-up." *Source: Maxient*
SWIS Suite pbisapps.org	PBISApps	"A reliable, confidential, web-based information system to collect, summarize, and use student behavior data for decision making." *Source: PBISApps*

8. ***Does the problem-solving team report intervention effectiveness information to stakeholders?*** Several groups would benefit from knowing about the problem-solving team's work. For instance, in individual cases, both family members and school staff that interact with a referred student may be interested in understanding intervention assignment and progress. Although he or she may not be interested in individual-level data, the school superintendent may be interested in understanding how the team makes intervention decisions and how those interventions relate to overall academic outcomes. Due to the sensitive nature of the work, the problem-solving team will want to ensure that stakeholder(s) receiving information have the appropriate permissions for the level of data shared, especially with regard to any data that have the student's name or other identifying information attached to them

This chapter of the SMHRP Toolkit outlined four self-assessment stages, each characterized by several assessment questions, that schools—problem-solving teams, specifically—can use to gauge the quality of their referral systems. By reflecting on their answers to these questions, problem-solving teams can identify the strengths of their referral systems, as well as the weaknesses and gaps that need to be addressed in order to optimally address students' social, emotional, and behavioral needs at all MTSS tiers.

1 List of software applications is not exhaustive and inclusion herein should not be interpreted as endorsement by SAMHSA.

Tool 1.1. *Example Referral Forms*

Example Referral Form: School Staff

Name of student: _____

Your name: _____

Relationship to student: _____

The school's problem-solving team may wish to contact you to discuss your referral concerns. Please provide your contact information and the best time to reach you.

Phone:_____ Best time to contact:_____

Area of concern (please describe):

- ☐ Academic Concerns:
- ☐ Behavioral Concerns:
- ☐ Social Concerns:
- ☐ Emotional Concerns:
- ☐ Physical Health Concerns:
- ☐ Family Concerns:
- ☐ Other: _____

Behavioral concerns (please mark all boxes that apply):

- ☐ Exposed to community violence, other trauma
- ☐ Nightmares, intrusive thoughts
- ☐ Anxious, fearful or irritable mood
- ☐ Jumpy or easily startled
- ☐ Avoids reminders of trauma
- ☐ Aggressive
- ☐ Sexualized play or behaviors
- ☐ Difficulty concentrating

- ☐ Talks excessively
- ☐ Gets out of seat and moves constantly
- ☐ Interrupts and blurts out responses
- ☐ Inattentive, distractible, forgetful
- ☐ Disorganized, makes careless mistakes
- ☐ Angry towards others, blames others
- ☐ Fights and is aggressive
- ☐ Argumentative and defiant

- ☐ Sad, depressed or irritable mood
- ☐ Hopelessness, negative view of future
- ☐ Low self-esteem, negative self-statements
- ☐ Difficulty concentrating
- ☐ Diminished interest in activities
- ☐ Low or decreased motivation

- ☐ Anxious and fearful
- ☐ Worries excessively
- ☐ Difficulty sleeping
- ☐ Restless and on edge
- ☐ Specific fears or phobias
- ☐ Difficulty concentrating
- ☐ Clingy behavior
- ☐ Appears distracted

How often is this behavior occurring? (e.g., several times per day; 1-2 times per week)

How long has this behavior been occurring? (e.g., several weeks, several months)

To your knowledge, what interventions have previously been tried?

- In school supports:
  _____
  _____
  _____
- Outside of school supports:
  _____
  _____
  _____

To your knowledge, what interventions are currently in place?

- In school supports:
  _____
  _____
  _____
- Outside of school supports:
  _____
  _____
  _____

What do you think will help the student to experience success?

Adapted from: Los Angeles Unified School District School Mental Health Referral Form, available at: http://achieve.lausd.net/Page/7249

Example Referral Form: Parent or Guardian

Date: _____

Name of child: _____

Your name: _____

Relationship to child: _____

The school's care team may wish to contact you to discuss your referral concerns. Please provide your contact information and the best time to reach you.

Phone: _____ Best time to contact: _____

Who does your child live with?

- ☐ Biological parents
- ☐ Adoptive parents
- ☐ Foster parents
- ☐ Relative care
- ☐ Group home
- ☐ Other: _____

Desired language of service?

- ☐ English
- ☐ Spanish
- ☐ Other: _____

Does your child have an individualized education plan (IEP)?

- ☐ Yes
- ☐ No
- ☐ I don't know

Area of concern (please describe):

- ☐ Academic Concerns:
- ☐ Behavioral Concerns:
- ☐ Social Concerns:
- ☐ Emotional Concerns:
- ☐ Physical Health Concerns:
- ☐ Family Concerns:
- ☐ Other: _____

Behavioral concerns (please mark all boxes that apply):

- ☐ Exposed to community violence, other trauma
- ☐ Nightmares, intrusive thoughts
- ☐ Anxious, fearful or irritable mood
- ☐ Jumpy or easily startled
- ☐ Avoids reminders of trauma
- ☐ Aggressive
- ☐ Sexualized play or behaviors
- ☐ Difficulty concentrating
- ☐ Talks excessively
- ☐ Gets out of seat and moves constantly
- ☐ Interrupts and blurts out responses
- ☐ Inattentive, distractible, forgetful
- ☐ Disorganized, makes careless mistakes
- ☐ Angry towards others, blames others
- ☐ Fights and is aggressive
- ☐ Argumentative and defiant

- ☐ Sad, depressed or irritable mood
- ☐ Hopelessness, negative view of future
- ☐ Low self-esteem, negative self-statements
- ☐ Difficulty concentrating
- ☐ Diminished interest in activities
- ☐ Low or decreased motivation

- ☐ Anxious and fearful
- ☐ Worries excessively
- ☐ Difficulty sleeping
- ☐ Restless and on edge
- ☐ Specific fears or phobias
- ☐ Difficulty concentrating
- ☐ Clingy behavior
- ☐ Appears distracted

How often is this behavior occurring? (e.g., several times per day; 1-2 times per week)

How long have you had this concern about your child?

To your knowledge, has your child ever received any supports or interventions for this behavior in the past?

To your knowledge, is your child receiving any supports or interventions for this behavior currently?

What do you think will help your child experience success?

Adapted from: Los Angeles Unified School District School Mental Health Referral Form, available at: http://achieve.lausd.net/Page/7249

Example Referral Form: Self or Peer

Date: _____

Your name: _____

Who are you looking for support for?

- ☐ Myself
- ☐ Another student at my school

The school's care team may wish to contact you to understand your concerns better.

- ☐ Yes, it's ok to contact me
- ☐ No, please don't contact me

Please share the reason you are seeking support for yourself or another student:

_____

Please mark all boxes that apply:

- ☐ Exposed to community violence, other trauma
- ☐ Nightmares, intrusive thoughts
- ☐ Anxious, fearful or irritable mood
- ☐ Jumpy or easily startled
- ☐ Avoids reminders of trauma
- ☐ Aggressive
- ☐ Sexualized play or behaviors
- ☐ Difficulty concentrating

- ☐ Talks excessively
- ☐ Gets out of seat and moves constantly
- ☐ Interrupts and blurts out responses
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- ☐ Fights and is aggressive
- ☐ Argumentative and defiant

- ☐ Sad, depressed or irritable mood
- ☐ Hopelessness, negative view of future
- ☐ Low self-esteem, negative self-statements
- ☐ Difficulty concentrating
- ☐ Diminished interest in activities
- ☐ Low or decreased motivation

- ☐ Anxious and fearful
- ☐ Worries excessively
- ☐ Difficulty sleeping
- ☐ Restless and on edge
- ☐ Specific fears or phobias
- ☐ Difficulty concentrating
- ☐ Clingy behavior
- ☐ Appears distracted

Please share any additional information you would like the care team to know:

Adapted from: Los Angeles Unified School District School Mental Health Referral Form, available at: http://achieve.lausd.net/Page/7249

Tool 1.2. ***Sample Completed Database***

Approved Service Providers for Local Education Agency Schools

Contact Information	Description of Service	Populations Served	Family/School Involvement	Effectiveness or Results	Vetting Licensure	Organization Capacity and Cost
Example: XYZ Program www.xyz.exp Youth Mental Health Services (YMHS) www.ymhs.exp Jane Doe 555-555-5555 jane.doe@ymhs.exp	*Example:* XYZ is an 8-week, 45-minute, small-group intervention for up to six students to help develop stress reduction skills.	*Example:* Students identified for internalizing behaviors interfering with learning at school.	*Example:* YMHS staff implements services to students and provides training to teachers and counselors. YMHS staff reach out to families through home visits, family group sessions, and one-on-one counseling.	*Example:* Pre/Post stress physiology test showed lower stress levels. Pre/Post student surveys showed increased empathy, emotional control, optimism, self-concept. Teacher interviews revealed more pro-social behavior and peer acceptance. Student referrals for physical and social aggression decreased.	*Example:* SAMHSA UCLA All YMHS staff have a master's degree or a PhD in social work. The staff are licensed by the state board.	*Example:* YMHS has the capacity to lead 10 XYZ groups at a time over a typical school year. Program is grant funded. Cost to participants is based on a sliding scale determined by free/reduced lunch applications and/or teacher/counselor recommendation.

Tool 1.3. *Additional Resources for Assessing Your Referral Management Approach*

Name of Resource	Name of Resource Developer	URL Resource	Short Description
Addressing The Unmet Mental Health Needs Of School Age Children: Guidelines For School-Community Partnerships	Illinois Children's Mental Health Partnership	http://www.icmhp.org/icmhppublications/files/ICMHP-SchoolGuidelinesFinalWEB11-19-10_ICMHP-.pdf	Steps to establish partnerships and finance strategies. Provides specific tools such as grant writing, creating effective strategic plans, appropriate oversight, etc.
Using Coordinated School Health to Promote Mental Health for All Students	National Assembly on School-Based Health Care	http://www.nasbhc.org/atf/cf/%7Bcd9949f2-2761-42fb-bc7a-cee165c701d9%7D/white%20paper%20csh%20and%20mh%20final.pdf	Provides resources and a framework for providing this care within the school context.
Strategic Planning Toolkit for Communities: 2012	National Forum on Youth Violence Prevention	http://ojp.gov/fbnp/pdfs/forum_toolkit.pdf	Toolkit for communities addressing prevention of youth violence. Includes data-driven strategies for prevention, intervention, enforcement, and reentry. Contains references and referrals for other relevant resources.
Community Conversations About Mental Health Planning Guide	SAMHSA	http://store.samhsa.gov/shin/content//SMA13-4765/SMA13-4765.pdf	Facilitating community discussions around mental health.
Comprehensive School Mental Health Programs: A Series of Four Interactive Modules	National Resource Center for Mental Health Promotion and Youth Violence Prevention	http://www.healthysafechildren.org/learning-portal	Four online learning modules designed to provide instruction on how to build Comprehensive School Mental Health Programs.
School-Community Partnerships: A Guide	School Mental Health Project, Dept. of Psychology, UCLA	http://smhp.psych.ucla.edu/pdfdocs/guides/schoolcomm.pdf	Guide to building partnerships, focusing on relationships and families.
Collaborative and Comprehensive Pupil Services	Wisconsin Department of Public Instruction	http://sspw.dpi.wi.gov/sites/default/files/imce/sspw/pdf/pscandc.pdf	Self-assessment tools for professionals evaluating system-wide approaches for prevention and referrals.
School Mental Health Capacity Instrument	Feigenberg & Watts Boston Children's Hospital	Contact Author: luba.feigenberg@childrens.harvard.edu	Quantitative assessment tool for school approaches to the prevention of mental health concerns.
NJ State Board of Education	Resource Manual	http://www.state.nj.us/education/students/irs/	A practical manual for school-based intervention and referral services from the NJ DOE with useful flow charts and examples of referral procedures and forms.
National Technical Assistance Center for Children's Mental Health	Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care	http://gucchdtacenter.georgetown.edu/resources/ECMHC/ECSOC%20Toolkit/PPT_Toolkit.pdf	Toolkit for developing each childhood systems of care. Provides detailed summaries of successful strategies for building mental health supports for young children and their families.
Office of Juvenile Justice and Delinquency Prevention (OJJDP) Strategic Planning Tool	National Gang Center	http://www.nationalgangcenter.gov/About/Strategic-Planning-Tool	Sign up for a free account to develop a program matrix and online community resource inventory.

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Wisconsin Department of Public Instruction. (2008). Collaborative and comprehensive pupil services: Student services/prevention & wellness team division for learning support: Equity and advocacy. Retrieved from: http://sspw.dpi.wi.gov/sites/default/files/imce/sspw/pdf/pscandc.pdf

CHAPTER 2

Building Effective Partnerships

CHAPTER 2

BUILDING EFFECTIVE PARTNERSHIPS

Key Questions

1. How can schools best build effective partnerships with other youth-serving organizations to support the mental health of young people?
2. What are the primary considerations for sharing information about a young person's functioning across providers?
3. How can schools and their partners plan to transition young people across youth-serving agencies?

Understanding the Need to Partner

Educators and their community partners share an interest in cultivating the mental health of young people by encouraging youth to realize their own potential, cope with stress, work and learn productively, and contribute to the community (World Health Organization, 2014). Approximately 20% of youth have a mental disorder (Centers for Disease Control and Prevention, 2013), yet only about one in three of these young people receive services (Merikangas et al., 2011). The situation is even more serious for young people of color; Black and Hispanic youth are less likely than their White peers to receive mental health services, especially for internalizing disorders (Merikangas et al., 2011).

Why Partner?

- Reduces barriers to access.
- Allows for intervention to occur in natural settings.
- Provides schools with a more diverse range of resources and supports to meet mental health needs within an MTSS framework.
- Improves outcomes for young people.

Schools are often where mental health concerns are first noticed. In fact, more than half of young people who receive mental health services at some point in their lives are diagnosed through the education system (Burns et al., 1995; Farmer, Burns, Philips, Angold, & Costello, 2003). This may be due to the fact that school professionals have sustained contact with young people and the expertise to detect problems at early stages, before the impact of mental health problems on academic and social functioning becomes more severe. Education may also be a more common access point due to the Individuals with Disabilities Education Act (1990), reauthorized as the Individuals with Disabilities Education Improvement Act (IDEIA; 2004), the federal law mandating that students whose mental health disabilities impact their ability to benefit from public education receive individualized education and related services in the least restrictive environment. That is, instead of enrolling a student with a mental health disability in a residential treatment school, hospital, or institutional setting, he or she must have the opportunity to receive the supports he or she needs within the public school, alongside peers.

A study of young people enrolled in the Substance Abuse and Mental Health Services Administration's (SAMHSA) Children's Mental Health Initiative, Systems of Care, found that young people referred for services from schools had significantly lower levels of global impairment than young people referred from mental health settings (Green, Xuang, Kwong, Hoagwood, & Leaf, 2015). What is more, young people referred through the education sector often do not receive services from other agencies (Farmer et al., 2003). The implication is that the education system is a central entry point for young people whose needs are identified, and regardless of the intensity of treatment needs, it may be the only setting in which services are provided.

Because schools are one of the few places where families interface with local resources, there are many advantages of providing multitiered mental health services in schools:

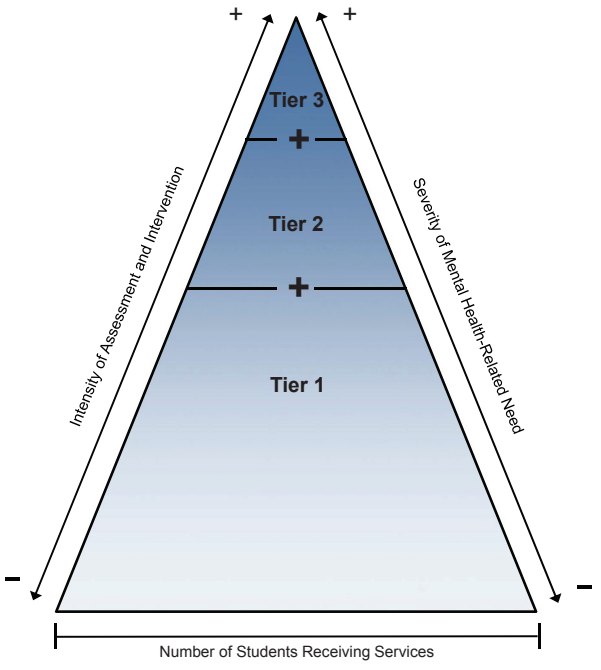
- It improves access to services by reducing barriers such as transportation, child care, cost, and stigma (Freeman, Grabill, Rider, & Wells, 2014; Hoover Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). Providing services in schools within a multitiered framework also allows for more prevention efforts that promote mental wellness.
- Because a local school is a known environment for young people and their families, mental health interventions can be more ecologically grounded (Hoover Stephan et al., 2007). Clinicians working in the schools are more able to influence aspects of the school environment (e.g., classroom structure, teacher–student interactions), which will positively impact mental health outcomes for the young people they serve. Indeed, multidisciplinary collaboration leads to increased coping and problem- solving skills, reduced emotional and behavioral problems, improved school climate, fewer special education referrals, and decreased disciplinary referrals (Ballard, Sander, & Klimes-Dougan, 2014; Hoover Stephan et al., 2007).
- It reduces the likelihood that young people will experience exclusionary discipline practices (e.g., suspension), academic difficulties, school disengagement, school drop out, and incarceration (Brown, 2007; Gregory, Skiba, & Noguera, 2010; Lee, Cornell, Gregory, & Fan, 2011).

Despite the advantages of providing mental health services in schools, serving mental health needs has not historically been central to the mission of schools and, therefore, schools often do not have the resources to identify and treat all young people with mental health needs. In addition, pressure to meet federal and state mandates to show academic gains (Bancroft, 2010) may prevent educators from focusing on mental health needs. Given the impact and severity of mental health challenges on academic, behavioral, and social functioning of young people in school settings, as well as the limits on school resources, it behooves schools to partner with other agencies to best meet the needs of young people and their families.

Partnerships may span the tiers of prevention within the MTSS framework (Figure 2.1, see SMHRP Toolkit Introduction for review). Examples include:

- At Tier 1, a non-profit community-based youth-development agency may partner with the school to provide universal, classroom-based prevention efforts (e.g., social and emotional skill development).
- At Tier 2, a private mental health clinician may be contracted to provide targeted skill training to small groups of young people with emerging internalizing or externalizing problems during the school day. This type of early intervention would be provided to help reduce the likelihood that mental health problems will interfere with school functioning.

Figure 2.1. ***The Multitiered System of Support Model for Mental Health Supports in Schools***



Adapted from: Renshaw & O'Malley (2015)

- At Tier 3, students who do not respond to less intensive interventions may need more individualized treatment, which may be addressed on or off school campus through effective partnerships with other sectors (e.g., health and medical, mental health). For instance, a mental health clinician from the local public mental health agency may be engaged to provide evidence-based individualized treatments on the school campus before, during, and after school hours.

Mental Health Partnerships: Leveraging Community Resources for Maximum Impact

To effectively meet the mental health needs of young people, schools must partner with a variety of sectors, including mental health, health and medical, child welfare, and juvenile justice (Burns et al., 1995). Examples of creative partnerships between schools and each of these sectors are described below.

Mental Health. In the mental health sector, services are provided by a wide variety of organizations, including hospitals and medical clinics, public and private mental health agencies, and private mental health clinicians. State Departments of Mental Health are responsible for delivering public mental health services in a variety of settings, including: psychiatric inpatient, residential treatment, partial hospitalization, community-based mental health centers, and outpatient drug/alcohol clinics or rehabilitation centers. Through their state office of mental health, schools can also locate mental health programs in their vicinity. Despite the comprehensive services available, only one-quarter of young people receiving mental health services enter through the mental health sector (Farmer et al., 2003). Many of these individuals are only receiving care at the Tier 3 level of intervention once a mental health concern has developed into a serious condition. These data underscore the fact that, in order to better realize their mission to reduce the impact of mental illness in the community, the mental health sector has a stake in partnering with schools for the purpose of prevention and early intervention. Examples of effective education-mental health partnerships include:

- At Tier 1, school and community mental health agency partnerships may provide social and emotional learning programs (see www.casel.org) or participate as team members in whole-school model programs, such as Positive Behavioral Interventions and Supports (PBIS). School and community partners can provide cross-training for staff and co-lead classroom groups on prevention topics such as drug and alcohol use, problem-solving, and suicide prevention (Freeman et al., 2014).
- At Tier 2, small groups to target specific areas of need (e.g., bereavement, anger management) may be facilitated on the school campus by a clinician from the local community mental health agency.
- At Tier 3, students in greatest need may be provided with more intensive and coordinated services, such as multisystemic therapy (MST; Henggeler, Schoenwald, Rowland, & Cunningham, 2002) by local, private-licensed mental health clinicians on the school campus. Schools in some districts have partnered with mental health clinicians to create family resource centers that provide individualized, family, or group interventions for youth and their families at no cost. These centers are housed within the district, and referrals may come from school-based providers, but the centers function as separate entities in order to maintain confidentiality and allow clinicians to address non-school-related concerns.

Health and Medical. The health and medical sector has an increasingly important role in mental health. A study of national trends found that the number of youth visiting physicians and resulting in mental disorder diagnoses (e.g., disruptive behavior disorders, anxiety and mood disorders, developmental disorders, psychotic disorders) have doubled over the past two decades (Olfson, Blanco, Wang, Laje, & Correll, 2014). In addition, the number of visits to physicians for psychotropic medication has increased for young people (Olfson et al., 2014). The medical sector also becomes involved once a young person is in a mental health crisis and needs more intensive services and treatment. However, physician diagnoses are often based on limited information provided by parents and gained during a relatively short office visit. This can lead to differences between medical diagnosis and educational placement, causing stress for the young clients and their parents. Physicians and educators are often unable to collaborate with individual students due to time constraints inherent to both professions.

Examples of partnerships between schools and the health and medical sector include:

- School-based health clinics, where medical professionals, such as physicians, dentists, nurse practitioners, and mental health professionals (e.g., psychologists, social workers) are placed in targeted schools to provide additional supports to meet the needs of young people (Glaser & Shaw, 2014). The Center for Health and Health Care in Schools lists several such model programs at http://www.healthinschools.org/model-programs.aspx.
- Medical professionals may also serve on collaborative teams and provide information on issues of importance to schools (e.g., accident prevention, substance abuse, violence).

Child Welfare. The primary purpose of the child welfare sector, or social services, is to provide protection for young people who are physically, sexually, or emotionally abused, neglected, or exploited. Once young people have contact with the child welfare system, their use of mental health services may increase (Leslie, Hurlburt, James, Landsverk, Slymen, & Zhang, 2005). Schools and child welfare services must collaborate to prevent new incidents of abuse and, when incidents have been identified, to intervene early and effectively. Ideas for innovative partnerships between education and child welfare include:

- Child welfare agencies can offer training to school staff and families at the school building. Services that can be provided to families include case management and planning, day care, housekeeping, parent aide, parent training, transportation, emergency cash or goods, housing, crisis respite care, and clinical services (Erie County Child Protective Services Agency, n.d.).
- Child welfare agencies can have a caseworker housed within the school to offer families who need support the help they need (e.g., mental health, substance abuse) and to assist with reports of abuse or neglect (Erie County Child Protective Services Agency, n.d.).
- Child welfare agencies can help schools support homeless youth. Issues such as enrollment, medical needs, mental health, and other services can be coordinated by social workers from the child welfare agency in collaboration with the school.

Juvenile Justice. Some young people living with mental illness may also be involved with the juvenile justice sector (e.g., detention center, family court, law enforcement, probation). Young people in the juvenile justice sector are about three times more likely to have a mental health diagnosis than their peers, with girls in the juvenile justice sector being even more likely than boys to have mental health diagnoses (Anoshiravani et al., 2015). Serious concerns exist about the "school-to-prison pipeline," where some of the most severely affected young people, many of whom have been exposed to violence and other forms of trauma, are subject to suspension, expulsion, and other forms of exclusionary discipline that deprive them of educational benefits and push them toward involvement in the juvenile justice sector. Instead of viewing juvenile justice as a last resort, schools can partner with juvenile justice to engage in more prevention efforts, such as:

- **School resource officers** (SROs) are police officers who act as law enforcers (e.g., provide supervision, investigate crimes, serve as liaisons between school and police), educators (for young people, parents, and school staff about law-related issues), and informal counselors or role models (Canady, James, & Nease, 2012; James, Logan, & Davis, 2011; Quinn, 2014). Properly trained SROs can form strong relationships with young people and work collaboratively on schools' student assistance and crisis response teams (James et al., 2011).
- **Law enforcement** is also an important part of the threat-assessment process, which is the recommended standard approach for schools to take to determine the extent to which a student poses a serious threat to the safety of others (Fein et al., 2002). This process seeks to understand the meaning and context of a student's threatening behavior and uses this information to address the underlying context of the problem rather than rely on uniform discipline alone (Cornell & Allen, 2011; Cornell & Sheras, 2006).

Business and Philanthropic Organizations. Members of local business and philanthropic sectors can be important partners for schools by providing funding for initiatives to improve mental health. Local businesses may provide schools with positive behavioral interventions and supports (Eagle & Dowd-Eagle, 2014). Businesses may also provide grant funding for positive youth-development initiatives and other preventive programs to promote mental health. Local businesses and health foundations created as part of the business sector may also fund school mental health positions and services (Freeman et al., 2014). Philanthropic organizations often have funding opportunities for schools that may be used to improve mental health and can develop proposals to meet an unmet need. Many such organizations and foundations require schools to identify their expected measurable objectives, evaluation data, and capacity to sustain initiatives after the funding period ends.

Community-Based Organizations. Community-based organizations (CBOs), especially those whose mission is to promote youth development, can be engaged in a variety of ways. For example, the Big Brothers Big Sisters Program links with school to provide mentoring within the community or at school for in-need students. Organizations like the Boys and Girls Club, YMCA, and YWCA can collaborate with schools to provide a safe transition from school to after-school care and provide opportunities to develop social skills and character education (Eagle & Dowd-Eagle, 2014).

How Can Schools Partner Effectively?

Historically, mental health services have been fragmented and uncoordinated across sectors, and most young people with identified mental health needs do not receive services (Hoagwood, Bruns, Kiser, Ringeisen, & Schoenwald, 2001). To address these issues and better meet the needs of young people with serious mental health challenges, the system of care concept was developed to guide the field in reforming child-serving systems, services, and supports (e.g., education, juvenile justice, child welfare, and mental health; Pires, 2002). The concept and philosophy were the result of a participatory process in the early to mid-1980s that initiated the National Institute of Mental Health's Child and Adolescent Service System Program (CASSP) to provide funding and technical assistance nationwide to improve systems coordination (Pires, 2002; Stroul, Blau, & Friedman, 2010).

In the 30 years since its introduction, the system of care framework has shaped the work of nearly every community nationwide, and it serves as the foundation of the Federal Comprehensive Community Mental Health Services for Children and their Families (Stroul et al., 2010). The framework is not a proposed model of services, agencies, and organization of the systems but rather a vision for transformation to meet the needs of the local community (Stroul et al., 2010). The *wraparound service delivery model* is consistent with this vision; it is a team-based, collaborative process that identifies, implements, and coordinates a number of services and supports to meet the needs of young people and their families, with an emphasis on natural and community-based supports, resulting in improved academic, mental health, living situation, and overall outcomes for young people (Suter & Bruns, 2009).

Defining features of the system of care philosophy and approach:

- Coordinated network of effective, community-based services and supports for young people with mental health challenges and their families.
- Family driven and youth guided.
- Infrastructure of structures, processes, and relationships at community level.
- Cultural and linguistic competence.

Source: Pires, 2002; Stroul et al., 2010

The Partnership Process

The process of building effective partnerships involves three phases: (a) defining roles and responsibilities, (b) sharing information and monitoring progress across systems, and (c) planning for transitions between levels of care. Each phase of the partnership process is described below.

Phase 1: Defining Roles and Responsibilities

Before establishing a formal partnership process, key stakeholders need to be invested in the partnership. Initial meetings about the partnership might involve surveying existing efforts in the community that focus on mental health needs of young people, documenting the need for the partnership, ensuring buy-in by getting a commitment to attend meetings and provide resources (e.g., space), and developing a clear vision (Illinois Children's Mental Health Partnership, n. d.). Developing a stakeholder group is also important. This may begin initially by engaging groups with preexisting relationships. Although there is flexibility in terms of the composition of the group, it may include:

- someone with decision-making power from each group,
- educators (teachers, administrators, school support staff),
- family members,
- youth,
- someone with expertise in evaluation,
- community stakeholders (elected officials),
- juvenile justice providers,
- representatives from parks and recreation, and
- social service providers (Illinois Children's Mental Health Partnership, n. d.).

The group should also be culturally diverse and represent a range of perspectives. Some of the skills that are valuable for stakeholders in collaborative groups include:

- commitment to collaboration,
- training and skills,
- dependability,
- collegiality,
- flexibility,
- effective communication,
- knowledge of community, and
- positive working relationships with potential partners (Illinois Children's Mental Health Partnership, n. d.).

Because collaborative efforts have different purposes, there are various structures and processes for collaboration, ranging from simple sharing of information to complex relations for sharing data, financial resources, and integrated decision-making. Once potential collaborators are identified, it is important to identify the type of relationship that will exist between the school and the outside organization. Toolbox 2.1 provides a breakdown of the varying levels of partnership development, with information about the purpose, structure, and process of each.

Toolbox 2.1. ***Levels, Purpose, Structure, and Process of Partnerships***

Level	Purpose	Structure	Process
Networking	Information clearinghouse Create base of support Increase community action	Roles loosely defined Participation is variable	Low leadership Minimal decision-making Little conflict Informal communication
Cooperation or Alliance	Match needs Coordinate and limit duplication of services Ensure task completion	Roles somewhat defined Central body of people as hub of communication	Facilitative leadership Complex decision-making Some conflict Formal communications within central group
Coordination or Partnership	Share resources Merge resource base to create something new	Central body of people as decision makers Roles defined Links formalized Development of new resources and joint budget	Autonomous leadership (focus on issue) Group decision-making (central and subgroups) Frequent and clear communication
Coalition	Share ideas Pull resources from existing systems Commit for at least 3 years	Decision-making involves all Roles and time defined Written agreement to formalize links (e.g., MOU) Development of new resources and joint budget	Shared leadership Formal decision-making (all members) Common and prioritized communication
Collaboration	Accomplish shared mission Build independent system to address issues and opportunities (e.g., school-based mental health services)	Decision making by consensus/shared Roles, time, and evaluation formalized (e.g., grant proposal) Written work assignments and formal links	High leadership, trust, and productivity Equally shared decision-making Highly developed communication

Adapted from Bridging Refugee Youth and Children's Services "Refugee Children in U. S. Schools: A Toolkit for Teachers and School Personnel"

Stakeholders should discuss the resources, structures, and processes that will need to be in place to maintain a successful partnership. When making decisions about what types of partnership to enter into, schools need to have information about the partners and a process for vetting service providers (for examples, see Chapter 1: Toolbox 1.2, Toolbox 1.3). This is important for any level of partnership but may be particularly important for coalitions or collaborations where joint services are provided.

In building effective partnerships, schools and other agencies also need to consider the differences in their terminology, issues of confidentiality and information sharing, perceptions about the role in the school, processes involved in diagnosing mental health needs, service provision, licensure and continuing education requirements, and funding (Freeman et al., 2014). For example, school-based mental health professionals adhere to educational laws (e.g., IDEA, FERPA), which guide their scope of work, diagnostic, information sharing, and intervention procedures. Professionals in partner agencies may be governed by health care laws and regulations (e.g., HIPAA) and may focus on specific areas or populations (e.g., intensive treatment needs for young people experiencing trauma, diversion programs to prevent involvement in the juvenile justice

system). Access and funding issues also differ, as families do not pay directly for education and related services provided within public schools, whereas in other agencies, services may be reimbursed from health insurance, Medicaid, or self-pay. State departments of education also have school Medicaid claiming guides that allow for reimbursement of particular services. Many of the partnership levels detailed in Toolbox 2.1 allow for shared funding through school, community, business, state and county, and foundation support.

Memoranda of Understanding (MOU)

Once stakeholders have agreed upon the nature of the collaboration, it is important to further detail and clarify the roles of each agency, a process that is typically codified by a memorandum of understanding (MOU). An MOU should include the purpose of the program or partnership, the roles and responsibilities, requirements for information sharing, and relevant procedures (U.S. Department of Justice, Office of Community Oriented Policing Services, 2015). An MOU is commonly required when partners receive grant funding. An MOU can also be a policy instrument within the context of applicable state and federal laws; all partners should sign and abide by the MOU (U.S. Department of Justice, Office of Community Oriented Policing Services, 2015). Toolbox 2.2 displays a checklist of topics that should be included in an MOU and discussed when defining the parameters of the collaboration with mental health partners.

Toolbox 2.2. *MOU Checklist*

1. **Parties to the Collaboration**
   - ☐ Education partner name
   - ☐ Community partner name (police department, mental health service, counseling service, etc.)
2. **Purpose for the Collaboration**
   - ☐ Include goals and objectives
3. **Collaborative Functions**
   - ☐ Assessment (initial screening, diagnosis, and intervention planning)
   - ☐ Referral, triage, or monitoring/management of care
   - ☐ Direct service and instruction (e.g., primary prevention programs/activities; early intervention; individual, family, and group counseling; or crisis intervention and planning)
   - ☐ Indirect services (consultation, supervision, in-service instruction)
4. **Roles and Responsibilities of Mental Health Clinician**
   - ☐ Prevention, early intervention, treatment, and assessment services to young people in the school
   - ☐ Individual/group therapy
   - ☐ Social skill training or coaching
   - ☐ Family therapy
   - ☐ Substance abuse counseling
   - ☐ Psychosocial evaluations
   - ☐ Consultation, training, and support to teachers, administrators, and other school staff
   - ☐ Collect data/notes on students to monitor progress
   - ☐ Complies with a request to share any other information related to a student's treatment (requires an appropriate release of information signed by the student's parents)
   - ☐ Visits students' homes or community agencies (permission not needed from the school)

5. **Supervision Responsibility of the Community Agency Partner**
   - Provide supervision and support for mental health clinicians
   - Hire and supervise one or more clinicians who will be placed in participating schools
   - Hold weekly supervisory and training meetings for clinicians
   - Report any unusual incidents to school principal and work with school to resolve disputes
   - Provide monthly reports to school principal with gathered information, such as the number of students seen, the number and theme of therapeutic groups, and general concerns raised

6. **Roles and Responsibilities of the School**
   - Provide a private space, a locking filing cabinet, and a dedicated phone line for each clinician assigned to a school
   - Provide supplies, materials, and use of office equipment
   - Convene a team of relevant individuals to meet regularly to review and assign requests for services
   - Use the referral format specified by the community agency for all referrals, whether from staff, student, or parent
   - Maintain confidentiality of all referrals, whether a self-referral by the student or by the staff
   - Work to resolve dilemmas that arise from the legal confidentiality requirements so that all staff involved with a student can work together in the student's best interest while adhering to mandatory mental health laws

7. **Miscellaneous Procedures**
   - Mental health clinicians can/cannot be financially compensated by the school for work completed as part of their normal duties
   - Mental health clinicians are responsible for reporting their hours; clinicians should sign in and out of the school if the school requires such a procedure
   - Clinicians will report their schedules to the school on a monthly basis, and each carries a cell phone provided by the program to ensure that they can be reached when out of the building
   - Requests for leave time will be approved by supervisors at the community agency
   - Principals will be informed of this leave in writing
   - School staff (administrators and teachers), families, and students will be asked to participate on a regular basis in the evaluations
   - Schools will be asked to share school-level data (e.g., attendance records, disciplinary actions, grades)

8. **Legal Considerations**
   - Mandatory reporting laws
   - Mental health records are confidential and not part of the school record
   - Disclosure of mental health information
   - Release of mental health records can be pursuant to a court order

Phase 2: Sharing Information and Monitoring Progress Across Sectors

In a partnership that includes authentic connection and collaboration, there needs to be a communication mechanism that allows for timely dissemination of information to all agencies and stakeholders (SAMHSA, 2000). Although protecting privacy and maintaining confidentiality are essential, these are challenges that can be navigated through careful planning and engagement of families, staff, and providers across agencies committed to a common goal (Pires, 2002).

Family Education Rights and Privacy Act (FERPA). Under federal law, if a local or state education agency receives funds under the Elementary and Secondary Education Act, it must adhere to the Family Education Rights and Privacy Act (FERPA). FERPA is the primary federal law protecting the privacy and confidentiality of students' personally identifiable information (address, social security number, grades, behavioral referrals).

Health Information Portability and Accountability Act of 1996 (HIPAA). Medical records, including those kept by a school nurse employed by the health department, are subject to the Health Information Portability and Accountability Act of 1996 (HIPAA). More detailed information about each of these laws is provided in Tool 2.1. An essential take-home point from all of these privacy laws is that the parent or legal guardian for young people under the age of 18 must give consent by signing a release of information sharing form in order for schools and other agencies to share any information about young people (for example, see Tool 2.2).

Information sharing between partner agencies is critical to meet the needs of young people. The signed consent of a parent or legal guardian to obtain and release information is essential to comply with privacy laws.

Toolbox 2.3. ***Consent to Release Information Checklist***

A form indicating guardian consent to release information should include the following key elements (see Tool 2.2 for an example):

- ☐ The purpose of the disclosure
- ☐ The identity of the party or class of parties to whom the disclosure may be made
- ☐ The name and contact information of the agency requesting the information
- ☐ The name and contact information of the agency releasing the information
- ☐ The guardian name and contact information for young persons under 18 years of age
- ☐ The name and contact information for young persons 18 years of age or older
- ☐ The types of records or other information to be received (e.g., education, substance abuse, medical, or mental health records)
- ☐ The process by which information will be released (e.g., U.S. mail, fax, electronic mail)
- ☐ The signature of the guardian or young person 18 years of age or older
- ☐ The contact information for individual(s) providing consent
- ☐ The date the consent will expire, after which a new consent would be needed

Considerations in Crisis Situations. In relation to privacy regulations, there are exceptions when it comes to imminent danger. For example, HIPAA permits a provider to notify a patient's family members of a serious and imminent threat to the health or safety of self or others if the family members are in a position to lessen or avert the threat (U.S. Department of Health and Human Services, 2014). Schools must know which hospitals are equipped to work with young people in crisis. A school-based mental health professional can facilitate the

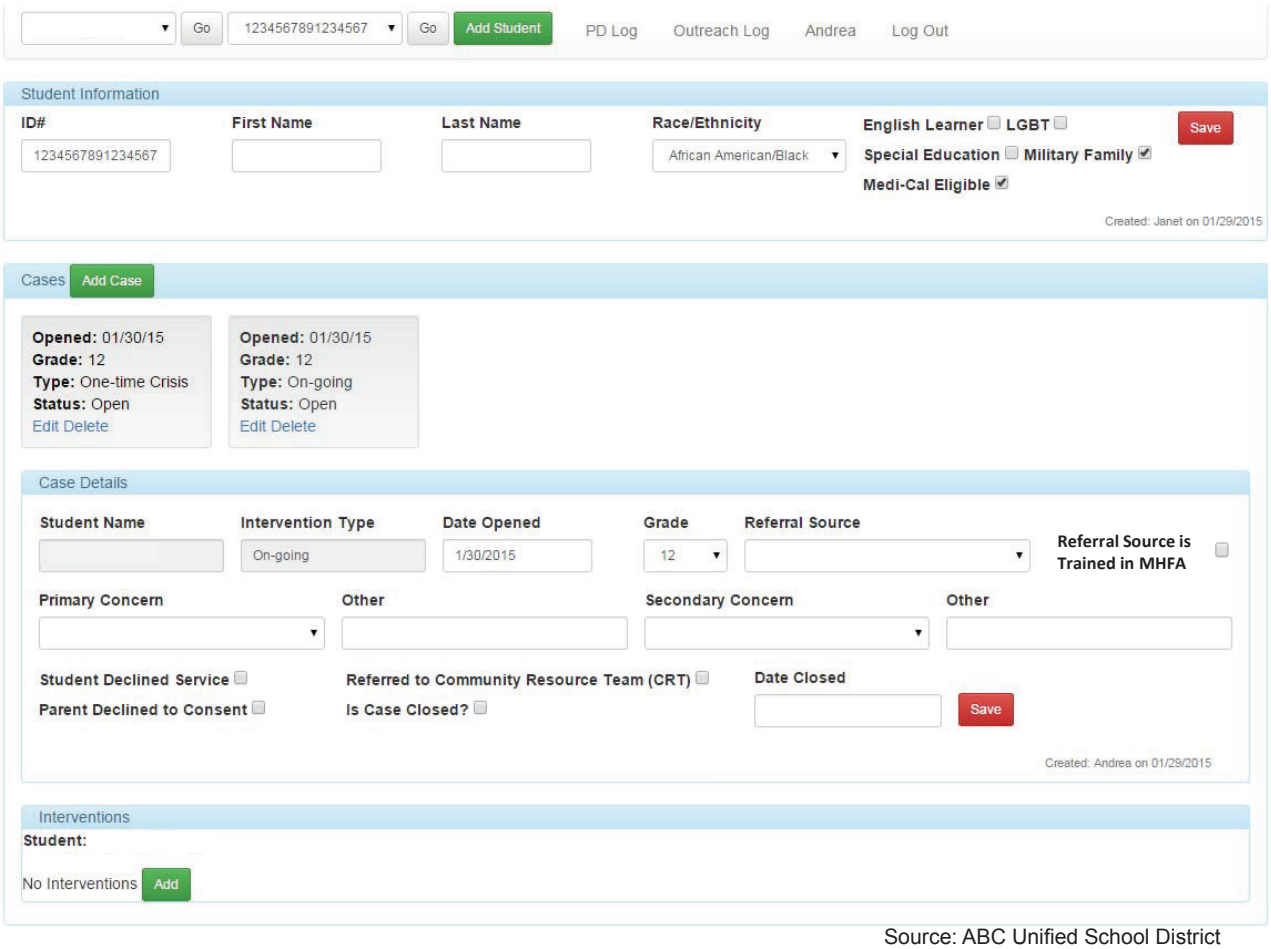
admittance to a hospital in a crisis situation, or if the young person is already under the care of a psychiatrist, that doctor can often assist with a direct admittance. Some community mental health centers and mobile crisis teams also provide emergency assessments to help determine level of risk and the corresponding level of care required. Schools should have arrangements with agencies and practitioners that can assist them prior to a crisis.

Tracking Referrals Across Partners. Technology has advanced several tools for improving collaboration and data sharing between schools and their community partners. Some pioneering education agencies have developed student information systems that mental health professionals can use to enter data to monitor and track students who have been identified as in need of services (see Chapters 1 and 3 for additional details). In addition to basic student information (e.g., student identification number, demographics), logged data may include the referral source, whether the referral source was trained in mental health first aid, the range of concerns that led to the referral, and the type and number of interventions provided. Figure 2.2 displays the user interface for this type of student information system.

When tracking referrals in this way, confidentiality and data security must be considered and systems need to comply with HIPAA's security rule in terms of the safeguards for electronic records. Such security precautions might include (U.S. Department of Health and Human Services, Office of Civil Rights, n.d.):

- Access controls (information only accessed by passwords, PINs)
- Encryption codes (information only accessed by those with a key)
- Audit trails to record who accessed information and what changes were made
- Notifications of any breaches to privacy

Figure 2.2. ***Electronic Data Tracking System, User Interface***



Source: ABC Unified School District

Monitoring Treatment Progress within Partnerships. Evidence-based practices, or interventions that have been shown to be effective through rigorous research, are now the gold standard for treatments. However, resources for establishing evidence-based practices are still not widely available in community settings, as treatments shown to be effective in carefully controlled studies cannot be assumed to be effective when implemented under routine practice conditions (Beidas et al., 2015; Hoagwood et al, 2001; President's New Freedom Commission on Mental Health, 2003). Therefore, schools and other agencies need to examine their own processes and outcomes to ensure that services are being delivered and making an impact (Garland et al., 2010). Some considerations for partners wishing to establish shared indicators of success include:

- Partners must define *progress monitoring measures*, which are used to produce clinical data for feedback about progress and to inform intervention, and outcome measures, which are used to assess the amount and type of change young people experience from the start to the end of an intervention (Meier, 2015).
- Partners can use a *practice-based evidence approach*, which includes systematic and frequent measurement of both the treatment process and progress within a continuous quality improvement framework (Bickman, 2008). An example is the contextualized feedback and intervention treatment (CFIT), an outcome-driven quality-improvement system with four major components: organizational assessment, treatment progress measurement, feedback, and training (Bickman, 2008).
- Partners should engage in *continuous partnership quality improvement*, wherein intervention effectiveness data are used to inform decisions that fortify the quality of the partnership (e.g., improved personnel training, coordination of services).

Assessing outcomes is an important way to ensure that schools and their partners are meeting their shared goals. Schools and their partners must determine their shared outcomes of interest to ensure that data are gathered on shared metrics, when possible. Schools should consider following these steps for measuring intervention effectiveness:

1. **Decide *what* to measure based on the young person's presenting needs**. There are many reasons that a young person may be referred for mental health support, including internalizing problems and externalizing problems. Chapter 3 of the SMHRP Toolkit provides a detailed procedure for evaluating the specific presenting needs that should be measured before, during, and after treatment. Partners must reach agreement about what exactly the presenting need is and how response to treatment will be measured.
2. **Decide *how* to measure intervention effectiveness.** Partners must select measures that are sensitive to change and specify levels of performance to be attained. Toolbox 2.4 provides several resources for identifying treatment monitoring and behavioral progress monitoring instruments.

Toolbox 2.4. *Resources for Identifying Treatment Monitoring Instruments*

- **Patient Reported Outcomes Monitoring Information System (PROMIS): Dynamic Tools to Measure Health Outcomes from the Patient Perspective (National Institutes of Health).**
  A set of freely available, validated, computerized measures of self-report (ages 8-17) and parent proxy report (ages 5-17) for measuring patient related outcomes (PROs), including physical health, mental health, and social well-being outcomes.
  URL: nihpromise.org
- **Contextualized Feedback Intervention and Training (CFIT).**
  A treatment progress monitoring battery, including 10 measures of clinical processes and mental health outcomes for young people ages 11-18.
  URL: peabody.vanderbilt.edu/docs/pdf/ptpb/PTPB_Chapter1.pdf
- **National Center on Intensive Intervention.**
  Provides information on behavior progress monitoring tools for young people
  URL: intensiveintervention.org/chart/behavioral-progress-monitoring-tools

3. **Determine the *level of change* expected.** Partners need to discuss what level of change is needed to confidently say that the young person has responded to intervention. Because measuring meaningful change can be a complex statistical issue, partners should consider referring to the user guidebooks associated with any measures they select. User guidebooks will provide information that can inform decisions about meaningful change.
4. **Determine *how often* to measure intervention effectiveness**. An important part of monitoring progress is feeding back the information to the person(s) providing the intervention so that it can be used to improve services and quality of care. Young people whose mental health clinicians receive session-by-session feedback improve more quickly than those where feedback is more delayed (Bickman et al., 2011).
5. **Determine *how to share* effectiveness information across partners**. The use of technology is an important consideration, as most educators and clinicians do not have the time to hand-enter and calculate data. Toolbox 3.5 provides examples of software systems that can be used to measure treatment progress. Also refer to Toolbox 1.4 in Chapter 1 for software systems that may apply to your partnership needs.

Toolbox 2.5. *Sample Software Systems for Monitoring Progress*[2]

- **YouthServices.net**
  Customizable software for registering participants, tracking attendance and measuring outcomes. Service providers use the software for data collection, service management and program evaluation needs of the youth services sector.
  URL: youthservices.net

- **Wisconsin Department of Public Instruction Student Intervention Monitoring System**
  Created by the Madison Metropolitan School District with support from the Department of Public Instruction, the Student Intervention Monitoring System (SIMS) is a software program designed to monitor interventions and help educators provide additional support for children who are not learning. SIMS is a systematic way to share information between teachers and to monitor student progress over time.
  URL: rti.dpi.wi.gov/rti_sims2

Phase 3: Planning for Transitions between Levels of Care

The intensity of mental health needs can vary at different points in a young person's life, making it critical that partnerships support coordinated and seamless transitions across organizations providing mental health services. In the most severe of circumstances, the mental health needs a young person has may require intensive treatment in restricted settings, such as hospitalizations in emergency situations, that must occur quickly and without time for prolonged planning. Transition out of hospital placement can be equally abrupt; psychiatric hospital lengths of stay are typically only a few days (Balkin & Roland, 2007; Clemens, Welfare, & Williams, 2011). Young people released from detention centers and residential placements often do not return to school after release (Holman & Ziedenberg, 2006; Mears & Aron, 2003), and less than 15% of incarcerated ninth graders go on to complete their high school education (Holman & Ziedenberg, 2006).

For partnerships to effectively support young people returning to school after receiving intensive mental health services in more restrictive settings, such as juvenile detention centers, hospitals, day treatment centers, or residential treatment centers, several considerations should be addressed. Paramount in reintegration planning is the need to maintain required levels of support while placing the young person in the least restrictive educational environment. The responsibility to coordinate reintegration is often placed on schools (Glaser & Shaw, 2014), although communication and collaboration between school personnel and partner agencies is needed. In addition to ongoing collaboration for building systems of support, partner agencies should consider engaging in the following practices for transition planning:

2 List of software systems is not exhaustive and inclusion herein should not be interpreted as an endorsement by SAMHSA.

- *Reentry planning*, where a multidisciplinary team (problem-solving team, IEP team, transition team) engages in systematic decision-making to plan for the appropriate transitional services, supports, and goals based on the needs of the family, educators, and student.
- *Monitoring and follow-up* related to a transition plan in order to continuously evaluate the transition process.
- *Education of school community*, including preparing school staff and students about the issuesunder consideration for the student returning. School reentry teams may consider preparing the school community by meeting with school faculty and students in the young person's classroom (e.g., Stony Brook Children's School Intervention and Re-entry Program http://www.stonybrookchildrens.org/school-reentry).

Examples of specific considerations to take into account in transition and reentry plans include (Clemens et al., 2002; Cook-Cottone, 2004; Kaffenberger, 2006; Vermeire, 2008):

- Meet with the young person and family to find out what information will be shared and how they want information shared.
- Ensure that appropriate release of information documents are signed to share information among providers for intervention planning.
- Designate a "go to" person who will meet and greet the student upon return.
- Provide support and understanding to the student, including assessing the student's perceptions of his or her functioning as well as his or her preferences regarding the type of support wanted (e.g., check-in with staff at end of day, role-play how to respond to questions from classmates).
- Make up a list of missed work for each class, review it with the parents and the student, and assist in contacting teachers to compile this information.
- Implement appropriate modifications (reduced workload, half-day attendance for a period of time, alternative assignments, extended time on tests, peer tutoring or mentoring if desired).
- Inform student of supportive resources available (consider special support systems such as personal phone contact, an assigned counselor, school-based continuity of care support group).
- Adhere to recommendations from outpatient providers.
- Provide specific plans and guidance about issues that contribute to the student's problems (e.g., people, places, and things that may trigger a response).
- Ensure staff are trained in signs of relapse and appropriate interventions and strategies.
- Keeping privacy considerations and constraints in mind, provide information and direction to staff who will interact with the student.
- Monitor systematically and adjust educational plan as needed.

Conclusion

Meeting the mental health needs of young people can best be accomplished through strong partnerships between schools and their youth-serving counterparts in a variety of sectors. Building on the strengths and resources in each setting, a coordinated system of care model allows young people and their families to receive multidimensional care that is tailored to their needs. This SMHRP Toolkit chapter detailed specific considerations and provided several related tools and techniques to assist educators in their partnership-building efforts.

The Family Educational Rights and Privacy Act (FERPA)

see http://www2.ed.gov/policy/gen/guid/fpco/pdf/ferparegs.pdf

In general, personally identifiable information and education records cannot be disclosed without written consent, even for case management. For aggregated data, system-level data may be shared since it is does not compromise individual confidentiality (Partnership for Children and Youth, n.d.).

Personally Identifiable Information (PII):

Includes	Does NOT Include
1. Student's name 2. Names of student's family members 3. Address of student or student's family 4. Personal identifier (e.g., student's social security number) 5. Indirect identifiers that are not unique to the student or family but can be used in combination with other information to identify the student	1. Records kept in the sole possession of the maker (e.g., personal notes) 2. Records of the law enforcement unit of an educational agency or institution 3. Records relating to an individual who is employed by an educational agency or institution, except when the records are of a student employee 4. Records created or received by an educational agency or institution after an individual is no longer a student in attendance and that are not directly related to the individual's attendance 5. Classwork not graded by a teacher

Circumstances Under Which or Individuals to Whom An Educational Agency Can Disclose PII
Privacy Technical Assistance Center, US Department of Education
ptac.ed.gov

1. To other school officials (e.g., teachers) within the agency/institution or to an authorized representative (e.g., contractor, consultant, volunteer) of a contracted education program that has legitimate educational interest
2. To officials of another school, school system, or institution of postsecondary education if the student seeks or intends to transfer or where the student is already enrolled for enrollment or transfer purposes
3. To an authorized representatives of certain government agencies who are performing an audit, evaluation, or enforcement or compliance activity
4. If information is in connection with financial aid for which the student has applied
5. To state and local officials or authorities if disclosure concerns the juvenile justice system and the system's ability to effectively serve the student whose records are being requested
6. To organizations conducting research for or on behalf of schools, school districts, or postsecondary institutions for developing, validating, or administering predictive tests; administering student aid programs; or improving instruction
7. To accrediting organizations to carry out their accrediting functions
8. To parents of a dependent (minor) student or to the student
9. To a parent of the child if the student is under 21 and violates any federal, state, or local law or any rule or policy of the institution regarding the use or possession of alcohol or a controlled substance
10. To comply with a court order or subpoena
11. In a health or safety emergency
12. If the information is not considered harmful or an invasion of privacy (e.g., directory information)
13. If the student is an alleged perpetrator of a crime of violence or a non-forcible sex offense (regardless of whether the institution concluded a violation was committed), final results of the institution's disciplinary proceedings can be released to the victim.
14. To an alleged perpetrator if information relates to a disciplinary proceeding (i.e., an investigation, adjudication, or imposition of sanctions by an educational agency or institution with respect to an infraction or violation of the internal rules of conduct applicable to students of the agency or institution) at an institution of postsecondary education
15. If the information concerns sex offenders and other individuals required to register under section 170101 of the Violent Crime Control and Law

FERPA or HIPPA?

	FERPA	HIPPA
Records covered	Education records, including information directly related to a student maintained by an educational agency or a party acting on behalf of the educational agency: • Grades. • Behavior referrals. • Information relating to young people with disabilities who receive evaluations, services or other benefits under the Individuals with Disabilities Education Act.	Records relating to: • past, present, or future physical or mental health or condition • providing health care to the individual • past, present, or future payment for the use of health care. Students' immunization and other health records that are maintained by a school district or individual school, including a school-operated health clinic.
Levels of protection	• Personally identifiable information and education records cannot be disclosed without written consent, even for case management. whereas aggregated data, system level data sharing is sharable. • Need written consent from guardian in order to share records.	It may only be shared with: • with the individual (or his/her personal representatives) when they request access to or share their protected health information • with the Department of Health and Human Services when an investigation is underway. • If there is written consent from the guardian
Exceptions to confidentiality/ procedural safeguards	Confidentiality may not be broken except in certain circumstances.	The Security Rule specifies a series of administrative, physical, and technical safeguards for service providers and their associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.

Tool 2.2. ***Example Parental Consent for LEA to Release Student Information***

Name of Student:_____ Date of Birth: ___/___/____

Name of Parent/Guardian:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone:_____ Email:_____

I [Name of Parent/Guardian]:_____hereby authorize information from

[Name of LEA] _____ to be released to [Name of Agency] _____
_____ for the purpose of coordination of services.

In addition, hereby authorize the following institutions and practitioners _____
to release information concerning the above named student to [Name of LEA]_____

The types of information that I allow to be released are (check all that apply):

Education	Juvenile Justice	Health/Mental Health
☐ School grades	☐ Probation history	☐ Human service records
☐ School attendance records	☐ Court records	☐ Child welfare history
☐ School discipline reports	☐ Detention record	☐ Mental health intake
☐ IEP/504	☐ Programs attended	☐ Mental health screen
☐ Psychoeducational evaluation	☐ Pre-trial services	☐ Summary of alcohol/drug and mental health assessment
☐ Other: _____	☐ Other: _____	☐ Summary of mental health services plan, progress, and compliance
		☐ Discharge summary

This authorization will automatically terminate on _____ unless previously revoked or extended by me, the undersigned.

_____ _____

Signature of Parent/Guardian Date

Tool 2.3 *Additional Resources for Building Effective Partnerships*

Name of Resource	Name of Resource Developer	URL Resource	Short Description
Information Sharing Toolkit	National Center for Mental Health Promotion and Youth Violence Prevention, Education Development Center	http://informationsharing.promoteprevent.org/	A web-based resource for schools and community agencies to learn how to share information about young people involved in multiple systems.
School-Community Partnerships: A Guide	Center for Mental Health in Schools, School Mental Health Project, Dept of Psychology, UCLA	http://smhp.psych.ucla.edu/pdfdocs/guides/schoolcomm.pdf	Guide to building school-family-community partnerships; contains recommendations, steps, and tools.
Mental Health Toolkit	Elkhart and St. Joseph County Educators (supported by Office of Safe and Drug Free Schools, U.S. Department of Education)	http://www.thefamilygateway.net/home/special-note-to-schools/mental-health-tool-kit/	A toolkit to guide educators in making linkages to support mental health services within a systems of care model.
Data Sharing: Federal Rules and Best Practices to Improve Out- of- School-Time Programs and Student Outcomes	Partnership for Children and Youth	http://www.expanding-learning.org/sites/default/files/ost_data-sharing_and_ferpa.pdf	Provides examples of sharing data between schools and partners to improve outcomes and opportunities for young people.
Resource Manual for Intervention and Referral Services	Vermeire, G. L. (New Jersey Department of Education)	http://www.state.nj.us/education/students/irs/	Provides guidance for schools' program of intervention and referral services to meet needs of at-risk and high-risk young people.
Addressing the Unmet Mental Health Needs of School Aged Youth: Guidelines for School- Community Partnerships	Illinois Children's Mental Health Partnership	http://icmhp.org/icmhpproducts/files/ICMHP-SchoolGuidelinesFinalWEB11-19-10_ICMHP-.pdf	Resource for developing local and statewide cross-system collaborations to coordinate prevention, early intervention, and treatment for young people's mental health.
Using Coordinated School Health to Promote Mental Health for All Students	National Assembly on School-Based Health Care	http://www.nasbhc.org/atf/cf/%7Bcd9949f2-2761-42fb-bc7a-cee165c701d9%7D/white%20paper%20csh%20and%20mh%20final.pdf	Provides resources and gives framework for providing this care within the school context.
The Role of System of Care Communities in Developing and Sustaining School Mental Health Services	American Institutes for Research	http://www.air.org/resource/role-system-care-communities-developing-and-sustaining-school-mental-health-services	Focused on the school and community connection and the role of systems of care, this brief addresses developing and sustaining effective and coordinated networks of supports and services.
Collaborations of Schools and Social Service Agencies	National Center for Homeless Education	http://center.serve.org/nche/downloads/collab_school_social.pdf	Addresses how social service/welfare agencies and schools can collaborate to assist students in need. Specific examples of collaboration and implementation across the country are detailed.

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CHAPTER 3

School-Based Problem-Solving to Promote the Mental Health of Young People

CHAPTER 3

SCHOOL-BASED PROBLEM-SOLVING TO PROMOTE THE MENTAL HEALTH OF YOUNG PEOPLE

Key Questions

1. What is a problem-solving approach, and how can the four-step problem-solving model be used to promote youths' mental health in schools?
2. What roles do school personnel and community partners play on problem-solving teams dedicated to promoting mental health?
3. How can problem-solving teams use the antecedent–behavior–consequence theory of behavior to effectively solve youths' mental health problems?
4. What evidence-based assessment and intervention practices are available for problem-solving teams to use to promote mental health within multitiered systems of supports?

A Problem-Solving Approach for Promoting Mental Health

A *problem-solving approach* is a practical and scientific way to effectively address mental health problems experienced by youth in schools. This approach is practical because it gives school personnel and community partners an organized way to think about and work with youths' mental health problems. It is scientific because it uses a systematic, hypothesis-testing approach that is driven by evidence-based theory and current data

Within a problem-solving approach, the word *problem* is defined as:

> *An unacceptable discrepancy between desired levels of valued behavior and observed levels of that behavior.* (Deno, 2013)

In other words, a problem is when school personnel care about the way students behave (i.e., valued behavior) and a student is unable to meet the school's behavioral expectations (i.e., there is a large discrepancy between the desired and observed levels of that behavior).

This definition implies that problems do not exist solely inside of students; they are situational and arise from students interacting with their school environments. As Deno (2013, p. 11) plainly put it: "problems exist in the eye of the 'beholder' [i.e., school personnel] rather than in the behavior or performance of the student."

As with academic problems, many students also experience mental health problems that make school and life more challenging. Just as a problem-solving approach is useful for resolving academic concerns (Deno, 2013), it is also useful for solving mental health issues (Barrett, Eber, & Weist, 2015). Although students can experience mental health issues in different forms, a useful way of classifying these problems is to divide them into two general categories: *internalizing problems* and *externalizing problems* (Form, Abad, & Kirchner, 2014).

- **Internalizing problems** occur when students experience an excess of unwanted, aversive thoughts and feelings that are directed inwards toward the self. The most common internalizing problems are depression and anxiety. Because students' thoughts and feelings are only observable to themselves, these problems can sometimes be difficult for school personnel to notice them. However, excess, unwanted, aversive thoughts and feelings are usually associated with deficits in adaptive behavior, such as withdrawing from social interaction or avoiding school tasks, that school personnel are likely to notice over time.
- **Externalizing problems** occur when students exhibit an excess of behaviors that are disruptive to social harmony or that threaten others' physical or psychological well-being. The most common externalizing problems are non-compliance, defiance, hyperactivity, impulsivity, and aggression. Although these problems are often associated with unwanted internal experiences, such as anger or impulsive feelings, the outward behavior usually concerns school personnel because of its negative effects on other students and staff.

Whether used to address internalizing or externalizing problems—or any other kind of problem—a school-based, problem-solving approach is characterized by six core features (Deno, 2013; Pluymert, 2014):

- **Values based.** As mentioned above, a problem is a discrepancy between valued behavior and actual behavior. From this perspective, values can be defined as desired qualities of behavior that are intentionally chosen and used to guide goal setting. Goals can then be defined as behavioral expectations that can be quantified and achieved, while values are the things people care about that motivate them to set and achieve goals in the first place. Probably the most common value for school personnel is that youth be academically successful. This value guides the setting of various academic goals, including benchmark and test scores that indicate mastery of skills and subject areas. Working toward goals is a way to realize values—to support students in behaving in desirable ways—but achieving goals doesn't finalize values, as there is always more to do to be a "successful student." When school personnel choose to value youths' mental health in a similar way that they value academic success, then they empower themselves to set and achieve goals for student well-being.

- **Outcome focused**. The ultimate aim of a problem-solving approach is to improve student outcomes that reflect alignment between student behavior and school personnel's related values. The practical implication of this is quite simple: if student outcomes are improving and goals are being met, then school personnel's problem-solving efforts are working. And if student outcomes are not improving and goals are not being met, then problem- solving efforts are ineffective and need revising. To that end, the important principle underlying an outcome- focus is to set realistic goals that are tightly linked with values, and which can be feasibly evaluated to determine success.

- **Data driven**. A problem-solving approach relies on data-based decision-making as the primary means for identifying problems, generating hypotheses for how to best solve problems, selecting specific strategies to intervene with problems, and evaluating the effectiveness of problem-solving efforts. Such data are collected and interpreted systematically and repeatedly, using pre-established decision rules. From a problem-solving perspective, the only way to judge if mental health outcomes are improving, if goals are being met, and if values are being realized is by collecting and using student behavior data.

- **School led**. When a problem-solving approach is used by school personnel, they take responsibility for leading all aspects of the process, including establishing values, determining outcomes, collecting data, and testing solutions. This means that the responsibility for achieving desired student outcomes rests squarely on school personnel's shoulders. If problem-solving efforts are ineffective for promoting students' mental health, the onus is on the school personnel, not the student or the student's family. If school personnel do not have the time, resources, or expertise to lead a particular aspect of the problem-solving process or to provide students with needed mental health services, it is their responsibility to contact and collaborate with community partners to ensure that such services are made available.

- **Collaborative**. Although school personnel begin and lead the problem-solving process, they must also actively collaborate with students, families, and community partners to efficiently and effectively accomplish their purposes. Depending on the scope of the problem, it can be helpful to invite students and families into the problem-solving process to clarify and establish shared values, develop culturally sensitive outcome goals, and design socially feasible intervention procedures. And when mental health problems become severe or require time and resources beyond those available in the local school setting, community partners with advanced expertise should be engaged in the problem-solving process to provide necessary or specialized support services.

- **Process oriented.** Instead of being a quick fix, a problem-solving approach is a process-oriented method that involves following specified steps of a logic model (described below), which requires a significant time and resource investment from school personnel. The payoff of this investment is that staff members' efforts are likely to effectively achieve valued student outcomes. Also, when efforts to promote mental health in schools are ineffective, the logic model underlying the problem-solving process provides a self-correcting mechanism to act more effectively in the future.

When initiating a problem-solving approach in schools to promote mental health, school personnel can begin by taking two key steps: establishing a problem-solving team and selecting a problem-solving model.

Establishing a Problem-Solving Team

Problem-solving teams, described in detail in Chapter 1, can take different shapes in schools, depending on the number and type of personnel who are available and dedicated to promoting youths' mental health. Several different types of school personnel are commonly involved in problem-solving teams: school mental health professionals, teachers, support staff, and administrators.

- **School mental health professionals** are practitioners who have graduate-level training in promoting mental health and who provide support services to youth in school settings. These individuals may be employed part time or full time by the school and may come from a variety of training backgrounds. Common school mental health professionals include school psychologists, child clinical psychologists, counseling psychologists, school social workers, marriage and family therapists, and behavior analysts or behavior specialists. The role of school mental health professionals on the problem-solving team is to share their specialized knowledge related to assessing and intervening with youths' internalizing and externalizing behaviors and to apply that knowledge by providing indirect (e.g., consultation) and direct (e.g., counseling or skill-training) mental health services to youth at school.
- **Teachers** are educators employed by the school to teach core content area courses or elective courses. The role of teachers on the problem-solving team is to share their specialized knowledge of students' educational functioning, to offer observations on how youths' mental health problems are interfering with their success in school, and to assist school mental health professionals in providing support services to students by collecting data and implementing classroom or school-wide interventions.
- **Support staff** are educators employed by the school to assist teachers in their duties. These individuals may be employed to support academic instruction (e.g., reading specialists) or to support youth with challenging behaviors (e.g., one-on-one aid). Similar to teachers, the role of support staff on the problem-solving team is to offer observations on how youths' mental health problems are interfering with their success in school and to assist mental health professionals at school in providing support services to students by collecting data and implementing classroom or school-wide interventions.

- **Administrators** are responsible for supervising teachers and school staff, managing student concerns, and establishing and enforcing school-wide policies and practices. Common administrative professionals include the principal, vice principal, dean of students, and school counselor. The role of administrators on the problem-solving team is to share their specialized knowledge of school-wide policies and practices, to offer observations on how youths' mental health problems are interfering with their success in school, to function as the liaison with families and community partners when necessary, and to oversee the provision of mental health services within the local school setting.

Although a problem-solving team should have members from each of these key categories of school personnel, sometimes this may not be possible. At the least, problem-solving teams devoted to promoting youths' mental health should consist of at least two school personnel: a school mental health professional and an administrator. Although problem-solving teams consisting only of educators can effectively solve academic problems, they should not target mental health problems without the expertise of a school mental health professional, as this is likely to result in unethical practice.

That said, given that school mental health professionals have such varied training backgrounds, it is important to recognize the limits of their expertise and then contact and collaborate with other school or community mental health practitioners who are capable of providing necessary services that cannot be provided by the local school-based practitioner. This point is described in mental health professionals' codes of ethics as "practicing within the bounds of one's competence" (e.g., National Association of School Psychologists, 2010) and must be a major consideration when forming a problem-solving team. Common examples of school mental health professionals' limited expertise and their need for collaboration include:

- Some school mental health professionals may only have expertise in solving externalizing problems and may therefore not be capable of providing support to students with internalizing problems, necessitating referrals to other mental health providers.
- Many school mental health professionals are only competent to provide mental health services to students with mild to moderate problems and will therefore need to refer to specialized community practitioners, such as child clinical psychologists and psychiatrists, when youth present with severe mental health problems (e.g., bipolar disorder or early-onset childhood schizophrenia).
- Some school mental health professionals may have substantial knowledge and skills regarding small-group and individual supports but lack expertise in school-wide assessment and prevention strategies, necessitating supervision or consultation from other school-based practitioners with expertise in this area.

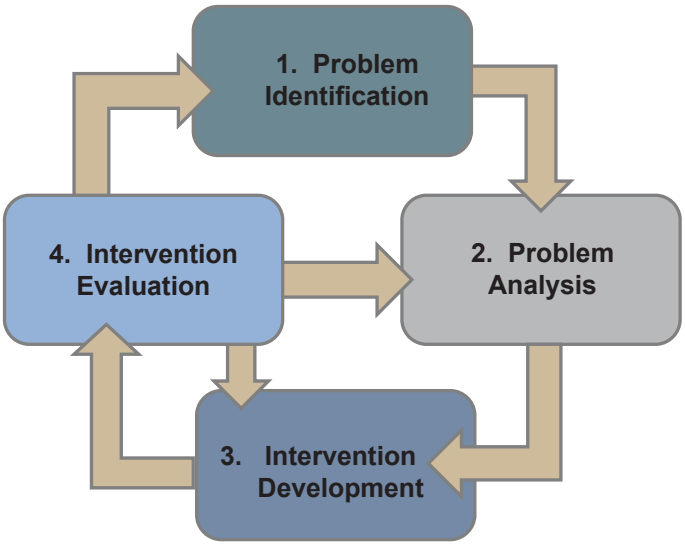
After a core group of school personnel and community partners have been established as a problem-solving team, the next major step is to select a problem-solving model that will guide all future steps the team will take in promoting youths' mental health.

Several logic models have been recommended for helping school-based problem-solving teams accomplish their purposes: models specific to academic skill problems (Deno, 2013), externalizing problems (Erchul & Schulte, 2009), internalizing problems (Huberty, 2009), and any kind of problem (Pluymert, 2014). This section presents a synthesis of what can simply be called the **four-step problem-solving model** for promoting mental health in schools (see Figure 3.1).

The Four-Step Problem-Solving Model

The four steps within this particular problem-solving model are: (1) problem identification, (2) problem analysis, (3) intervention development, and (4) intervention evaluation. Each of these steps is outlined below according to its (a) formative questions, (b) analytic aims, and (c) core procedures. When followed closely, these three elements form a tight logical sequence that guides school personnel in effectively resolving youths' mental health problems.

Figure 3.1. ***Four-Step Problem-Solving Model for Promoting Mental Health in Schools***



Step 1: Problem Identification

- *Formative questions*
  - What does the problem-solving team value?
  - Is there a problem?
  - If so, what exactly is the problem?
- *Analytic aims*
  - Identify school personnel's values regarding student behavior.
  - Determine the presence of student problem behavior.
  - Define student problem behavior in a way that is useful for guiding the remaining problem-solving steps.
- *Core procedures*
  - Clarify values and make a public commitment to promoting valued behavior.
  - State the problem behavior in measurable and understandable terms.
  - Obtain a baseline measure of the problem behavior.
  - Conduct a discrepancy analysis to identify differences between desired and observed levels of behavior.

Step 2: Problem Analysis

- *Formative questions*
  - What factors are maintaining the problem?
  - How can maintaining factors be changed to positively influence the problem?
- *Analytic aims*
  - Identify the factors maintaining the problem behavior.
  - Identify an intervention strategy for the problem behavior that is logically connected to the maintaining factors.
- *Core procedures*
  - Assess potential factors maintaining the problem behavior.
  - Determine the factors maintaining the problem behavior and link them with an intervention strategy to positively influence problem behavior.

Step 3: Intervention Development

- *Formative questions*
  - How can we implement the intervention strategy to positively influence the problem?
  - How can we ensure the intervention is implemented with fidelity?
  - How can we know if the intervention is working?
- *Analytic aims*
  - Develop an intervention plan for intervening with the problem behavior.
  - Determine a method for gauging and improving implementation fidelity.
  - Determine the valued behavioral outcome and an associated evaluation procedure.

- *Core procedures*
  - Select an evidence-based intervention that operationalizes the intervention strategy.
  - Develop the procedures and schedule for the intervention.
  - Develop an implementation fidelity measure and establish a schedule and procedures for evaluating and enhancing intervention integrity.
  - Develop an outcome goal, select a progress-monitoring method, and establish a schedule and procedures for evaluating intervention effectiveness.

Step 4: Intervention Evaluation

- *Formative questions*
  - Is the intervention being implemented as planned?
  - Is the intervention positively influencing the problem behavior?
  - If not, what can be done to improve intervention effectiveness?
- *Analytic aims*
  - Determine the level of implementation fidelity.
  - Determine the effect of the intervention on the problem behavior.
  - If needed, identify potential improvements to the problem-solving process.
- *Core procedures*
  - Calculate the proportion of intervention components implemented with fidelity and, if needed, provide support to enhance implementation fidelity.
  - Graph progress-monitoring data.
  - Use pre-established decision rules to determine intervention effectiveness.
  - If needed, revisit the problem analysis step and the intervention development step and then re-implement the intervention.

Toolbox 3.1. ***Core Procedures Checklist for the Four-Step Problem-Solving Model***

Completed	Problem-Solving Step/Core Procedure
_____	*Step 1: Problem Identification*
_____	Clarify values and make public commitment
_____	State the problem behavior in measureable terms
_____	Obtain a baseline measure of the problem behavior
_____	Conduct a discrepancy analysis
_____	*Step 2: Problem Analysis*
_____	Assess factors maintaining the problem behavior
_____	Link factors maintaining the problem behavior with an intervention strategy
_____	*Step 3: Intervention Development*
_____	Develop an intervention plan for intervening with the problem behavior
_____	Determine a method for gauging and improving implementation fidelity
_____	Determine the valued behavioral outcome and associated evaluation procedure
_____	*Step 4: Intervention Implementation*
_____	Calculate implementation fidelity and provide implementation support
_____	Graph progress-monitoring data
_____	Use decision rules to determine intervention effectiveness
_____	If needed, revisit the problem analysis and intervention development steps

The four-step problem-solving model provides school personnel with a straightforward method for effectively solving youths' mental health problems that are within their scope of influence. However, nothing in the formative questions, analytic aims, or core procedures of each step tells problem-solving teams how to use this logic model efficiently to serve an entire school population.

One way to apply this model efficiently is to adopt a common theoretical perspective on what mental health problems are, how they are maintained, and how they can be improved. Although some presentations of the problem-solving model have advocated for a specific theoretical viewpoint (e.g., Erchul & Schulte, 2009), others have allowed for diverse theoretical perspectives, as long as they are grounded in empirical evidence (e.g., Gimpel Peacock, Ervin, Daly, & Merrell, 2010).

When a problem-solving team chooses a unified, common theoretical perspective, team members are able to communicate with each other more clearly and easily make decisions to accomplish problem-solving steps. Although several theories explain youths' mental health problems (see Mash & Barkley, 2014), the most straightforward, feasible, and proven theory for school personnel to use in the problem-solving process is the antecedent–behavior–consequence (ABC) theory of behavior (see Ramnerö & Törneke, 2008; see Figure 3.2).

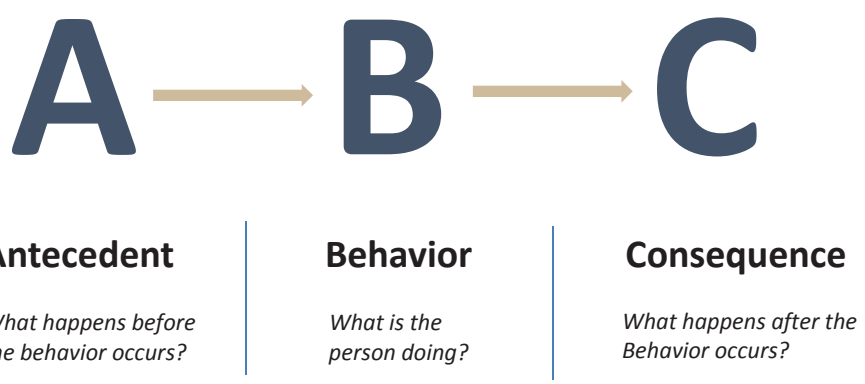
Using the ABC Theory to Promote Youths' Mental Health

The ABC theory of behavior is useful within the four-step problem-solving model for a few reasons:

- It provides problem-solving teams with a way to understand how all behavior can be improved using basic principles. Therefore, it is useful for resolving internalizing and externalizing problems as well as for promoting valued behaviors that mental health problems commonly interfere with.
- It focuses problem-solving teams on observable factors that are under their control. Research shows that many factors are involved in youths' mental health problems that are not accessible to problem-solving teams (e.g., genetics and history), but there are also many factors that are accessible (e.g., current school and home environments). The ABC theory focuses squarely on those things that promote youths' mental health in the present moment.
- It provides opportunities for students and their families to engage and participate meaningfully in the problem-solving process. Because the ABC theory centers on changeable factors in youths' environments and because students and caregivers are key players in shaping those environments, they can often play important roles in promoting mental health in schools.

At the core of the ABC theory is the idea that three defining features characterize everything people do: antecedents, behaviors, and consequences (Ramnerö & Törneke, 2008).

Figure 3.2. ***Key Features of the ABC Theory of Behavior***



- **Antecedents** are the environmental events that happen right before a behavior occurs. For example, a common antecedent for a student's aggressive behavior is being teased by his peers, while a common antecedent for a student's test anxiety is being told by the teacher that there will be a test tomorrow. Antecedents can be seen as the environmental triggers or sparks for mental health problems, as they set the stage for them to occur. The important thing to remember is that antecedents are not important in and of themselves but rather because they signal the availability of a consequence that is somehow beneficial to a student. Because of this tight relationship, mental health problems can sometimes be improved by simply altering the antecedents that are reliably associated with problem behaviors and their consequences.

- **Behaviors** are the actual actions of the student: the things the student is doing or, in some situations, is not doing. Mental health problems usually consist of combinations of *public behaviors* (observable by other people around the student) and *private behaviors* (only observable by students themselves). For externalizing problems, common examples of public behaviors include hitting or yelling at other students and disrupting the teacher during instruction. Private behaviors associated with these kinds of externalizing problems are angry thoughts and impulsive feelings. For internalizing problems, common examples of private behaviors include fear about things happening in the future or negative thoughts about one's self-worth, while public behaviors associated with these private behaviors include avoiding school tasks or escaping social interactions with peers. Although private problem behaviors are often aversive and unwanted, the public problem behaviors associated with them produce the consequences that are most perceptible to others and are therefore most commonly reported as problematic.

- **Consequences** are the external or internal changes that take place following a behavior. For instance, a common environmental consequence for a student's aggressive behavior is that his peers will stop teasing him, while a common internal consequence of a student's test-avoidance is that her negative thoughts and feelings about how poorly she will perform will cease. When something happens following the problem behavior that is likely to make that behavior more likely to occur in the future, this is called a *reinforcing consequence*. From the perspective of the ABC theory, mental health problems are maintained because of the reinforcing consequences that the problem behavior brings about. So although the behavior is a problem to caregivers, it continues to occur because it is actually functional in some way for students. How behaviors that are viewed as problems can actually be useful to students is better understood by considering the two types of reinforcing consequences: *positive reinforcement* and *negative reinforcement*.

    - **Positive reinforcement** occurs when a behavior helps a student increase or obtain a desirable consequence. This kind of reinforcement is positive because it adds something to the situation that benefits the student in some way, making the behavior more likely to occur in the future. Both externalizing and internalizing behaviors can be positively reinforced.

        - *Externalizing problem example #1.* Disrupting a teacher's classroom instruction might help a student get attention from peers.
        - *Externalizing problem example #2*. Bullying other youth can be a means for a student to get money, food, clothing, or other desired things.
        - *Internalizing example #1*. Withdrawing from one's peers can lead to increased attention from concerned adults at school.
        - *Internalizing example #2*. Telling caregivers that they feel depressed or anxious might result in a student receiving privileges or gifts that he or she wouldn't have had otherwise.

    - **Negative reinforcement** happens when a behavior helps a student reduce or avoid an unwanted consequence. This kind of reinforcement is negative because it subtracts something from the situation that benefits the student in some way, making the behavior more likely to occur in the future.

        - *Externalizing problem example #1.* Verbally threatening a peer might stop the current teasing or harassment from that peer.
        - *Externalizing problem example #2.* Talking to other students during classroom instruction can allow a student to escape from the demands of academic tasks.
        - *Internalizing problem example #1.* Not attending school on the day of a major test may substantially reduce a student's feelings of anxiety associated with that test.
        - *Internalizing problem example #2.* Avoiding social interaction with peers can lead to reduced negative thoughts about one's self-worth in comparison to those peers.

When applied to mental health problems, the ABC theory shows that problem behaviors are actually functional for youth in some way and that they are maintained by logical connections between antecedents and consequences. Problem behaviors work for students in the short term, but they often become problematic over time because they produce poor long-term outcomes.

- For example, a young student who spends his independent seatwork time disrupting and talking to other students may obtain peer attention and escape academic tasks that he finds undesirable in the short term, but he will also fail to acquire key academic skills and knowledge in the long term.
- As another example, an adolescent student who refuses to come to school because of test anxiety may successfully achieve temporary reductions in aversive thoughts and feelings related to test-taking, but she will also fail courses as a result and may put herself at risk for failing to graduate high school.

These examples make an important point about consequences: the immediate consequences maintain problem behavior, not the distant ones. Although problem behaviors are somehow functional in the short term, they can also be distressing. This point can lead some school personnel to think that an internalizing or externalizing behavior is not working for a student because it brings about obvious negative consequences (e.g., apparent unhappiness or school discipline). However, the fact is that most problem behaviors bring about multiple short-term consequences, yet only select consequences maintain that behavior. The same could also be said about antecedents: most problem behaviors are preceded by multiple antecedents, yet only select antecedents trigger that behavior.

The major task of the problem-solving team during the first two steps of the model—problem identification and problem analysis—is not to understand all possible ABCs of student mental health problems, but rather to identify the ABCs that are the most relevant and changeable by the team. Decades of applying the ABC theory in practice have given rise to several assessment strategies that are useful in school settings for gauging youths' mental health.

Assessment Strategies for Gauging Youths' Mental Health

All assessment strategies serve one of three purposes that inform intervention: *describing behavioral topography, measuring behavioral dimensions, or determining behavioral function* (Cooper, Heron, & Heward, 2007).

- **Describing behavioral topography** refers to strategies for detailing what the mental health problem looks like in behavioral terms. The purpose of this type of assessment is to replace the common language used to talk about mental health problems (e.g., "disrespectful" or "anxious") with more specific descriptions that detail what the student is actually *doing* that is problematic for school personnel (e.g., "shouts out in class and talks back to teachers" or "cries upon arriving at school and refuses to enter the classroom without parents"). Clarifying the details of mental health problems is a helpful first step for focusing future assessment efforts on the behaviors that matter most. It also helps with communication among school personnel, students, families, and community partners, who may misunderstand or overgeneralize vague descriptors often used to describe mental health problems (e.g., "impulsive" or "depressed").
- **Measuring behavioral dimensions** refers to strategies for quantifying how often (frequency) the problem behavior occurs as well as how long it lasts (duration) when it happens. Although all problem behaviors have a frequency and duration, it is only necessary to measure the dimension that allows the problem-solving team to gauge how well the behavior is responding to intervention. If a problem behavior occurs fairly often and has a brief duration (e.g., shouting-out in class or pushing other students), then frequency is the most useful dimension to measure. If a problem behavior occurs less often but has a longer duration (e.g., crying or putting head down on desk), then duration is the most useful dimension to measure. However, some problem behaviors can occur often and for extended periods of time (e.g., arguing or crying) and may therefore benefit from measuring both dimensions.

Ultimately, behavioral dimensions should be addressed because they are the baseline measures and progress-monitoring measures in the problem-solving process.

  - **Baseline measures** are the starting points of a problem behavior prior to intervention. Intervention effectiveness is judged by comparing measures of the problem behavior obtained after intervention to baseline measures.
  - **Progress-monitoring measures** are the follow-up points of a problem behavior at different times during the intervention process. If progress-monitoring measures show improvement in relation to baseline measures as well as earlier progress-monitoring points, then the intervention is working and is judged to be effective.

- **Determining behavioral function** refers to strategies for mapping the logical connections between problem behaviors, the antecedents that trigger them, and the consequences that maintain them. This aspect of behavioral assessment helps the problem-solving team identify the factors that are maintaining the problem behavior so that an appropriate intervention strategy can be selected. Prior to determining the function of any problem behavior, school personnel must first describe it. But it makes little difference if the dimensions of the problem behavior are measured prior to, in combination with, or following this process.

The three purposes of assessment can be accomplished using five different assessment methods: (a) direct behavior observations, (b) self-monitoring, (c) direct behavior ratings, (d) behavior rating scales, (e) interviews, and (f) surveys. Although some of these methods are useful for accomplishing only one assessment purpose, others are useful for accomplishing multiple purposes (see Table 3.1).

Table 3.1. ***Relation of Behavioral Assessment Methods to Assessment Purposes***

Behavioral Assessment Method	Behavioral Assessment Purpose		
	Describing behavior	*Measuring behavioral dimensions*	*Determining behavioral function*
Direct behavior observations	X	X	X
Direct behavior ratings		X	
Behavior rating scales		X	
Interviews	X	X	X
Surveys	X	X	X

- **Direct behavior observation** refers to assessment methods that have an observer watch and record student behavior as it occurs in real time. Several different direct observation methods can be used to accomplish each of the three assessment purposes. Probably the most common direct observation methods are event recording, timing, time sampling, and ABC recording.
  - **Event recording** involves counting each time the target behavior happens by simply marking a tally each time it occurs during the period of observation. Because observations can have varying durations (e.g., 10, 20, or 30 minutes), which makes them difficult to compare, results from event recordings are usually represented as the number of behavioral events observed per minute (e.g., two talk-outs per minute during class-wide instruction). Event recording is most useful for behaviors that are brief, have a clear beginning and end, and are likely to occur often during the observation period. This method is reasonable for use by school mental health professionals, teachers, support staff, students (self-monitoring), and peers (peer-monitoring).

However, it can be challenging because it requires continuous observation of behavior, which is difficult for teachers, students, and peers to perform during their other activities. (See Tool 3.1 for an example of event-recording form.)

- **Time sampling** involves measuring the occurrence of the target behavior during specified times throughout the observation period. Results from this method are presented as the percentage of times for which the target behavior was observed (e.g., disruptive behavior was observed for 80% of specified times). In this approach, the length of the specified time is uniform, but adjustable depending on the capability of the observer—ranging from 10 seconds to 10 minutes. There are three common time-sampling methods: whole interval, partial interval, and momentary. (See Tool 3.2 for an example time-sampling form.)
  - **Whole interval** time sampling is useful for target behaviors that are expected to occur frequently, consist of several different sub-behaviors, and have long durations (e.g., academic engagement or on-task behavior). When using this method, the target behavior is marked as occurring during the interval only if it is maintained for the entire interval (e.g., all 30 seconds).
  - **Partial interval** time sampling is useful for target behaviors that are expected to occur frequently and consist of several different sub-behaviors, but have brief or variable durations (e.g., disruptive or off-task behavior). When using this method, the target behavior is marked as occurring during the interval if it happens at any time, no matter for how long, during the interval (e.g., once for ten seconds or twice for five seconds).
  - **Momentary** time sampling is useful for the same purposes as either whole interval or partial interval methods, but it is usually a more achievable method for use by teachers, students, and peers, who are likely to be engaged in other tasks during the observation period and cannot spend as much time observing as a school mental health professional. When using this method, the target behavior is only observed at a specified moment during the interval (e.g., at the end of every minute or every five minutes) and is marked as occurring only if it is observed at that time.
- **Timing** involves measuring the duration of the target behavior, typically in minutes and seconds. Timing is best for target behaviors that have moderate to long durations, have a clear beginning and end, and that are not likely to occur often during the observation period (e.g., tantrums or social withdrawal). This method is usually practical for use by school mental health professionals, teachers, and support staff, but not by students or peers.
- **ABC recording** involves select observation of the target behavior (B) that is accompanied by a brief written narrative of the antecedent events preceding the behavior (A) and the consequential events following the behavior (C). Although ABC recording is not always necessary, it can often be helpful when there is ambiguity about the environmental events that are maintaining the problem behavior. (See Tool 3.3 for an example ABC recording form.)
- **Narrative observation** involves continuous observation of all behaviors occurring within a sampling period (e.g., 15 or 30 minutes) that is accompanied by a written narrative of what is observed. The purpose of this method is to generate an adequate description of a students' full range of observed behaviors so that problem behavior can be discriminated from valued behavior. Although narrative observation is not always necessary, it can often be a helpful first step when there is ambiguity surrounding the nature of the problem behavior.

- **Direct behavior** ratings refer to assessment methods that have observers watch behavior and then rate that behavior immediately following its occurrence. Direct behavior ratings only measure relative behavioral frequency and serve similar purposes as event recording and time sampling. Because recording of observations is not required continuously or regularly throughout the monitoring period, direct behavior ratings are easier for teachers, support staff, students, and peers to use. Examples of direct behavior ratings can be found at www.directbehaviorratings.org.

- **Behavior rating scales** refer to assessment methods that have observers rate behavior based on previous experiences over the past several weeks to several months. These methods are contrasted with direct behavior ratings because they are not immediately preceded by an actual observation, but rely on knowledge obtained from historical observations, which may be more or less recent. Similar to direct behavior ratings, however, behavior rating scales also only function to measure relative behavioral frequency and are comparable to the purposes of event recording and time sampling. Because immediate observation is not required, behavior rating scales are feasible methods for all informants, including students, teachers, and caregivers. (See Tool 3.4 and Tool 3.5 for examples of self-report behavior rating scales for internalizing and externalizing problem behaviors.)
- **Interviews** refer to assessment methods where one observer meets with another observer to ask them about their previous observations of the target behavior. Interviews can be useful for all assessment purposes, and they can be conducted with target students, caregivers, teachers, and support staff who work closely with the target student. Several resources are available to school personnel that provide examples of interviews that can be used at various steps within the problem-solving process (see Sheridan & Kratochwill, 2007).
- **Surveys** are assessment methods where observers are provided with a survey that asks them to answer several questions that might be related to any of the purposes of behavioral assessment and then to return it when completed. The advantage of surveys is that they can be used to reach more informants, and their content is flexible, but they do not allow for in-depth or follow-up questions, which are common in interviews.

Once assessment strategies have been used within the problem-solving model to describe the topography of problem behavior, measure the dimensions of that behavior, and determine the functions of that behavior, the next step is to use this assessment data to select and then monitor the effectiveness of appropriate intervention strategies.

Intervention Strategies for Promoting Youths' Mental Health

The ABCs theory of behavior indicates three basic intervention strategies: *altering antecedents, altering consequences,* and *teaching skills* (Noell & Gansle, 2009). Although these strategies are described separately below, problem-solving teams should remember that these strategies can also be used in combination to effectively address both simple and complex mental health problems.

- **Altering antecedents** refers to intentionally changing the environmental events that precede behavior.Of the three intervention approaches, this is probably the most underused and overlooked, yet it can be effective. There are two main approaches to altering antecedents: removing antecedents and adding antecedents.
    - **Removing antecedents** refers to taking away environmental events that trigger the problem behavior so that the problem behavior occurs less often because the desired consequence is now unavailable. Problem-solving teams should remember that just because an antecedent triggers a problem behavior, that does not mean it should always be removed (e.g., taking a test at school, playing at recess, or group-work in class). Some antecedents are quite easy to remove and others are difficult but important to remove to improve student well-being.
        - *Externalizing problem example.* If sitting next to a friend during independent seatwork (antecedent) results in a student being off-task during instruction (problem behavior) in order to get his friend's attention (consequence), then changing the student's seating assignment so that he is no longer seated next to a friend (removing an antecedent) may reduce the likelihood of off-task behavior.

        - *Internalizing problem example.* If being bullied by her peers (antecedent) results in a student experiencing depression-related thoughts and feelings and withdrawing from participating in class (problem behavior) to avoid further contact with those same peers (consequence), then her depression-related problems may be alleviated by intervening with her peers and preventing them from bullying her in the first place (removing the antecedent).
    - **Adding antecedents** refers to adding new environmental events so that there's either a reduced need for the problem behavior or so that prosocial or healthy behavior is more likely to be exhibited instead. This strategy is always applicable and is helpful to use in combination with other strategies to enhance student success. Teachers, other students, and families can all participate in adding small antecedents to the environment that are likely to improve youths' mental health.
        - *Externalizing problem example.* If during class-wide instruction (antecedent) a student calls out and disrupts the teacher (problem behavior) in order to get the teacher's attention (consequence), then either providing the student with more teacher attention earlier in the day or intentionally calling on the student to answer questions during class-wide instruction (adding antecedents) may reduce the likelihood of the disruptive behavior later in the day.
        - *Internalizing problem example.* If whenever a student feels anxious doing schoolwork (antecedent) he tells the teacher he feels sick and is sent to the school nurse and misses instruction (problem behavior), which then relieves his anxiety (consequence), then scheduling frequent breaks during classwork or establishing a signal the student can use to tell the teacher he needs a break from his work (adding antecedents) may reduce the likelihood of the student leaving class and missing instruction.
- **Altering consequences** refers to intentionally changing the external events that follow behavior. Although consequences in the ABC theory can also refer to internal events, the only consequences that problem-solving teams have direct influence over are the external kind. There are three main approaches to altering consequences: *differentially reinforcing lower rates of problem behavior, differentially reinforcing valued behavior,* and *withholding reinforcement from problem behavior*.
    - **Differentially reinforcing lower rates of problem behavior** refers to providing students with desirable consequences when they exhibit continually lower rates of the target behavior. When using this strategy, it is important to clearly communicate to students that they are receiving desirable consequences because their problem behavior is decreasing. It is also helpful to let other young people in the setting know the expectation they must meet to access these consequences.
        - *Externalizing problem example.* If when standing in line (antecedent) a student constantly touches and pokes those around him (problem behavior) to get their attention (consequence), then allowing the student to select a toy from a prize box every time he touches others less often than he did the previous time (differentially reinforcing lower rates of the problem behavior) may result in less problem behavior in the future.
        - *Internalizing problem example.* If upon arriving at school each day (antecedent) a young student cries and refuses to enter the classroom for several minutes (problem behavior) so that she can prolong her contact with her parent (consequence), then allowing the student to engage in a preferred play activity immediately when entering the classroom if she cries for less time than she did the previous time (differentially reinforcing lower rates of the problem behavior) may reduce the refusal behavior over time.

- **Differentially reinforcing valued behavior** refers to providing youth with desirable consequences when they exhibit valued behaviors that either replace or are incompatible with the problem behavior. This approach is effective by itself, but is also useful when used in combination with the other two approaches. When using this strategy, it's important to explicitly tell students why they are receiving a desirable consequence so that they do not mistakenly attribute the reinforcement to an unrelated or non-valued behavior.
    - *Externalizing problem example.* If while standing with friends in the hallway during passing periods (antecedent) a student makes rude comments to those walking by (problem behavior) to make her friends laugh and get their attention (consequence), then specifically praising the student when she talks kindly or is helpful to other students in class who are not her friends (differentially reinforcing valued behavior) may increase her likelihood of being respectful towards similar students in other situations in the future.
    - *Internalizing problem example.* If during unstructured times in class (antecedent) a student puts his head down on his desk (problem behavior) to avoid interacting with peers that he says don't like him (consequence), then specifically praising the student when he interacts positively with others during structured class activities (differentially reinforcing valued behavior) may increase the likelihood of more prosocial behavior occurring in the future.
- **Withholding reinforcement from problem behavior** refers to not providing youth with the desirable consequences that usually follow their problem behavior. This strategy is best used in combination with one of the previous two strategies, not as a standalone strategy.
    - *Externalizing problem example.* If during recess on the playground (antecedent) a student yells at and hits her peers (problem behavior) to get immediate access to the play equipment she wants (consequence), then having a supervising adult prevent her from accessing the equipment when she is aggressive (withholding reinforcement from the problem behavior) until she waits her turn (differentially reinforcing valued behavior) may reduce the likelihood of the aggressive behavior continuing in the future.
    - *Internalizing problem example.* If during in-class testing (antecedent) a student often complains of feeling depressed (problem behavior) and as a result is allowed to stop taking the test (consequence), then having the teacher encourage the student to persist in the test following the complaint (withholding reinforcement from the problem behavior) and providing him with verbal praise for finishing the exam (differentially reinforcing valued behavior) is likely to reduce the likelihood of this problem behavior in the future.

- **Teaching skills** refers to explicitly instructing students in new behaviors that help them act in valued, prosocial, and healthy ways when they encounter antecedents that have historically triggered problem behaviors. The important thing for problem-solving teams to remember is that new skills must help students experience similar or more preferred consequences than the problem behavior did, otherwise these skills will not be maintained. Although an infinite number of skills can be taught to students, a useful way of talking about them is to divide them into two general categories: *teaching replacement behaviors* and *teaching self-regulation behaviors*.
    - **Teaching replacement behaviors** refers to explicitly teaching students skills that serve the same function as problem behaviors, but that are considered to be appropriate and valued by the problem-solving team. Although school personnel often assume that students don't know the right thing to do and need to be taught replacement behaviors, students often already possess the necessary skills and they will engage in valued behaviors when antecedents and consequences are altered. However, this is not always the case, and young children and students with developmental disabilities are especially likely to benefit from teaching replacement behaviors.

- *Externalizing problem example.* If during small-group activities (antecedent) a young child takes toys and materials from other children in his group without asking (problem behavior) so that he can use them himself (consequence), then instructing the student in strategies for appropriately getting what he wants—such as asking politely trading and waiting his turn (teaching replacement behaviors)—may allow him to experience desirable consequences without frustrating peers and teachers.
- *Internalizing problem example.* If when working with a one-on-one aid on a new academic task (antecedent) a student with a development disability covers her face and cries (problem behavior) to escape from the demands of the aid (consequence), then instructing the student in strategies to appropriately request short breaks when she feels overwhelmed (teaching replacement behaviors) may allow her to briefly escape the academic demands while facilitating greater overall work completion.

- **Teaching self-regulation behaviors** refers to teaching students skills that help them manage their problem behavior more effectively by disrupting the tight connection that has been formed between the antecedents, problem behaviors, and consequences. Specifically, this approach consists of three core strategies: making students aware of the antecedents that trigger their problem behavior, teaching them skills that calm their aversive thoughts and feelings (private behaviors) that automatically follow those triggers, and training them to use problem-solving skills to guide their actions in difficult situations (public behaviors).
  - *Externalizing problem example.* If during most cooperative social interactions with peers (antecedent) a student becomes frustrated or angry with them (problem behavior) and this results in him getting his way (consequence), then being instructed to use deep breathing techniques accompanied by positive self-talk in response to feeling angry (teaching self-regulation behaviors) may enable him to interact more prosocially with his peers in the future.
  - *Internalizing problem example.* If when engaged in a challenging academic task (antecedent) a student experiences negative self-talk (e.g., “I’m a complete failure—I’ll never be good at anything and nobody likes me”) that is followed by giving up on the task (problem behavior), which temporarily stops the negative self-talk (consequence), then being instructed to be mindful and accepting of her negative self-talk while persisting in challenging tasks (teaching self-regulation behaviors) may allow her to be more academically successful in the long run.

Direct instruction is widely considered to be the most effective method available for conducting skill training with youth with problem behaviors (Forness, Kavale, Blum, & Lloyd, 1997), and its core components can be applied to effectively train both replacement behaviors and self-regulation behaviors related to internalizing and externalizing concerns. A helpful sequence of direct instruction components is (a) tell, (b) show, (c) do, (d) review, and (e) repeat.

- **Tell.** Skill training begins by explicitly telling students what skill they will be learning and why it is important to learn this skill. Following this, the interventionist describes the parts of the skill in detail and how they are enacted.
- **Show.** Next, the interventionist models the skill for the students so they can see what it looks like in practice. If the skill has several parts, each should be modeled in turn, accompanied by behavioral narration. It is helpful to model several examples of the skill as well as to model non-examples of the skill and then ask students to identify why the non-examples were incorrect.
- **Do.** The next step is for students to role-play the skill. This can be done one-on-one with the interventionist, in pairs with other students, or in small groups. Students should be provided with ample opportunities to practice the skill in different hypothetical contexts.
- **Review.** Throughout the role-playing process, the interventionist should immediately provide performance feedback to students. This feedback should clearly identify and reinforce successful demonstrations of the skill as well as successive approximations of the skill, and it should also clearly correct errors exhibited by students along the way.
- **Repeat.** The skill training process is then repeated as many times as necessary until students demonstrate that they have mastered the skill. For complex skills that are made up of several sub-skills (e.g., anger management skills), it is often useful to train one sub-skill at a time and progressively combine them until students can successfully demonstrate the entire skillset.

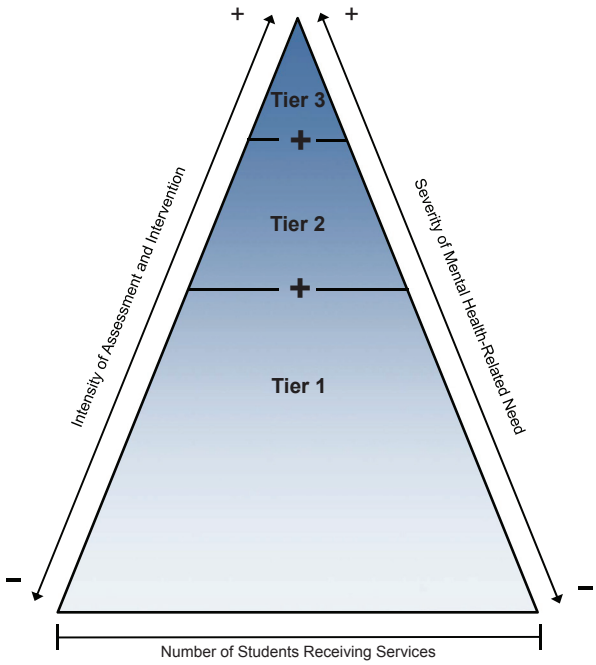
When teaching replacement behaviors and self-regulation behaviors, interventionists should remember that it is almost always easier for students to successfully demonstrate skills in teaching situations than to actually use the skill when they need it in real-life situations. Therefore interventionists should make efforts to help students generalize their skills outside of teaching situations by identifying opportunities when students can use, did use, or could have used the target skill in natural settings. The tell step can be used in natural settings to remind students how to use the skill prior to actually using it and to coach them in using the skill in the moment, while the review step is useful to reinforce and correct students' actual use of the skill or missed opportunities to apply the skill.

Although all of the examples above suggest school personnel are the interventionists, the same intervention strategies can be implemented in similar ways by peers and parents, who should be encouraged to be involved as active members of the problem-solving team. Also, although all of the examples provided above for intervention strategies are related to individual students, the same strategies can be scaled up to small groups of students, classrooms, and whole schools (see Little, Akin-Little, & Cook, 2009; Simonsen & Sugai, 2009; Skinner, Skinner, & Burton, 2009; Wehby & Lane, 2009). That said, the ABC theory of behavior does not provide guidance on how to efficiently address youths' mental health problems at different levels of service delivery. Problem-solving teams are therefore encouraged to apply the four-step problem-solving model and the ABC theory within a multitiered system of supports (MTSS) for promoting mental health in schools, which has been developed for just this purpose.

Using the Problem-Solving Model within MTSS for Promoting Mental Health

Whereas the purpose of the four-step problem-solving model is to ensure that problem-solving team members' efforts to promote mental health in schools are effective, the purpose of MTSS is to ensure that those efforts are structured in a way that serves all students and conserves school resources (see SMHRP Toolkit Introduction for a detailed overview of MTSS; Stoiber, 2014). The formative questions, analytic aims, and core procedures that guide school personnel through each step in the problem-solving model remain the same in each of the three tiers of MTSS. Most of the practices used to accomplish the core procedures of the four-step problem-solving model do not vary much from tier to tier because they are characterized by general techniques that can be flexibly applied to variations in the number of students, the severity of the problem behavior, and the intensity of assessment and intervention practices. However, the practices used to operationalize some core procedures tend to vary more among the three tiers because some assessment and intervention techniques are more feasible and useful for targeting different scopes of students and problems than others.

Figure 3.3 ***The Multitiered System of Support Model for Mental Health Supports***



Adapted from: Renshaw & O'Malley (2015)

Core Problem-Solving Procedures that are Flexibly Applied Across Tiers

- **Step 1: Problem Identification**
    - **Clarify values and make a public commitment to promoting valued behavior.** This procedure is accomplished by having the problem-solving team define what they value for youth and why, and then to publicly commit to work together to promote these values for the betterment of youth. The intent is to make explicit values that are often implicit in the problem-solving process so that the problem-solving process can proceed with shared purpose among the team members. This procedure should be carried out each time the problem-solving team begins the problem-solving process anew, whether for the entire school, for a classroom or small group, or for an individual student. An example exercise for accomplishing this procedure is provided in Tool 3.6.
    - **State the problem behavior in measurable terms.** This procedure is accomplished by defining the problem behavior in a way that makes it amenable to baseline measurement while also making it understandable to the members of the problem-solving team. For example, what is initially described as "naughty" or "disrespectful" may be stated as "disruptive behavior during class-wide instruction, including shouting-out and throwing objects." Although this process is similar across tiers, more specific problem statements are useful in Tier 2 and Tier 3 and more general problem statements (e.g., "disruptive behavior" or "social withdrawal") are often useful enough in Tier 1, as the measurement procedures used across tiers vary in specificity (see below for more on this point).

- **Conduct a discrepancy analysis to identify differences between desired and observed levels of behavior.** This procedure involves comparing baseline data obtained on the problem behavior to determine exactly how it is different from the values and expectations of the problem-solving team. The intent is to clarify exactly how much change is desired for the problem-solving process to be considered successful. An example exercise for accomplishing this procedure is provided in Tool 3.7.

- **Step 2: Problem Analysis**

  - **Determine the factors maintaining the problem behavior and link them with an intervention strategy to positively influence problem behavior.** This procedure involves stating the factors that appear to be maintaining the problem behavior and then linking intervention strategies to these factors. The intent of this exercise is not to fully develop an intervention but rather to clearly lay out the logic underlying why a particular approach to intervention is selected over other approaches. An example exercise for accomplishing this procedure is provided in Tool 3.8.

- **Step 3: Intervention Development**

  - **Plan the procedures and schedule of the intervention.** This procedure explicitly plans out all aspects of the evidence-based intervention to ensure it is capable of being effectively implemented to resolve the problem behavior. An example exercise for accomplishing this procedure is provided in Tool 3.9.
  - **Develop an implementation fidelity measure and establish a schedule and procedures for evaluating and enhancing intervention integrity.** This procedure requires the problem-solving team to create a measure that can be used to track implementation of the core procedures of the intervention plan to gauge if it is being implemented appropriately. Although some intervention plans have various procedures and are quite complex, the point here is not to track all possible intervention components but rather to track those that appear to be the most important.
  - **Develop an outcome goal, select a progress-monitoring method, and establish a schedule and procedures for evaluating intervention effectiveness.** This procedure is accomplished by establishing a goal that is derived from the discrepancy analysis from Step 1 and then determining how often progress-monitoring will occur and what decision rules will be used to determine how well the intervention is working. Although evaluating intervention effectiveness should occur on a schedule that is feasible for school personnel, the following schedules are recommended:
    - *Tier 1.* Three or four times per school year
    - *Tier 2.* One or two time per month
    - *Tier 3.* One or two times per week

- **Step 4: Intervention Evaluation**

  - **Determine the level of implementation fidelity.** This procedure involves determining how effectively the intervention is being applied. All that is required is that the measure, schedule, and procedures that were established for this purpose in Step 3 be followed according to plan.
  - **Determine the effect of the intervention on the problem behavior.** This procedure involves following the plan that was developed for this purpose in Step 3.
  - **If needed, identify potential improvements to the problem-solving process.** If the intervention evaluation process indicates that the intervention is not effective and it has already been determined that it is being implemented with fidelity, then the first option in this procedure is to systematically revisit Step 3 (intervention development) and look for potential improvements that can be made to the intervention plan to increase its effectiveness. If no improvements can be made to the plan, then the second option is to systematically revisit Step 2 (problem analysis) to

investigate other maintaining factors that may have been missed during the first analysis, which may then be linked with a new intervention strategy. If no maintaining factors were missed but the problem-solving team does not possess the expertise or resources necessary to implement an appropriate intervention, then the third and final option is to refer the student to an outside service agency that is equipped to support the problem behavior.

Core Problem-Solving Procedures that are Variably Applied Across Tiers

- **Step 1: Problem Identification**
    - **Obtain a baseline measure of problem behavior**. The types of measures used to obtain baseline observations of problem behavior typically differ across tiers. A key point for problem-solving teams to remember is that measures used with greater numbers of students typically have less specificity and therefore require that the problem behavior be understood and intervened with in more general terms. On the other hand, measures used with individual students and small groups of students mhave greater specificity and therefore result in more targeted intervention plans.
        - *Tier 1.* Brief behavior rating scales called *universal screeners* are most useful because they provide an efficient way to measure the mental health of every student in a school (see Table 3.2 for a listing of common behavior rating scales and their key characteristics). Brief behavior rating scales are available that measure overall mental health problems as well as general internalizing and externalizing problems. Teacher-report screeners are most efficient for primary students, while youth self-report screeners are most efficient for secondary students.
        - *Tier 2*. Brief rating scales can be useful, but lengthier behavior rating scales called *narrowband* (targeting a single problem) or *broadband* (targeting multiple problems) measures are recommended because they provide a more in-depth assessment of mental health problems. Teachers or students can complete these lengthier rating scales. Additionally, direct behavior ratings and direct behavior observations of groups' or individual students' data can be used to obtain measures of problem behavior that are easily seen by school personnel, such as aggression or social withdrawal.
        - *Tier 3.* Although narrowband and broadband measures may be useful, direct behavior ratings and direct behavior observations should be used as the primary methods. Although using a single measurement method is most efficient in the previous tiers, using multiple methods to measure the problem behavior is helpful in this tier.
- **Step 2: Problem Analysis**
    - **Identify the factors maintaining the problem behavior.** The assessment techniques useful for understanding the factors that maintain the problem behavior are likely to vary across tiers, as targeted methods are more useful for understanding more specific problems, while general methods are useful for understanding less specified problems.
        - *Tier 1.* Brief surveys asking teachers or students to report on the context of problem behaviors are the most useful. Survey items should directly state the mental health concerns and should ask specific questions about the relation of problem behaviors to antecedents and consequences so that the most appropriate approach to intervention can be determined. Both multiple-choice and free-response questions may be helpful.
        - *Tier 2.* Brief interviews with caregivers and students can provide information on the relation of mental health problems to antecedents and consequences. Similar to surveys, interviews should be directly linked to the identified problem behavior and focus on intervention planning. The primary benefit of interviews over surveys is that they allow respondents to provide detailed information or offer important information that was overlooked on surveys.

        - *Tier 3.* Although interviews are also recommended in this tier, the distinguishing feature is the use of ABC recordings to systematically observe the relationships between problem behaviors, antecedents, and consequences within the school environment. It is imperative that ABC recordings be conducted not only in contexts where the problem behavior occurs but also in contexts where the problem behavior does not occur so that differences in maintaining factors can be compared across environments.

- **Step 3: Intervention Development**

    - **Select an evidence-based intervention to operationalize the intervention strategy.** The three general approaches to intervention—altering antecedents, altering consequences, and teaching skills—are often packaged, combined, and presented differently across the three tiers of service delivery, yet the strategies themselves remain the same. Problem-solving teams should not only select an intervention that has evidence supporting it but should also examine the contents of the intervention to determine if it contains appropriate strategies to target the present problem behavior. Given that mental health problems are often complex, it is also appropriate to select multiple evidence-based interventions or to supplement interventions when needed.

        - *Tier 1.* Social–emotional learning (SEL) and social-skills curricula provide guides to help students learn common replacement behaviors as well as self-regulation behaviors. These skill-building curricula can vary widely in the number and nature of skills included, so the important principle is to ensure that a curriculum is selected based on its ability to target the identified mental health concerns. Many of these curricula also contain strategies for teachers and caregivers to adjust antecedents and consequences.
        - Additionally, alterations to antecedents and consequences can be made without these curricula by simply employing school-wide and classroom practices to improve problem behavior, such as those commonly recommended by Positive Behavioral Interventions and Supports (www.pbis.org). The important characteristic of any intervention selected at this level is that it be feasibly implemented by teachers amidst typical school duties. The Collaborative for Academic, Social, and Emotional Learning (CASEL) offers two guides to help school personnel identify effective social and emotional learning programs: one for preschool and elementary schools and another for secondary schools. Both guides can be found at casel.org/guide.
        - *Tier 2.* Skill-building curricula are also common at this level, as are alterations to antecedents and consequences in the classroom or other settings. These interventions are more intensive and usually benefit from the use of a school mental health professional—such as a school psychologist, school counselor, or behavior specialist—to provide direct services to targeted students (e.g., skill-building groups) or indirect services to assist teachers in providing more focused and effective interventions in the classroom (e.g., behavioral consultation to reduce disruptive behavior). Typically, one intervention approach is selected and implemented at a time in order to determine its effects on improving students' mental health problems.
        - *Tier 3.* Intervention approaches in this tier are similar to those used in the previous tiers, but the implementation of these interventions is characterized by collaborations among school personnel as well as with parents. Unlike previous tiers, this tier is typically characterized by a treatment package that consists of multiple intervention approaches that are both time and resource intensive. However, if the time and resources needed to provide a comprehensive intervention are not available within the school, then referrals are recommended to community mental health professionals.

Table 3.2. ***Example Behavior Rating Scales for Measuring Student Mental Health Problems***

Name	Type	MTSS Tiers	URL
Youth Internalizing Problems Screener	Screener	1, 2	https://www.researchgate.net/publication/279295613_Youth_Internalizing_Problems_Screener
Youth Externalizing Problems Screener	Screener	1, 2	https://www.researchgate.net/publication/279295611_Youth_Externalizing_Problems_Screener
Strengths and Difficulties Questionnaire	Screener	1, 2	http://www.sdqinfo.com/
Behavioral and Emotional Screening System	Screener	1, 2	https://www.pearsonclinical.com.au/products/view/250
Pediatric Symptoms Checklist	Screener	1, 2	http://www.massgeneral.org/psychiatry/services/psc_home.aspx
Student Risk Screening Scale	Screener	1, 2	http://www.sai-iowa.org/10_%20Behavior%20Screeners.pdf
Achenbach System of Empirically Based Assessment	Broadband	2, 3	http://store.aseba.org/
Conners Comprehensive Behavior Rating Scales	Broadband	2, 3	http://www.mhs.com/product.aspx?gr=edu&id=overview&prod=cbrs
Burks Behavior Rating Scales (2nd ed.)	Broadband	2, 3	http://www.mhs.com/product.aspx?gr=cli&prod=bbrs2&id=overview
Behavior Assessment System for Children (2nd ed.)	Broadband	2, 3	http://www.pearsonclinical.com/education/products/100000658/behavior-assessment-system-for-children-second-edition-basc-2.html
Beck Youth Inventories (2nd ed.)	Narrowband	2, 3	http://www.pearsonclinical.com/psychology/products/100000153/beck-youth-inventories-second-edition-byi-ii.html
Revised Children's Manifest Anxiety Scale	Narrowband	2, 3	http://www.mhs.com/product.aspx?gr=edu&prod=rcmas2&id=overview

Overall, problem-solving teams must remember that there is no perfect way to use the problem-solving model to promote students' mental health. Rather, there are more- or less-useful ways, depending on the number of students being served, the severity of the problem behavior, and the availability of school personnel's expertise and resources. Using the four-step problem-solving model, the ABC theory of behavior, and MTSS, school personnel will be empowered to make substantial contributions the mental health and well-being of the youth they serve. However, as mentioned above, school personnel must recognize the limits of their expertise and resources and arrange relationships with community partners who are capable of providing mental health services that they cannot provide.

Although the information provided in this chapter is intended to guide problem-solving teams to effectively and efficiently promote youths' mental health, teams should seek out further practical resources to guide them in these efforts. For a list of high-quality resources that are relevant to problem-solving for promoting youths' mental health in schools, see Tool 3.10.

References

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Tool 3.1. *Example Event Recording Form*

Example of Event Sampling Data Collection Sheet

Setting	Length of observation	Date	Behavior: Bites hand	Total # of times
Free time	20 minutes	7/26/08	XXXXXXXXXXXXX	13
Recess	15 minutes	7/27/08	XXXXXXXXXXXXXXXX	16
Science	13 minutes	7/28/08	XXXXXXXXXXXXXX	14
Lunch	10 minutes	7/29/08	XXXXXXXXXXX	11

Tool 3.2. *Example Time Sampling Form*

Sampling Record Sheet
10-Minute Intervals

Student: _____ Date: _____

Behavior: _____
(Circle 1, 2, or 3)

TYPE: 1. Whole Interval
+ = behavior is continuous in interval

TYPE: 2. Partial Interval
+ = single instance is observed in interval

TYPE: 3. Momentary
+ = record only if behavior present at end of interval

Record + or –

	+ or –	Comments		+ or –	Comments		+ or –	Comments
8:00-8:09			11:10-11:19			2:20-2:29		
8:10-8:19			11:20-11:29			2:30-2:39		
8:20-8:29			11:30-11:39			2:40-2:49		
8:30-8:39			11:40-11:49			2:50-2:59		
8:40-8:49			11:50-11:59			3:00-3:09		
8:50-8:59			12:00-12:09			3:10-3:19		
9:00-9:09			12:10-12:19			3:20-3:29		
9:10-9:19			12:20-12:29			3:30-3:39		
9:20-9:29			12:30-12:39			3:40-3:49		
9:30-9:39			12:40-12:49			3:50-3:59		

Tool 3.3. ***Example ABC Recording Form***

ABC Observation Form

Student Name: _____ Observation Date: ☐☐ / ☐☐ / ☐☐

Observer: _____ Time: _____

Activity: _____ Class Period: _____

ANTECEDENT	BEHAVIOR	CONSEQUENCE

Tool 3.4. *Example Self-Report Behavior Rating Scale for Internalizing Behavior Problems*

Youth Internalizing Problems Screener (YIPS)

- Student Name: _____
- Date: _____
- How OLD are you? _____
- Are you MALE or FEMALE? _____
- What is your RACE or ETHNICITY? _____

Here are some questions about what you think, feel, and do. Read each sentence and circle the one best answer.

	Almost Never	Some-times	Often	Almost Always
1. I feel nervous or afraid.	1	2	3	4
2. I feel very tired and drained of energy.	1	2	3	4
3. I find it hard to relax and settle down.	1	2	3	4
4. I get bothered by things that didn't bother me before.	1	2	3	4
5. I have uncomfortable and tense feelings in my body.	1	2	3	4
6. I feel moody or grumpy.	1	2	3	4
7. I feel like I'm going to panic or think I might lose control.	1	2	3	4
8. I do not really enjoy doing anything anymore.	1	2	3	4
9. I feel worthless or lonely when I'm around other people.	1	2	3	4
10. I have headaches, stomachaches, or other pains.	1	2	3	4

THANK YOU for completing the survey!

Source: Renshaw, T. (2015). Youth internalizing problems screener. Available for download at: https://www.researchgate.net/publication/279295613_Youth_Internalizing_Problems_Screener

Tool 3.5. *Example Self-Report Behavior Rating Scale for Externalizing Behavior Problems*

Youth Externalizing Problems Screener (YEPS)

- Student Name: _____
- Date: _____
- How OLD are you? _____
- Are you MALE or FEMALE? _____
- What is your RACE or ETHNICITY? _____

Here are some questions about what you think, feel, and do. Read each sentence and circle the one best answer.

	Almost Never	Some-times	Often	Almost Always
1. I forget things and make mistakes.	1	2	3	4
2. I lose my temper and get angry with other people.	1	2	3	4
3. I have a hard time sitting still when other people want me to.	1	2	3	4
4. I fight and argue with other people.	1	2	3	4
5. I have trouble staying organized and finishing assignments.	1	2	3	4
6. I break rules whenever I feel like it.	1	2	3	4
7. I talk a lot and interrupt others when they are talking.	1	2	3	4
8. I say or do mean things to hurt other people.	1	2	3	4
9. I have hard time focusing on things that are important.	1	2	3	4
10. I like to annoy people or make them upset.	1	2	3	4

THANK YOU for completing the survey!

Source: Renshaw, T. (2015). Youth externalizing problems screener. Available for download at: https://www.researchgate.net/publication/279295611_Youth_Externalizing_Problems_Screener

Tool 3.6. *Values Clarification and Public Commitment to Promoting Valued Behavior Exercise*

Date:

Young person receiving services:

Problem-solving team members:

Step 1. As a problem-solving team, discuss the following questions:

- What do we value for her/him/them?
- What skills and knowledge are in her/his/their best interest to acquire?
- What would "being successful" and "living well" look like for her/him/them?

Step 2. As a problem-solving team, complete the following statements using a written response:

- The things we value for her/him/them are . . .
- We value these things because . . .

Step 3. As a problem-solving team, make a verbal commitment to each other to work together to promote these values for this/these youth.

Tool 3.7. *Discrepancy Analysis Exercise*

Date:

Young person receiving services:

Problem-solving team members:

Step 1. Describe observed levels of problem behavior obtained from baseline measures:

Step 2. Describe how the observed levels of problem behavior differ from the desired levels of behavior (values and expectations of the problem-solving team):

Step 3. Describe exactly how much the current observed levels of problem behavior would need to change to meet the desired levels of behavior.

Tool 3.8. ***Linking Maintaining Factors and Intervention Strategies Exercise***

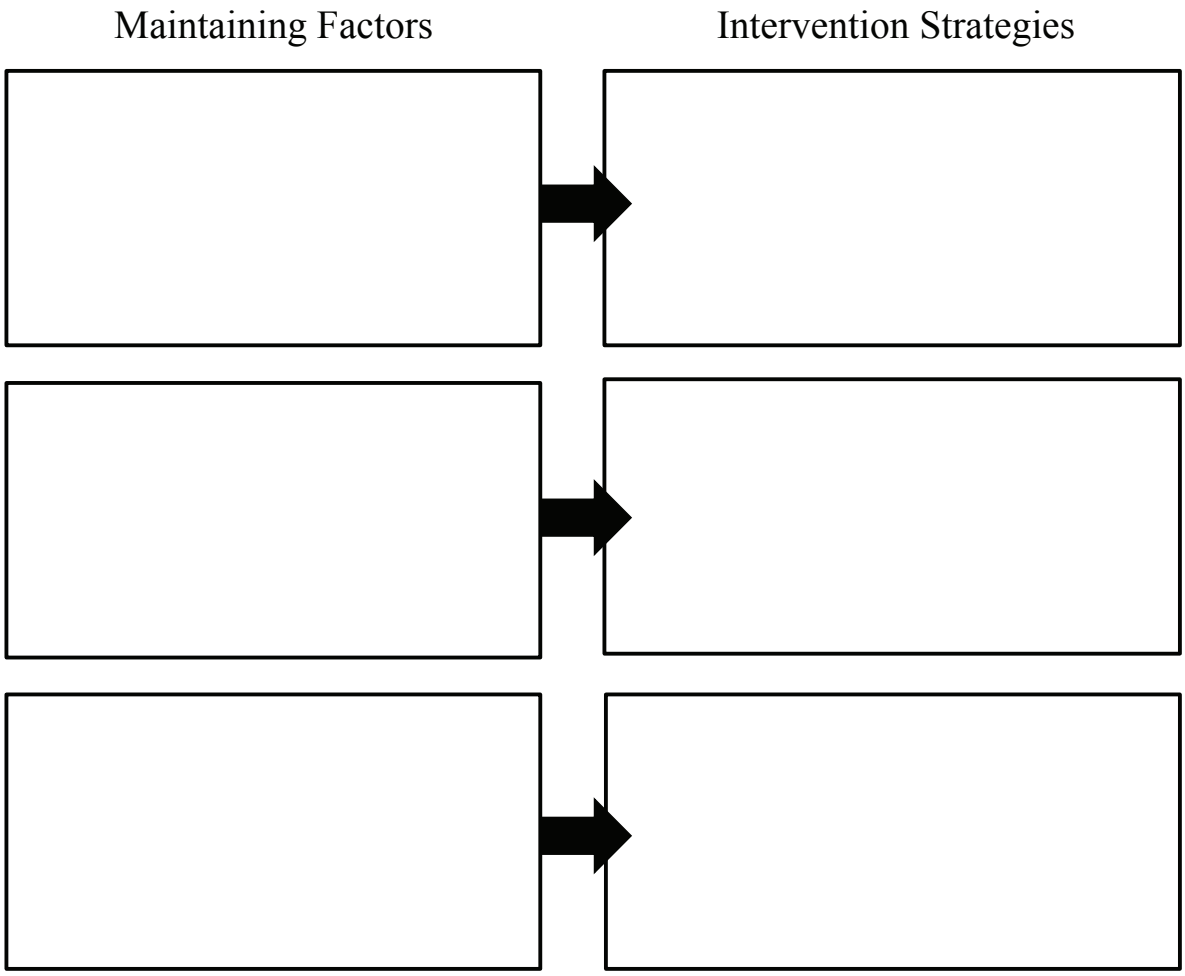
Date:

Young person receiving services:

Problem-solving team members:

Step 1. List the factors that appear to be maintaining the problem behavior.

Step 2. Link each maintaining factor with an appropriate intervention strategy that would positively influence the problem behavior by addressing the maintaining factor.



Tool 3.9. ***Intervention Planning Exercise***

Date:

Young person receiving services:

Problem-solving team members:

Step 1. Describe the procedures for implementing the intervention strategy:

- *How* will it be implemented?

Step 2. Describe the schedule for implementing of the intervention:

- *Where* will it take place?
- *When* will it take place?
- *How often* or for *how long* will it take place?

Step 3. Describe the personnel, materials, and resources needed to carry out the above procedures on the above schedule:

- *Who* will implement it?
- What *materials* are needed?
- What other *resources* are needed?

Tool 3.10. *Available Resources for School-Based Problem-Solving*

Topic: Behavior Assessment and Consultation

Chafouleas, S. M., Riley-Tillman, T. C., & Sugai, G. (2007). *School-based behavioral assessment: Informing intervention and instruction.* New York, NY: Guilford.

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Young, E. L., Caldarella, P., Richardson, M. J., & Young, K. R. (2011). *Positive behavior support in secondary schools: A practical guide.* New York, NY: Guilford.

Topic: Interventions for Specific Mental Health Needs

Burrow-Sanchez, J. J., & Hawken, L. S. (2007). *Helping students overcome substance abuse: Effective practices for prevention and intervention.* New York, NY: Guilford.

Gimpel Peacock, G., & Collett, B. R. (2009). *Collaborative home/school interventions: Evidence-based solutions for emotional, behavioral, and academic problems.* New York, NY: Guilford.

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CHAPTER 4

Cultural and Linguistic Considerations

CHAPTER 4

CULTURAL AND LINGUISTIC CONSIDERATIONS

Key Questions

1. Why do we need to consider culture and language when addressing school mental health referrals?
2. How do mental health disparities manifest in culturally and linguistically diverse students?
3. How do we address the diverse cultural and language needs of students being referred to mental health services?
4. What can teachers and members of school-based problem-solving teams do to ensure that the referrals are culturally and linguistically competent?

The Need for Cultural and Linguistic Competence in School Mental Health Referral Systems

There are numerous ethical and practical reasons why school-based mental health referral systems need to be culturally and linguistically competent. Three critical reasons for providing culturally and linguistically competent services were initially enumerated by the National Center for Cultural Competence (Goode & Dunne, 2003) and recently reiterated in the Enhanced National CLAS Standards (2013). These reasons continue to apply as we consider school mental health:

1. To respond to current and projected demographic changes in the school population within the United States.
2. To eliminate long-standing disparities in the health status of students of diverse racial, ethnic, and cultural backgrounds.
3. To improve the quality of mental health services and mental health and educational outcomes in schools.

The work of addressing long-standing disparities has been occurring in health care for the last forty years. During the same period of time, systemic bias and the disproportionate outcomes that result from it have been reported in the education sector. As early as 1975, the Children's Defense Fund studied national data provided by the Office for Civil Rights (OCR) on school discipline and reported that rates of school suspension for Black students were 2-3 times more than White students on a variety of measures (Drackford, 2006).

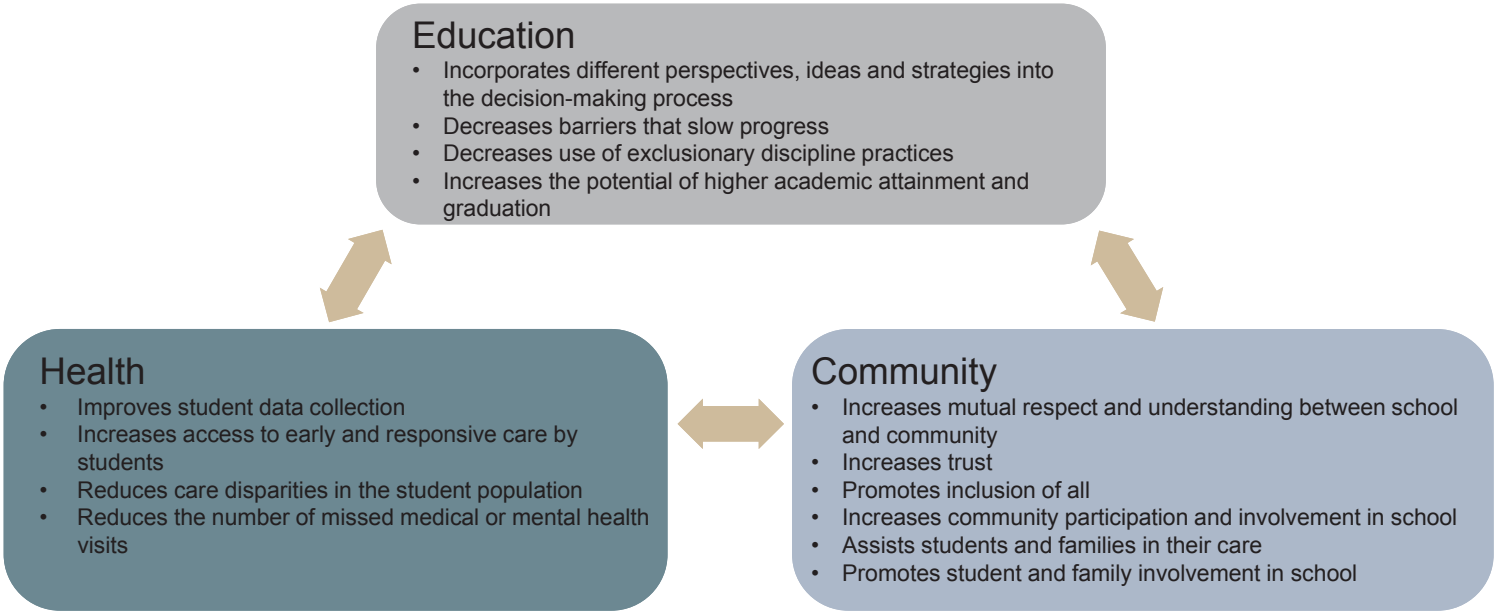
A large amount of research evidence has shown that punitive, reactionary discipline approaches are often unfairly applied to students who are English-learners, Black, Hispanic, and American Indian (Gregory, Skiba, & Noguera, 2010; Sullivan, Van Norman & Klingbeil, 2014). This pattern of bias has continued, and, in some instances, has worsened significantly. According to the Kirwan Institute for the Study of Race and Ethnicity, "racialized disproportionality in the administration of school discipline is now a national crisis" (Rudd, 2015). What is more, this systemic bias in school discipline practices contributes to the disproportionate number of minority youth, English Language Learners, and youth with disabilities who become disconnected from school over time.

In response to this crisis, the U.S. Department of Justice, Civil Rights Division, and the U.S. Department of Education, Office for Civil Rights, issued a national guidance package to assist public schools in administering student discipline without discriminating on the basis of race, color, or national origin. The guidance emphasized the impact of discipline bias, provided a national overview of racial disparities in the administration of school discipline, and included a list of remedies to be implemented in cases where a school is in violation of Title IV or Title VI in the administration of discipline.

Schools can work to reduce punitive, exclusionary discipline by providing all students the social, emotional, and behavioral supports they need to be successful at school. Universal Tier 1 programs that are culturally and linguistically appropriate can help reduce disparities by supporting the mental health and wellness of all students. Tier 2 and Tier 3 interventions can also reduce disparities when mental health referrals are responsive to cultural and linguistic differences and designed to ensure that students are neither over- nor under-referred based on minority group status. To achieve this, the school-based problem-solving team must see it as their charge to make their mental health referral system free of bias. To this end, schools can learn from the work of several organizations in the health sector that have, over the course of decades, developed and refined frameworks for providing culturally and linguistically competent services to their leadership, staff, and stakeholders.

Recently, the American Health Association (AHA, 2013) identified three major arenas—social, health, and business—in which cultural and linguistic competence are beneficial. The AHA framework has been adapted here to show the benefits of cultural and linguistic competence to schools. Figure 4.1 shows how culturally responsive strategies help engage other sectors and stakeholders.

Figure 4.1. ***Benefits of Cultural and Linguistic Competence to School Mental Health***



Foundational Concepts to Achieve Cultural and Linguistic Competence in the School Setting

In order to provide culturally and linguistically competent services in the school, there needs to be a shared understanding and a common language to engage in this work. Below is a working list of definitions that will assist school personnel as they begin the process of integrating cultural and linguistic competence into school referral processes.

Culture. At its most basic definition, culture is a powerful social system based on a group's values, norms, and expectations. It is a communication and interaction guide for a group's way of thinking, feeling, and acting. Culture informs how a group perceives health, wellness, disease, health care, and prevention of harm. Therefore, health values, beliefs, practices, and behaviors are culturally bound. Given the diverse cultures within the U.S., it is critical to understand how intimately these two concepts intersect. Many of the conflicts and challenges encountered when integrating cultural and linguistic competence into the United States health care system come from the role of culture in defining health.

Elements of Culture
Most people assume that when we speak of culture, we mean race and ethnicity. In fact, culture is much more than race and ethnicity. It involves multiple other factors, including:

- Country of origin or tribal affiliation
- Number of generations living in the U.S.
- Level of acculturation or assimilation
- Communication, including languages spoken, written, or signed; dialects or regional variants; literacy levels; verbal and non-verbal cues
- Family household and composition
- Socioeconomic status
- Educational attainment
- Employment
- Health and mental health beliefs and practices
- Religious and spiritual beliefs and practices
- Military affiliation
- Racial and ethnic groups
- Sexual orientation
- Gender identity

Schools should keep the meaning of culture in mind as they consider ways to integrate cultural and linguistic competence into their mental health referral management systems. There are many cultural influences to help-seeking behaviors and attitudes among diverse communities. Many cultural groups use traditional healers, practices, and medicines, and may have a limited understanding of western medical systems based on their culture and levels of acculturation. Additionally, they may have had experiences of racism, discrimination, and bias in general and within the health and educational environment, or a mistrust of health care professionals and institutions outside of their culture. Finally, first-generation immigrants, refugees, and asylees can also have communication and language barriers that may complicate interactions with schools.

Cultural Competence. The concept of cultural competence initially evolved through work conducted by the Child and Adolescent Service System Program, a comprehensive system of care for children and adolescents with behavioral health needs and their families. Since the time of its origin, defining and developing cultural competence has expanded in various disciplines of human services, such as primary care, public health, education, and social services. The term *cultural competence* was first defined as a set of congruent behaviors, attitudes, and policies that enable systems, agencies, and individual professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989). Cultural competence requires the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes as well as the subsequent application of these standards, policies, practices, and attitudes in appropriate cultural settings to increase the quality of service, thereby producing better outcomes (Davis & Donald, 1997). Cultural competence is an ongoing process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills over time and along a continuum (Ponterotto & Alexander, 1996).

Linguistic Competence. *Linguistic competence* is less debated and is more universally understood as the capacity of an organization and its personnel to communicate effectively and to convey information in a manner easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities (Goode & Jones, 2004). In practice, however, the focus of linguistic competence has been narrowly applied. Most organizations recognize the need to provide translated materials and interpreters to individuals with limited English proficiency, as well as individuals with disabilities. Rarely, however, do they recognize that providing materials for individuals who have low literacy skills is part of the framework of providing linguistically competent services.

Table 4.1. ***Elements of the Cultural and Linguistic Competence Framework***

Individual Level	Organizational Level
Acknowledge cultural differences among school personnel, students and their families, and the communities being served	Value and adapt to diversity and cultural contexts of students and their families and communities being served
Engage in self-assessment	Conduct cultural self-assessment
Understand one's own cultural values and beliefs that inform perspectives and worldview	Manage the dynamics of difference among culturally diverse school personnel
Acquire cultural knowledge and skills by building awareness, and through cultural encounters in diverse communities	Institutionalize cultural knowledge through professional development activities
View all behavior within a cultural context	Adapt policies, structures, practices, and services
Manage personnel behaviors such as negative assumptions, stereotyping, and micro-aggressions	Eliminate systemic racism and bias within school policies, infrastructure, and standard operating procedures

Mental Health Disparities in Culturally Diverse Students

Exposure to adversity at a young age is a risk factor for mental disorders. Factors that disproportionately affect people of color, such as poverty, racism, attendance at under-resourced schools, and lack of access to health care, place non-white young people at greater risk for mental health disorders (Table 4.2). Other vulnerable children may live in poverty, have parents with chronic health and mental health conditions, be exposed to maltreatment and neglect, be exposed to substance use, or experience bias and discrimination due to factors including sexual orientation, gender identity, physical or mental ability, religion, national origin, or other cultural markers.

Table 4.2. ***Existing Mental Health Disparities Among Racial and Cultural Populations in the United States***

Populations	Disparities
American Indian/ Alaskan Native	*Elevated substance use disorders.* Of more than 72,000 youth between ages 12 and 17, federal surveys report that 37% said they had used alcohol or drugs in the past year, and about 8% misused substances to the extent that they had a substance use disorder. http://californiawatch.org/dailyreport/drug-use-highest-among-american-indian-teens-lower-among-blacks-13463 *Higher suicide rates.* Suicide rates are more than double those for non-native populations, and Native teens experience the highest rate of suicide of any population group in the United States. http://www.aspeninstitute.org/sites/default/files/content/images/Fast%20Facts.pdf
Hispanic/ Latino	*Highest suicide attempt rates.* The percentage of high school students who seriously considered attempting suicide is 26% amongst Hispanic girls, 21.1% among White girls, and 18.6% among Black girls. http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf *Elevated rates of depression.* The percentage of high school students who described feeling sad or hopeless as is at 47.8% for Hispanic females, compared to 35.8% for Black and 35.7% for White females. http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6304a1.htm *Limited access to mental health services.* The percentage of Black and Latino youth who use mental health care services is less than half that of White children (4–5% and 10%, respectively). An estimated 88% of Latino children with mental health issues have unmet needs. http://archive.ahrq.gov/research/findings/nhqrdr/nhdr11/nhdr11.pdf, http://nccp.org/publications/pub_687.html
Native Hawaiian/ Pacific Islander	*Highest rates of illicit drug use and underage drinking.* Of Hawaiian youth, 46% reported using alcohol within the past 30 days compared to 19–29% for Asian American youth (Wong, Klingle, & Price, 2004). Of Hawaiian high school students, 36% engaged in binge drinking behavior compared to 31% of Caucasian students and 19% of other Asian Pacific Islander youth (Nishimura, Goebert, Ramisetty-Mikler, & Caetano, 2005).

Populations	Disparities
Asian American	*Increasing risk of suicide*. In the Asian American youth population, suicide ideation and suicide rates continue to increase. http://www.naminys.org/images/uploads/pdfs/Asian%20American%20Outreach%20Resource%20Manual.pdf
African American	*Increasing risk of suicide*. The suicide rate for Blacks between the ages 10 and 19 years increased from 2.1 to 4.5 per 100,000 (114%) between 1980 and 1995 and continues to rise. http://www.cdc.gov/mmwr/preview/mwrhtml/00051591.htm *Lack of access to mental health services*. Black youth are much less likely to enter traditional forms of mental health treatment than their white counterparts, even when presenting problems are similar (Wu, Hoven, Cohen, et al., 2001). *Unmet mental health needs*. More than 25% of African American youth exposed to violence have been shown to be at high risk for post-traumatic stress disorder. http://www.apa.org/about/gr/issues/minority/access.aspx
Lesbian, Gay, Bisexual, Transgender	*Elevated risk of suicide*. Lesbian, gay, bisexual, and transgender (LGBT) youth experience higher levels of suicide (35%) than the heterosexual population (10%). *Risk of bullying and violence*. LGBT youth (19%) are more likely to be threatened or injured with a weapon in school than the heterosexual population (5%). LGBT youth (13%) are more likely to be in physical fights that require medical treatment than the heterosexual population (4%). https://www.americanprogress.org/issues/lgbt/report/2009/12/21/7048/how-to-close-the-lgbt-health-disparities-gap/

High rates of unmet need exist across all racial, ethnic, and cultural groups, with only about 20% of children with mental health problems receiving care. Yet youth from minority racial and ethnic groups only receive one-third to one-half as much mental health care as White youth. This is true of both private and public mental health services (Holm-Hansen, 2006).

Despite the data, which suggest they are at disproportionate risk, access to mental health care is a major challenge for young people of color. In comparison to the White, non-Hispanic population (62%), Hispanic, American Indian, Alaskan Native, and African American children are less likely (32%) to have access to care. Asian children are 17% less likely than White, non-Hispanic children to receive care. In a California study, children from families below the federal poverty level and children with parents who are not proficient in English also have less access to care (Padilla-Frausto, Grant, Aydin, & Aguilar-Gaxiola, 2014).

Disproportionalities in Child Welfare
Within the U.S., all states have a disproportionate representation of African American children in foster care. As of 2000, the child welfare system in 16 states had extreme rates of disproportionality that were more than three and one-half times the proportion of children of color in the state's total child population (Hill, 2005). In the child welfare system, in states where there is a large population of Native Americans, this group can constitute between 15% to 65% of children in foster care (Casey Family Programs, 2005). Latino children may be significantly over-represented based on locality; e.g., in Santa Clara County, CA, Latino children represent 30% of child population but 52% of child welfare cases (Congressional Research Service, 2005). Besides the adversity of losing parents and becoming part of the child welfare system, children from underserved populations may also experience personal trauma such as exposure to violence at home or in the community, either as victims or witnesses.

Schools must be sensitive to the needs of these youth and recognize that some students with unmet behavioral health needs and youth with disabilities, particularly those with emotional disturbances, are more likely to experience high suspension rates and lower academic achievement (Skiba et al., 2002). For many of the reasons highlighted above, racially and ethnically diverse children and adolescents with mental disorders face major challenges with isolation and discrimination. This type of trauma can impact individual attributes such as the ability to manage one's thoughts, emotions, behaviors, and interactions with others. That is why addressing their needs through a culturally and linguistically competent referral pathway is critical.

Addressing the Challenges of Diverse Cultural and Language Needs

Cultural competence has faced its share of skeptics and non-believers. The challenge has been around the use of the term competence, because needing it implies incompetence on the part of the professional and the school system. Additionally, there is confusion about how we learn about culture given the diversity in the U.S. population. The section that follows highlights the major outcomes of work on cultural competence in the health care system; it provides practical linkages to the education system and the development of referral pathways.

Culturally and Linguistically Appropriate Services

Cultural competence can serve as a tool to reduce disparities and disproportionalities when tackled at the student, family, community, provider, organizational, and system level. Schools that maintain strong partnerships with community stakeholders, including health care providers, families, community- and faith-based organizations, and local mental health service providers are positioned to be culturally responsive to the specific needs of their students and families. These partnerships should be represented on the school-based problem-solving team and guide the consideration of language and culture in planning, implementing, and evaluating referral pathways. This process needs to recognize that children and families from diverse cultural backgrounds may have differing values, beliefs, and practices as they relate to mental health than the school personnel with whom they interact. These differences include the definition of mental health, including emotional and spiritual health; the perception of illnesses and diseases and their causes; healing and well-being; help-seeking behaviors and attitudes towards the U.S. health care system and its providers; and personal experiences of bias and discrimination when accessing and utilizing services. An understanding of these different belief systems and how they affect the families of the children in our schools is critically important for school-based problem-solving teams.

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). Culturally and linguistically appropriate services (CLAS) are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs and are used by all members of an organization (regardless of size) at every point of contact.

The enhanced National CLAS Standards, released by the U.S. Department of Health and Human Services in 2013, are intended to advance health equity, improve quality, and help eliminate health care disparities. They offer a blueprint for individuals, as well as health care organizations, to implement culturally and linguistically appropriate services. The enhanced Standards are a comprehensive series of guidelines that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services. By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve an organization's ability to address health care disparities.

The enhanced CLAS Standards were intended to provide guidance to health care organizations and systems around the development of culturally and linguistically appropriate services. The principles that guide the standards can apply within the educational context, as well. (Tool 4.1 indicates ways each CLAS standard can be integrated into schools.) There are three overarching areas of focus:

1. **Governance, Leadership, and Workforce.** Administrators and school leaders need to take on the adaptive work of leadership and assist the school in shifting values and beliefs to integrate culturally and linguistically appropriate practices. They need to promote policies and practices that support cultural responsiveness and allocate resources to promote educational equity. The school board should promote and support culturally and linguistically diverse school administration, personnel, and teachers. School leaders should provide ongoing education and training to school personnel on cultural and linguistic competence in the school environment.

2. **Communication and Language Assistance**. School leaders need to ensure that language assistance is offered at no cost to students and families to facilitate effective communication about the referral process. They need to inform students and families of the availability of language assistance services either verbally or in writing in their preferred language. School leaders need to ensure that interpreters are either certified or trained appropriately, and they also need to provide printed and multimedia materials in appropriate languages.
3. **Engagement, Continuous Improvement, and Accountability.** There should be goals, policies, standard operating procedures, and accountability infused in the planning, implementation, and evaluation of the mental health referral pathways to ensure the provision of appropriate mental health services to students who need it. This includes encouraging meaningful engagement with representative stakeholders from the school and community, collecting and analyzing data to continuously reflect on the effect of policies on disparities, and designating responsibility for analyzing and sharing data findings.

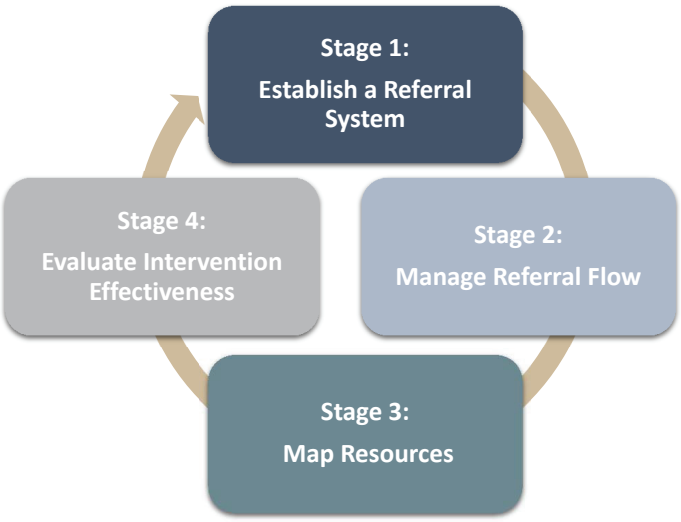
Culturally and Linguistically Competent Referral Systems: Step-By-Step

Addressing the needs of culturally and linguistically diverse students in schools is a critically important undertaking that requires the will of leadership and the resources of all stakeholder groups. (Tool 4.2 provides several resources to build awareness, knowledge, and skills in educators and their community partners.) Key aspects of this work include:

- educating all stakeholders about the disproportionalities that exist, including local government, school personnel, families and communities, and stakeholders representative of the entire community;
- working to change the school experience for families and communities from diverse cultures to one that is welcoming and inclusive;
- collecting, analyzing, and utilizing data on disproportionalities and disparities to continuously inform school practices; and
- ensuring that the academic, social, emotional, and behavioral referral pathways are culturally and linguistically competent.

The last bullet in the list above is the primary focus of the remainder of this SMHRP Toolkit chapter. Figure 4.2, introduced originally in Chapter 1, anchors the remainder of the discussion on cultural and linguistic considerations for each stage of the referral system.

Figure 4.2. ***Four Stages of Referral Pathways Development***



Stage 1: Cultural and Linguistic Considerations when Establishing a Referral System

In order to ensure that the referral system established by your school reflects the essential cultural and linguistic competencies of your community, your school's problem-solving team will need to establish a baseline of knowledge about both their own and the school's degree of cultural and linguistic competence. Individual self-assessment tools can help school-based problem-solving team members recognize their own unconscious biases and create both space for dialogue and an impetus to pursue additional training. An organizational self-assessment measures program components associated with cultural competence such as administration and policies, services and supports, quality of environment, and communication and language capacity. A variety of individual and organizational self-assessment tools are available to help establish this baseline knowledge and can be found in Tool 4.2. By establishing a starting point for existing knowledge, it is possible to inform capacity-building strategies of the school's problem-solving team. ossible strategies for increasing the capacity of schools to promote cultural and linguistic competence through both school-wide and classroom approaches are detailed in Toolbox 4.1.

1. **What cultural and linguistic competencies should problem-solving team members demonstrate?**
   A key first step is to help the school's problem-solving team establish both self-knowledge and knowledge of the school community. First and foremost, the school problem-solving team members will need to develop knowledge and awareness about:

   - their own cultural identities,
   - their own biases and assumptions,
   - how culture and language influence the behavior of young people in the classroom,
   - cultural factors that influence the expression of mental health issues, and
   - social determinants that influence the health of the community.

Toolbox 4.1. ***Activities and Practices to Build Cultural and Linguistic Competence***

School Leadership (e.g., school board, district level administrators, school building administrators)

- Develop and adopt a school "Diversity Statement" to ensure an inclusive work environment and service delivery system.
- Create and support a cultural and linguistic competency committee within the school.
- Populate or link your website with comprehensive cultural and linguistic competency resources, publications, tools, and news.
- Partner with cultural leaders and brokers to learn about the needs of diverse communities.
- Recruit employees in key leadership and direct service positions who reflect the populations of focus.
- Post welcoming and cultural images, art, photographs, posters, and other media materials throughout the school to reflect diverse communities.
- Post student rights in highly visible, easy to see and read locations in English and other common languages at locations where health services are provided.
- Recruit youth and family members from diverse communities to serve as co-trainers, facilitators, speakers, advisors, content experts, or consultants.
- Engage youth and families in developing language, content, logos, and images for anti-stigma social marketing materials.
- Sponsor youth events to focus on positive, youth-driven, and tobacco- and alcohol-free events.
- Commemorate heritage months (Native American, Asian/Pacific Islander, Hispanic, African American, etc.) and awareness months (children's mental health, disability, mental health, minority mental health).
- Sponsor intercultural dialogue events to develop understanding of the needs of local community needs and issues of diverse communities.
- Identify translators (for written communications) and interpreters (for oral communications) to assist with language access in your community.
- Sponsor diversity presentations by local partners, such as LGBT advocates, deaf/hard of hearing and disability organizations, and ethnically and culturally diverse groups.
- Organize, sponsor, or partner with annual health fair events.
- Partner with faith-based organizations, local churches, and traditional or holistic healing groups to organize wellness campaigns.
- Partner with minority-serving and tribal organizations and groups.
- Identify community resources about what services, care, and support are available, accessible, and affordable and which organizations offer services to meet the diverse needs of students.
- Conduct anti-stigma campaigns that involve and provide leadership opportunities for members of diverse communities in developing culturally appropriate messages; include images and individuals of diverse backgrounds.

Teachers/School Personnel

- Sign up for cultural and linguistic competency training.
- Take a cultural self-assessment.
- Learn about community-defined, evidence-based, and best practices that effectively serve diverse communities.
- Partner with cultural leaders and brokers to learn about the needs of diverse communities.
- Post welcoming and cultural images, art, photographs, posters, and other media materials to reflect diverse communities in your classroom and work space.

Toolbox 4.1. *Continued*

- Commemorate heritage months (Native American, Asian/Pacific Islander, Hispanic, etc.) and awareness months (children's mental health, disability, mental health, minority mental health).
- Attend language courses to increase your bilingual language capacity.
- Maintain and follow protocols and customs established in tribal communities and governments to ensure sovereignty and that program practices are acceptable.
- Identify community resources about what services, care, and support are available, accessible, and affordable and which organizations offer services to meet the needs of students.
- Become a member of a minority affiliate association that advocates for the behavioral health needs of diverse communities (e.g., National Leadership Council on African American Behavioral Health, National Latino Behavioral Health Association, First Nations Behavioral Health Association, National Asian American Pacific Islander Mental Health Association).

2. **What elements can the problem-solving team build into the referral system to maximize the team's ability to make culturally and linguistically competent decisions?** Ensuring that your school-based problem-solving team includes representation from diverse groups in your community is a good first step. Beyond group membership, however, the most effective team members will have specific skill sets that enable them to act as cultural brokers between the school and the community. Cultural brokers need not be mental health professionals, but may be caregivers or family members with lived experience navigating the school or community mental health system. These stakeholders can be identified through local parent advocacy groups, community mental health providers; or health or other personnel on your campus. Building relationships with cultural brokers in your community is unlikely to occur all at once, but a commitment to ongoing and continuous outreach can help build your network over time.

   a. Identify the right members to participate on the problem-solving team. Look for team members who:
      - have a true understanding of their own cultural identity,
      - are aware of the fact that others have diverse identities,
      - understand that culture is a part of all behavioral contexts,
      - represent various lived experiences and can bring diverse perspectives to this work, and
      - are committed to ongoing personal assessment.

   b. As a practice, recruit diverse team members who can serve as natural networks of support.

   c. Identify cultural brokers to participate on the school-based problem-solving team. Cultural brokers are individuals from the community who can serve as a bridge between an organization and people of different cultural backgrounds. Cultural brokers should be familiar with educational institutions and mental health services within the community in which they live or from where they originated. They can become a valuable source of cultural information and serve as mediators in conflicts and as agents for change.

      Cultural brokers may come from various stakeholder groups (e.g., parent groups, faith-based organizations) who will be helpful in working with diverse communities and school personnel towards increasing access to mental health services and eliminating mental health disparities for culturally and linguistically diverse students and their families.

Toolbox 4.2. ***Characteristics of Effective Cultural Brokers***

Cultural brokers are aware of:

- their own cultural identity,
- the cultural identities of the members of diverse communities, and
- the social, political, and economic factors affecting diverse communities within a cultural context.

Cultural brokers are knowledgeable of:

- the values, beliefs, and practices regarding the health, wellness, and well-being of their cultural groups as well as the natural variance from individual to individual and family to family;
- traditional or indigenous health care networks within diverse communities;
- medical, health care, and mental health care systems (e.g., health history and assessment, diagnostic protocols, treatment and interventions);
- multiple factors impacting community diversity;
- social services provided in the community; and
- school climate and culture.

Cultural brokers have a range of skills that enable them to:

- communicate in a cross-cultural context,
- communicate in two or more languages,
- interpret and/or translate information from one language to another,
- manage the dynamics of differences among people, and
- self-care and sustain their role.

Toolbox 4.3. ***Guiding Questions for Identifying Effective Cultural Brokers***

When working to identify cultural brokers within the school community, work with stakeholders to answer the following questions:

- Is the person knowledgeable about the cultural beliefs, attitudes, values, and practices of the target community?
- Is the person recognized and respected by the target community members?
- Is the person knowledgeable about resources within the community?
- Is the person able to make connections within the community that school personnel would not be able to on their own?
- Is the person fluent in the primary language of the target population?
- Is the person knowledgeable of the educational needs of the target community?
- Is the person knowledgeable of cultural beliefs about educational needs in the target community?
- Is the person knowledgeable of cultural barriers to education in the target community?
- Is the person knowledgeable of the mental health needs of the target community?
- Is the person knowledgeable of cultural beliefs about mental health in the target community?
- Is the person knowledgeable of cultural barriers to mental health service utilization in the target community?

d. Use trained and certified translators (for written communications) and interpreters (for oral communications) effectively when working with young people and family members with limited English proficiency. Translate referral-related materials (e.g., referral forms, interview protocols) as much as possible. If translation is required, the resulting translations must be discussed by a team, including translators, members of the local ethnic community, and mental health professionals. Translators and consultants from the local community can help ensure that the translated referral-related documents are meaningful, appropriate, and acceptable for the community. However, translators who have also been trained in mental health are rarely available. Therefore, involvement of mental health professionals on the team is essential to help ensure that the translated and adapted referral documents continue to be valid and capture the topic of concern or interest. Refer to Tool 4.2 for tips on how to effectively use translators, interpreters, and resources for mental health interpreter training services.

Toolbox 4.4. ***Using Translators and Interpreters Effectively***

The following recommendations apply to using translators (for written communications) and interpreters (for oral communications) within all stages of referral systems.

Pre-Work:

- Determine whether the translator or interpreter is certified to translate in the language being requested and has adequate training and background knowledge to work in schools.
- Allow the translator or interpreter to review the school-based problem-solving team's agenda prior to the team's meeting regarding a student referral.
- Discuss expectations about what will be translated or interpreted and for whom.
- Schedule frequent breaks for the translator or interpreter to deliver messages with fewer translation errors.
- Describe the boundaries of confidentiality with the translator or interpreter.
- Provide the translator with the opportunity to examine and translate any documents that may need translation during the session (e.g., referral forms, academic records).
- Discuss technical terms that will be used during the session (e.g., mental health diagnoses).
- Discuss cultural expectations regarding communication and behaviors (e.g., appropriate greetings).
- Provide the information that the interpreter needs to understand the unique context of the referral(s) being discussed (e.g., child trauma history).
- Ask the interpreter where he or she prefers to be seated to ensure effective interpretation.

During Problem-Solving Team Meetings:

- Have the interpreter introduce himself or herself, and translate the names and titles of all present.
- Ask all present to speak in short sentences and allow time for the interpreter to communicate between languages.
- Avoid idioms, slang, and metaphors because they are difficult to translate.
- Take notes relevant to any issues that need to be discussed during debriefing. The interpreter should also take notes. For example, terms that are difficult to interpret or cross-cultural issues relevant to communication can be noted and discussed during debriefing sessions.
- If necessary, ask clarifying questions to prevent information loss as a result of translation or interpretation.

During Debriefing Conversations:

- Discuss the outcomes of the meeting with the interpreter, as well as any problems that may have surfaced.
- Discuss any cultural issues that may have surfaced during the meeting.
- Encourage the interpreter to discuss his or her perceptions of the meeting, with specific attention to the cultural and linguistic competency expressed by the team.

Do:	**Don't:**
• repeat and summarize the major points • be specific (e.g., "daily" rather than "frequent") • use diagrams, pictures, and translated written materials to increase understanding • clarify that you understand or that you have understood the person	• use metaphors, colloquialisms (e.g., pull yourself up by your bootstraps), and idioms (e.g., kick the bucket) because such phrases are unlikely to have a direct translation • use medical terminology unless the interpreter and person are familiar with the equivalent term

Adapted from Department of Health, Queensland, Australia, https://www.health.qld.gov.au/multicultural/interpreters/interp-tips.pdf and Lopez, E. (2002), Recommended Practices for Working with Interpreters, available for download at http://www.nasponline.org/resources/culturalcompetence/recommend.pdf.

e. Create a friendly and inviting space for team meetings.
   - When it is in the best interest of culturally and linguistically diverse families, consider hosting problem-solving meetings in a neutral environment, such as a community library or community center.
   - Providing food and drink (even water and simple snacks) is an indication of good intentions.
   - Consider whether the length of the meeting is sufficient to appropriately address all the issues, particularly if a cultural broker or interpreter is part of the team.
   - Consider whether your team has arranged a meeting time that's accessible for the student's family.

f. Create routines that incorporate regular self-assessment of the team's cultural and linguistic competence.

g. Communicate to family members and stakeholders within the community how the referral system works and make modifications as feedback is collected.

h. Use referral tools that have built-in cultural and linguistic considerations. (Refer to Tool 4.2 at the end of this chapter for guidance in building a culturally competent referral system.)

i. Add cultural and linguistic identifiers to referral forms and team protocols. These identifiers will assist the team in constructing a deeper understanding of the young person's environment and will be useful later when examining data for persistent disparities in referral and intervention. Consider adding the following identifiers:
   1. Country of origin
   2. Generation
   3. Acculturation (may need to collect data from student and families)
   4. Linguistic characteristics, including languages spoken, written or signed; dialects or regional variants; and literacy levels
   5. Family household and composition
   6. Socioeconomic status
   7. Educational attainment
   8. Employment
   9. Health and mental health practices
   10. Religious and spiritual practices
   11. Military affiliation
   12. Racial and ethnic groups
   13. Sex
   14. Sexual orientation
   15. Gender identity
   16. Disability

Stage 2: Cultural and Linguistic Considerations when Managing Referral Flow

1. What sensitivities should the problem-solving team build in people who will use the referral system (e.g., parents/family members, school personnel, peers)?

a. All school personnel asked to use the referral system must be trained to be culturally and linguistically competent as they complete referrals.

Toolbox 4.5. ***Key Characteristics of Cultural Competence Training***

An effective educational or training program for cultural competence correlates with a lasting awareness and understanding of culture by school personnel. Although there are several approaches to educate staff, all successful educational programs include (a) cultural assessment, (b) multiple training methods, (c) ongoing professional development, and (d) tracking of participant outcomes. (See Tool 4.2 for training tools.) Common topics included in cultural competence trainings for educators are:

- exploration of school personnel members' own cultural backgrounds and the cultural backgrounds of the students, families, and communities served;
- effects of differences between the cultures of school personnel and students;
- effects of cultural differences among staff, families, and the community on access to mental health care, service utilization, quality of mental health care, mental health outcomes, and satisfaction with services;
- effects of health and mental health beliefs and practices within community groups represented in the school system;
- effects of factors such as socio-economic status, race, ethnicity, disability status, sexual orientation, gender identity, religious and spiritual background, and other factors on perceptions of health, wellness, and well-being;
- challenges in accessing available mental health services for individuals with limited English proficiency, low mental health literacy, and disabilities or special needs;
- impact of discrimination based on race, ethnicity, sex, national origin, socioeconomic status, disability status, religion, sexual orientation, and gender identity on students and families;
- prevalence of mental health disparities and disproportionalities in youth;
- discipline beliefs and practices within the local community and how those beliefs and practices fit (or do not fit) within an multi-tiered systems of support framework;
- strategies for collecting race, ethnicity, sex, language, sexual orientation, gender identity and disability status data in a culturally appropriate manner;
- strategies to help families and students overcome individual and institutional barriers that exasperate mental health disparities;
- when and how to access language services for individuals with limited English proficiency; and
- application of laws and provisions that pertain to the delivery of culturally and linguistically appropriate mental health care and services.

2. After receiving referrals, what cultural and linguistic considerations should the problem-solving team make?

When a school-based problem-solving team receives a referral and begins the process of expanding on the referral by conducting interviews, observations, and records reviews, several key considerations are warranted:

Considerations for Interviews with Parents and Caregivers. Parents and caregivers are already in a state of stress by the time they come into the interview. The purpose for the interview is often unclear, even though a letter discussing the interview and other relevant documentation may have been sent to them. This situation is further exacerbated if the family is not fluent in English, has a low level of acculturation or assimilation, or has beliefs about education that differ than that of the system. It is critical that the problem-solving team identify areas of potential conflict and plan accordingly. Here are some considerations:

- If the family (parent or caregiver) is not fluent in English, then the school should use a certified or trained interpreter (Toolbox 4.4 provides guidance on the use of interpreters).
- Use effective cross-cultural communication strategies such as:
  - using open-ended, clarifying, or restating questions;
  - carefully reframing and restating if it appears that there is miscommunication; or
  - summarizing information and confirming understanding.
- Make sure that the parent or caregiver has clearly understood the reason for the referral and knows their next steps.

Considerations for Observations. Observation is a process of registering, interpreting, and recording. Both the process and the data collected are influenced by the problem-solving team members' interactions with the student. While an objective standpoint is impossible to achieve in situations in which the observer knows the student personally, recognizing the cultural lens that the observer brings is critical to ensuring that observations are not biased by that perspective. What is observed and how it is interpreted are partially based on the observer's lived experience, cultural lens, and personality traits.

Anxiety and bias can influence the observation and should be effectively managed. Things to consider:

- Individual perspectives and assumptions will color the observer's lens and should be acknowledged and taken into consideration when making interpretations.
- The student being observed may also be affected by the observation, and this may skew behavior and the subsequent interpretations of the student's mental health status.

Considerations for Reviews of Records. The cultural identities of problem-solving team members may also influence the information reviewed and the way it is interpreted. Culturally specific perspectives may affect how data is collected, how it has been interpreted, and what has been written down in the student records. Things to consider:

- Review the record, taking into consideration that there might be cultural assumptions and biases inherent in the record.
- If possible, check statements and observations with the school personnel or teacher who may have initiated the record to check the team member's assumptions about the data in the record.

Considerations for Writing Summary Reports. Communicating in writing is much like oral communication in that there are two parties with varying levels of education and literacy skills, varying cultural values and beliefs, and different life experiences. The written summary reports will be shared with the family or caregiver. Things to consider:

- Know your audience—such as age, sex, race, cultural background, level of education, religion, and social class—and tailor your writing accordingly.
- If the report is to be shared with the parent or caregiver, you should consider their expectations. You might put yourself in your reader's place and imagine what would be helpful and informative to them.
- Remember the purpose of the report and communicate information that will be most useful and meaningful to the family and to service providers.
- If the information is to be translated for the family or caregiver, review considerations for the use of translators (Toolbox 4.4).

Considerations for How Records are Held. Most schools have policies and protocols that determine how the records are stored. This information should be shared with the family or caregiver. Things to consider when imparting this information to the family or caregiver:

- Describe why the information developed by the school-based problem-solving team is critical in supporting the health and well-being of the student.
- Explain that this record will be stored in the school but will remain confidential.

Stage 3: Cultural and Linguistic Considerations When Mapping Resources

1. **What should the problem-solving team do to make sure they have identified community partners that are culturally and linguistically competent? (That is, partners to whom referrals can be made?)**

The school-based problem-solving team must identify resources in the community that can support the diverse populations served by the school. A cultural and linguistic competency skills matrix is a helpful tool to construct when identifying resources in the community. Skills matrices list community resources (e.g., advocacy organizations, mental health care providers, businesses, faith-based organizations) based on cultural and linguistic competencies (e.g., translation services, interpretation services, cultural brokers, communication and broadcasting for specific cultural groups, specialized mental health services). An example of a skills matrix is provided in Toolbox 4.6.

Toolbox 4.6. ***Example Skills Matrix, Community Partner Cultural and Linguistic Supports***

	Translation Services: Language 1 (e.g., Spanish)	Translation Services: Language 2 (e.g., Korean)	Interpretation Services: Language 1 (e.g., Spanish)	Interpretation Services: Language 2 (e.g., Korean)	Cultural Broker: Population 1 (e.g., asylee)	Cultural Broker: Population 2 (e.g., Latino/a)	Communication & Broadcasting: Population 1 (e.g., Afghani)	Family & Child Mental Health Services, Specialized: Population 2 (e.g., refugee)
Mental Health Agency A								X
Non-profit Organization A					X			
Faith Based Organization A	X		X			X		
Business A							X	

2. What cultural and linguistic considerations should be made for selecting interventions at all three MTSS tiers and for matching young people to appropriate interventions?

In theory, most of the interventions in MTSS are evidence based, and most organizations are encouraged to identify programs and practices that will work for their environment. All evidence-based programs, however, have not been developed for all cultural groups. Many have not tested effectiveness for specific cultural groups, and those that have been developed and tested for cultural groups often do not have materials (e.g., training manuals) that reflect the breadth of cultures served (Samuels & Schudrich, 2009).

While many organizations are mandated to implement specific interventions or choose from a catalogue of options, there is a move toward determining the cultural fit of programs and practices (Bernal, Chafey, & Rodriquez, 2009; Cardemil, Moreno, & Sanchez, 2010; Samuels & Schudrich, 2009). The team will need to take into consideration whether the program is appropriate for diverse populations.

Below are considerations for the team when selecting an evidence-based program for a young person:

Structure of the intervention

- Modality – is the intervention delivered in individual or group format?
- Number and frequency of sessions
- People involved in services – should services include individuals, families, and/or natural supports?

Delivery of the intervention

- Location of intervention – is the location or setting comfortable for the young person and their caregivers? Might a nonclinical setting (e.g., community center, faith-based setting) be more appropriate?
- Provider behavior – does the provider attend to relevant cultural values and other social determinants of health?
- Persons – is a mental or behavioral health provider, peer, spiritual leader, elder, cultural broker, or someone else providing services?

Program content

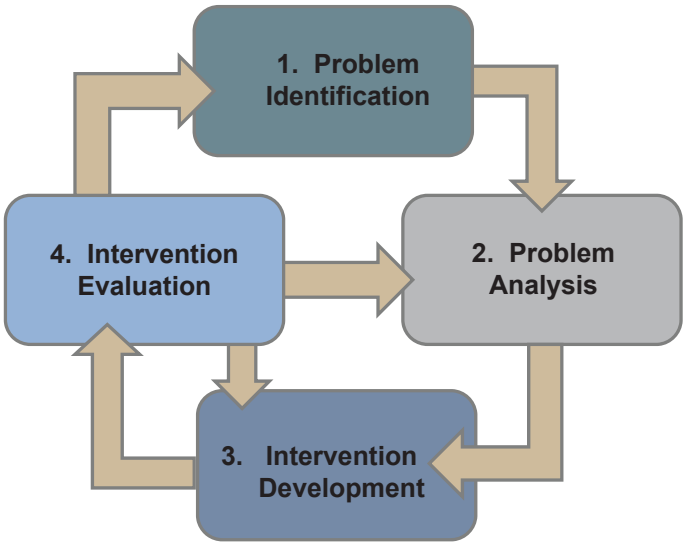
- Language – do young people and their families understand language, idioms, and words used?
- Can fidelity be maintained while incorporating issues that address culturally relevant themes?
- Use of culturally relevant metaphors and sayings – are sayings common to the group who is part of the intervention?

Stage 4: Cultural and Linguistic Considerations When Evaluating Intervention Effectiveness

This section revisits the four-step problem-solving model introduced in Chapter 3. In this chapter, cultural considerations for problem-solving under each step have been added. When used in conjunction with the toolboxes provided in this chapter and the tools provided at the end of the chapter, these cultural considerations can help school-based problem-solving teams infuse cultural competence into the referral process.

1. **When using the four-step problem-solving model for individual referrals, what cultural and linguistic considerations should be made at each stage?**

Figure 4.3. ***Four-Step Problem-Solving Model for Promoting Mental Health in Schools***



Step 1: Problem Identification

- *Formative questions*
  - What does the problem-solving team value?
  - Is there a problem?
  - If so, what exactly is the problem?
- *Analytic aims*
  - Identify school personnel's values about student behavior.
  - Determine the presence of student problem behavior.
  - Define student problem behavior in a way that is useful for guiding the remaining problem-solving steps.
- *Core procedures*
  - Clarify values and make a public commitment to promoting valued behavior.
  - State the problem behavior in measurable and understandable terms.
  - Obtain a baseline measure of the problem behavior.
  - Conduct a discrepancy analysis to identify differences between desired and observed levels of behavior.

Cultural considerations: The collective values of the team are informed by the cultural identities of individual members. These values will shape team members' perceptions and assumptions and this should be taken into consideration when:

- determining the existence of the problem,
- identifying the type and source of the problem,
- assessing a student's behavior and how different it is from what is considered to be normal, and
- determining problem-solving steps.

Step 2: Problem Analysis

- *Formative questions*
  - What factors are maintaining the problem?
  - How can maintaining factors be changed to positively influence the problem?
- *Analytic aims*
  - Identify the factors maintaining the problem behavior.
  - Identify an intervention strategy for the problem behavior that is logically connected to the maintaining factors.

- *Core procedures*
  - Assess potential factors maintaining the problem behavior.
  - Determine the factors maintaining the problem behavior and link them with an intervention strategy to positively influence problem behavior.

Cultural considerations: When analyzing the factors that are creating or maintaining the problem, it will be important for the team to understand the cultural factors that inform the student's cultural identity and the social determinants within the student's community that influence both the student and his or her family.

Social determinants are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as place. In addition to the more material attributes of place, the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on health and education outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency and health services, and environments free of life-threatening toxins.

Step 3: Intervention Development

- *Formative questions*
  - How can we implement the intervention strategy to positively influence the problem?
  - How can we ensure the intervention is implemented with fidelity?
  - How can we know if the intervention is working?
- *Analytic aims*
  - Develop an intervention plan for intervening with the problem behavior.
  - Determine a method for gauging and improving implementation fidelity.
  - Determine the valued behavioral outcome and an associated evaluation procedure.
- *Core procedures*
  - Select an evidence-based intervention that operationalizes the intervention strategy.
  - Develop the procedures and schedule for the intervention.
  - Develop an implementation fidelity measure and establish a schedule and procedures for evaluating and enhancing intervention integrity.
  - Develop an outcome goal, select a progress-monitoring method, and establish a schedule and procedures for evaluating intervention effectiveness.

Cultural considerations: Identifying and developing effective interventions will require an understanding of the different cultural values that are placed on education, academic attainment, discipline, elder respect, familial and community beliefs, and practices related to mental health. This is a critical juncture when working with a cultural broker, and other gatekeepers of culture in the community are critical when identifying what could serve as culturally appropriate interventions.

It is not always possible to identify evidence-based interventions that have been normalized to the culture of the student. It is appropriate to look into community-informed practices or even promising practices acceptable to the family and the community. The referral team may want to ask the following questions when identifying evidence-informed, community-informed practices rather than evidence-based intervention from an accredited registry:

- Does the intervention consider the culture and lived experience of the student?
- Does the intervention consider the cultural and social characteristics of the student's family and community?
- Is the intervention negotiated with the student and his or her family to ensure that both the student's and the school's interests are addressed?
- Does the intervention have the capacity to fulfill the intended outcomes?

Step 4: Intervention Evaluation

- *Formative questions*
  - Is the intervention being implemented as planned?
  - Is the intervention positively influencing the problem behavior?
  - If not, what can be done to improve intervention effectiveness?

- *Analytic aims*
  - Determine the level of implementation fidelity.
  - Determine the effect of the intervention on the problem behavior.
  - If needed, identify potential improvements to the problem-solving process.
- *Core procedures*
  - Calculate the proportion of intervention components implemented with fidelity and, if needed, provide support to enhance implementation fidelity.
  - Graph progress-monitoring data.
  - Use pre-established decision rules to determine intervention effectiveness.
  - If needed, revisit the problem analysis step and the intervention development step and then re-implement the intervention.

Cultural considerations: In evaluating the intervention, the team needs to clearly identify whether the outcome that is sought fits the culture and customs of the family and community. The team should communicate the purpose of the intervention and the hoped-for outcomes to both the student and his or her family.

2. Why should problem-solving teams separate intervention effectiveness data into subgroups?

In order to track disproportionalities and disparities, the problem-solving team will need to occasionally take a step back from problem-solving for individual students to look at whether their decisions are improving the well-being of their school's culturally diverse young people overall. Consider dividing referral and intervention effectiveness into:

1. Country of origin
2. Generation
3. Acculturation (may need to collect data from student and families)
4. Linguistic characteristics, including languages spoken, written or signed; dialects or regional variants; literacy levels
5. Family household and composition
6. Socioeconomic status
7. Educational attainment
8. Employment
9. Health and mental health practices
10. Religious and spiritual practices
11. Military affiliation
12. Racial and ethnic groups
13. Sex
14. Sexual orientation
15. Gender identity
16. Disability

Tool 4.1. ***Applying National CLAS Standards in Schools***

National CLAS Standards	School Application
Standard 1: Provide effective, equitable, understandable, and respectful quality [mental health] care and services	Overarching goal of schools providing mental health services to students and families. This will be accomplished through strategies provided in Standards 2-15.
Standard 2: Advance and sustain governance and leadership that promotes CLAS and [mental] health equity	Provide CLAS training and cultural competence training on a regular and on-going basis. Commit to building a district-wide capacity for cultural competence trainings. Ensure necessary financial resources are allocated to provide CLAS. Review school policies (e.g., mental health referrals, student support teams) and discipline practices.
Standard 3: Recruit, promote, and support a diverse governance, leadership, and workforce	Conduct regular assessments of hiring and retention data (workforce demographics, promotion demographics, community demographics). Advertise job opportunities in targeted languages, publications, and other media. Hire school personnel who reflect the characteristics of the students and families in your school. Create a work environment that respects and accommodates the cultural diversity of the local workforce.
Standard 4: Educate and train governance, leadership, and workforce in CLAS	Engage administration in dialogues about the needs of underrepresented communities. Administration and management attend CLAS trainings and cultural competence trainings, possibly becoming trainers themselves. Engage with the community through volunteer work, focus groups, or learning a new skill.
Standard 5: Offer communication and language assistance	All staff understand how to acquire interpretation services and are capable of doing so for both face-to-face encounters and over-the-phone encounters. Staff understand that the use of interpretation services is necessary for all encounters (e.g., parent-teacher conference, IEP and 504 meetings).
Standard 6: Inform individuals about the availability of language assistance	Exhibit a card or poster (“I speak…”) listing linguistic options to help identify what language assistance to acquire through interpretation and translation. Post signs in common areas (e.g., office, guidance department, nurse’s office).
Standard 7: Ensure the competence of individuals providing language assistance	Hire well-trained, certified interpreters and translators. Be sure that you check bilingual and multilingual staff for proficiency; testing programs are available online.

National CLAS Standards	School Application
Standard 8: Provide easy-to-understand materials and signage	Provide signage in languages represented in your school system. Be sure signage is posted in easy-to-understand wording, and utilize American Sign Language if necessary. Signs should be posted in common areas.
Standard 9: Infuse CLAS goals, policies, and management accountability throughout the organization's planning and operations	All programs and departments are infusing CLAS into their policies and procedures. All staff are aware of the impact of culture on conflict resolution and the evaluation process. Staff are aware of cultural differences in communication styles and behaviors.
Standard 10: Conduct organizational assessments	Schools will evaluate their progress in implementing the CLAS standards. Conduct individual assessments for school personnel. Conduct an organizational assessment for schools.
Standard 11: Collect and maintain demographic data	Collect race, ethnicity, and language (REaL) data using collection standards put forth in the Affordable Care Act section 4302a. Keep this data easily accessible so staff can utilize it to schedule interpreters when needed. Analyze this data and use it to improve the mental health referral system, services, and programs.
Standard 12: Conduct assessments of community [mental] health assets and needs	Identify all services available to all populations in your community. Collaborate with other community organizations to ensure cultural and linguistic services are planned and implemented within the community setting.
Standard 13: Partner with the community	Collaborate with staff, families, and local stakeholders to develop and review policies, services, and programs to reflect and respond to a variety of community groups and perspectives. Engage cultural brokers as a bridge between schools and people of different cultural backgrounds.
Standard 14: Create conflict and resolution processes	The conflict and grievance process should be easily understood and accessible (e.g., multiple languages) by all members of the school community. All materials should be developed at a 6th-grade reading level.
Standard 15: Communicate the organization's progress in implementing and sustaining CLAS	Progress regarding the CLAS standards is shared with the community via school and district websites and other social media outlets (e.g., Facebook, Twitter), school and district newsletters, and brochures. Engage all communities in on-going discussions of progress and self-assessment.

Tool 4.2. ***Additional Resources for Cultural and Linguistic Competency (CLC)***

Name of Resource	Organization	Source	Summary	Audience
Cultural and Linguistic Competence Knowledge and Awareness Building Tools				
How is Cultural Competence Integrated in Education?	Center for Effective Collaboration and Practice	http://cecp.air.org/cultural/Q_integrated.htm	A brief conceptual background for cultural competence, and elements of cultural competence in programs serving children with or at risk of developing serious emotional disturbance.	Child-Serving Government Agencies School Personnel
Diversity Toolkit: Cultural Competence for Educators	National Education Association	http://www.nea.org/tools/30402.htm	Describes main issues, skill areas, and strategies for addressing cultural competence.	School Personnel
Project Implicit	Project Implicit is a non-profit organization and international collaboration between researchers	https://implicit.harvard.edu/implicit/	Project Implicit provides training services on implicit bias, diversity and inclusion, and leadership.	Child-Serving Government Agencies Mental Health Providers School Personnel
Cultural and Linguistic Competence Training Resources				
E-Learning Continuing Education Programs	The Office of Minority Health	https://www.thinkculturalhealth.hhs.gov/Content/ContinuingEd.asp	Continuing education programs designed to help individuals at all levels and in all disciplines promote health and health equity.	Mental Health Providers
Curricula Enhancement Module Series	National Center for Cultural Competence, Georgetown University	http://nccccurricula.info	The goal of the series is to incorporate principles and practices of cultural and linguistic competence into all aspects of leadership training.	Child-Serving Government Agencies School Personnel Mental Health Providers
Infusing Cultural and Linguistic Competence into Health Promotion Training (Video)	National Center for Cultural Competence, Georgetown University	http://nccc.georgetown.edu/projects/sids/dvd/index.html	A training video designed to guide development of outreach materials for diverse populations in a CLC manner.	Child-Serving Government Agencies School Personnel Mental Health Providers

Name of Resource	Organization	Source	Summary	Audience
Culture, Language and Health Literacy	Health Resources and Services Administration, U.S. Department of Health and Human Services	http://www.hrsa.gov/culturalcompetence/index.html	A compilation of resources for general CLC and health literacy.	Child-Serving Government Agencies School Personnel Mental Health Providers
Closing the Gap: Cultural Competency in Health and Human Services	Cross Cultural Health Care Program	http://xculture.org/cultural-competency-programs/cultural-competency-training/	A training series to build awareness, knowledge, and skills through a variety of teaching methods including direct instruction, role playing, case studies, facilitated group discussions, and technology and media.	Mental Health Providers
Cultural and Linguistic Competence Icebreakers, Exercises, Videos & Movies	Technical Assistance Partnership for Child and Family Mental Health	http://www.tapartnership.org/COP/CLC/default.php	Tools and resources to implement and improve their cultural and linguistic competence.	Child-Serving Government Agencies Mental Health Providers School Personnel
Cultural and Linguistic Competence Self-Assessment Tools (Group)				
Program-Level Cultural Competency Assessment Scale	Center of Excellence in Culturally Competent Mental Health	http://nned.net/docs-general/NKICulturalCompetencyAssessmentScale-Program_Level-June2012.pdf	The cultural competency assessment scale is applicable to behavioral health care programs serving multicultural populations.	Child-Serving Government Agencies School Personnel Mental Health Providers
Cultural Competency in Mental Health Peer-Run Programs and Self-Help Groups	National Alliance on Mental Illness (NAMI) STAR Center, University of Illinois at Chicago	http://www.consumerstar.org/pubs/SC-Cultural_Competency_in_Mental_Health_Tool.pdf	Tool for self-assessment and development of action plans to enhance cultural competency.	Child-Serving Government Agencies Mental Health Providers
Culturally Competent Care: Some Examples of What Works	Commission on the Public's Health System	http://www.cphsnyc.org/cphs/reports/august_2010-_culturally_competen/http__cphsnyc_org_pdf_childhealth.pdf	Evidence-based cultural and language components in different provider health care settings.	Child-Serving Government Agencies School Personnel Mental Health Providers
Planning and Implementing Cultural Competence Organizational Self-Assessment	National Center for Cultural Competence, Georgetown University Center for Child and Human Development	http://nccc.georgetown.edu/documents/ncccorgselfassess.pdf	A guide to conducting an organizational self-assessment.	Child-Serving Government Agencies Mental Health Providers School Personnel

Name of Resource	Organization	Source	Summary	Audience
Promoting Cultural Diversity and Cultural Competency: Self-Assessment Checklist for Personnel Providing Behavioral Health Services	National Center for Cultural Competence, Georgetown University Center for Child and Human Development	http://nccc.georgetown.edu/documents/	A self-assessment checklist.	Child-Serving Government Agencies Mental Health Providers School Personnel
Multicultural Health Care: A Quality Improvement Guide	National Committee for Quality Assurance	http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_toolkit.pdf	A guide and toolkit to apply CLAS standards to assessment, planning, implementation, and evaluation.	Child-Serving Government Agencies Mental Health Providers
Program-Level Cultural Competency Assessment Scale	Nathan S. Kline Institute for Psychiatric Research and the Center of Excellence in Culturally Competent Mental Health	http://nned.net/docs-general/NKICulturalCompetencyAssessmentScale-Program_Level-June2012.pdf	The program-level cultural competency assessment scale measures 14 program components of cultural competence	Child-Serving Government Agencies Mental Health Providers School Personnel
Cultural and Linguistic Competence Family Organization Assessment Instrument	National Center for Cultural Competence, Georgetown University Center for Child and Human Development	http://gucchdgeorgetown.net/NCCC/CLCFOA/NCCC_CLCFOAAssessment.pdf	An assessment tool developed to address the unique functions of family organizations concerned with children and youth with behavioral-emotional disorders, special health care needs, and disabilities.	Mental Health Providers
Cultural and Linguistic Competence Policy Assessment (CLCPA)	National Center for Cultural Competence, Georgetown University Center for Child and Human Development	http://clcpa.info	A self-assessment tool to assist community health centers to advance and sustain cultural and linguistic competence.	Child-Serving Government Agencies School Personnel
Foreign Language Assessment Resources				
Language Proficiency Assessments	American Council on The Teaching of Foreign Languages	http://www.actfl.org/professional-development/proficiency-assessments-the-actfl-testing-office	Certified speaking, reading and listening, and writing skill assessments to determine functional language ability.	Mental Health Providers

Name of Resource	Organization	Source	Summary	Audience
Intercultural Communication Tools				
Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies	Center for Health Professions, University of California, San Francisco	http://futurehealth.ucsf.edu/LinkClick.aspx?fileticket=d5X/OqyqeuY=	The curriculum teaches providers to recognize when cultural differences exist in patient encounters and to utilize specific communication skills to elicit their patients' cultural perspectives about health and illness.	Mental Health Providers
Worlds Apart: A Four-Part Series on Cross-Cultural Health Care	Fanlight Productions	http://www.fanlight.com/catalog/films/912_wa.php	A tool for raising awareness about the role sociocultural barriers play in patient-provider communication.	Mental Health Providers
Best and Promising Practices				
Evidence-Based Practices and Multicultural Mental Health	National Alliance on Mental Illness Multicultural Action Center	https://www2.nami.org/Template.cfm?Section=Fact_Sheets1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=63974	Presents the challenges of using evidence-based practices (EBPs) with diverse populations and describes promising cultural adaptations to EBPs that are being made. Explains practice-based evidence (PBE), and offers policy.	Child-Serving Government Agencies School Personnel
Culturally Competent Mental Health Services in the Schools: Tips for Teachers	National Association of School Psychologists	http://www.nasponline.org/resources/culturalcompetence/cultcompmhservices.pdf	Best practices for teachers and school personnel in navigating culturally competent mental health services in schools.	School Personnel
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community	The Joint Commission	http://www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf	A compilation of strategies, best practice examples, resources, and testimonials designed to help hospitals in their efforts to improve communication and provide more patient-centered care to their LGBT patients.	Mental Health Providers

Name of Resource	Organization	Source	Summary	Audience
A Pastoral Education Guide: Responding to the Mental Health Needs of Multicultural Faith Communities	New York State Office of Mental Health, The Nathan Kline Institute for Psychiatric Research, Center of Excellence in Culturally Competent Mental Health	http://ssrdqst.rfmh.org/cecc/sites/ssrdqst.rfmh.org.cecc/UserFiles/	This guide describes four pathways to respond to the different mental health care needs in multicultural faith communities.	Child-Serving Government Agencies Mental Health Providers School Personnel
Keeping the Faith	National Center for Cultural Competence, Georgetown University Center for Child and Human Development, Georgetown University Medical Center	http://nccc.georgetown.edu/documents/SIDS_california.pdf	This promising practice program exemplifies key values of culturally competent health promotion that can inform the referral process.	Mental Health Providers
Innovative Self-Assessment and Strategic Planning: Addressing Health Disparities in Contra Costa County	National Center for Cultural Competence, Georgetown University Center for Child and Human Development	http://nccc.georgetown.edu/documents/Contra%20Costa.pdf	These promising practices and procedures are congruent with frameworks and models of cultural and linguistic competence and can inform the referral process.	Mental Health Providers
Latino Network: A Natural Fit in a Community-Driven Model Westchester County Community Network	National Center for Cultural Competence, Georgetown University Center for Child and Human Development	http://nccc.georgetown.edu/documents/Westchester.pdf	This promising practice demonstrates guiding values and principles of community engagement and family involvement in the Latino community to inform the referral process.	Mental Health Providers
Guides for Effective Use of Resources (Interpreters, Translators, Cultural Brokers, etc.)				
INTERPRET Tool: Working with Interpreters in Clinical Settings	Think Cultural Health, Office of Minority Health, US Department of Health and Human Services	https://www.thinkculturalhealth.hhs.gov/Content/communication_tools.asp	A concise guide for health providers working with interpreters.	Mental Health Providers
Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs	National Center for Cultural Competence, Georgetown University Center for Child and Human Development, Georgetown University Medical Center	http://culturalbroker.info	A guide to cultural brokering as a key approach to increase access to and enhance delivery of culturally competent care.	Child-Serving Government Agencies Mental Health Providers School Personnel

Name of Resource	Organization	Source	Summary	Audience
Provider Training	National Latino Behavioral Health Association, National Asian American Pacific Islander Mental Health Association	http://www.nlbha.org/index.php/programs/mental-health-interpreter-training/19-programs-and-initiatives/mhit/32-provider-training	In-person training on fundamental principles of using interpreters for providers in mental health settings.	Mental Health Providers
Mental Health Interpreter Training	National Latino Behavioral Health Association, National Asian American Pacific Islander Mental Health Association	http://www.nlbha.org/index.php/programs/mental-health-interpreter-training	Training services for interpreters in mental health settings.	Mental Health Providers
Multicultural Health Care: A Quality Improvement Guide	National Committee for Quality Assurance	http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_toolkit.pdf	Best practices for implementing CLAS standards.	Child-Serving Government Agencies Mental Health Providers
Cultural And Linguistic Competence Tools for Serving Specific Populations				
Screening and Assessing Immigrant and Refugee Youth in School-Based Mental Health Programs	Center for Health and Health Care in Schools	http://www.rwjf.org/en/library/research/2008/05/screening-and-assessing-immigrant-and-refugee-youth-in-school-ba.html	An overview of screening, identification, and assessment tools and processes that can be used by practitioners who care for immigrant and refugee youth.	Child-Serving Government Agencies Mental Health Providers School Personnel

Tool 4.3. *Facilitating a Referral for Mental Health Services for Students*

Facilitating a referral for mental health services involves helping families understand the value of engaging in these services and matching them with the best available provider to ensure a good fit. When school staff take intentional steps to facilitate a referral, families are more likely to accept, participate, and benefit from services.

Considerations When Making Child and Family Referrals to Mental Health Providers
Families may be hesitant to move forward with a referral for various reasons, including existing stigma surrounding mental health, strong cultural beliefs about how mental health issues should be handled, concerns about how to pay for services, and transportation challenges. Any referral process should include strategies to help address economic, logistic, and cultural considerations. School staff can help facilitate an effective referral by addressing the following elements of the process.

Preparing for the Referral
A. Identify the most appropriate school personnel to facilitate the referral process. Consider which school staff member has the:

- best relationship with the family. If a trusted school staff member, such as a family advocate or teacher, recommends that the family meet with a mental health provider, a family may be more likely to accept the recommendation.
- deepest understanding and respect of the family's culture, beliefs, and values. When the referring agent understands the family's culture, he or she can link the family with a mental health provider who best matches the family's unique needs and qualities. Families are more likely to actively participate in services that reflect their values, culture, and preferences.

B. Ensure that school personnel and teachers have knowledge of the mental health services available in the local community, including information about who offers services, the cost for services, and what type of services are offered (e.g., family therapy, child or parent therapy, groups for domestic violence, substance abuse services, child play therapy, etc.). School personnel and teachers can expand their knowledge by exploring the following sources of potential recommendations:

- School mental health consultant
- Staff at the local community mental health center
- The state children's mental health director
- The liaison to the state chapter of licensed psychologists
- The Individuals With Disabilities Act (IDEA) Part C or 619 coordinator
- Department leaders at university schools of social work, child psychiatry, psychology, and special education

C. Engage the family in a discussion about the benefits of mental health services and what type of mental health provider might match their needs best, including the potential style of a therapist or identified cultural factors. Help families address relevant barriers, including:

- the cost of services,
- transportation barriers,
- cultural and linguistic competence of the mental health professional (e.g., ensuring that the mental health professional speaks the family's primary language),
- fear of losing other services already in place, and
- stigma or unpleasant past experiences with mental health services.

Taking the first step in accessing treatment can be uncomfortable for some families. A number of families have never had experience with mental health services and are unsure of what to expect. Others may have had past experiences with mental health providers or other service providers that were unpleasant. It may be helpful to ask families before their first visit with the mental health provider about their prior experiences, concerns, or worries about the referral and take time to thoroughly address them.

Facilitating the Process Once the Referral Has Been Made

Once the referral has been made, school staff has an opportunity to help families navigate what can sometimes be a confusing and overwhelming process. A family's difficulty in following through with a referral can often be influenced by multiple issues, such as having to wait a long time for their appointment, meeting with a provider who isn't prepared, having expectations that don't match how the first meeting was handled, etc. School staff can be intentional about their support to families to help ensure they get access to these critical services.

School staff can take the following actions to help families have a smooth and successful experience:

- Come to an agreement with the family about the reason for referral.
- It is best not to assume everyone agrees why a referral is being made unless a clear conversation has occurred. Having a dialogue that includes the family's views and expectations before contacting the mental health provider will lessen any confusion and concerns as the referral progresses.
- Call the mental health provider ahead of time to let them know a referral is coming.
- Work with the family to help them understand the protocols and limits of confidentiality. Explain that calling ahead allows the mental health provider to be aware and ready for a referral, but does not allow the school staff and provider to share private information about the family unless prior consent has been received.
- Request consent to release information only if doing so will not jeopardize the referral. Having prior consent to share information can allow for less repetition of questions when the family engages in the initial paperwork and information session (i.e., intake) to begin services.
- Discuss with the family how the initial referral might go. School staff should be aware of the differences in referral processes across mental health service providers so they can best prepare families. For example, referrals may work differently between a large community mental health organization and a private practitioner in a single office. ("First you call the community mental health center, and then you can ask for Ms. Jones. She will ask you some questions to begin the process.")
- Offer to be close by when the first call is made to answer any questions.
- This may provide support to some families, but others may want privacy or independence. Be sure to have private space available if the family is making the call from the school.
- Offer to accompany the family on their first visit to the mental health provider to give support and to answer any additional questions that come up.
- School staff can ask families how they can be supportive. For example, the school staff might drive them to the appointment and wait in the waiting room, or staff might meet the family at the center to help them check in and then spend time after the appointment reflecting on what happened.
- Assign one person to check in on how things are progressing by phone or in person. This ensures barriers to service and solutions are identified early on. School staff can ask families how they can followed up with them. Often, families will want to continue communicating in ways that have already been established. For example, if you chat for a few minutes each week with a parent about their child's experiences in the classroom, this might be a good time to check in on how services are progressing. ("Why don't I check in on how it's going with Dr. Keller when we talk on Friday, does that work for you?")

Checklist Items for Facilitating the Referral Process for Children and Families

I have...

- identified the appropriate school personnel to talk with the family about the referral.
- reached agreement with the family on the reason for referral.
- identified mental health service providers that treat the specified needs of the child or family and know about their:
    - cost
    - availability (wait list, hours of service)
    - location/bus route
    - array of service options
- asked the family about possible barriers (cost, transportation, hours available to attend treatment).
- discussed family concerns or worries about the referral.

- discussed and received signed consent from the family to share agreed-upon information with the mental health provider.
- contacted the mental health provider to let them know a referral is coming and shared necessary information (with family consent), such as reason for referral, background and history, strengths and culture of the family, and any known barriers.
- sent any necessary documentation to the mental health provider before the family's first visit.
- followed up with the mental health provider to be sure the information was received and reviewed.
- asked the family what kind of support I might provide them, such as being close by when they make their first appointment and going to the first appointment with them.
- established a follow-up plan for the family and designated someone who can keep in contact with the family, help to organize services, and answer questions that arise.

School staff can help create a coordinated system of care that meets the needs of children and families. Referrals to mental health services are an important part of the continuum of mental health services. When school personnel are intentional about referral processes, it can lead to consistent access to and use of services that help to identify, treat, and reduce the effects of mental illness for many families and their children.

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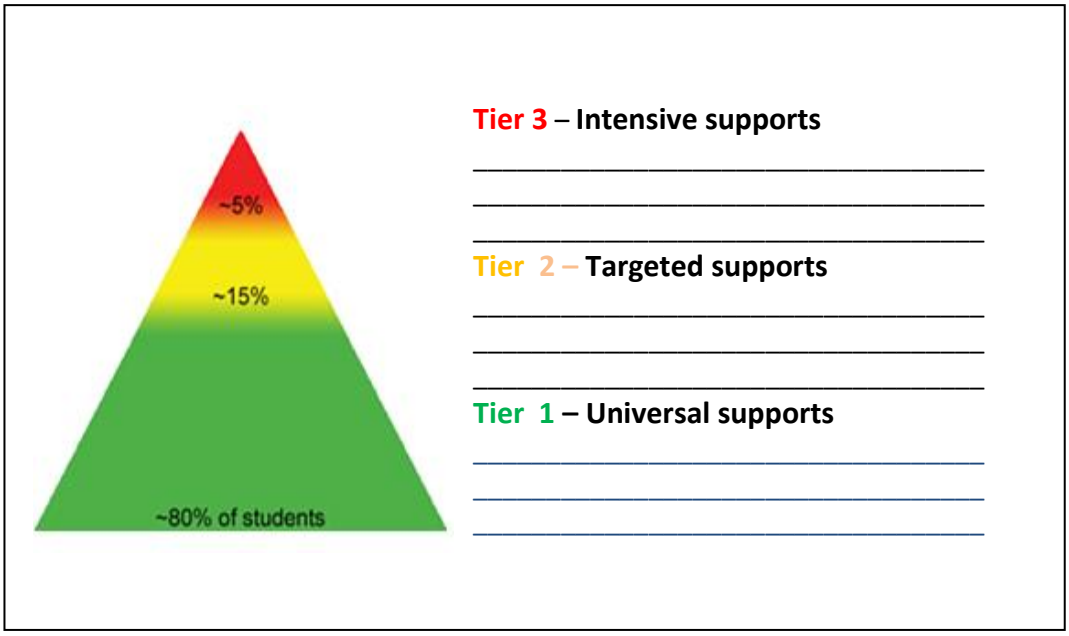
TAB # 5

Resource Mapping in Schools and School Districts: A Resource Guide



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Developed for the Maryland Safe and Supportive Schools Grant
By the Center for School Mental Health
October 2014

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Resource Mapping for Schools and School Districts: A Resource Guide

Introduction

In the wake of No Child Left Behind and subsequent high-stakes testing, schools are increasingly focused on instructional content and its' effective delivery as a way to promote achievement and success for all students. While a focus on academics is important to advance student success, addressing non-academic barriers to learning is also critical. There are likely to be several students in each classroom that have impairments that impede their own and other students' learning and if not addressed can worsen and can impact student success for the individual student and the larger classroom of students.

> ***Consider:*** *Nearly 20% of students experience mild mental health concerns that impair their functioning at home, school and/or in the community, while 10% have severe concerns that significantly impair their functioning.*

In addressing the full array of student needs, schools have access to a wide variety of national-, state-, district-, and school-run programs and resources that can begin to help address the wide array of individual and family needs that can interfere with optimal learning. Most schools and school districts have developed at least some partnerships with and regularly make referrals to an array of organizations and programs that can complement educational supports in the school setting to better meet the needs of the whole child. There are a wide range of resources and supports that can be helpful to students and their families. Some examples of specific categories of resources are listed below.

Examples of the type of resource categories that can be available in schools and/or the larger community include:				
Crisis Hotlines	***Support Groups***	***Housing Resources***	***Food Resources***	***Recreation Programming***
Mentoring	***Group Therapy***	***Individual & Family Therapy***	***Inpatient Programs***	***Day Treatment Programs***
Outpatient Mental Health Services	***After School Care Programming***	***School-Based Mental Health Services***	***Tutoring***	***Enrichment Activities***
Mobile Crisis Teams	***Hospitals***	***Urgent Care Facilities***	***Emergency Room Departments***	***Advocacy Programs***

Ideally, the types of supports and resources that are available offer a compliment of educational and social/emotional/behavioral resources. Yet, with the many demands within a

school setting, it is common for schools and school districts to have not strategically mapped and have a clear listing of the comprehensive array of school-based and community supports available for their students and families.

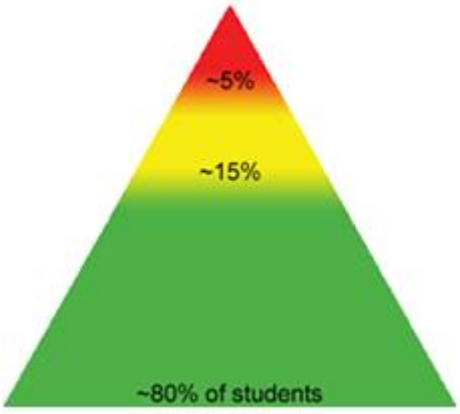
This can happen for several reasons:

- **With everyone being so busy, school staff has not taken the time to share the resources that they are aware of with one another.**
- Many times the decision to use a given resource was made related to a particular funding stream, mandate, or as a reaction to a particular incident rather than as part of a systematic mapping process.
- Awareness of a given program may be limited to a school or a small subset of individuals within a school-- even when services may be available to the larger community.

Over time, it becomes easy to lose track of all the supports and resources that are available, who can access them, how they can be accessed, and the reasons that they are offered. Lack of awareness of and coordination of resources can **lead to significant gaps in care, as well as to unintended duplication of services.**

Resource mapping offers a strategy that can help schools/districts to view the larger picture of supports and resources that are available to its students and families. Mapping can offer a visual picture of services /programs and can provide detailed information on who can refer and how to access the supports and resources. The mapping or listing process can also help in the process of identifying gaps in care and to help inform new outreach and funding opportunities.

Many schools rely on a multi-tiered framework of support to address the interconnected academic and behavioral health needs of students. An essential component of this three-tiered framework is being proactive by providing students with necessary foundational knowledge and skills that can promote well-being and student success. This same framework can be used to address behavioral health and other basic human needs. **As part of the resource mapping process, resources can be categorized across a three-tiered system of support:**



Level 3 – **Intensive** supports that are individualized to meet the unique needs of each student who is already displaying a particular concern or problem

Level 2 – **Targeted** supports that are provided for groups of students who have been identified as being at risk for a given concern or problem. When problems are identified early and supports put in place, positive youth development is promoted and problems can be eliminated or reduced.

Level 1 – **Universal** supports that all students receive. A strong **foundation in promoting wellness and positive life skills can prevent or reduce** concerns or problems from developing.

Resource Mapping Definition

It is essential to be in agreement as to what is meant by the term "resource mapping" and what specific components of resource mapping are important for a given school or school district. Resource mapping is often referred to as **"asset mapping"** or **"environmental scanning."**

> ***A Definition:*** *Resource mapping is a* ***system-building process*** *historically utilized by communities, organizations, schools, and service centers to align resources, strategies, and outcomes available (Crane & Mooney, 2005).*

Resource mapping offers a **method to link regional, community, and school resources** with an agreed upon vision, organizational goals, specific strategies for addressing problems, and expected outcomes so that youth and families have access to the full array of services that they need.

Graphically mapping resources helps to better organize the heterogeneous resources and assets that are available within a larger system into a standardized, understandable, and centralized format.

As a result of resource mapping, community partners, school staff, families, and youth have more flexibility, autonomy, choice, and a better understanding of the resources and services that are available within a school and the larger community.

Why Resource Mapping for Schools?

A key goal of resource mapping is to ensure that all staff is aware of what resources are available within the school and community and for there to be clear systems of who can make referrals, how referrals will be made, and a plan to follow-up to determine the success of the referral. Resource mapping identifies school and community assets, providing more specific details about the resources/services that are available within the school, neighborhoods, larger community, and State. When resource mapping is done well, there is a systematic process that can match available resources with student and family needs. **Successful resource mapping offers a clearer understanding of how to link to services and programs that can address child, adolescent, and family needs that may be interfering with student achievement.**

> **Consider:** *When communication, coordination, and collaboration exists across education and nonacademic supports, available services and resources can be used to their fullest extent.*

Resource mapping can also help to improve existing school-community partnerships. Many schools have partnerships with outside agencies and community members – but may lack true coordination and collaboration to insure integrated care. For instance, when school-based mental health staff communicates and collaborates with classroom teachers there are better

outcomes for students than when school-based mental health staff simply sees youth for 30 minutes in the school setting in isolation from teachers and school staff in the treatment process.

In addition, **resource mapping increases youth, family, and staff awareness of the many resources available within their building or community.** Even when they may know of given resources, they may not know how to actually access the resource and which resource would be the best to address the needs of an individual student or family. Developing a comprehensive mapping process and corresponding resource directory that is regularly updated and informed by diverse and informed stakeholders can allow for improved access to care and match to services and resources for youth and families.

Resource Mapping in Your School

Consider for a moment why it is important for your team to undertake a resource mapping process to document school and community-based resources. List three reasons below as to why this is an important endeavor for *your* team to devote time and energy towards.

1. _____

2. _____

3. _____

Take a moment to see how your responses are similar and/or different from the responses generated below. **Resource mapping assists school teams in the following areas:**

1. Helps to document the broad array of resources that are truly accessible within a given school or within the larger community
2. Aids in the identification of new or additional resources to sustain existing initiatives, as well as gaps in support.
3. Illustrates what resources are available across a multi-tiered system of support in an effort to document and build capacity for a more comprehensive system of care.
4. Broadens the number of individual staff in a school who is aware of the diverse array of resources in the school and community.

Consider: *In conducting resource mapping activities with teams of stakeholders, it is common to hear statements like – "I never knew about that resource, even though I have worked here for years." "With resources coming and going due to funding, it is too much for one person to keep track of."*

Resource mapping and your staff

Often within a school building there may be an individual or a small group of individuals who are knowledgeable of the vast array of resources within the school and larger community. This may include school psychologists, social workers, counselors, nurses, parent volunteers, educators, learning support specialists, and administrators. The challenge is when a resource is needed in the moment and one of these individuals is not available because they are absent that day or busy attending to another student in need

Working as a team increases the likelihood that a broader array of resources will be identified and included in the resource listing. Awareness of available and appropriate resources by all school staff increases the likelihood that referrals will actually be provided to families when a student has a specific need. Brainstorming a list of resources across a larger group of individuals will likely result in an increased number of resources and programs that are identified and a lower likelihood of inadvertent oversight of helpful programs and resources that could address key student and family needs

Resource mapping and your students

Many students who come to school each day may not be ready to learn. Expecting students to be able to leave their challenges at the school door each day is not a realistic expectation. School-based staff needs to be prepared to address the variety of issues that may interfere with a student's ability to effectively learn in the classroom. While school staff have tremendous talent and capability, it is essential for there to be collaboration with community resources and programs that cross over child-serving agencies (e.g., education, health, mental health, juvenile services, social services) so that there is necessary staff capacity and the fiscal means available so that the needs of the whole child are addressed.

Consider: Do your students have all of their needs addressed?

- ✓ **Basic Human Needs:** Food, shelter, clothing, safety
- ✓ **Physical Needs:** Asthma care, medical insurance, treatment for acute or chronic illness
- ✓ **Behavioral Health Needs:** Treatment for anxiety, depression, ADHD, social skills
- ✓ **Love and Relationships:** Friendship, Family
- ✓ **Esteem:** Self-esteem and esteem from others
- ✓ **Meaningful Activities and Involvement with others:** Recreation, sports, arts, religious
- ✓ **Intellectual:** academic, enrichment

When a particular need is identified, think about the corresponding resources and services that would help to address that particular need. For example—for basic human needs, the resource list could contain a list of food banks and kitchens, housing resources including shelters and resources for homeless students, and clothing banks.

Benefits of Resource Mapping

Schools are increasingly called upon to collaborate across multiple agencies (e.g., health, juvenile services, social services, behavioral health) and programs. A clear understanding of what services are being provided by each agency/program helps to reduce duplication and poor utilization of services. Having a systematic process that helps individuals to better understand more specific details about the type of service that is offered and how and when it can be accessed in and of itself can help to improve student follow-through with services and coordination of care.

School and district-wide resource mapping offers a systematic process to:

- Identify all available resources/programs in the school and surrounding community
- Recognize gaps in services/resources that can inform strategic planning and outreach
- Better understand program requirements to access services (e.g., insurance, hours of operation, eligibility)
- Avoid duplication of services and valuable resources
- Better match service needs with available resources/programs
- Increase awareness of underutilized partnerships/resources
- Cultivate relationships with new programs/resources that can address gaps in care

Resource Mapping Steps

To get started, three essential steps to resource mapping for schools will be presented and described.

Steps to Resource Mapping

Step	Stage	Description
1	Pre-Mapping	Establishes a clear vision, defined goals, and productive collaboration for the mapping process. Come to a consensus on what will be mapped and what will be the process and infrastructure for mapping
2	Mapping	Identification of and actual mapping of resources available to students and families both in and outside of the school;
3	Maintaining, sustaining, & evaluating mapping	Analysis of strengths, challenges, and gaps in resources, services, and programs. Develop system to monitor the follow-through with referrals and the success of referrals that are made to inform future referrals;

Step 1: Pre-Mapping

The pre-mapping step allows stakeholders to lay the foundation for a productive collaboration and to establish a clear vision and defined goals for building a system of care. Mapping can occur at the school level to identify school-based resources, but in terms of mapping community resources, it may be beneficial to conduct resource mapping at the district level so that a larger group is informing the identification of potential resources that youth and families can access.

Who is the resource guide intended for?

Your decision of who the resource guide is intended for can influence the type of resources that you include, what information you provide, the extent to which definitions of terms within the manual are included, and how the resources are intended to be used. Use this checklist below to identify who might use your resource guide.

- ❑ Administrative staff
- ❑ Teachers
- ❑ School nurse
- ❑ Behavioral health professionals
- ❑ Families
- ❑ Students and Youth
- ❑ Other: _____
- ❑ Other: _____

Who should inform the mapping process?

In an effort to complete a comprehensive mapping process, it is essential for the process to not just involve a few individuals from the same stakeholder group. Stakeholders who participate in this process should be comprised of a diverse group of individuals who are representative of the community and understand its needs and challenges and who have a grasp of some of the resources that are available within the school and community. If you decide to include a particular group as the intended recipient of the information, make sure to ask individuals from that group what information they would want to have included in a resource guide. This will increase the likelihood that the information you include is comprehensive and that the resource will actually be used.

Does a template of a mapping process (e.g., resource directory, resource map) already exist?

Schools often have pre-existing lists of programs that identify many of the resources available within your community. Don't be afraid to build upon these efforts! Take the time to ask individuals on your team if they are aware of resource maps and directories that exist for either your school and/or the larger community. Having some of this information already available can help reduce the time it takes to complete a comprehensive resource mapping process. If you are using a list that already exists, make sure to find out the date it was created and how if at all it has been updated since its inception,

> **Tip:** *Don't reinvent the wheel! Build upon resource mapping efforts that may already be in existence within your community.*

If a mapping or resource directory exists, review it with your team and decide how it can best be used. Some good questions to ask if a current resource directory is available include:

- ✓ Does the resource directory offer a good foundation to add other resources to?
- ✓ Do you like the format of the resource directory or would another format be more helpful?
- ✓ Can the information in the directory be used to help populate a new mapping or directory process that is developed?
- ✓ If there are multiple resources, what are the best components from each?

Tip: *Be realistic about whether your team has the capacity to identify and maintain a directory that extends beyond the school building.*

What do you actually want to map?

When thinking about setting goals for the mapping process, it is important to ask questions. Use the reflection template below to set your goals.

What do you want to map?

While it can be helpful to have a resource directory that includes a broad array of resources and programs, it is also important to be realistic about whether your team has the capacity to find out about and maintain a directory that extends beyond the school building. Use these reflection questions to help guide the process.

What kind of resources do you want to map?

Do you just want to know what is available in the school building, or do you want to know what else is available within the community?

Reflect: _____

What is the scope of your mapping project?

If you are including community resources that are available outside of the school building, how broadly are you reaching out (e.g., neighborhood, community, district, State, national)?

Reflect: _____

Are you limiting the inclusion of programs/services to a given distance (e.g., within 5 miles, 10 miles)?

Reflect: _____

Are you interested in mapping resources across the full three-tiered framework or just the top tier?

Reflect: _____

What other guidelines do you want to place on your team's mapping process?

How does actual data inform the resources that you are mapping?

To better understand the resource needs of students within a given school or district, it can also be helpful to turn to school level and district data. Local data can highlight student challenges and strengths, and helps to more effectively match student needs with available services and resources.

Think about all the data sources you have in the school and if you can use these to help determine the most pressing student needs and potential gaps in services.

What kinds of data would be most useful for your school?

- ❑ Records of office referrals
- ❑ Expulsion and suspension rates
- ❑ Attendance and truancy records
- ❑ Nursing/Counselor logs
- ❑ Crisis referrals
- ❑ Emergency petitions
- ❑ Teacher Ratings of Student Behavior/Effort
- ❑ School Climate and Behavioral Surveys (YRBS)
- ❑ Minor incident reports
- ❑ Homework completion rates
- ❑ School test scores
- ❑ Demographic data for the school or district (e.g., income, free and reduced lunch, homelessness rates)

List other useful data here that could help inform student and family needs:

_____

_____

_____

Identify your stakeholder team

Convene a team of stakeholders in your school/community that can work together to identify other critical questions to help guide your resource mapping process. Asking key stakeholders about the most pressing needs of the students helps inform what resources would be the most helpful within the school. Seeking input can also begin the process of identifying which referrals can be made in the community.

Some examples of important collaborators that may be a part of your school resource mapping team include: youth, caregivers, educators, school administrators, school social workers, school psychologists, school counselors, and staff from outpatient programs, juvenile justice programs, recreational programs, social services and more.

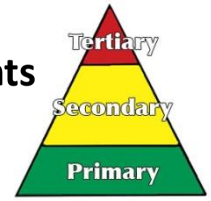
Use the table below to make a list of who should be on your mapping team. Some potential roles of individuals you may want to include on your team are listed in the table. Be sure to add names and other categories to this list.

Name	Role
	Administrator
	School-Based Community Provider
	PBIS Coordinator
	Family Member
	Youth
	School-Employed Behavioral Health Staff
	Community Health Provider

An activity to identify the most pressing needs is highlighted below. Consider conducting this activity with your stakeholder team.

Using the worksheet on the next page, please take a moment to identify the most pressing mental/behavioral health concerns in your school. Think about issues that are most relevant at each of the three tiers. What are the most pressing behavioral health issues that are impacting most students, some students, and just a few students?

The Most Pressing Mental Health/Behavioral Issues Impacting Students



TIER 3 **A Few Students** **(Intensive/Selective)**	**TIER 2** **Some Students** **(Targeted)**	**TIER 1** **All Students** **(Universal)**

What other information do you want to gather?

Once you have decided on the different resource categories, it is important to consider what information you would be interested in obtaining for each of the resources. Circle the information you'd like to include.

- ✓ name
- ✓ website
- ✓ address
- ✓ phone number/fax
- ✓ hours of services
- ✓ eligibility requirements
- ✓ accepted insurance/cost
- ✓ waitlists
- ✓ description of services
- ✓ key contact

Are there other information might be important for you to include?

Reflect: _____

What will it look like?

How will you actually be mapping/collating the information that you obtain?

What will your map look like? Will it be. . .

Electronic? Handwritten? Entered into a database? Written on a chart? Kept in a binder?

Who will have access to entering/updating the data? Where will the database be housed?

Who will have access to the final product?

These are all decisions that need to be made. When successful, your pre-mapping preparations can set up a system that allows for regular updating, broad access to the school staff, and other relevant stakeholders.

Step 2: Mapping

Your careful and deliberate pre-mapping process will set the foundation for successful mapping. Congratulations! It's now time to convene your team, to begin brainstorming about available staff, services and resources. This is where the fun begins. ☺

To get started, we have included a list of questions that school staff and other stakeholders have found useful as they begin the mapping process.

1. Review the categories identified in the pre-mapping process.
   - Are you in agreement about these categories?
   - Are there any modifications that you would like to make to the categories?
   - Are there additional categories that should be considered?
2. Reflect upon your potential resources
   - How will you know if a resource is a good one?
   - Is there additional information you would like to collect that will help to clarify the resource that is provided?
   - Are there categories that you would like to modify?
   - How do you know if students and families can access and use identified resources?
3. Plan for sustainability
   - What individual or team is going to take the lead in developing, updating, and maintaining a directory?
   - How will you update the list with new resources, or edit out old or ineffective ones?
   - How will you effectively follow-up on resources so that you know referrals were successful?

Brainstorm known staff and resources

In order to make appropriate referrals within and outside the school, you need to know who does what. As a beginning activity, make a list of colleagues in and outside of the school who are supporting student mental health and wellbeing.

Use the worksheet and example on the following pages to guide your efforts. This is a basic activity that can be done to gage and promote awareness of resources within and outside of the building. These charts can also be used to help inform a larger repository or directory, shared with relevant team members, and can begin the process of identifying services available in and outside the school building.

We have provided a template that is partially filled in to give you an example, but have also provided a blank template to be helpful. The template that would be best for your team to use will be dependent on where your team is in the process.

EXAMPLE

	Person/ Position	What do they do?	What days/times are they available?	Best way to reach them	Who can they serve
Inside the school	Mr. Oriole School Psychologist	Educational Testing, Meeting with Students who have Counseling Services on IEP, Leads School Improvement Team	Wednesdays and Fridays 8:00-3:00	Email moriole@gmail.com	All students, but required to meet all IEP requirements
	Ms. Raven School Social Worker	Lead Student Support Team, Manage Attendance Team, Meetings, Meets with Students with Counseling Servicers on IEP	M, T, W from 8:00-3:00	Extension 458	All students, but required to meet all IEP requirements
	Outpatient Success Services	School-based individual and group counseling	Monday and Thursdays from 8:00-5:00	Cell phone of clinician 410-838-4535	Students with clinical diagnosis and insurance with consent from parents
Outside the school	Boys and Girls Club	After school enrichment program	Monday-Friday 3:00-6:00	Phone - 410-456-4545, director@bgc.org	Students in grades 1-5 who have consent from families to be a part of the program

	Person/ Position	What do they do?	What days are they available?	Best way to reach them	Who can they serve?
Inside the school					
Outside the school					

Mapping existing resources at each tier

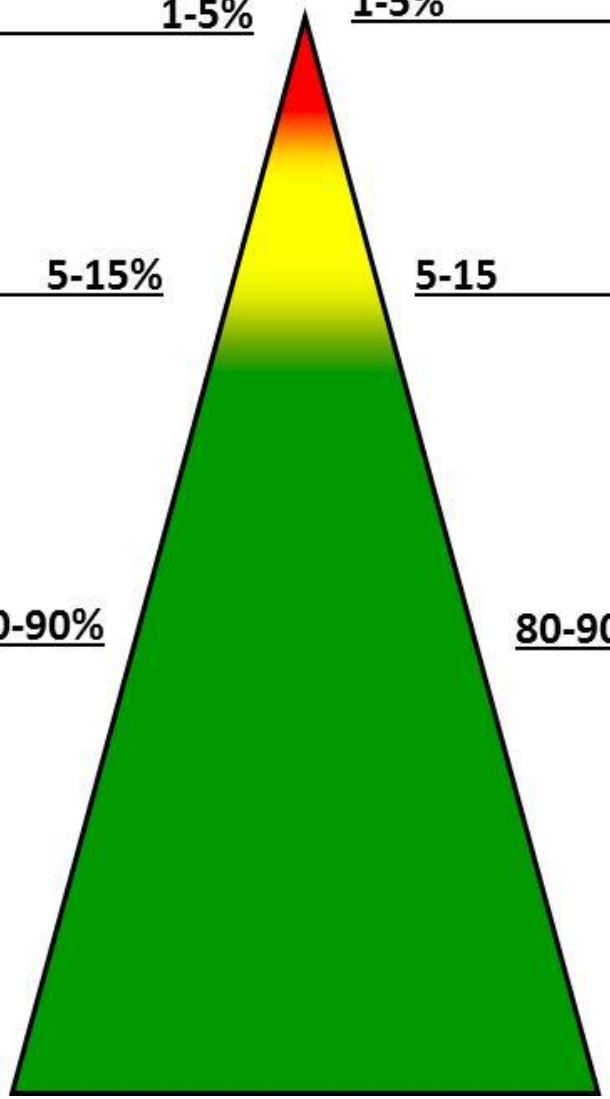
After identifying a list of colleagues and resources that are available in your school and community, it can be helpful to map these different resources and interventions at each tier to better understand areas where you may need to identify or build additional resources so that your school can better develop a multi-tiered system of support. Using the worksheet below, think about what resources/services you have access to for each of the three tiers.

Mapping: What services are already in place in the school and community? Use this next worksheet to help you to identify resources that are already being utilized in your school and community and organize them by tier.

What's in Place?

List some examples of . . .

School-Based Services/Resources		Community-Based Services/Resources	
Tier 3- Interventions for a Few	1-5%	1-5%	Tier 3-Interventions for a Few
Tier 2- Interventions for Some	5-15%	5-15	Tier 2- Interventions for Some
Tier 1- Interventions for All	80-90%	80-90%	Tier 1 – Interventions for All



Searching the Community and Developing a Directory

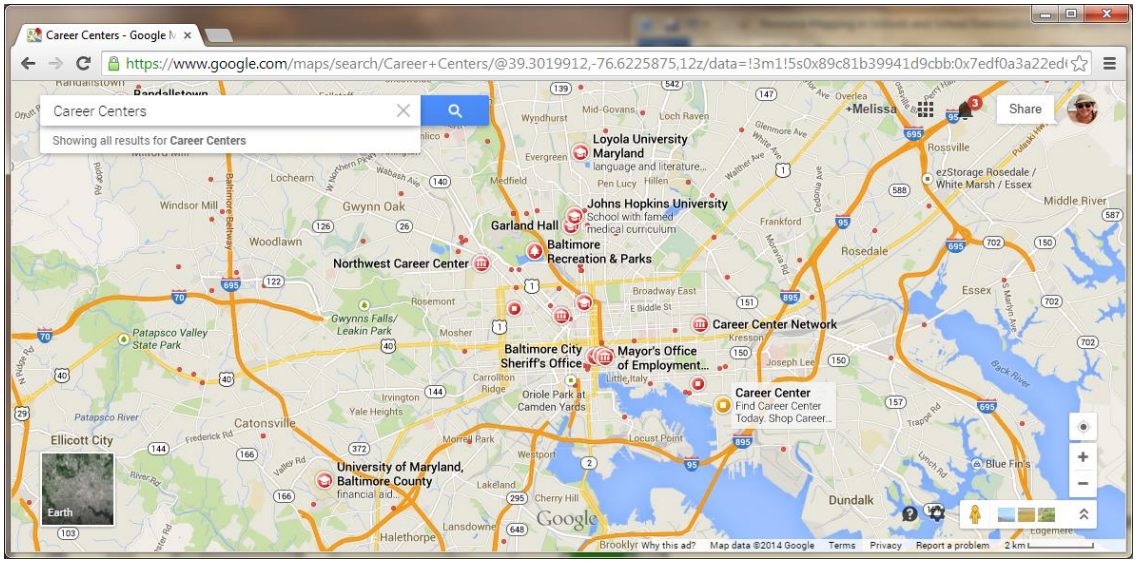
Make a listing of community resources that you are familiar with and have personal experience utilizing. You may also want to ask colleagues about resources that they know about that may be useful to refer students and families. Lastly, when you call a new referral source, also ask them about other resources that may be available in the community that they have found helpful when working with youth and families.

When trying to develop a list of available services and resources, assembling individuals with knowledge of the resources from within the school and the larger community can be a helpful process. Conducting some of the activities within the manual with cross-stakeholder teams can result in the identification of a broader array of services and resources.

Another strategy to initially identify available resources is to use the internet.

A simple web-based search can also be tremendously helpful! Below are some tips on some wyas to effectively conduct these searches.

1. Use search engine such as www.google.com
2. Click “Maps” at top of page and locate your neighborhood, city, or state
3. Click “Search maps” button
4. Click “Search nearby” and enter words related to the resource. For example, we searched for “Career Centers” in Baltimore.

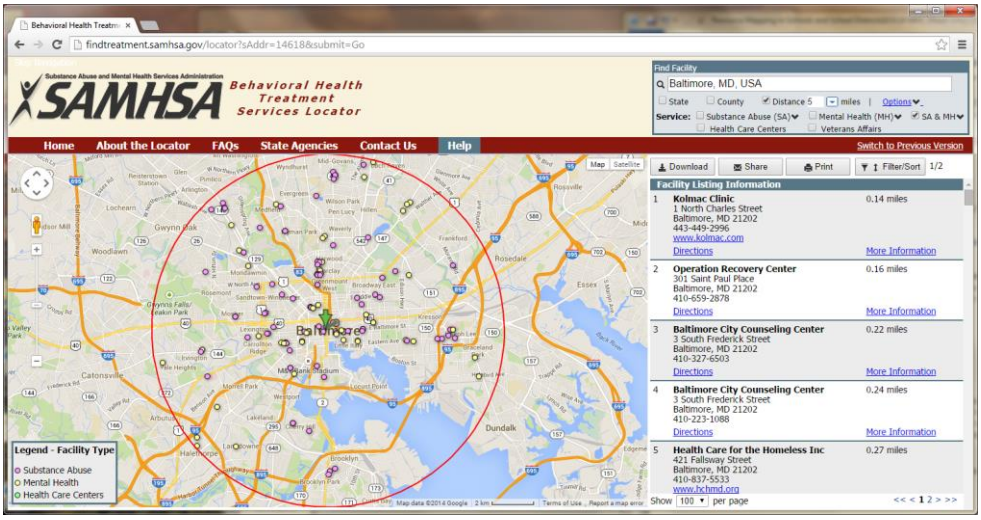


There are also a number of national databases that may aid in providing resources in your community.

The Behavioral Health Treatment Services Locator

http://findtreatment.samhsa.gov/

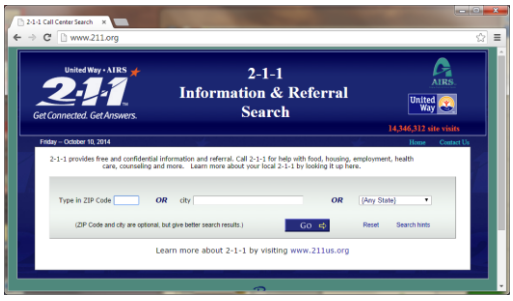
This online database was developed by SAMSHA's Center for Mental Health Services. It provides comprehensive information about mental health services and resources and is useful for professionals, consumers and their families, and the public. Information can be accessed by zip code and service setting.



211 United Way

http://www.211.org/

2-1-1 is an easy-to-remember phone number that links people to the health and human services they need. It is a confidential informational and referral service that is available 24 hours a day, seven days a week in 150 languages. 211 United Way uses a comprehensive database of more than 4,600 federal, state and local services — both government and nonprofit.



REMEMBER: *It is important that you always verify the information you find through searches by calling the program directly to confirm what services are available and how they can be accessed*

Community Resource Database in Practice

The next three forms can be used to help identify resources both in your school, and within your community.

Template for Searching the Community and Developing a Directory

This template is helpful for identifying the resources both in- and outside of your school. This form can be used for a variety of purposes, including:

- Note taking before entering into a database
- As a resource list to share in a school

Mental Health Program Resource Mapping Form

Many programs have barriers that make it difficult to access services, and it may be important to know additional information about hours, friendliness of staff, access to transportation, insurance/fees, bilingual services, etc. *Conducting site visits to find out more about organizations housing resources could help in this step of the process.*

This form can help you capture these details, and may be a useful appendix for your resource mapping project.

Resource Information Sheet

Once you've identified the resources available within your community, it's time to track them! Many schools use information sheets similar to the one listed to serve as the foundation of their resource directory.

These can be aggregated into many forms, including:

- A binder
- A word document or .pdf
- A packet to be sent home with staff, families, and students

Template for Searching the Community and Developing a Directory

On-Site Resources	School psychologists:	
	School counselors:	
	School mental health therapists:	
	School social workers:	
	IEP coordinators:	
	Department of Social Services liaisons:	
	University, community partner agencies:	
	Others:	

Community Resources	Mental health clinics:	
	Psychiatrists:	
	Social workers:	
	Addiction specialists:	
	Psychologists	
	Food banks:	
	Shelters:	
	Others:	

Mental Health Program Resource Mapping Form

Program Name	Program Location	Target Population	Program Focus	Eligibility Requirements	How to Enroll

Resource Information Sheet

Name of Organization: Key Contact at the Organization:	
Phone Number:	Address:
Hours of Operation:	Website:
Insurances Accepted:	
Near Public Transportation:	
Bilingual Staff Available (if yes, languages)	
Associated Fees (if applicable):	
Description of Services Provided:	

Step 3: Maintaining, Sustaining, and Evaluating Mapping Efforts

The final step in resource mapping is to ensure that you are maintaining, sustaining and evaluating your mapping efforts. One time mapping isn't enough! Resources change over time and it is important to know whether the available resources are working well for your school community. The following steps are important to ensure ongoing quality resources are available for students and families.

1. Identify your resource mapping evaluation needs

Coordinating Services between the School and Community

- There is more to the resource mapping process than points on a resource map or pages in a directory! Mapping resources can inform the team as to where there are gaps in care and can help with prioritizing outreach to programs and services to help address these gaps. In addition, this coordination and communication can improve partnerships between schools and community agencies. Most importantly, it can help ensure that students in need are connected with the appropriate services and resources to help address particular needs in an effort to improve student outcomes.

- **Identify your resource mapping evaluation strategies**
    - Determine how you will evaluate whether you have identified resources to address the needs that have been identified
    - Once referrals are made, how will you monitor whether families are following through with and whether they are satisfied with the services.
    - How will you be able to integrate feedback from school-based staff and community partners on the comprehensiveness of a directory and feedback on individual resources that are accessed?

- **Identify who will evaluate the mapping**
    - What group of individuals within a school (best not to leave to just one person) will help to identify resource mapping successes, challenges, and areas for improvement?
    - What will be the process for effecting change based on the feedback that is provided
    - How often and in what way will the mapping process itself be evaluated?

- **Identifying how information will be collected to help evaluate the success of the mapping process**
    - Brief Questionnaires and focus groups can both help to clarify what is currently being done, whether it is being done well, and what else is desired related to

mapping of school and community resources. Yearly or every other year surveys and focus groups can help inform the advancement of a resource mapping process and product.

Key Questions to Ask Your Team

How is input about the quality of service going to be collected?

How can identified resources be improved or strengthened? Are there any programs that are not effective and should not be included as a potential resource to refer to?

How can students, parents, and teachers evaluate the strengths and ongoing needs of the community or school? Is there a self-study questionnaire that might be useful?

What gaps were identified, and which needs are still not being met? What are the priorities for addressing these needs?

Do you want a more sophisticated system that can keep track of success with referrals and actual follow through with accessing services?

Measuring Outcomes

The following factors are essential to understanding whether the resource mapping process worked well for your community.

- **Impact**
  - Evaluate whether the resource mapping goals were achieved
  - Evaluate whether unmet needs were reduced
- **Satisfaction**
  - Evaluate whether multiple stakeholders, including staff/providers and student/families are satisfied with the mapping efforts. Do they feel more confident that they have access to referral options, including services, programs, and informational resources
- **Function**
  - Consider the following questions when evaluating the functionality of your resource mapping.
    - How easy is it for school-based staff to access resource information?
    - What is the ease with which youth and families access resources?
    - Is communication enhanced among providers?

Use the worksheet on the next page to evaluate the results of your mapping process.

Evaluating the Mapping Process

While it can be helpful to have a resource directory that includes a broad array of resources and programs, it is also important to have a process for evaluating your efforts and to know if there are resources that you should prioritize related to their quality. Use the reflection questions below to guide this process.

How easy is it for school-based staff to access the resource information?

Reflect:

Is the information readily available, even when staff isn't directly at work? Is there a better place for housing the directory?

Reflect:

Did the resource mapping process help to facilitate coordination and communication across agencies and programs?

Reflect:

What new contacts or programs did you learn about as a result of the resource mapping?

Reflect:

Did your team's resource process help you gage the efficacy of the individual resources?

Reflect:

Did the resource directory make it easier to help youth and families connect to resources?

Reflect:

Were the overall goals of your school/district's resource mapping process achieved?

Reflect:

How would you improve the resource mapping process?

Reflect:

SCHOOL DISTRICT MENTAL HEALTH PROFILE | JEFFERSON UNIFIED SCHOOL DISTRICT

Last Updated: October 14, 2016

Understanding this Summary.

This report is generated based on the information you provided for your School District Mental Health Profile.

This profile provides a snapshot of the structure and operations of your school district's comprehensive school mental health system.

Number of schools in your district:

120

Number of students in grades K-12:

137,000

Grades served:

K-12

About Your School District Mental Health Report

Congratulations! Your district's team has been counted in the National School Mental Health Census and achieved Bronze SHAPE recognition for completing the School Mental Health Profile. Complete the National School Mental Health Performance Measures on SHAPE (the Quality and Sustainability Assessments) to achieve Silver and Gold SHAPE Recognition.

Schools and districts who register with SHAPE aspire toward having strong school-community-family partnerships that provide a multi-tiered continuum of evidence-based mental health services to support students, families, and the school community.

To learn more about this team's SHAPE account, inquire about being added as a team member, and/or join them in their quality improvement and sustainability efforts, contact the team leader.

To register a new school or district with SHAPE, please visit: https://theshapesystem.com/register.

Last Updated: October 14, 2016

DATA COLLECTION AND USE					
Data Point	**Data Collected**	**Identify Students for Mental Health Risk**	**Match/Triage Students to SMH Service Delivery**	**Track Individual Student Progress in SMH Interventions**	**Monitor/Evaluate SMH System Outcomes**
Attendance	✔	✔	✔	✔	✔
Grades	✔		✔	✔	✔
Office discipline referrals	✔	✔	✔		
Out of school suspensions	✔	✔			
Mental health functioning	✔			✔	✔
School climate	✔	✔			✔

Last Updated: October 14, 2016

SERVICE COMPONENTS	
Comprehensive School Mental Health System Components	**Currently Included**
Universal mental health screening and assessment	✔
Universal mental health promotion services and supports at the school or grade level (Tier 1)	✔
Selective services and prevention supports to students identified as being at risk for mental health concerns (Tier 2)	✔
Indicated, individualized services and supports for students identified with mental health concerns (Tier 3)	✔
Evidence-based practices and programs (as identified in national evidence-based registries)	
Community partnerships to augment school mental health services and supports provided by the school system	✔
Quality improvement process used to understand and improve the comprehensive school mental health system	

SCHOOL DISTRICT STAFFING INFORMATION | JEFFERSON UNIFIED SCHOOL DISTRICT

Last Updated: October 14, 2016

STAFF MEMBER	SCHOOL School or school district employed		COMMUNITY Not school or school district employed (e.g., community mental health partner employed)	
	Number of Members	Total FTE	Number of Members	Total FTE
Behavioral Specialist	25	12.5	6	3
Community Behavioral Health Worker	10	8	38	38
Community Mental Health Supervisor/Director	0	0	2	2
Family Support Partner (Family Member)	30	10	0	0
Nurse Practitioner	20	20	10	5
Psychiatrist	0	0	15	15
Psychologist	35	20	0	0
School Administrator (e.g., Principal, Assistant Principal)	120	120	0	0
School Counselor	55	55	0	0
School Guidance Counselor	89	89	0	0
School Nurse	111	111	0	0
School Psychologist	108	54	0	0
School Social Worker	120	60	0	0
Social Worker	0	0	21	7
Youth/Family Advocate	16	4	0	0

Last Updated: October 14, 2016

Your school district provided services and support to address the following student concerns at each tier:

Tier 3: Indicated services and supports

Tier 2: Selective services and supports

Tier 1: Mental health promotion services and supports

✚ : Referrals to community providers not in the school building

- Anxiety/Nervousness/Phobias
- Attention/Concentration/Hyperactivity Problems
- Bullying
- Depression/Sadness/Suicide
- ✚ Disordered Eating
- Environmental Stressors (housing, food, parental employment, access to health care, etc.)
- Grief/Loss/Bereavement
- Oppositional or conduct problems/Anger management
- ✚ Psychosis (hallucinations, delusions)
- Relationship issues/Conflict (family, peer, teacher)
- Social and emotional skills/Problem solving/Character development/Self-esteem
- Substance use (alcohol, tobacco, drugs)
- Transitions (new school, moving, separation/ divorce)
- Trauma/PTSD/Abuse/Neglect/Exposure to violence

TAB #6

SCHOOL MENTAL HEALTH SCREENING PLAYBOOK

Best Practices and Tips from the Field

CSMH

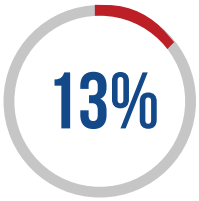
Center for School Mental Health

Background

Mental health screening is the assessment of students to determine whether they may be at risk for a mental health concern. Screening can be conducted using a systematic tool or process with an entire population, such as a school's student body, or a group of students, such as a classroom or grade level(s). This is different than using assessment measures with students who are already identified as being at-risk for or having mental health problems. However, using a systematic assessment process with referred or enrolled students is also best practice; you can use some of the information in this guide for initial evaluation or progress monitoring as well.

Importance of Screening

Mental health screening in schools is a foundational element of a comprehensive approach to behavioral health prevention, early identification, and intervention. Early recognition and treatment of mental health challenges leads to better outcomes for students. Given the high prevalence and recurrence of mental health disorders, and the availability of effective treatments, it is important to identify problems early and connect students to services and supports. Schools are a critical setting for screening, consistent with the public health framework to improve population health of all students and families.



In a recent schoolwide screening of middle school students using the Revised Child Anxiety and Depression Scale (RCADS), **13%** of students were identified as being high to moderate risk for a mental health concern and required follow up (Crocker & Bozek, 2017).

Purposes of Screening

- ✓ Identify students at risk for poor outcomes
- ✓ Identify students who may need monitoring or intervention (i.e., secondary or tertiary)
- ✓ Inform decisions about needed services
- ✓ Identify personal strengths/wellness as well as risk factors/emotional distress
- ✓ Assess effectiveness of universal social/emotional/behavioral curriculum

Screening tools or processes in schools may include:

- ✓ Reliable, valid screening measures
- ✓ Academic and behavioral indicators (e.g., attendance, grades, office discipline referrals)
- ✓ Teacher/Peer nominations

Number of individuals screened is the most common national behavioral health performance indicator. However, a quality improvement process also involves monitoring the number of students who were identified, triaged to, and received services and supports based on screening data. Review the Action Steps on the next page to get started.

A northeastern school district found through universal mental health screening that students who scored in the moderate to severe range for depression are absent 47% more often than the average student.

They also found that GPA was consistently lower for students who scored in the moderate to severe range on two different mental health screeners (Crocker & Bozek, 2017).

ACTION STEPS

Build a Foundation

Assemble a Team

Assemble a team of key family-school-community stakeholders that will plan and implement the screening process for your specific school or district.

Generate Buy-in and Support

Use strategies to market and promote your comprehensive school mental health system. See System Marketing and Promotion resources on The SHAPE System to help with this process.

- Utilize data and other strategies to justify mental health screening.
- Consider how mental health screening fits with other initiatives or goals in your school/district.
- Review how students are currently being identified for mental health services. Consider whether current practices may contribute to over- or under-identification of mental health problems.

Tips from the Field

ALIGN WITH KEY DECISION MAKER PRIORITIES

"We knew we had to have buy-in from key leadership in our district for mental health screening to be a success. Our superintendent is dedicated to early intervention work across initiatives in our district, so we made sure to highlight how universal mental health screening fits with this priority."

Clarify Goals

Identify Purpose and Outcomes

Decide how mental health screening will improve system issues and/or student outcomes at the grade, school, or district level.

Identify Resources and Logistics

Identify Student Mental Health Support Resources

Make sure you are familiar with in-school and community-based mental health services to refer students to who are identified via screening. See Needs Assessment and Resource Mapping resources on The SHAPE System to help with this process.

Create a Timeline

Create a timeline for executing the screening process including frequency of screening (e.g., once or multiple times per year).

Identify Staffing and Budget Resources

Identify resources necessary for execution including staffing and budget.

Develop Administration Policies

Develop policies and practices for administration including:

- Materials to share the screening process with staff, caregivers, students, and community members
- Consent procedures
- Data collection process (e.g. when/how/where will the screening take place, who will administer, what supports need to be in place to collect data)
- Follow up process for all students
- Administration timeline and checklist

Select an Appropriate Screening Tool

When selecting a screening tool(s), consider the following questions:

Is it reliable, valid, and evidence-based?	Is it free or can it be purchased for a reasonable cost?	How long does it take to administer and score?	Does it come with ready access to training and technical support for staff?	Does it screen for WHAT we want to know? (e.g. type of mental health risk, positive mental health and well-being, age range?)

Screening tools may include measures and rating scales administered to students, teachers, and/or parents; academic and behavioral data (e.g., attendance); and teacher/peer nominations.

RESOURCE SPOTLIGHT: The SHAPE System Screening and Assessment Library includes instruments appropriate for use in school mental health. Search for the screening or assessment tool that fits your school by focus area (academic, school climate, or social/emotional/behavioral), assessment purpose, student age, language, reporter, and cost. The CSMH team has carefully reviewed every measure to provide a brief summary of each with direct links to copies of the instrument and scoring information. https://theshapesystem.com

Determine Consent and Assent Processes

Schools and districts have found success using passive consent and opt-out procedures to garner parent consent and student assent for universal screening procedures. To successfully implement passive consent, consider the following strategies:

Deliver a consistent message

Deliver a consistent message about the purpose and importance of mental health screening in advance of all screenings. Schools are routinely involved in physical health screenings like eye exams to ensure students are ready to learn. It can help to explain the importance of mental health screening as a similar process, tied to learning.

Share information in multiple formats

Ensure all caregivers are aware of screening procedures by sharing the passive consent message in multiple formats, such as:

- automated phone calls to all families
- information on the school website
- written notification sent in the mail
- signs posted in the school building

Example Passive Consent and Opt-out:

"In an effort to promote the health and well-being of students in XX Public Schools, students will be periodically provided with questionnaires, surveys, and screeners that address issues related to mental health. The information gained will support the school's ability to provide comprehensive and timely support for your son or daughter if they require any assistance. Students can opt-out of filling out any questionnaire, survey, or screener that they are not interested in taking and you can opt-out your son or daughter at any time by contacting the Guidance Office of your son's/daughter's school or filling out the opt-out form here. A list of the questionnaires, surveys, and screeners is available below for you to review. We are committed to ensuring your son or daughter is supported academically, socially, and emotionally, and we look forward to partnering with each of you toward achieving this goal."

Develop Data Collection, Administration, and Follow Up Processes

Data collection

Develop screening data collection and progress monitoring systems.

- An **electronic format** for data collection, such as Google forms, allows students to complete screening data online and facilitates prompt analysis of results and follow up.

Administration

Determine what students will be screened and the process for screening.

- Who to screen: **Pilot screening procedures** with small groups of students (e.g. five students in one grade at one school) to test procedures before administering to an entire grade or school. Collect feedback from students, caregivers, and staff administering the pilot screening about the screening tool and process to inform screening procedure modifications.
- When to screen: **Consider using advisory or home room time to administer screenings.**
- Staff to support screening: Determine who will help to support the screening process. **Provide screening instruction scripts for staff** to read to students immediately prior to the screening administration and include procedures for any questions that arise during screening administration.

Tips from the Field

START SMALL

"By screening students in one homeroom in one middle school in our district we were able to really test out our procedures and gain valuable feedback. Starting small allowed us to make critical changes to our screening process before screening the entire grade and ultimately led to a very successful administration."

Follow up

Determine systematic process and data rules to follow up with students identified with different levels of risk for a mental health concern.

- Determine what scores/indicators will identify students who need immediate follow up (high risk – same day), prompt follow up (moderate risk – within the week), or non-urgent follow up (low risk – follow up to communicate negative findings).
- Determine what interventions will be implemented for students at different levels of risk (e.g., immediate crisis referral, referral to a school-based or community mental health provider, referral to early intervention/prevention group).

Tips from the Field

GET THE MESSAGE OUT

"We wanted to make sure that everyone in our district — parents, educators, administrators, students, mental health providers — knew that we would be administering the mental health screener to our sixth grade students, so we shared the message using all of our district communication networks including the district website, automated phone calls and print materials in multiple formats in our schools."

- Determine a plan to ensure mental health staff receive and analyze data the same day as the completed screening to ensure prompt follow up.
- **Ensure any students endorsing risk of harm to self or others receive immediate follow up (same day).**
- Determine a plan for following up with the parent/guardian of students with elevated scores and with negative results.
- Determine a plan for following up with school staff about screening and progress monitoring results.
- **Alert crisis teams and local community mental health providers to be on call in advance of screenings.**

Resources

Websites and Web-based Materials

- The SHAPE System Screening and Assessment Library — The SHAPE System Screening and Assessment Library includes instruments appropriate for use in school mental health. Search for the screening or assessment tool that fits your school by focus area (academic, school climate, or social/emotional/behavioral), assessment purpose, student age, language, reporter, and cost. The CSMH team has carefully reviewed every measure to provide a brief summary of each with direct links to copies of the instrument and scoring information. https://theshapesystem.com/

- CSMH Comparative Review of Free Measures for School Mental Health. http://bit.ly/compreviewofmeasures (link is case sensitive)

- Center on Response to Intervention at American Institutes for Research Screening Briefs. http://www.rti4success.org/resource/screening-briefs

- Crocker, J. & Bozek, G. (2017). District-wide Mental Health Screening: Using Data to Promote Early Identification and Quality Services. http://bit.ly/dwmhscreening (link is case sensitive)

- Desrochers, J., & Houck, G. (2013). Depression in Children and Adolescents: Guidelines for School Practice. Handout H: Mental Health Screening in Schools. https://www.schoolhealth.com/media/pdf/handout_mental_health_screening_JD.pdf

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Developing an Evidence Base for Your Program:

A Resource Guide

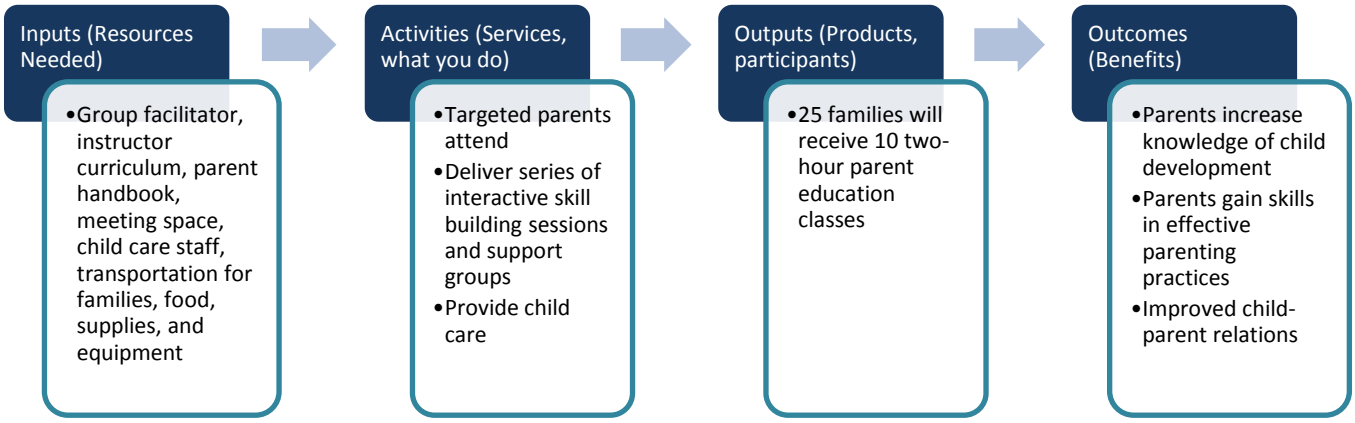
An organization does not always need to adopt an evidence-based program (EBP) to meet their needs. Establishing an evidence base for an existing program that seems promising is an alternative to adopting an EBP. There are critical steps that need to happen prior to testing the effectiveness of a program. This guide is intended to highlight important concepts related to program evaluation and provide resources to assist organizations with creating a plan for building an evidence base for an established program.

CEBC
THE CALIFORNIA EVIDENCE-BASED CLEARINGHOUSE FOR CHILD WELFARE

Creating a Logic Model to Know How the Program Works

Creating a logic model (or a theory of change) is an important first step to building an evidence base. A logic model is a map or flow chart that details how activities help the program achieve its short-term and long-term goals. A logic model answers the question, "How does the program work?" Logic models can vary in their level of detail and complexity but they all share the benefit of serving as a powerful image that conveys the importance of the program for the target population and the community. Below is an example of a basic logic model.

Logic Model Example: Parent Training Program



A logic model can also provide opportunities for identifying issues and engaging in quality improvement. By explicitly stating the relationship between the activities and outcomes, a logic model allows agencies to test assumptions (such as the number, type, and duration of activities) and determine the overall effectiveness of the program. To learn more about evaluating program effectiveness, read *Conducting Program Evaluations* below. A logic model is needed prior to evaluating the program in order to determine if the program is actually true to the original plan and if the outcomes can be measured.

Resources on Logic Models:

1) *Logic Model Builders* (Child Welfare Information Gateway) - Assists programs with defining their service goals and outcomes, identifying indicators, and selecting evaluation instruments to measure success.
https://www.childwelfare.gov/topics/management/effectiveness/logic-model/

2) *Creating Logic Models that Outline an Effective Program Path* (Strategies; February, 2015) - A recorded webinar which provides information on logic model development and presents multiple logic model styles, examples, and resources.
http://www.familyresourcecenters.net/resources/recorded-webinars/

Utilizing Measurement Tools to Examine Outcomes

A program cannot be identified as effective until it has supporting data. Research-supported measurement tools (including screening and assessment tools) help to efficiently identify family strengths and issues, ensure that families receive the most appropriate services for their needs, allow providers to design a plan to resolve the presenting issues, and ultimately measure their progress toward meeting those issues.

Evidence-based measurement tools are rigorously tested to determine if they effectively measure what they are intended to measure. See the *Important Measurement Terms* box for a list of areas that measurement tools are tested. The CEBC reviews and rates select measurement tools based on the tool's supporting published, peer-reviewed research evidence.

There are diverse measurement tools that examine a wide variety of areas, including exposure to and risk for child maltreatment, family strengths, mental health/trauma, protective factors, and many other areas. Agencies need to make several considerations when selecting a measurement tool in order to determine the tool's fit with the agency and target population. Tools can vary in length of time to complete, costs, available languages and cultural appropriateness, informants, age-range, supporting research evidence, and if the tool requires a clinical license to administer.

In addition to being trained to use the tool, organizations should have policies that promote sound data collection. Visit the BetterEvaluation link below for more information.

Important Measurement Terms

- **Screening** – A brief questionnaire or procedure that examines risk factors, mental health/trauma symptoms, or both. A positive result on a screening tool should result in a referral for a more thorough assessment.
- **Assessment** – An in-depth collection of information to identify strengths and issues the family is facing, design a plan, and provide services that will resolve the identified issues.
- **Reliability** – The extent to which the same result will be achieved when repeating the same tool again.
- **Validity** – The degree to which the tool's results are likely to be true and free of bias.
- **Sensitivity** – A measure of how well a tool *identifies* people *with* a specific problem
- **Specificity** - A measure of how well a tool *excludes* people *without* a specific problem.

Resources on Measurement Tools:

1) *Measurement Tools for Child Welfare* (California Evidence-Based Clearinghouse [CEBC]) - Detailed information on various measurement tools and a recorded webinar (http://www.cebc4cw.org/assessment-tools/)
2) *Assessment* (Child Welfare Information Gateway) - Assessment information & resources (https://www.childwelfare.gov/topics/systemwide/assessment/)
3) *Manage Data*(BetterEvaluation) - Details various aspects of data quality assurance (http://betterevaluation.org/plan/describe/manage_data)

Conducting Program Evaluations to Determine Effectiveness

Outcome evaluations ask the question "Is the program working?" The aim of an evaluation is to determine if there are positive (or negative) changes in the children, youth, or parents served. Organizations are encouraged to partner with a university or another type of research institution to help them select an evaluation design that works best for their program. It is typically recommended that an organization first start with a *process evaluation*, which examines the program's structures and practices, including the logic model, data systems, and implementation. An **Evaluability Assessment (EA)** is a type of process evaluation that helps identify whether an outcome evaluation is justified, feasible, and likely to provide useful information. Click on the link in the box below for more information.

Important Evaluation Terms

- **Random assignment** - A process that reduces the likelihood of bias by assigning people (or sites or counties) to specific groups (e.g. your program or a control group) by chance alone (i.e., randomly). When groups are created by random assignment, individual characteristics are less likely to make the results inaccurate.
- **Control group** - A group that receives no intervention or a different type of intervention (e.g. treatment as usual). Allows researchers to compare the impact of the intervention to other groups.

A **Randomized Controlled Trial (RCT)** is the scientific gold standard for determining the effectiveness of a program. An RCT measures a program's effect by *randomly assigning* a sample of program participants to a group that completes the program, or to a *control group* that does not. Many policymakers and administrators use findings from RCTs to make evidence-based policy and programming decisions. An **Opportunistic Experiment (OE)** is an RCT for real-world settings with limited time or resources. OE examines the effects of an initiative, program change, or policy action that an agency or program plans or intends to implement. See links in box below for more information on both types of RCTs.

Lastly, **Quasi-Experiments** can be a second best alternative when an RCT is not possible**.** Quasi-experiments feature an intervention group and control group but lack the randomization of participants into each group, which limits the generalizability of the study's findings.

Resources on Program Evaluations:

1) *Evaluability Assessment* (BetterEvaluation, 2015) - Information & resources on conducting an EA
http://betterevaluation.org/themes/evaluability_assessment

2) *Key Items to Get Right When Conducting Randomized Controlled Trials of Social Programs*(Arnold Foundation, 2016) - A checklist and description of critical tasks for conducting a successful RCT
http://www.arnoldfoundation.org/wp-content/uploads/Key-Items-to-Get-Right-in-an-RCT.pdf

3) *Opportunistic Experiments Toolkit* (Mathematica Policy Institute, 2015) - Detailed information on OE
http://www.acf.hhs.gov/sites/default/files/opre/oe_learning_what_works_toolkit_final_2_b508.pdf

4) *Which Quasi-Experimental Study Designs are Most Likely to Produce Valid Estimates of a Program's Impact?* (Coalition for Evidence-Based Policy, 2014) - Considerations for quasi-experimental designs
http://coalition4evidence.org/wp-content/uploads/2014/01/Validity-of-comparison-group-designs-updated-January-2014.pdf

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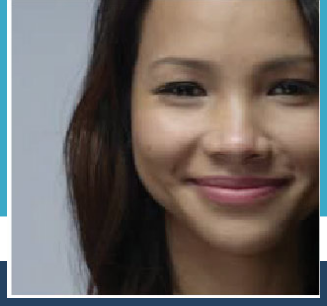

Selecting Evidence-Based Programs

NATIONAL RESOURCE CENTER FOR
MENTAL HEALTH PROMOTION & YOUTH VIOLENCE PREVENTION

Contents

Selecting Evidence-Based Programs (EBPs)

Following a comprehensive needs assessment, it is important to get a clear picture of the context in which any evidence-based program (EBP) will be implemented. Understanding the context will help your team select the EBP that best fits the goals and needs of the population as well as available resources, existing practices, and system readiness. This guide provides a framework for identifying key pieces of information you should use/know to select EBPs. In the Appendix, you will find key questions summarized in a discussion guide, along with other worksheets and resources to help you select an EBP. Although "evidence-based program" and "evidence-based intervention" (EBI) are often used interchangeably, for ease of comprehension this document uses EBP throughout.

1. Identifying the EBP's Scope

As a starting point in the process of selecting an EBP, it is important for the team to identify the scope of the EBP. This step has four components: (a) intended population, (b) intervention target, (c) baseline severity level, and (d) intervention delivery characteristics (see Figure 1).

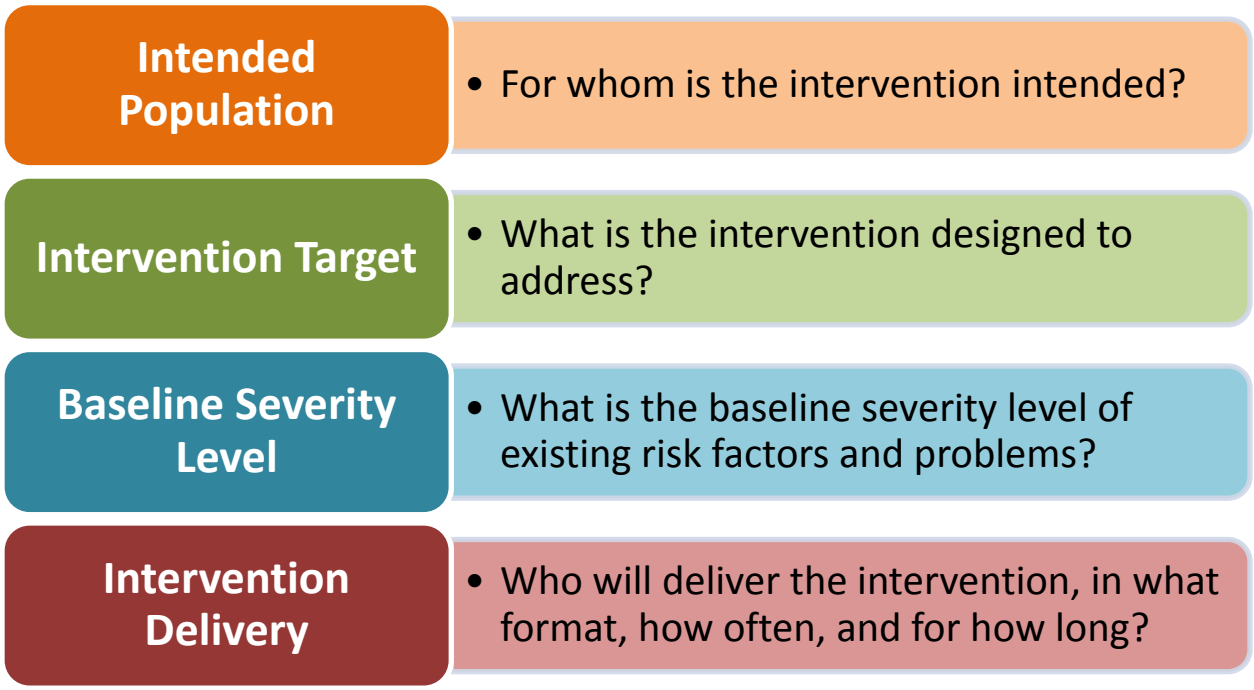

Figure 1. *Four components involved in identifying the EBP's scope.*

Intended population refers to who will receive the intervention. EBPs typically specify certain population characteristics for whom they are intended and/or with whom they have been tested. These characteristics include attributes such as developmental level (specified as either an age range or grade range), gender, race/ethnicity, and language. Therefore, it is important to specify this information for your own locality to use as a roadmap for selecting an appropriate EBP (see Worksheet 1a in the Appendix). In some cases, you might not find an EBP that exactly matches your intended population, so you might need to decide which population characteristics are most important to guide EBP selection. Additionally, making explicit the population characteristics can

help you avoid selecting an EBP that has known adverse effects for that population (such as group therapy for boys with significant disruptive behavior).

Intervention target refers to the need that the intervention is designed to address. Identifying the intervention target for your locality is vital to the appropriate EBP selection because EBPs typically have well-specified targets. This framework includes three broad targeted intervention groupings (see Worksheet 1b in the Appendix):

- Behavioral, emotional, and physical health
- Academic and related skills
- Student-family-school connections

Within the "behavioral, emotional, and physical health" category are problems or targets such as aggression, alcohol and other drug use, emotion regulation, and social skills. For many targets in this category, existing interventions can be delivered to individual students, small groups, or classroom groups.

Examples of "academic and related skills" targets include early childhood education and time management. Again, there is versatility in the interventions available for academic and related skills targets.

"Student-family-school connections" targets include support for academic, social, and civic learning and school connectedness. Although some EBPs may be intended for delivery at the individual student or family levels, many interventions fit targets in this category that are better suited for school-wide initiatives. These three broad categories include target problems consistent with the five SS/HS elements:

1. Promoting early childhood social and emotional learning and development;
2. Promoting mental, emotional, and behavioral health;
3. Connecting families, schools, and communities;
4. Preventing behavioral health problems, including substance use; and
5. Creating safe and violence-free schools

Localities might select aggression as a target problem if they are working on goals reflecting Element 4 or 5, for example. Your team can select multiple targets in a locality that wants to reduce alcohol and other drug use as well as to improve school connectedness. It might be the case that your team will identify one EBP that can address both targets, or that multiple EBPs will be better suited for this focus.

Baseline severity level reflects the population's baseline (before intervention) *need level* relative to its experience of risk factors and challenges (see Worksheet 1c in the Appendix). "Low" need reflects mild or no problems and low-level risk factors. Typically, populations with low risk and severity are well-suited to universal interventions that are designed to be delivered to everyone in the identified population. For example, for low severity level, this may involve an elementary school with high attendance rates, student reports of high connectedness, and low office referral and suspension rates. This school might seek an intervention to help them maintain their high levels of school connectedness and safety and would likely consider a universal intervention that is designed for the entire school population. Another example is a universal intervention designed to help all students manage mild and periodic sadness.

"Moderate" need reflects elevated risk or evidence of problems in certain individuals in a population. Populations with moderate risk are often well-suited to receive selective interventions with a focus specific to the identified risk or severity level. For example, a selective intervention might be used to support students experiencing grief and loss because this is a risk factor for depression.

"High" need reflects high risk or significant evidence of problems in certain individuals in a population. Populations with high risk are often well-suited to receive "indicated" interventions with content tailored to the students' high level of need. For example, an indicated intervention might be used with students who score high on a depression screening measure or who have reported suicidal ideation.

It is imperative that your team identify the intended population's baseline severity level because all EBPs are not created equal when it comes to addressing risk factors and existing problems. Fortunately, the terms "universal," "selective," and "indicated" are common descriptors of EBPs. So, if you understand the population's baseline severity level, your team will be well-equipped to select an appropriate EBP.

Intervention Delivery characteristics include the interventionist, format, frequency, and time (see Worksheet 1d in the Appendix). Typically, EBPs specify these characteristics based on how the EBPs were tested or how they were intended to be delivered. Using the worksheet, your team can discuss options about the ways in which you would like the intervention to be delivered. As with the other worksheets, this worksheet will serve as a roadmap to help guide EBP selection.

The "interventionist" is the person who will deliver the EBP. There are numerous options from which to choose, reflecting a variety of professional roles. "Format" refers to the audience who will receive the intervention from the interventionist. Will the EBP be delivered to students individually, a student along with his/her family, in small groups, in classroom groups, or in another format? "Frequency" refers to how often the intervention will be delivered, and ranges from multiple times per day to one time only. Finally, "time" refers to how long the intervention delivery requires each instance the intervention is used. In some cases, the intervention delivery might be brief (for example, 5-10 minutes) or it might be a few hours or even a full day.

2. Determining Readiness to Implement EBPs

To effectively implement an EBP, you must determine your locality's readiness to implement the EBP. Moreover, it is important to determine if the EBP will be implemented in all or just some of the local communities, at the district level, at the state level, or both. Hybrid implementation models might plan for smaller-scale implementation in one or a few communities, and then use knowledge and experience based on that pilot as a foundation from which to extend the implementation to a given region(s), and even to the entire state or territory. Critical readiness factors include motivational readiness, organizational climate, current staff capacity, and resource availability (see Figure 2).

Motivational readiness occurs when an individual recognizes that a situation requires change and he or she prioritize those changes (Weiner, 2009). To successfully implement a new EBP effectively, your team must get support at all levels (e.g., individual, administration, organizational, community). For example, in a school setting, your team will need support and buy-in from school administrators, mental health providers, educators, paraprofessionals, students, and families. High motivational readiness reflects a unified perspective that there is a problem that needs to be

addressed (Weiner, 2009). People feel motivated to work as a team to find a solution. Low motivational readiness reflects lack of cohesion around a problem. There may be disagreement regarding the problem's existence and the urgency for a solution.

Organizational climate involves an organization's dynamics and structure regarding who makes decisions, how those decisions are communicated, the incentive structure for doing a good job (e.g., recognition, salary increase, promotion), and the openness for change and innovation (Glisson, 2002; Weiner, 2009). A strong organizational climate might reflect leaders who involve staff in decision-making and who clearly communicate the rationale for a decision. In strong organizations, staff perceive that their values match the leadership's values, and they feel supported in their jobs (Rogers, 1995). Moreover, staff members in these organizations have more positive attitudes towards adopting EBPs (Aarons, Glisson, Green, Hoagwood, Kelleher, Landsverk, & The Research Network on Youth Mental Health, 2012). In contrast, a poor organizational climate might reflect leaders who make decisions about an intervention without talking to those who will implement it and who mandate using the intervention without providing support or incentives. Staff members in these organizations are likely to have unfavorable views regarding EBP implementation (Aarons et al., 2012).

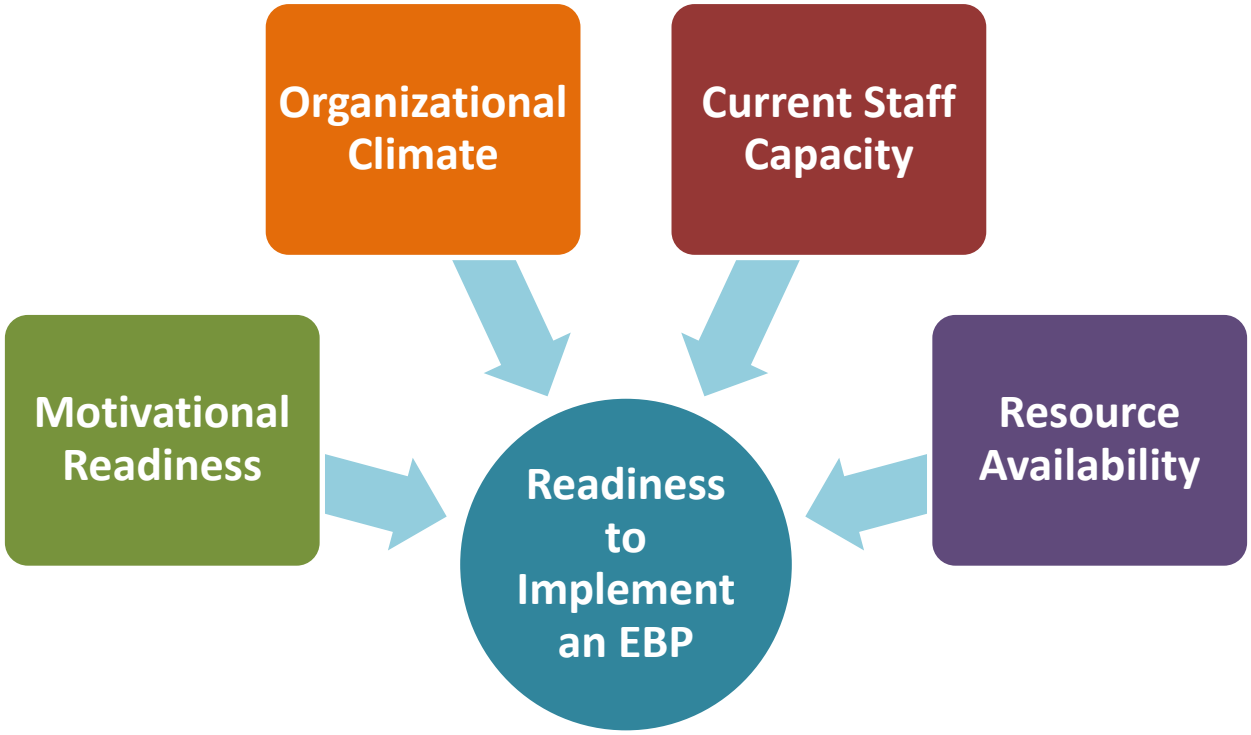

Figure 2. *Factors Associated with Readiness to Implement an EBP.*

Current staff capacity refers to the number of staff available to implement the intervention as well as the staff's collective ability (e.g., skills) to implement it. The number and skills of existing staff will help inform hiring and training decisions, as well as subsequent resource allocation.

Resource availability is the ability to finance costs associated with EBP implementation. Typically, start-up costs associated with implementation include staff/provider training, periodic consultation with experts in the EBP to discuss issues associated with implementation, equipment, and materials related to the EBP, and facilities or space for the staff/providers to use. Additionally, consider that the goal is not to implement the EBP for just one student cohort, but to integrate it into the school's intervention repertoire; therefore, there will be costs associated with the intervention's long-term sustainability. For example, staff/provider turnover may require additional trainings for newcomers, low implementation might require booster trainings to sharpen provider skills, and equipment and materials may need to be replaced or replenished over time.

Furthermore, an implementation readiness assessment is an essential step in EBP rollout. Your team can use Worksheet 2 in the Appendix to begin discussing and assessing your organization's readiness to implement an EBP. However, a more thorough assessment might be helpful. One useful tool is the Texas Christian University's (TCU) Organizational Readiness for Change (ORC) Scale (http://ibr.tcu.edu/forms/organizational-staff-assessments/). The TCU ORC has one version designed for intervention staff and another for supervisors and directors. Each version takes approximately 25 minutes to complete and assesses motivational factors (e.g., program needs, training needs, pressures for change), staff attributes (e.g., growth, efficacy to do their job, job satisfaction), program resources (e.g., office facilities, equipment, access to internet), and organizational climate (e.g., mission, cohesion, communication, openness to change).

Another useful tool to guide readiness assessment is the *Show Me Am I Ready Scale* created by the Missouri Department of Health and Senior Resources. The *Show Me Am I Ready Scale* provides a series of questions to prompt thoughtful discussion around readiness to implement an intervention and action steps to enhance readiness. This tool can be accessed at http://health.mo.gov/data/InterventionMICA/ReadinessPreparation.html, and the website provides feedback based on measure scores.

3. Where to Look for EBPs

After mapping out the intervention characteristics your team would like to implement as well as assessing your organization's readiness to change, it is time to search for EBPs. But first, what does it mean to be "evidence-based"? The term "evidence-based" generally means that there is some evidence or data that indicate that the intervention works. For example, the intervention showed positive outcomes for a group of students compared to another intervention in a well-designed study in which students were randomly assigned to receive one intervention or the other. This is called a randomized controlled trial (RCT). Another type of evidence involves data which show that students who participated in an intervention improved on some outcome, but in this case there was no comparison group (this is known as a single group pre-post design). Another variation of evidence involves data that show a particular student improved on an outcome, but there were no other students for comparison (this is referred to as a single case design). There are many more variations on the study designs that can potentially provide evidence for an intervention. However, in science, the RCT is viewed as the "gold standard" for evaluating an intervention. In other words, interventions that have performed well in an RCT are typically viewed more favorably than interventions that have performed well in studies with other designs.

In children's mental health, there are hundreds of EBPs, and the number continues to grow (Chorpita et al., 2011). However, there is often a long lag between the time that an intervention is tested in a study and the time that providers in the field become aware of the intervention. In the past, there were few ways for providers in the field to find out about interventions without reading

scientific journals. Fortunately, today searchable registries exist to help the public learn more about EBPs (see Figure 3).

One highly regarded registry is SAMHSA's "National Registry of Evidence-based Programs and Practices" (NREPP; http://nrepp.samhsa.gov/). NREPP's registry includes mental health and substance abuse interventions. Each intervention has been nominated by the intervention developer, but has been independently reviewed and rated, and has met NREPP's minimum requirements for inclusion in the registry. NREPP provides each intervention's description, a research summary testing the intervention, ratings on the intervention's readiness for dissemination (e.g., materials, training and support, quality assurance procedures), and associated costs.

The Institute of Education Sciences' "What Works Clearinghouse" (WWC; http://ies.ed.gov/ncee/wwc/) is another searchable registry that includes academic and emotional/behavioral interventions. The WWC provides a program description, a summary of the research evidence, and a cost estimate.

The Annie E. Casey Foundation's "Blueprints for Healthy Development" is another searchable registry (http://www.blueprintsprograms.com) that includes interventions with outcomes demonstrated in the domains of behavior, education, emotional wellness, positive social relationships, and health.

Take time to explore NREPP, WWC, and Blueprints. Use your team's worksheets as a roadmap to selecting search criteria related to the intended population, intervention target, severity level, and intended delivery. Get a sense of which interventions might fit your students' needs. Remember that identifying an EBP is an important process; therefore, your team should plan to set aside a few hours to generate potential options.

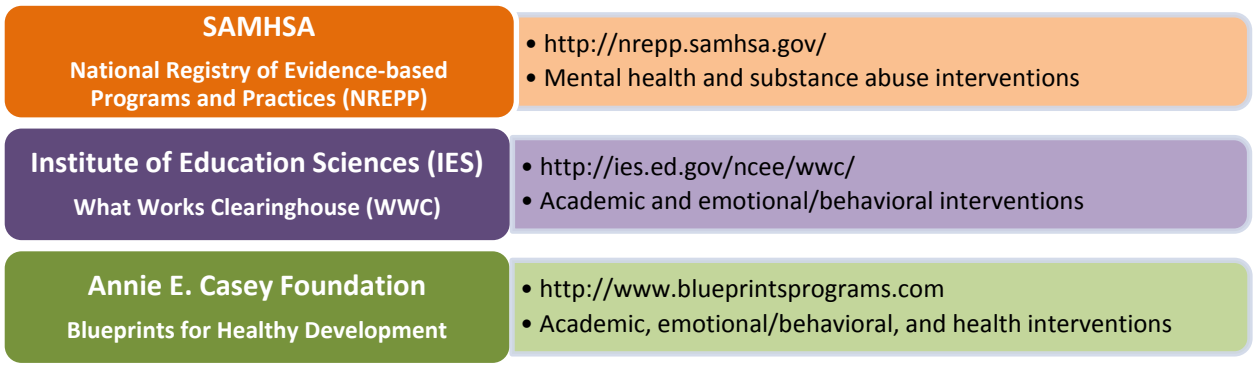

Figure 3. *Searchable Intervention Registries.*

4. Selecting an EBP

Congratulations! You've made it to an exciting point in the process—selecting an EBP. There are many considerations as you choose among possible EBPs, including:

- the EBP's evidence base
- population strengths and needs
- cultural relevance

- intervention features, materials, and implementation supports
- stakeholder values
- existing practices and organizational support
- current workforce capacity
- cost

Use Worksheet 3 in the Appendix as a framework to guide your team through the process of choosing among possible EBPs.

Evidence base for EBP. One of the first things to do is to consider the evidence base for potential EBPs within the context of your targets/goals and intended population. To guide you, consider five questions:

1. Was the intervention tested multiple times with a rigorous study design?

Evaluating evidence involves considering the study design's context. Keep in mind that the gold standard study design is an RCT. Additionally, scientists value multiple studies conducted by different investigators, particularly investigators not involved in the intervention's development. Sometimes, however, science is not at a point at which RCTs have been conducted for a particular problem. Instead, studies might be in the pilot phase. This is acceptable because the research study's number and quality are two aspects of the evidence base that guide the EBP selection.

2. Is there clear documentation that implementation results in valued outcomes?

It is important to consider whether potential EBPs have an evidence base, or clear documentation that implementation results in valued outcomes. "Valued outcomes" refer to those that your team has identified as targets or goals. Scientists testing an intervention typically collect data on multiple outcomes, so it is important to determine whether the specific outcome(s) valued by your team demonstrated positive gains as a result of the intervention. For example, your team might value improved social skills and academic achievement as intervention outcomes. However, it is possible that youths who received a particular intervention improved on a social skills measure, but not on an academic achievement measure. Your team will need to dig deep into the evidence to determine whether valued outcomes were achieved after intervention implementation.

3. Is there clear documentation that implementation results in valued outcomes for your…
    … intended population?
    … intended setting?
    … intended population in your intended setting?

As your team imposes more criteria for assessing the evidence base for particular interventions, you will likely find differences among EBP outcomes. The purpose of this set of questions is to help you make your best informed decision about whether an EBP could have benefits for your intended population in your intended setting based on the similarities to the study samples and settings. Interestingly, research studies may include samples of youth who have similar characteristics to one another; thus, study samples may not reflect the complexities that characterize your intended population. This is because researchers try to reduce the likelihood that factors other than the intervention will influence study outcomes. Typically, after an intervention has demonstrated positive effects, researchers will test the intervention with more samples that include greater diversity of characteristics. Depending on the intervention's developmental stage your team is

considering, the study samples may or may not reflect the likely diversity of your intended population.

Of the population characteristics, severity level and developmental level (e.g., age/grade) are the most important characteristics to match to the EBP. EBPs are always designed with an identified severity level in mind and usually target youths at a specific developmental level. Sometimes research also identifies differences in the intervention effects based on gender, race/ethnicity, or other sample characteristics. The purpose of these comparisons is for your team to get a snapshot of the study findings' generalizability to your intended population.

With regard to setting, many interventions are initially tested in laboratory settings so that researchers have more control over the intervention delivery. Over time, researchers typically expand intervention testing to settings in which interventions typically are delivered, such as schools, community mental health centers, or residential treatment facilities. Is there evidence that the intervention has been effective in the setting in which your local communities intend to implement it? Also, if the local communities in which the intervention will be implemented are urban or rural, consider whether the intervention has been tested and shown to be effective in those settings as well.

Population Strengths and Needs. Once you have evaluated the evidence base for the EBPs you are considering, it is important to think about how well the EBPs capitalize on the strengths and address the population's needs that will be involved with and/or impacted by the EBP. First, consider the population's strengths, especially in regard to protective and promotive factors. These can be individual factors, such as their characteristics and current knowledge and skills (e.g., self-regulation, problem-solving, academic, relational), or they can be social factors, such as positive relationships with their families, peers, and supportive adults (e.g., teachers, school staff, or those implementing the intervention). These strengths could also exist at the community level, such as other services available in the community, particular school characteristics, or other social and economic resources. Is the population excelling in one or more of these areas? Additionally, you must consider the population's particular needs to determine the EBP's appropriateness. These needs could be associated with poverty, mental health issues, community violence, or low functioning levels, to name a few. What special needs does your population have? For example, think about a community attempting to reduce student aggression in an area with high levels of violence (a risk factor) and there is a good relationship between school personnel, families, and students (a protective factor). In this instance, it would make sense to select an EBP that involves school personnel and families to broaden the impact of the intervention and maintain the reduction in aggression (the valued outcome) across settings.

Cultural Relevance. Best practice for EBP adoption and uptake includes selecting interventions that are culturally and linguistically appropriate. Culture refers to the behaviors and beliefs characteristic of a specific group. Commonly, culture refers to someone's race or ethnicity, but consider culture in the broad sense of the word to include other groups, such as those centered on a particular religion or sexual orientation, for example. Has the EBP been tested with and shown to be effective with youths who are culturally similar to the youths in your intended implementation setting? Do stakeholders perceive that the intervention theory, content, and materials are culturally relevant? Are adaptations necessary? Consideration of adaptations based on diversity within the population of focus should include student, educator, family, and community variables, characteristics, learning histories, context requirements, and expectations. Adaptation may require an iterative process, beginning with contacting the intervention developer or others who have used the intervention to determine the extent to which the EBP can be adapted, tailored, refined, or

reinvented to meet specific population needs. Adaptation may also require assessment via focus group with diverse members of the intended population and piloting of the adapted intervention.

Intervention Features, Materials, and Implementation Supports. Are the features and strategies of the intervention well-specified? In other words, is your team able to describe what the intervention looks like in practice? If you are unable to articulate the key features of the EBP, it would be wise to connect with the intervention developer or with someone who has used the intervention. It is important to understand the details of the intervention strategies so that you can determine whether the EBP is feasible to implement in your communities.

Do the intervention features fit well within the context of the preferred intervention delivery characteristics, including who will deliver the EBP, the format of the EBP delivery, and the frequency and time required for the intervention?

Are particular materials required, and if so, are those materials pre-packaged with the intervention? On the one hand, pre-packaged materials can increase the cost of an intervention. On the other hand, requiring your team or your interventionists to create or assemble materials can be an added burden that could hinder implementation.

What types of implementation supports are available? Is consultation with intervention experts required or available on an as-needed basis? Are there individuals with expertise in the state or local communities that could be available for consultation on an as-needed basis? Does the intervention have specific progress monitoring or fidelity monitoring tools, or will tools need to be created?

Ideally, the intervention features are well-specified and not too complex. Complexity reduces the likelihood of consistent and high-fidelity implementation. The availability of materials and implementation supports potentially increases cost, but may also increase implementation.

Stakeholder Values. Are the intervention's features, goals, and theory of change consistent with stakeholder values? Sometimes an intervention does not align with every stakeholder's values. For example, an intervention might promote assertiveness skills, but perhaps a caregiver raises concerns that youth assertiveness conflicts with his or her cultural values regarding respecting elders. Conflicts between the EBP and stakeholder values might hinder implementation. Prior to implementation, consider holding information sessions during which the intervention features and goals can be explained and stakeholders can ask questions and raise concerns.

Existing Practices and Organizational Support. Prior to selecting and implementing an EBP, it is important to determine how it will fit with the existing practices. It is important to take an inventory of the current programs and practices available in the target setting (school, community, district, state). Also, determine if it is compatible with and will not duplicate current EBPs and programs in that setting. Considering how the EBP will fit into a multi-tiered system of support also will be important.

Related, consider the organizational support that is required to support EBP implementation. Does the intervention require strong and global organizational support that, if absent, would significantly hinder implementation? For example, an EBP delivered by a school mental health clinician to a small number of individual students may require profession-specific support from the clinician's supervisor. If school administrators were indifferent about the EBP, it is possible that the intervention could still be well-implemented. In contrast, the school-wide implementation of

universal and indicated EBPs might be at high risk for poor implementation without significant organizational support.

Current Workforce Capacity. Consider whether the current workforce is adequate in size to implement the intervention effectively or whether additional staff will need to be hired. Additionally, are the current workforce skills adequate to implement the EBP, or is training required? Each of these considerations will affect decisions about how to allocate resources.

Cost. The bottom-line cost of implementing the EBP will be an important consideration. Important (but not exhaustive) cost considerations include:

- **Staff salaries**. How many interventionists are required? Will you need to hire new staff?
- **Training**. Will you need to pay an expert (and cover travel costs) to conduct the training? Remember to consider costs for room reservations, equipment, and food. Are there required booster training sessions?
- **Consultation**. Costs include not only the consulting fees, but possibly communication fees (e.g., phone charges) or equipment (e.g., iPad, web camera).
- **Certification**. Is certification required for trainees? Are there costs associated with certification? This might include costs associated with performance reviews.
- **Materials**. Are there pre-packaged materials? Will materials need to be replenished? Can paper materials be duplicated locally or do they need to be purchased?
- **Equipment**. Is there special equipment required for implementation or training/consultation/certification? This might include video cameras to record implementation for review by expert consultations or for certification purposes.

Systematic consideration of each of these factors for each potential EBP can provide a framework for evaluating the potential relative costs and benefits. Your team will likely have to make tough decisions about which considerations carry more weight in the selection of an EBP. Connecting with others schools that have used any of the EBPs your team is considering might shed light on the factors that influenced their decisions. The EBP developer is one source of information regarding who has used the EBP in the past.

5. Tracking the EBP's Impact

It is important to track progress on selected outcome(s) to see how the intervention is working.

Tracking may include monitoring whole school outcomes including school climate, academic achievement, attendance, and behavioral and discipline indicators. Tracking may also include monitoring progress on student-specific factors such as perception of school connectedness, psychosocial functioning, and discipline referrals. Data used to track progress may come from a variety of sources including state or district data (e.g., attendance, tobacco use), school data (e.g., school climate, state performance assessments), and/or individual data (e.g., student grades, teacher turnover, parent empowerment).

Your choice of measures as well as the frequency of data collection will depend on considerations related to resource capacity, response burden, and data availability. Typically, measures are administered before an intervention is implemented and when the intervention is over, to yield an indicator of change. However, if resources allow, measuring progress at multiple time points while the intervention is being implemented can give you an early signal for whether or not the intervention is working. If the intervention is not working, you will have time to fix the situation if

you have tracked progress during implementation. If you only administer measures at the beginning and end of the intervention, you will not have the opportunity to fix an intervention that is not working.

In some instances, the assessment measure/methodology utilized to select the youth for inclusion may be repeated to monitor participants' progress. You should establish the EBP impact tracking plan at the outset of implementation. A list of potential measures is included in the Appendix (Worksheet 4. Tracking the EBP's Impact: Measures and Measurement Domains). Also, intervention registries such as NREPP and WWC summarize the outcome measures used in studies testing each intervention. This can be a great source of ideas for measurement.

What do you do when the data you are collecting suggest that the intervention is not working? Consider these questions and action steps:

- **Do the respondents understand how to provide information on the measure you are tracking?** Remember that reading levels and familiarity with questionnaires vary across people. If individuals are completing a questionnaire or providing ratings in some way, ensure that they understand the instructions, the items, and possible responses. Also ensure that the measures are culturally appropriate to increase accuracy of reporting.

- **Do the measures you selected reflect the stated target of the intervention?** For example, if your EBP is intended to reduce substance use, are you using a measure for substance use? If not, consider selected a measure that better fits the intervention's target. Refer to NREPP or WWC for more information on measures that were used in studies testing the intervention.

- **Do the measures you selected have sound psychometric properties?** Validity refers to the accuracy of the measurement. One way to determine validity is to find out if the results from the measure you are using are very similar to the results from other measures that are intended to measure the same thing. As an example, consider a scale used to measure weight. Suppose an average-sized adult male weighs himself and the scale indicates a weight of 63 pounds. The scale would not be considered valid because the adult male does not weigh 63 pounds according to other scales the he has used.

  Reliability has to do with a measure's ability to produce similar scores or results under consistent circumstances. One way to determine reliability is to administer the measure twice to an individual after a brief amount of time (for example, a day or week). Similar scores across two administrations suggest high reliability. Suppose that same adult male measured himself multiple times in a row with the following weights: 63lbs, 192 lbs, 170 lbs, 85 lbs. The scale would be considered unreliable because we would expect that the weights would be the same each time.

  Furthermore, although you want your measure to be reliable across consistent circumstances, you also want it to be sensitive to meaningful changes in what you are measuring. To continue our example, suppose the adult male used a valid and reliable scale and weighed in at 183 lbs. Over the course of the next 6 weeks, he made healthy changes to his lifestyle, after which he weighed himself again. This time, his weight was 172 lbs. This scale would be considered sensitive to change. Sometimes measures are not sensitive to change over brief periods of time and it might appear that progress is not occurring.

If your team selects publicly available measures, it is likely that you will be able to find out information about the validity, reliability, and sensitivity to change of the measures. If the psychometric properties of the measure are not sound, then the problem might be with the measurement and not the intervention. Consider using a measure that has been used by others and has been shown to be valid and reliable. Information about the measures used in studies in which the EBP was tested can be found in NREPP and WWC. It is possible that a measure for a particular targeted outcome does not exist. In these situations, it might be possible to change items or add items to an existing measure for a similar outcome, or to develop a new measure. Keep in mind that it will be important to monitor the data regularly to ensure that you are collecting information that is useful and that accurately measures progress.

- **Are interventionists implementing with high fidelity?** If not, take steps to ensure to support interventionists and their high fidelity implementation. The next section explores fidelity and quality improvement further.

Use Worksheet 4 to aid you in tracking the impact of your EBP.

6. Monitoring EBP Fidelity and Quality Improvement Methods

EBP fidelity refers to the extent to which an intervention is implemented the way it was intended. Fidelity is important because studies testing an intervention typically ensure that there is high fidelity. Changing the intervention reduces the fidelity. There is significant evidence to suggest that lower fidelity reduces the effectiveness of the intervention (Burke, Oats, Ringle, Fichtner, & DelGaudio, 2011; Derzon, Sale, Spring, & Brounstein, 2005; Schoenwald, Carter, Chapman, & Sheidow, 2008). Interestingly, programs that monitor implementation fidelity tend to have better outcomes than programs that do not monitor fidelity (DuBois, Holloway, Valentine, & Cooper, 2002).

To plan for fidelity assessment, identify the tools you will use, determine the frequency of fidelity measurement, and establish the benchmark that will represent an acceptable level of fidelity. Some EBPs may have already established fidelity measures specific to the practice/intervention, or published recommendations for fidelity assessment and benchmarking. Your team can find more about fidelity measurement specific to an intervention on the NREPP or WWC sites.

If information about fidelity monitoring specific to an intervention is unavailable, then identifying how other similar EBPs have measured fidelity can help inform fidelity assessment. A recent article reviewing studies testing EBPs found that observational methods are more frequently used (71.5%) than written methods to assess fidelity (Schoenwald & Garland, 2013). More than half the observations involved listening to audio recordings of a provider delivering an intervention (56.2%), followed by video recordings (41%), and live observations (2.8%). Fidelity was most often assessed once (55%) or twice (28%). Keep in mind, however, that fidelity tends to decrease over time (McCormick, Steckler, & McLeroy, 1994).

What do you do when the data you are collecting suggest that an EBP is implemented with low fidelity? The most important step is to work with the interventionists and other stakeholders to collaboratively identify and address barriers to high fidelity implementation. The following are common barriers and suggestions for reducing them.

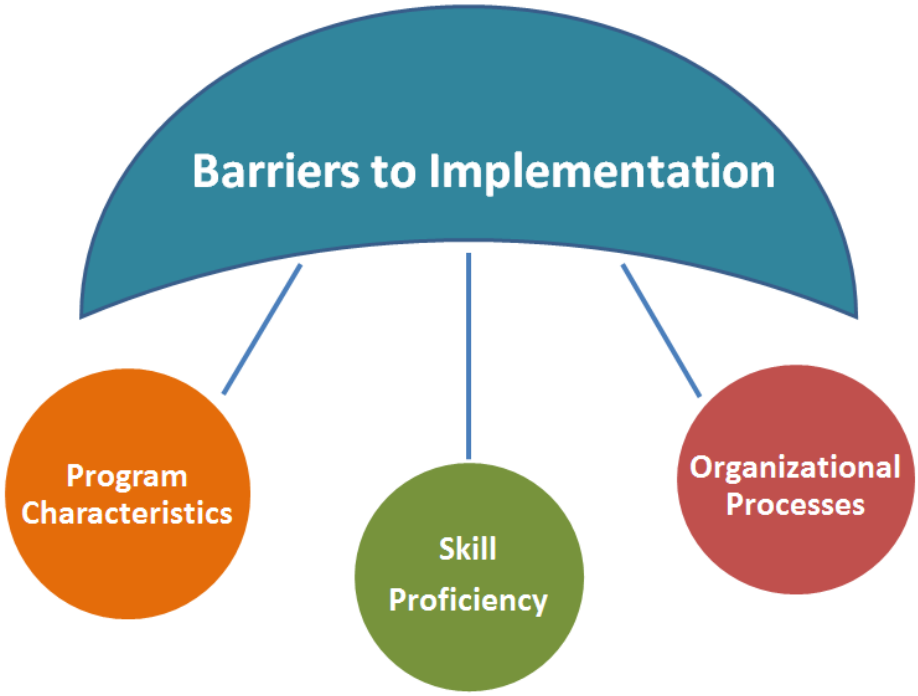

Figure 4. *Barriers to High Fidelity Implementation.*

Skill Proficiency. Sometimes low implementation occurs because the interventionists do not yet have sufficient proficiency in the skills required to implement the intervention. In this case, there are two related actions to take to improve implementation:

- **Provide high-quality training or coaching.** Research suggests that instruction alone is an ineffective way to train someone to do something new (Fixsen et al., 2005). Demonstrating the skill, providing opportunities for the interventionist to practice the skill, guiding reflection about skill use, and observing others use the skill in the natural setting are all ways that can enhance learning of a new skill. These activities can be used in follow- up training of large groups or individual coaching as needed.

- **Provide multiple opportunities for supported practice in the natural setting.** Research also suggests that one-time workshop trainings are generally ineffective at changing a person's behavior in their natural setting (Fixsen et al., 2005). Just like learning to read, ride a bike, or drive a car, learning an EBP requires practice in the natural setting. Observation, guided reflection, and feedback can enhance learning and application of an EBP.

Program Characteristics. Sometimes low implementation occurs because there is something about the intervention that does not fit well with the interventionists, other stakeholders, or the setting. Ways to address implementation challenges related to program characteristics include:

- **Connect about perceived needs and potential benefits of the intervention.** Have a conversation about the relevance of the intervention to the identified needs (Durlak & DuPre, 2008). Discuss how the intervention can help the locality achieve its stated goals. Open discussion can heighten the potential impact of the intervention, therefore helping stakeholders prioritize its implementation.

- **Try it out for a trial period.** Consider asking stakeholders to try out the intervention for a brief trial period, after which a collaborative discussion can take place about how the trial period went (Damshroeder et al., 2009). Committing to do something for a shorter period of time might facilitate program buy-in and can also highlight potential barriers that need to be addressed before more significant implementation can occur. However, keep in mind that this approach would still require an initial investment in any required training, but could save time and money if problems with the EBP were identified.

- **Consider adapting the intervention.** Sometimes, an intervention as it was designed doesn't quite fit within a given setting and therefore results in low implementation fidelity. Certainly, implementation fidelity is important. At the same time, sometimes small adaptations to one component of the intervention can improve the fit of the intervention and increase implementation of the other components. Before adapting, review the NREPP and WWC websites to see if and how the intervention has been adapted, and if those adaptations have been studied. Consider contacting the program developer, who may be working on adaptations to the intervention or who could help you think about whether your proposed adaptation would have potentially beneficial or detrimental effects on your outcomes.

Organizational Processes. Sometimes the leaders in an organization make decisions that influence the implementation of a program. These decisions might relate to setting priorities that do not include the EBP, burdening the workforce with EBP implementation without offering rewards, and not providing instrumental support for EBP implementation. Strategies for dealing with these issues include:

- **Identify a champion**. Find an internal individual who is trusted by the staff and leadership to advocate on behalf of the program and help resolve issues related to implementation (Durlak & DuPre, 2008; Fixsen et al., 2005).

- **Facilitate shared decision-making**. Connect with the interventionists and other relevant stakeholders to plan how the program will be implemented. This is important to program success. Encouraging open communication about barriers to implementation is the first step towards reducing barriers and promoting long-term sustainability (Durlak & DuPre, 2008).

- **Schedule implementation**. With all of the competing demands in the school setting, it is no wonder that time can be a significant barrier to program implementation. The time commitment should have factored into the EBP's selection. One strategy for helping address the time burden is to schedule specific days and times for EBP implementation, rather than having the interventionist try to find time here and there to fit it in. Having this time commitment on staff calendar helps them know that the intervention is coming up and it is less likely to be pushed aside for other things.

- **Ensure adequate administrative support**. There are many tasks associated with delivering an intervention, including scheduling the intervention delivery, keeping records, touching base with those who have questions or who were absent for the intervention, gathering and inventorying materials, to name a few. Identifying administrative assistants to assist with some of these tasks can be critical to enhancing implementation. For example, making extra copies or keeping attendance records might seem like tasks that take just a few minutes, but those extra minutes can add up for an interventionist over time (Durlak & DuPre, 2008).

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Appendices

Key Questions

1. Identifying the EBP's Scope

a. For whom is the intervention intended?

b. What is the intervention designed to address?

c. What is the baseline severity level of existing risk factors and problems?

d. Who will deliver the intervention, in what format, how often, and for how long?

2. Determining Readiness to Implement EBPs

a. Do individuals in the organization recognize that changes are needed?

b. Are individuals in the organization willing and able to prioritize changes?

c. Who makes decisions and how are decisions communicated?

d. Are there enough staff members to implement an EBP?

e. Do the staff members have the skills necessary to implement an EBP?

f. Are there resources to cover the costs associated with starting and sustaining an EBP?

3. Where to Look for EBPs

a. Where can your team find out more about EBPs?

b. Are there other schools that have implemented the EBPs you are considering?

4. Selecting an EBP

a. Where can your team look for evidence about an EBP?

b. Was the EBP tested multiple times with a rigorous study design?

c. Is there clear documentation that implementation results in valued outcomes?

d. Is there clear documentation that implementation results in valued outcomes for your…

   i. *… intended population?*

   ii. *… intended setting?*

   iii. *… intended population in your intended setting?*

e. Does the EBP fit with the population's strengths and needs?

f. Is the EBP culturally appropriate?

g. Are adaptations necessary?

h. Are the features and strategies of the EBP well-specified?

i. Do these features fit well within the context of your setting?

j. Are pre-packaged materials available?

Key Questions (continued)

k. What types of supports are available locally, or from the intervention developer, to help interventionists use the EBP?
l. Are the EBP's features, goals, and theory of change consistent with stakeholder values?
m. Is the EBP compatible with other EBPs and programs being used in the setting?
n. Does the EBP require strong and global organizational support that, if absent, would significantly hinder implementation?
o. Is the current workforce adequate in size to implement the EBP effectively? Will additional staff need to be hired?
p. Are the current workforce's skills adequate to implement the EBP, or is training required?
q. What are the EBP's costs?

5. Tracking the EBP's Impact

a. What measures will be used to determine if the intervention is working?
b. What will be done if the data suggest that the intervention is not working?

6. Monitoring EBP Fidelity and Quality Improvement Methods

a. What measures will be used to determine if the EBP is being implemented the way it was intended?
b. What will be done if the data suggest that the EBP is being implemented with low fidelity?

Worksheet 1a

1a. Intended Population

Instructions: Within each category, circle all of the options that characterize your intended intervention population.

Developmental Level: Age

- 0-3
- 3-4
- 4-5
- 6-8
- 8-12
- 12-15
- 15-18
- 18+
- Other:_____

Developmental Level: Grade

- Daycare
- Preschool
- Pre-K/K
- 1-2
- 3-5
- 6-8
- 9-12
- Post High School
- Other:_____

Gender

- Female
- Male
- Transgender
- Other:_____

Race/Ethnicity

- African American or Black
- American Indian/Alaska Native
- Asian
- Caucasian or White
- Hispanic or Latino
- Native Hawaiian or Pacific Islander
- Other:_____

Population Subgroups

- Students with disabilities
- English language learners
- Students with risk factors (e.g., exposure to violence, poverty, in utero substances)
- Other:_____

Language

- Primary: _____
- Secondary: _____

1b. Intervention Target

Worksheet 1b

Instructions: Circle all of the options that reflect what you want the intervention to address or target.

Behavioral, Emotional, and Physical Health

- Aggression
- Alcohol and Other Drug Use
- Anxiety/Depression/Trauma Exposure
- Autism
- Emotion Regulation
- Fitness & Nutrition
- Inattention/Hyperactivity
- Social Skills
- Other:_____

Academic and Related Skills

- Career Exploration/Training
- Early Childhood Education
- Language
- Math
- Motor Skills
- Reading
- Study Skills
- Time Management
- Other:_____

Student-Family-School Connections

- School Safety
- Support for Academic, Social, and Civic Learning
- Social Relationships
- School Connectedness
- Physical Environment
- Leadership
- Professional Relationships
- Other:_____

1c. Baseline Severity Level

Worksheet 1c

Instructions: Circle the level of need in your population with regard to the severity level of existing risk factors and problems.

Low	• Mild or no problems in population. Low-level risk factors may be present. • Consider a **UNIVERSAL** intervention designed for the overall population.
Moderate	• Elevated risk or some evidence of problems in certain individuals in a population. • Consider a **SELECTIVE** intervention designed for a group of students identified as at risk for adverse outcomes.
High	• High risk or significant evidence of problems in certain individuals in a population. • Consider an **INDICATED** intervention designed for students demonstrating problems.

1d. Intervention Delivery

Worksheet 1d

Instructions: Within each category, circle all the options that characterize your intended intervention delivery.

Interventionist

* Mental Health Specialist
* Regular Education Teacher
* Special Education Teacher
* Resource Teacher
* School Health Staff
* Cafeteria Staff
* Administrative Staff
* Paraprofessional
* Other: _____

Format

* Small group
* Classroom group
* Other: _____
* Individual student
* Individual student + caregiver/family

Frequency

* Once
* Daily
* Multiple times/day
* As needed
* Multiple times/week
* Weekly
* Monthly
* Multiple times/month
* Other: _____

Time

* Brief (about 5-10 minutes)
* Approx. 1 hour or less
* Approx. 1-2 hours
* Other: _____
* Approx. half a day
* Approx. 1 full day

2: Readiness to Implement EBP

Worksheet 2

Instructions: Fill in the name of each locality across the top row. Circle the status of each locality with regard to each consideration listed in the left-hand column.

Consideration	Locality 1: _____	Locality 2: _____	Locality 3: _____	Statewide
Motivational readiness	**Youths/Families:** *Low Fair High*	**Youths/Families:** *Low Fair High*	**Youths/Families:** *Low Fair High*	**Youths/Families:** *Low Fair High*
	Staff: *Low Fair High*	**Staff:** *Low Fair High*	**Staff:** *Low Fair High*	**Staff:** *Low Fair High*
	Administrators/Leaders: *Low Fair High*	**Administrators/Leaders:** *Low Fair High*	**Administrators/Leaders:** *Low Fair High*	**Administrators/Leaders:** *Low Fair High*
Organizational climate	*Poor Fair Strong*	*Poor Fair Strong*	*Poor Fair Strong*	*Poor Fair Strong*
Current staff capacity to implement	**Number of staff:** *Low Fair High*	**Number of staff:** *Low Fair High*	**Number of staff:** *Low Fair High*	**Number of staff:** *Low Fair High*
	Staff skills: *Poor Fair Strong*	**Staff skills:** *Poor Fair Strong*	**Staff skills:** *Poor Fair Strong*	**Staff skills:** *Poor Fair Strong*
Resource availability for intervention	**Budget: $_____**	**Budget: $_____**	**Budget: $_____**	**Budget: $_____**
	Training/Consultation: *Low Sufficient*	**Training/Consultation:** *Low Sufficient*	**Training/Consultation:** *Low Sufficient*	**Training/Consultation:** *Low Sufficient*
	Equipment/Materials: *Low Sufficient*	**Equipment/Materials:** *Low Sufficient*	**Equipment/Materials:** *Low Sufficient*	**Equipment/Materials:** *Low Sufficient*
	Facilities/Space: *Low Sufficient*	**Facilities/Space:** *Low Sufficient*	**Facilities/Space:** *Low Sufficient*	**Facilities/Space:** *Low Sufficient*
	Sustainability: *Low Sufficient*	**Sustainability:** *Low Sufficient*	**Sustainability:** *Low Sufficient*	**Sustainability:** *Low Sufficient*

3: Exploring EBPs

		EBP: _____	EBP: _____	EBP: _____	EBP: _____	EBP: _____
EBP Evidence Base, Relevance, and Replications	Do the EBP's outcomes align with the needs of your population of focus? (Note that needs must be identified from local data.)	Yes No	Yes No	Yes No	Yes No	Yes No
	Is there evidence from at least 2 randomized control trials of the EBP that demonstrate relevant outcomes?	Yes No	Yes No	Yes No	Yes No	Yes No
	If yes:					
	• Are there relevant outcomes for your population of focus (e.g., similar age, gender, language, culture/race)?	Yes No	Yes No	Yes No	Yes No	Yes No
	• Were the relevant outcomes achieved in a setting comparable to your setting?	Yes No	Yes No	Yes No	Yes No	Yes No
	Will the developer give you contact information for two or three sites that have implemented the EBP for two or more years?	Yes No	Yes No	Yes No	Yes No	Yes No
Adaptation	Does it appear that the EBP would need to be adapted to meet the needs of your population of focus?	Yes No	Yes No	Yes No	Yes No	Yes No
	If yes, has the EBP been adapted for populations similar to your population of focus (as indicated by the developer, published studies, or your knowledge of local adaptations)?	Yes No	Yes No	Yes No	Yes No	Yes No
	If adaptations will be needed, do you have-experienced staff or consultants who can make the adaptations while preserving the EBP's core components (i.e., components that should not be modified)?	Yes No NA	Yes No NA	Yes No NA	Yes No NA	Yes No NA
EBP Features and Implementa-tion Supports	Do the EBP's features align with your preferred delivery characteristics (e.g., setting, time of day, frequency, staff who will implement)?	Yes No	Yes No	Yes No	Yes No	Yes No
	How many and what type of staff are required to implement the EBP?					
	What types of implementation supports are available (e.g., consultation, online resources)? List here:					
	How long does it usually take a new implementation site to implement the EBP effectively?					
	Are evaluation and fidelity monitoring tools available for the EBP?	Yes No	Yes No	Yes No	Yes No	Yes No

		EBP: _____	EBP: _____	EBP: _____	EBP: _____	EBP: _____
Existing Practices & Organi-zational Support	What related programs and practices are currently being implemented in your setting? *(list)* (1) _____ (2) _____ (3) _____ (4) _____					
	Does the EBP duplicate or compete with existing programs?	Yes No	Yes No	Yes No	Yes No	Yes No
	What do you expect would be the net value of adopting the EBP in your setting?	Low Med High	Low Med High	Low Med High	Low Med High	Low Med High
	Does the EBP require strong organizational support (e.g., school leader support, administrative support)?	Yes No	Yes No	Yes No	Yes No	Yes No
	If yes, is this support likely to be forthcoming?	Yes No	Yes No	Yes No	Yes No	Yes No
Training	How long is the training for the EBP (hours, days)?					
	How will new staff (hired after the initial training) be trained?					
	What is the cost of the initial training? (Include trainers' fees, travel, space, equipment, food, etc.)	$	$	$	$	$
	What is the cost of ongoing training, including booster sessions?	$	$	$	$	$
	Can staff in your training become certified to conduct training?	Yes No	Yes No	Yes No	Yes No	Yes No
	If yes, what is the cost of certification training?	$	$	$	$	$
Additional Costs	Does the developer offer ongoing implementation consultation by phone and email?	Yes No	Yes No	Yes No	Yes No	Yes No
	If yes, what is the cost?	$	$	$	$	$
	What is the cost of materials?	$	$	$	$	$
	What is the cost of equipment?	$	$	$	$	$
	What is the total estimated cost of initial implementation? (Include training costs from section above.)	$	$	$	$	$

4. Tracking the EBP's Impact: Measurement Domains and Measures

Domain	Measure	For More Information
Academic Achievement	**Achievement Tests** • California Achievement Tests • Stanford Achievement Test • Wechsler Individual Achievement Test • Wide Range Achievement Test	
	Grades/Grade point average	
Attendance	**School records**	
Anxiety	**Revised Child Anxiety and Depression Scale** (RCADS; caregiver and youth report)	*http://www.childfirst.ucla.edu/Resources.html*
	Screen for Child Anxiety Related Disorders (SCARED; caregiver and youth report)	*http://www.psychiatry.pitt.edu/node/8209*
	Spence Children's Anxiety Scale (SCAS; caregiver and youth report)	*http://www.scaswebsite.com/*
Bullying	**Bullying Perpetration and Bullying Victimization Scales** (youth report)	*http://www.performwell.org/index.php/find-surveyassessments/outcomes/health-a-safety/aggression-or-violence-perpetration/bullying-perpetration-and-bullying-victimization-scales-sss*
	Illinois Bully Scale (youth report)	*http://www.performwell.org/index.php/find-surveyassessments/outcomes/health-a-safety/aggression-or-violence-perpetration/illinois-bully-scale--victim-subscale-ibs*
	Reynolds Bully Victimization Scales for Schools (youth report)	*http://www.pearsonclinical.com/education/products/100000032/reynolds-bully-victimization-scales-for-schools-rbvs.html?Pid=015-8630-009*

Domain	Measure	For More Information
Depression	**Revised Child Anxiety and Depression Scale** (RCADS; caregiver and youth report)	*http://www.childfirst.ucla.edu/Resources.html*
	Center for Epidemiological Studies Depression Scale for Children (CES-DC; youth report)	*http://www.brightfutures.org/mentalhealth/pdf/tools.html (then scroll down to the Bridges section and you will see the CES-DC listed under Mood Disorders)*
Disruptive Behavior	**Eyberg Child Behavior Inventory** (caregiver report) **Sutter-Eyberg Student Behavior Inventory** (teacher report)	*http://pcit.phhp.ufl.edu/Literature/Eybergch1992.pdf*
	Disciplinary Referrals	
Inattention/Hyperactivity	**Vanderbilt ADHD Diagnostic Teacher Rating Scale** (teacher report)	*http://www.brightfutures.org/mentalhealth/pdf/tools.html (then scroll down to the Bridges section and you will see the Vanderbilt listed under Attention Deficit Hyperactivity Disorder)*
Multiple Domains of Behavior/Emotion: *Anxious/Depressed Thought Problems* *Withdrawn/Depressed Attention Problems* *Somatic Complaints Rule-Breaking* *Social Problems Aggression*	**Achenbach System** • Child Behavior Checklist • (CBCL; caregiver report) • Youth Self Report • (YSR; youth report) • Teacher Report Form • (TRF; teacher report)	*http://www.aseba.org/*
Multiple Domains of Behavior/Emotion: *Activities of Daily Living Hyperactivity* *Adaptability Leadership* *Aggression Learning Problems* *Anxiety Social Skills* *Attention Problems Somatization* *Atypicality Study Skills* *Conduct Problems Withdrawal* *Depression* *Functional Communication*	**Behavior Assessment for Children** (BASC; caregiver, youth, and teacher report)	*http://www.pearsonclinical.com/psychology/products/100000658/behavior-assessment-system-for-children-second-edition-basc-2.html?Pid=PAa30000*

Domain	Measure	For More Information
Multiple Domains of Behavior/Emotion: *Emotional Symptoms* *Conduct Problems* *Hyperactivity/Inattention* *Peer Relationship Problems* *Prosocial Behavior*	**Strengths and Difficulties Questionnaire** (SDQ; caregiver, youth, and teacher report)	*http://www.sdqinfo.org/*
Multiple Domains of Behavior/Emotion: *Inattention* *Hyperactivity/Impulsivity* *Oppositional/Conduct Problems* *Anxiety/Depression*	**Vanderbilt ADHD Diagnostic Teacher Rating Scale** (teacher report)	*http://www.brightfutures.org/mentalhealth/pdf/tools.html (then scroll down to the Bridges section and you will see the Vanderbilt listed under Attention Deficit Hyperactivity Disorder)*
Multiple Domains of Behavior/Emotion: *Critical Items (e.g., suicidal ideation)* *Social Problems* *Interpersonal Distress* *Interpersonal Relationships* *Behavioral Dysfunction* *Somatic Complaints*	**Youth-Outcome Questionnaire** (Y-OQ; caregiver, youth, and teacher report)	*http://www.oqmeasures.com/page.asp?PageId=102*
School Climate	**California School Climate Survey** (staff report)	*http://cscs.wested.org/administer/core#core*
School Engagement	**Motivation and Engagement Scale** (youth report)	*http://www.lifelongachievement.com/the-motivation-and-engagement-scale-mes-i8/*
	Student School Engagement Survey (youth report)	*http://www.schoolengagement.org/index.cfm/Attachment (then scroll down to the Resources section and you will see the NCSE Student Survey)*
School Refusal	**School Refusal Assessment Scale** (SRAS; caregiver and youth report)	*http://nebula.wsimg.com/4f7f77874c6ae90ee581a8efe70fd881?AccessKeyId=5FA11D39B78CC67CC07D&disposition=0&alloworigin=1*
Substance Use	**CRAFFT Screening Tool** (youth report)	*http://www.ceasar-boston.org/clinicians/crafft.php*
Traumatic Stress	**Child PTSD Symptom Scale** (youth report)	*http://www.istss.org/ChildPTSDSymptomScale.htm*
	UCLA PTSD Reaction Index (caregiver and youth report)	*http://www.istss.org/UCLAPosttraumaticStressDisorderReactionIndex.htm*

Measurement Resources

- **University of Maryland Center for School Mental Health**
  Provides a *Free Assessment List* of publicly available and no-cost measures.
  http://csmh.umaryland.edu/Resources/ClinicianTools/index.html

- **The National Center on Safe Supportive Learning Environments (NCSSLE) at American Institutes for Research**
  Provides compendia of tools for assessing school climate, bullying, and student engagement
  http://safesupportivelearning.ed.gov/topic-research/school-climate-measurement

- **Massachusetts General Hospital School Psychiatry Program**
  Provides a table summary of screening tools and rating scales
  http://www2.massgeneral.org/schoolpsychiatry/screeningtools_table.asp

- **The California Evidence-Based Clearinghouse**
  Provides summaries of screening and assessment tools
  http://www.cebc4cw.org/assessment-tools/