Comprehensive School-based Mental Health: Building System Capacity

Bureau of Exceptional Education and Student Services

Student Support Services Project

December 10, 2018

FLORIDA DEPARTMENT OF EDUCATION
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Resources

- National Center for School Mental Health
  http://csmh.umaryland.edu
- UCLA Center for School Mental Health
  http://smhp.psych.ucla.edu/summit2002/toolbox.htm
- National Center for Healthy Safe Children
  https://healthysafechildren.org
- School Mental Health Referral Pathways Toolkit (SAMHSA)
- School Mental Health Toolkit (Colorado)
- Safe Schools FIT Toolkit
  https://healthysafechildren.org/safe-schools-healthy-students-framework-implementation-toolkit

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School-based Mental Health Overview

Prevalence of Mental Health Disorders

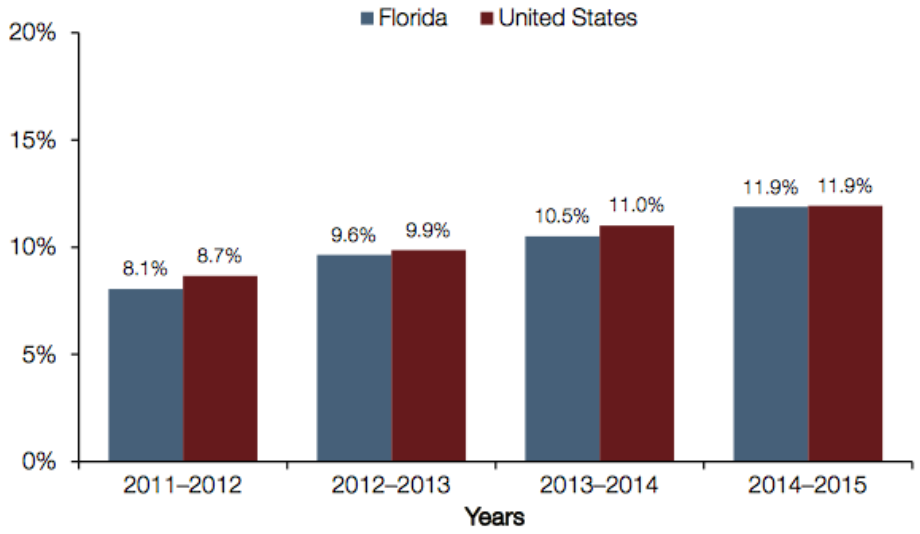
- An estimated 70% of children have experienced some type of physical or emotional trauma.
- Approximately 20% of school-age children and youth have a diagnosable mental health disorder (Merikangas et al., 2010; CDC, 2013).
- Prevalence of serious emotional disturbance with severe impairment among children and adolescents – 10% (Williams et al., 2017).
- More than 60% of children in juvenile detention have a diagnosable mental illness.
- The majority of mental illnesses emerge in childhood, yet fewer than half of the children receive treatment.

YOUTH MENTAL HEALTH AND SERVICE USE

DEPRESSION

Past Year Major Depressive Episode (MDE) Among Adolescents Aged 12–17 in Florida and the United States (Annual Averages, 2011–2012 to 2014–2015)[1,3]

In 2014–2015, Florida's annual average percentage of major depressive episode (MDE) among adolescents aged 12–17 was similar to the corresponding national annual average percentage.



11.9%

In Florida, an annual average of about 166,000 adolescents aged 12–17 (11.9% of all adolescents) in 2014–2015 had experienced an MDE in the past year. The annual average percentage in 2014–2015 was higher than the annual average percentage in 2011–2012.

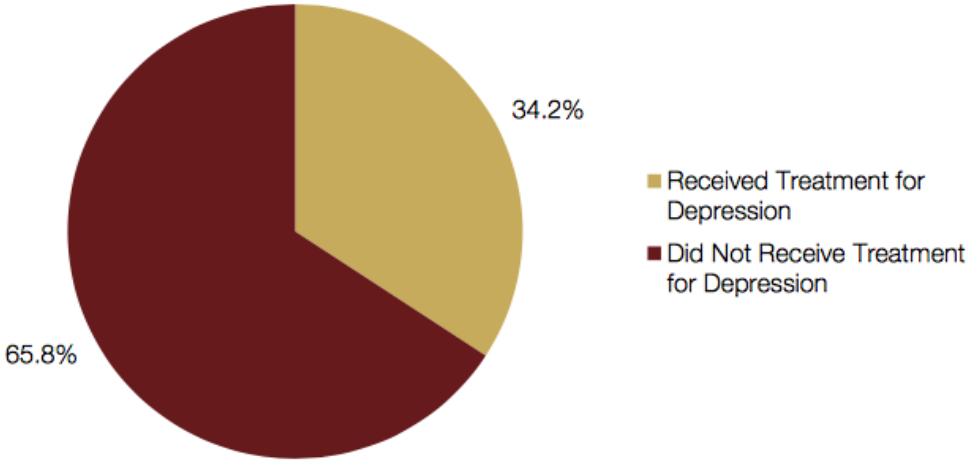
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2012 to 2014–2015.

YOUTH MENTAL HEALTH AND SERVICE USE

TREATMENT FOR DEPRESSION

Past Year Treatment for Depression Among Adolescents Aged 12–17 with Major Depressive Episode (MDE) in Florida (Annual Average, 2011–2015)[2,4]

From 2011 to 2015, Florida's annual average percentage of past year treatment for depression among adolescents aged 12–17 with past year MDE was lower than the corresponding national annual average percentage (38.9%).



34.2%

In Florida, an annual average of about 47,000 adolescents aged 12–17 with past year MDE (34.2% of all adolescents with past year MDE) from 2011 to 2015 received treatment for their depression in the past year.

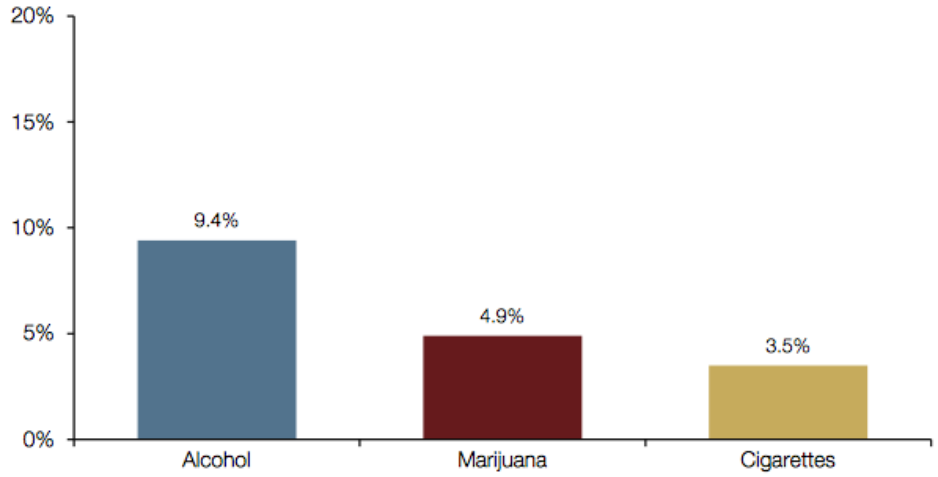
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2015.

YOUTH SUBSTANCE USE

INITIATION OF SUBSTANCE USE

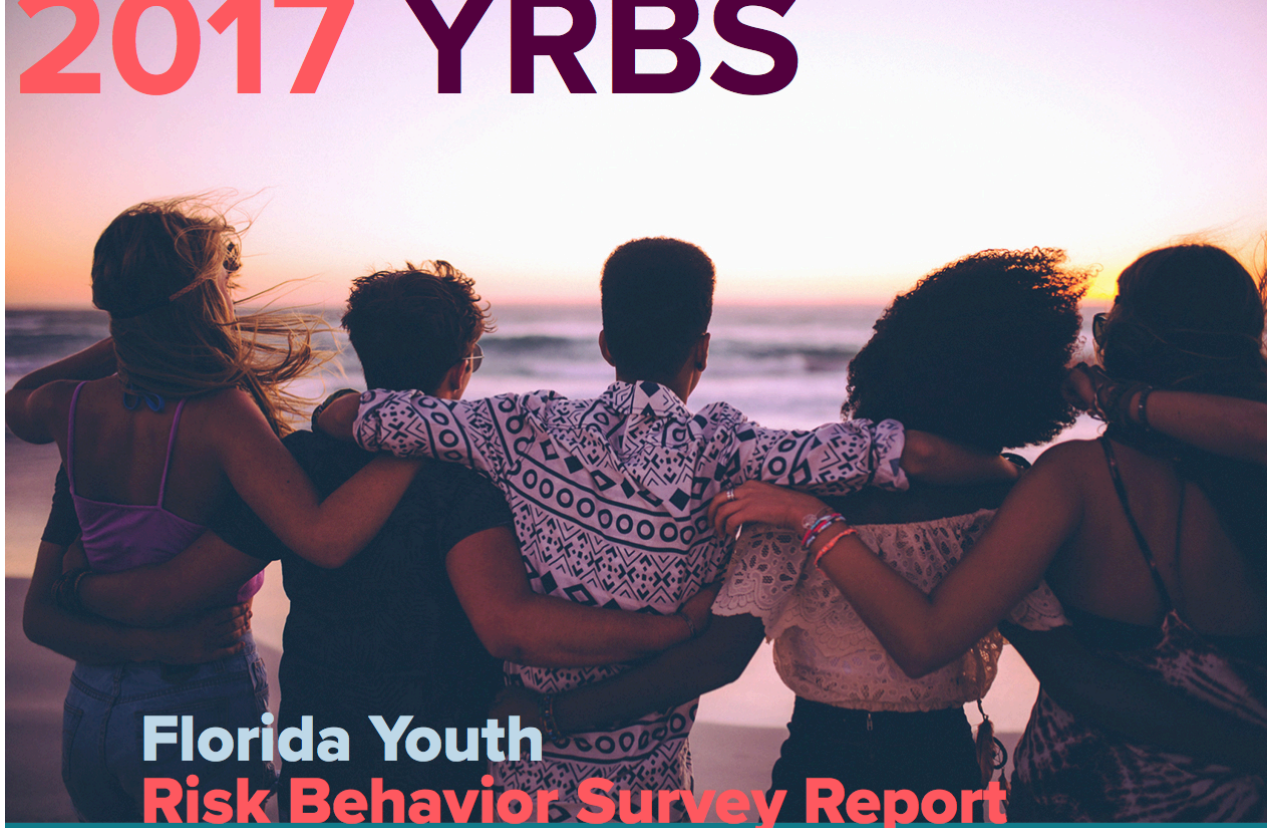
Past Year Initiation (First Use) of Selected Substances Among Adolescents Aged 12–17 in Florida (Annual Averages, 2011–2015)[2]

Among adolescents aged 12–17 in Florida from 2011 to 2015, an annual average of 9.4% initiated alcohol use (i.e., used it for the first time) in the past year, an annual average of 4.9% initiated marijuana use in the past year, and an annual average of 3.5% initiated cigarette use in the past year.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2015.

2017 YRBS



Florida Youth Risk Behavior Survey Report

Rationale for School-Based Mental Health

- School mental health services are essential to supporting safe schools & engaged learners.
- Mental and psychological wellness are correlated with academic achievement.
- Youth with mental health disorders are frequently absent from school.
- Growing and unmet need for mental health services for children and youth & schools are a natural place to provide services.
- School-employed mental health professionals are trained to provide services in educational settings.

Mental & Behavioral Health in ESSA

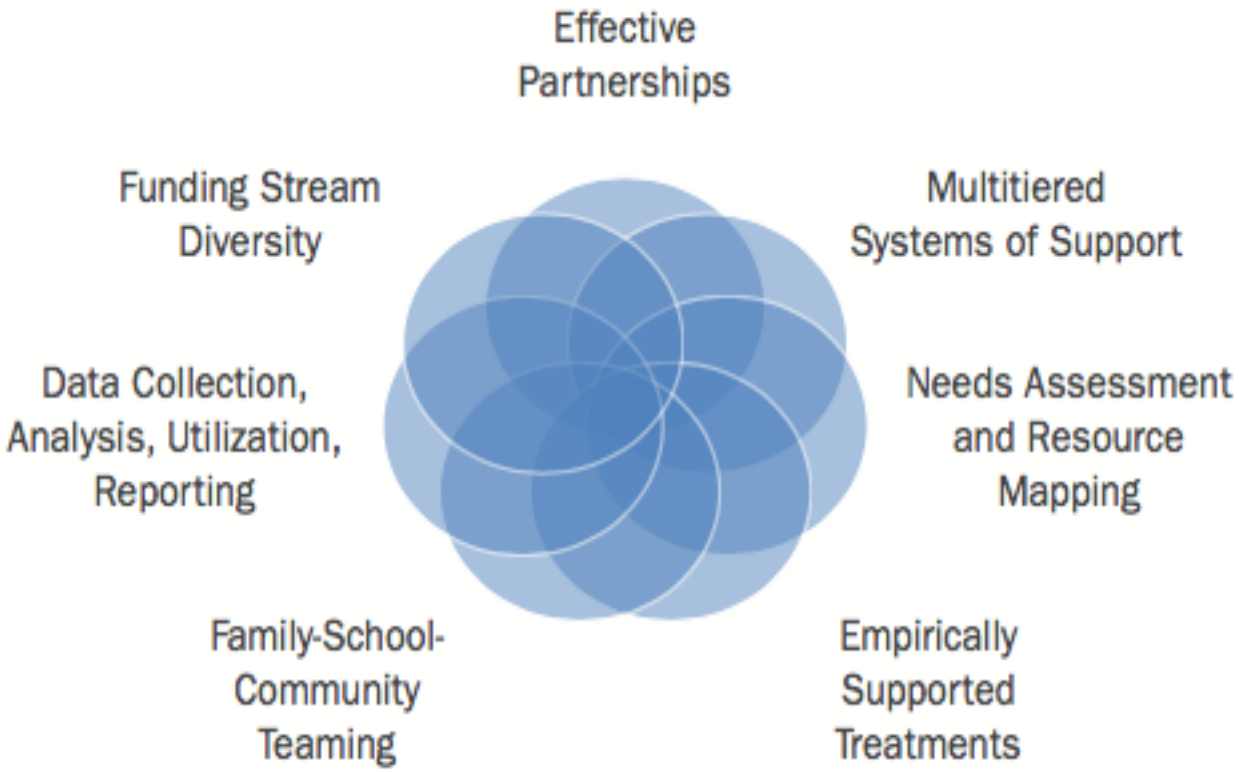
- Implementation of a schoolwide tiered model to prevent and address problem behavior & early intervening services.
- Counseling, school-based mental health programs, & specialized instructional support services.
- School-based mental health services, including early identification of mental health symptoms, drug use, and violence, and referrals to direct individual or group counseling services, which may be provided by school-based mental health services providers.
- School-based mental health services partnership programs.

Mental Health in FL Statutes and F.A.C.

Statute/Rule	Audience	Tier
Comprehensive health education that includes mental and emotional health and substance use (s. 1003.42)	All Students	Tier 1
Multi-tiered system of supports (6A-6.0331, F.A.C.)	All students	Tier 1, 2, & 3
Youth suicide awareness and prevention (s. 1012.583, F.S.)	Educators	Tier 1
Youth mental health awareness and assistance (s. 1012.584, F.S.)	School Staff	Tier 1
Student support services team program (s. 381.0057, F.S.	All Students	Tier 1, 2, & 3
Mental Health Assistance Allocation (s. 1011.62(16)	Students with MH Dx	Tier 2 & 3
Multiagency network/SEDNET (s. 1006.04, F.S.)	Students with E/BD	Tier 3
Threat Assessment (s. 1006.07, F.S.)	Students who are safety threat	Tier 3

School-based Mental Health in a Multi-tiered Framework

Best Practices in Comprehensive School Mental Health



Center for School Mental Health, 2014

Multi-tiered System of Supports, Interconnected Systems Framework, and Systems of Care

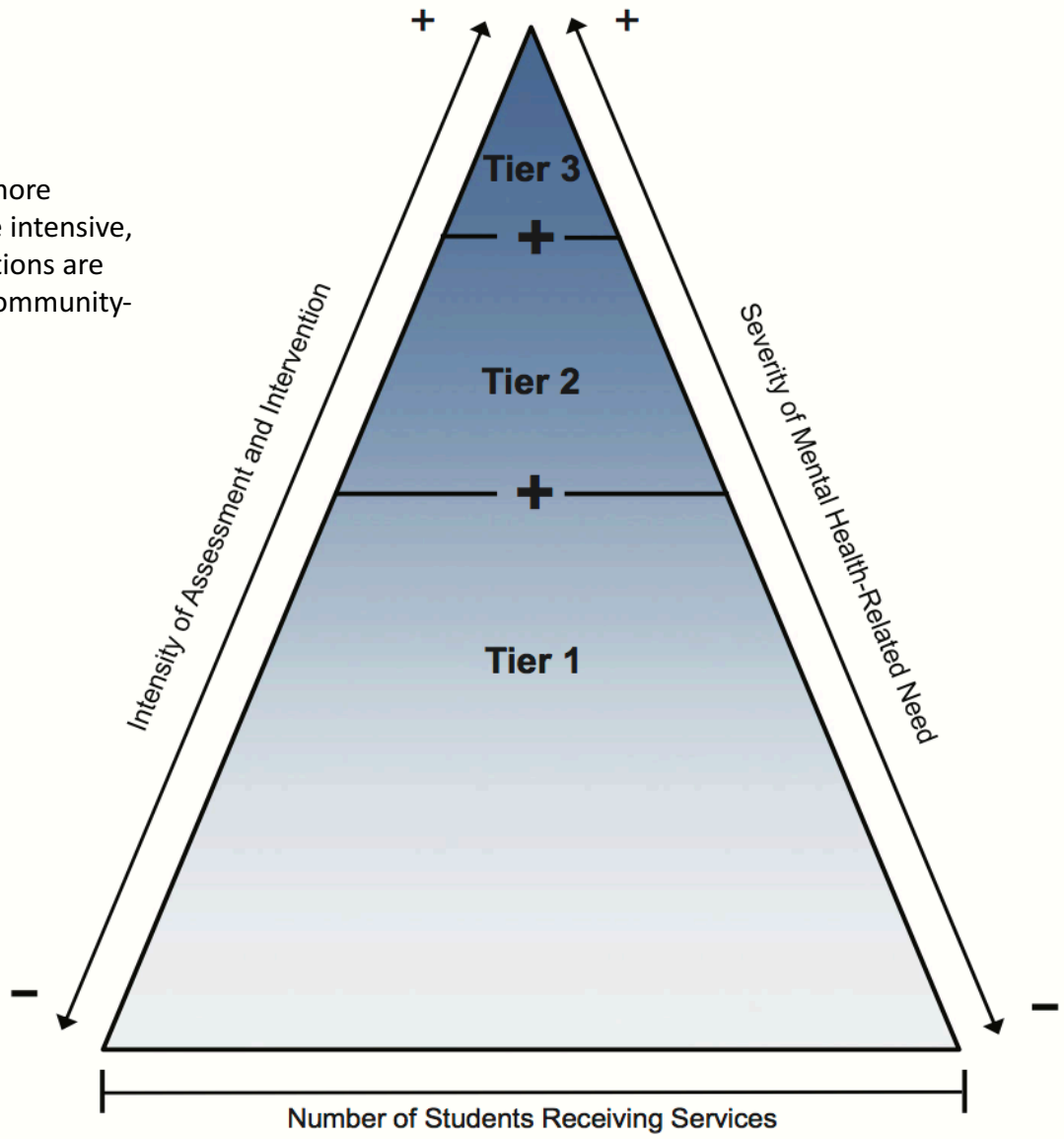
- The multi-tiered system (MTSS) is a continuum of supports and interventions that increase in intensity based on student need.
- Interconnected Systems Framework (ISF) blends school mental health practices, systems, and resources into all levels of a multi-tiered system of supports
- System of care is a collaborative network of services and supports to help children with serious emotional disturbance be successful at home, school, and in the community (wraparound services).

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

Tier 3 interventions are for students with more advanced mental health needs that require intensive, individualized intervention. Tier 3 interventions are individualized and delivered by school or community-based mental health service providers.

Tier 2 interventions are intended for students with mild or emerging mental health needs & are typically delivered in small group settings.

Tier 1 supports are typically implemented for wellness and prevention and are designed to reach all students in a school.



School Mental Health Referral Pathways Toolkit - SAMHSA

Florida AWARE
Advancing Wellness and Resiliency in Education

FLORIDA AWARE'S APPROACH TO Complete Mental Health

Florida AWARE defines complete mental health as the presence of social, behavioral, and emotional well-being and resilience factors, as well as minimal social, behavioral, and emotional problems, and the reduction of risk factors.

Students with complete mental health have many signs of well-being, such as happiness and strong relationships, coupled with few signs of mental health challenges, like symptoms of depression or behavior problems.

Increase Promotive & Resilience Factors

Positive Indicators (Mental Wellness or Well-Being)

- Life Satisfaction and Happiness
- Strong Social Relationships
- Building blocks of well-being (gratitude, empathy, persistence)
- Basic needs are met
- Social skills
- Healthy interactions (minimal bullying, high support)

Resilience Factors

Foster the factors within youth and their environments at school and home that promote resilience and well-being

- Teach social, behavioral, and emotional skills
- Create safe and nurturing environments that support well-being
- Foster resilience and increase protective factors

Negative Indicators (Mental Illness or Problems)

- Anxiety, Depression, and other forms of internalizing problems
- Disruptive Behaviors, such as defiance, rule violations, substance use
- Trauma and other environ-mental stressors
- Thinking errors, behavioral withdrawal
- Risky/ unsafe settings
- Inconsistent rules and expectations across settings

Risk Factors

Prevent, reduce, and manage the risk factors within youth and their environments that cause and maintain mental illness

- Identify students at-risk for mental health problems
- Provide targeted interventions matched to signs of risk and needs
- Provide support to youth in crisis or with chronic mental health needs

Decrease Risk Factors & Symptoms

Florida AWARE supports schools' implementation of a multi-tiered framework of evidence-based practices to promote complete mental health. Contact us at:

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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).

Florida Department of Education fldoe.org

Florida Center for Inclusive Communities FCIC

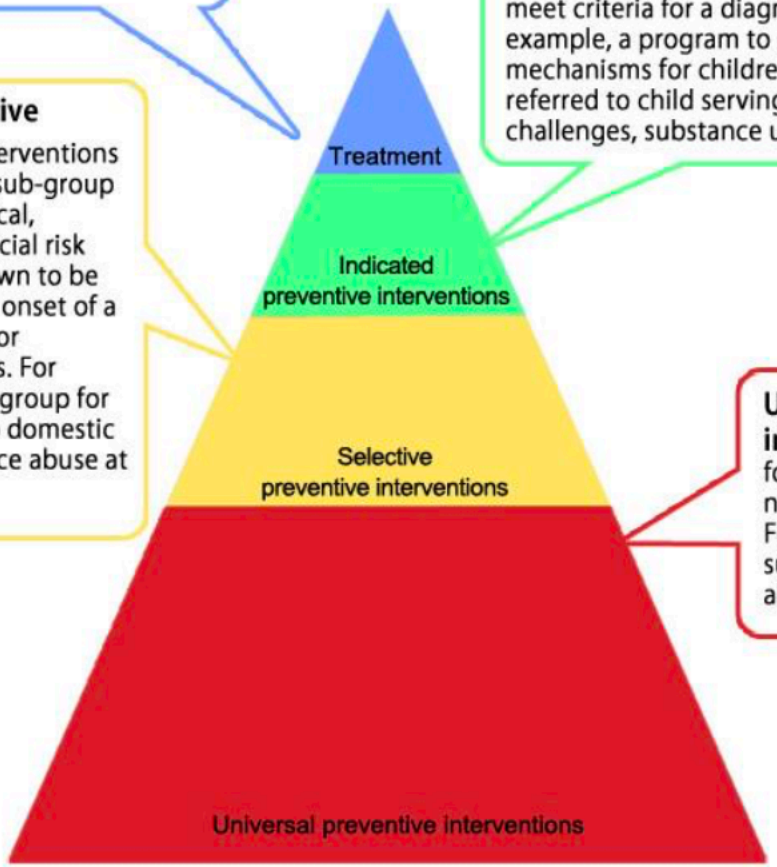
USF University of South Florida College of Behavioral & Community Sciences

MTSS for Mental Health

Treatment: Interventions for individuals who currently have a diagnosable disorder that are intended to cure or reduce the symptoms or effects of the disorder. For example, individual/family/group psychotherapy or evidence-based practice for an individual or family that has been diagnosed with a mental health disorder.

Indicated preventive interventions: Interventions for high-risk individuals who are identified as having some detectable signs or symptoms of a mental, emotional, or behavioral disorder, or who have a biological pre-disposition for such a disorder, but who do not meet criteria for a diagnosis at the current time. For example, a program to develop social skills and coping mechanisms for children or youth who have been referred to child serving systems due to behavioral challenges, substance use or truancy.

Selective preventive interventions: Interventions for individuals or a sub-group who exhibit biological, psychological, or social risk factors that are known to be associated with the onset of a mental, emotional, or behavioral disorders. For example, a support group for children exposed to domestic violence or substance abuse at home



Universal preventive interventions: Interventions for the general public that have not been identified to be at risk. For example, a mental health or substance abuse curriculum for all children in the school.

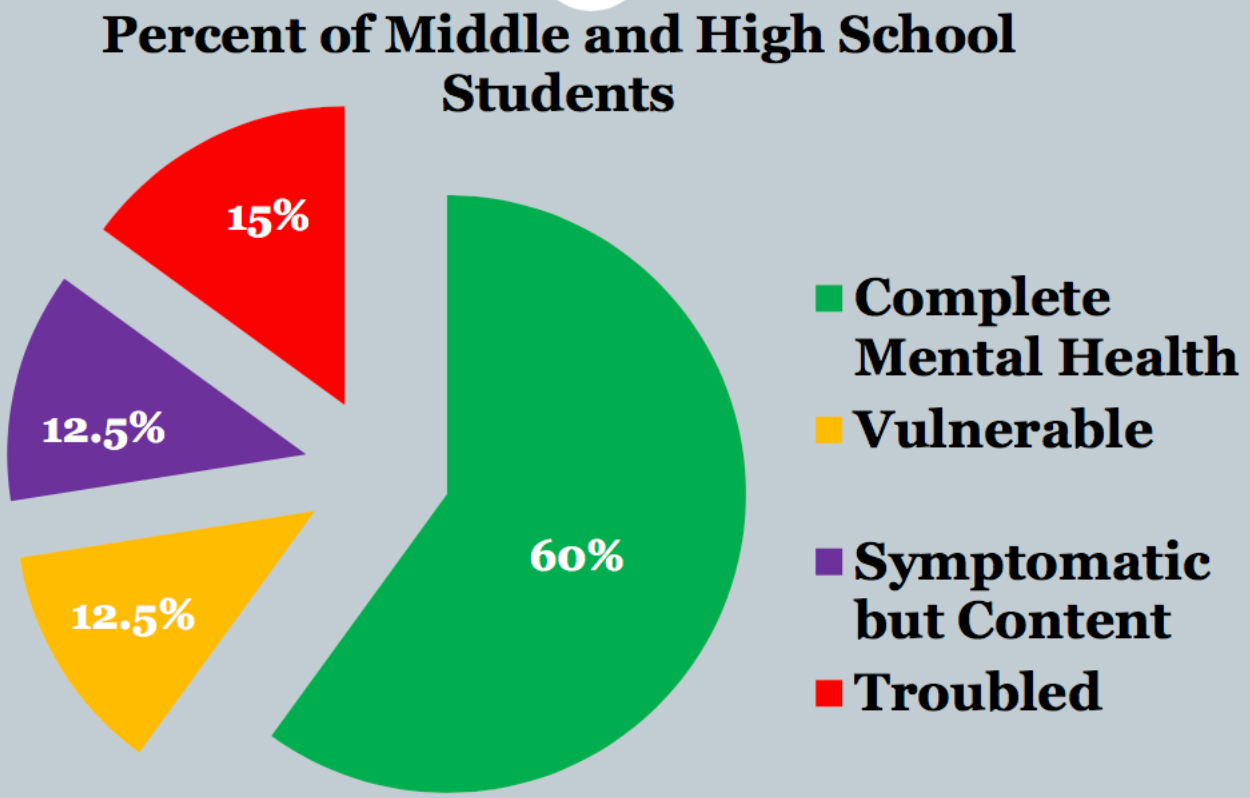
Dual Factor Model of Mental Health

- Factor 1 (Traditional Psychology): Mental *illness* or mental health *problems* (symptoms of emotional distress)
- Factor 2 (Positive Psychology): Subjective well-being

Mental Health Problems	**Subjective Well-Being**	
	Low	Average to High
Low	Vulnerable	Complete Mental Health
High	Troubled	Symptomatic but Content

-Suldo & Shaffer, 2008

% of Students in Mental Health Groups



-Suldo & Shaffer, 2008; Suldo, Thalji-Raitano, Kiefer, & Ferron, 2016

Reframing MTSS levels into a school-community intervention continuum of interconnected systems

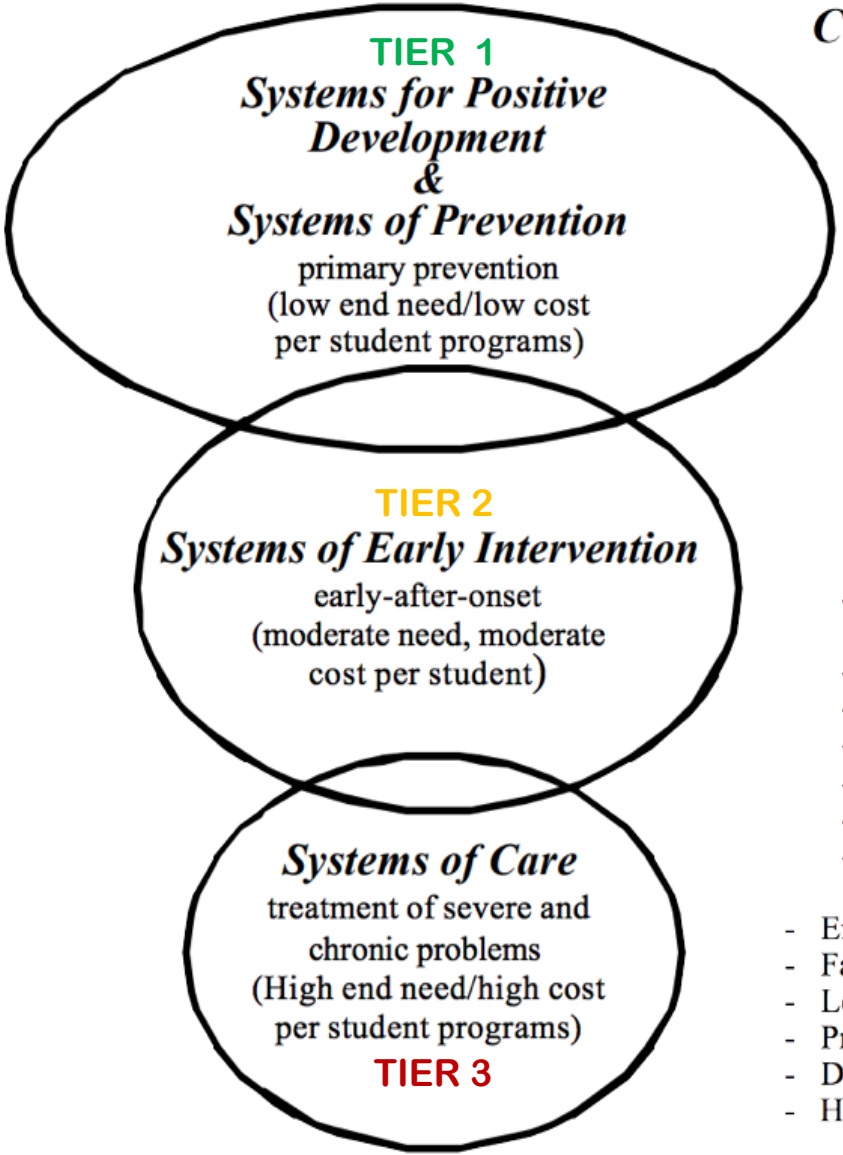
School Resources
(facilities, stakeholders, programs, services)

Examples:

- Enrichment & recreation
- General health education
- Promotion of social and emotional development
- Drug and alcohol education
- Support for transitions
- Conflict resolution
- Parent involvement

- Pregnancy prevention
- Violence prevention
- Dropout prevention
- Learning/behavior accommodations
- Work programs

- Special education for learning disabilities, emotional disturbance, and other health impairments



Community Resources
(facilities, stakeholders, programs, services)

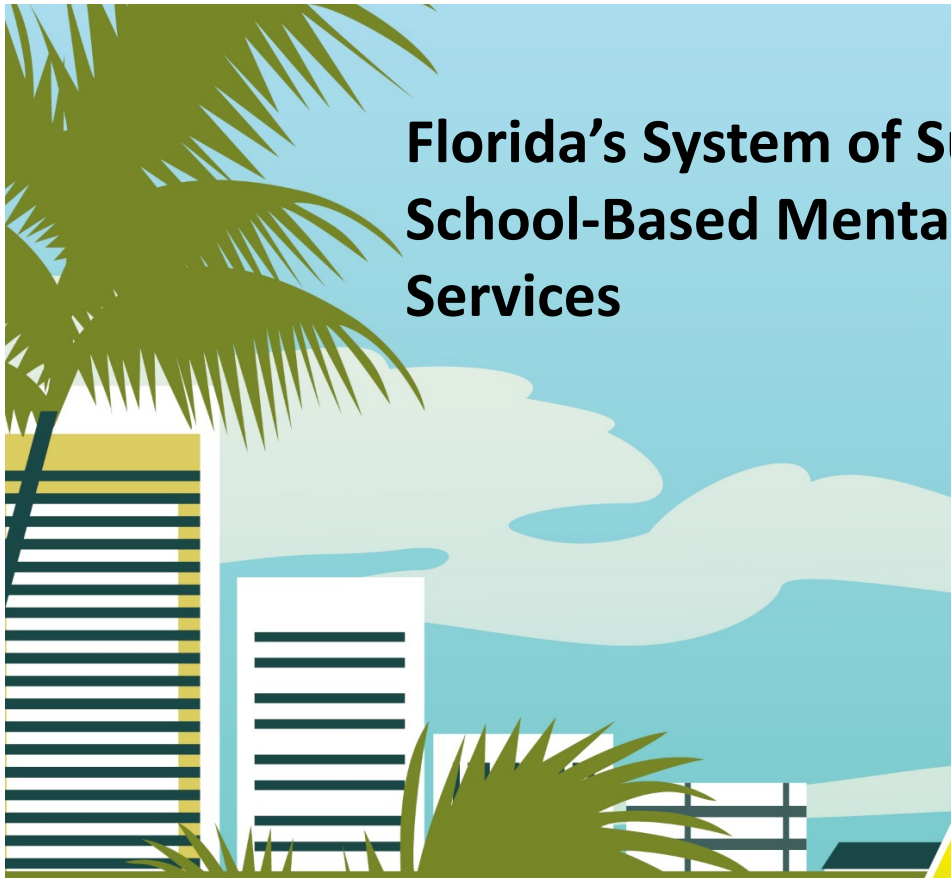
Examples:

- Youth development programs
- Public health & safety programs
- Prenatal care
- Immunizations
- Recreation & enrichment
- Child abuse education

- Early identification to treat health problems
- Monitoring health problems
- Short-term counseling
- Foster placement/group homes
- Family support
- Shelter, food, clothing
- Job programs

- Emergency/crisis treatment
- Family preservation
- Long-term therapy
- Probation/incarceration
- Disabilities programs
- Hospitalization

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

TIER 3

Individualized Intensive

Decision-rules & referral-follow-up procedures
Data and strategy sharing between school and agency staff
Individualized counseling/ intervention, behavior support plans
Intensive progress monitoring
Wrap around & crisis planning
Intensified family partnership and communication

System of Care

TIER 2

Supplemental/At-Risk

Decision rules for early identification and access
Evidence-based group social, emotional, and behavioral interventions based on need
Monitoring of intervention fidelity and student progress

TIER 1

Universal Prevention

Universal screening and progress monitoring
Needs assessment and resource mapping
Reduced Risk Factors - Create orderly and nurturing classrooms and public space, fair and positive discipline, curtailed bullying
Increased Protective Factors - Social-emotional skills instruction, positive/secure relationships, predictable environment
Restorative and Trauma Informed Practices
Data-based problem solving leadership teams - Including youth serving agency, youth and family
School-wide mental wellness initiatives to increase awareness and reduce stigma
Youth Mental Health First Aid Training, Wellness Fairs, Behavioral Health Campaigns

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Role of Student Service Professions

School-based mental health providers (i.e. school counselors, school psychologists, school social-workers) are uniquely trained to infuse mental health prevention and intervention in the learning process.

Student Services as Mental Health Providers in Every Student Succeeds Act (ESSA)

SCHOOL-BASED MENTAL HEALTH SERVICES PROVIDER.— The term 'school-based mental health services provider' includes a State-licensed or **State-certified school counselor, school psychologist, school social worker,** or other State licensed or certified mental health professional qualified under State law to provide mental health services to children and adolescents. – Section 4102(6)

SPECIALIZED INSTRUCTIONAL SUPPORT PERSONNEL.—The term 'specialized instructional support personnel' means—
(i) **school counselors, school social workers, and school psychologists**; and
(ii) other qualified professional personnel, such as **school nurses**, speech language pathologists, and school librarians, **involved in providing assessment, diagnosis, counseling, educational, therapeutic, and other necessary services (including related services** as that term is defined in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401)) as part of a comprehensive program to meet student needs. – Section 8002(47)(A)

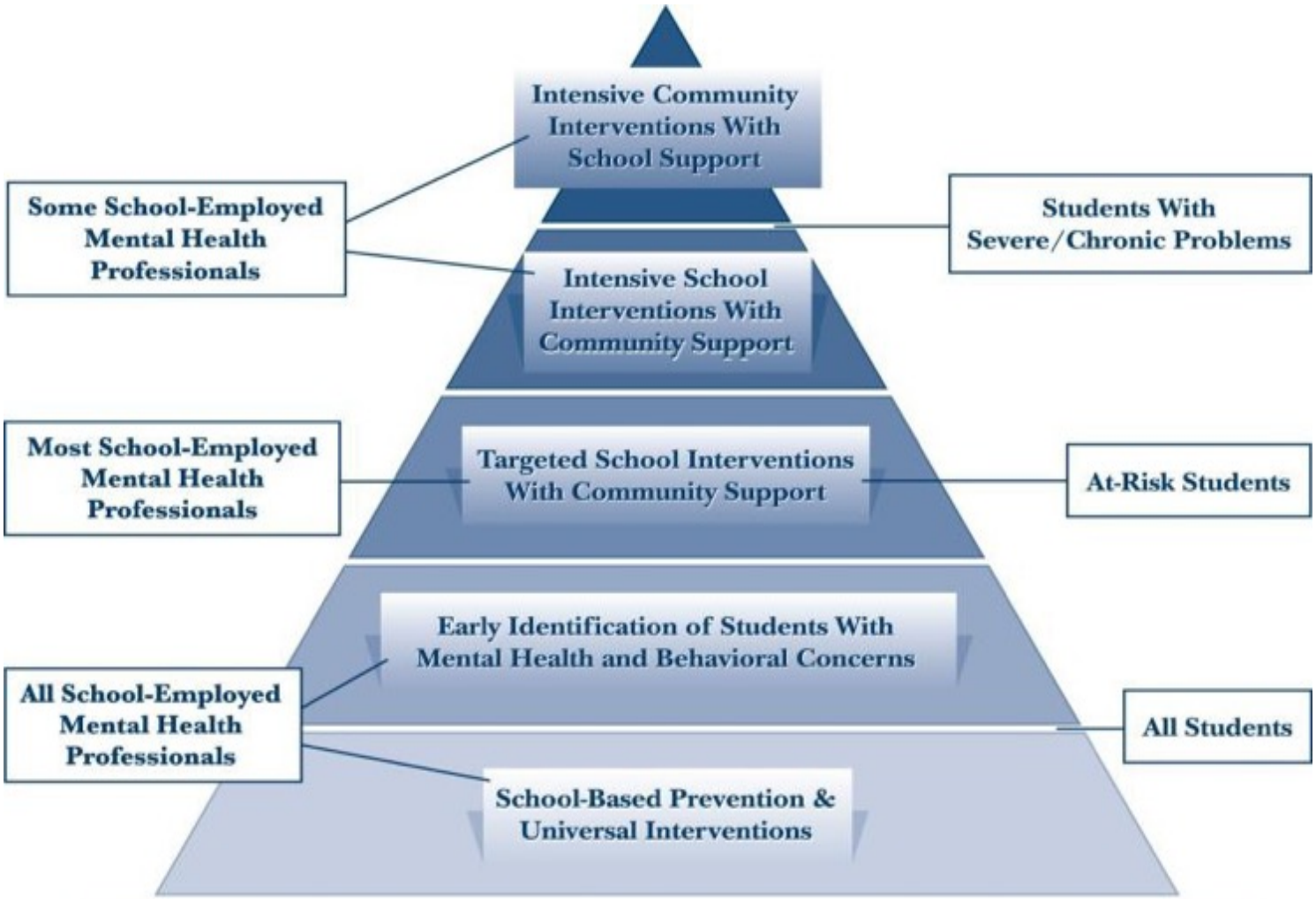
Student Services as Mental Health Providers in IDEA and State Board Rules

Related services providers in IDEA. "Related services includes counseling services, psychological services and counseling, social work services, parent counseling and training, and school nurse services. – 34 CFR § 300.34

Social work services in schools includes group and individual counseling with the child and family – 34 CFR § 300.34(14)(ii)

Psychological services includes planning and managing a program of psychological services including psychological counseling for children and parents. – 34 CFR § 300.34(10)(v)

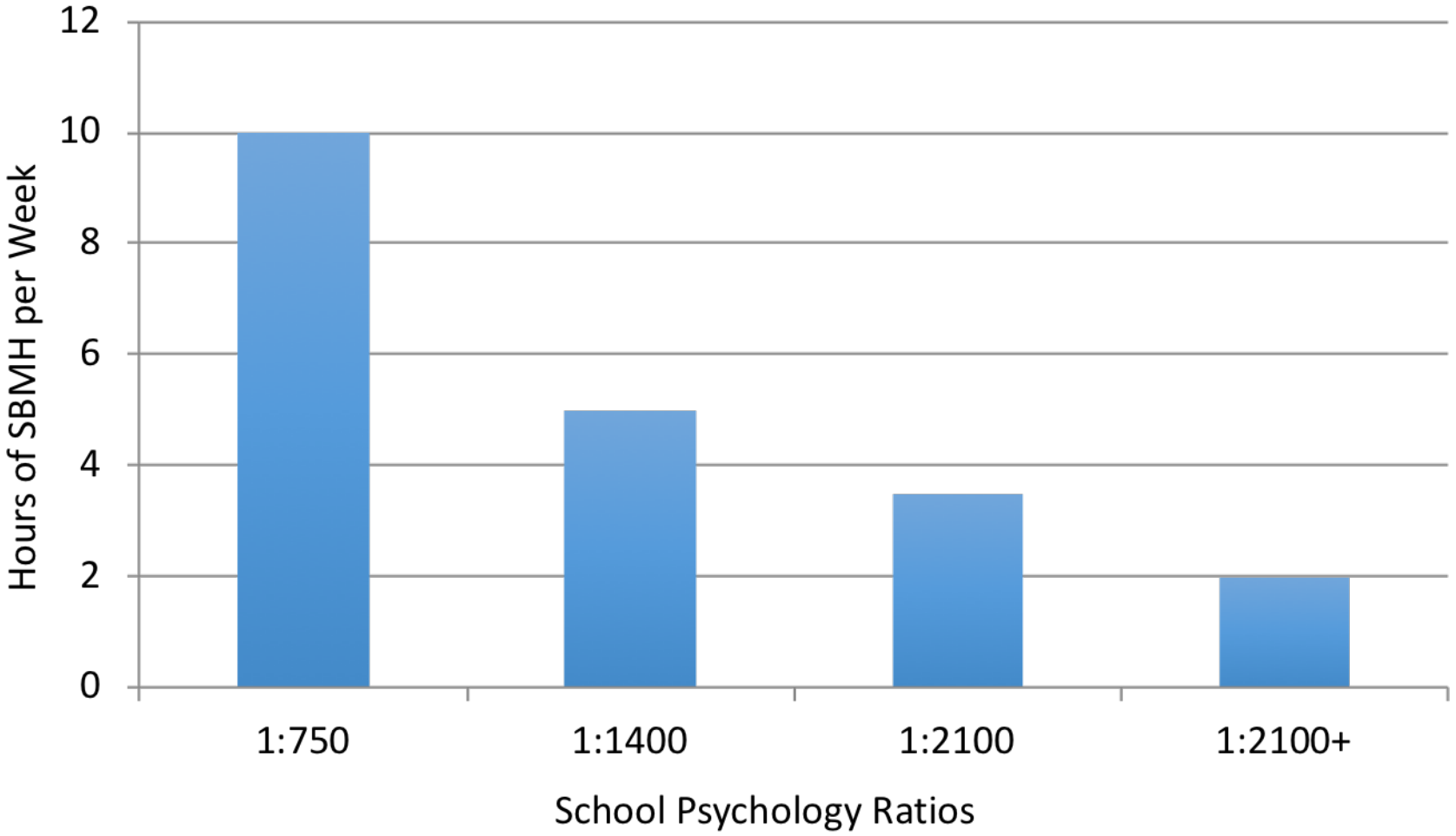
Counseling as a related service "counseling services means services provided by qualified social workers, psychologists, school counselors, or other qualified personnel." – Rule 6A-6.03411(1)(dd), F.A.C.



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.

Relationship Between Ratios and Mental Health Services



Eckland et. al. (2017)

Role of school nurses

- Front-line professionals familiar warning signs and symptoms of mental health challenges (early identification)
- Assist in managing ongoing mental health and substance abuse disorders as part of a student services team.
- Provide behavioral health screening and basic behavioral health skills that include education about substance abuse disorders, psychotropic medication, self-injury.
- Monitor treatment compliance.
- Help connect students & families with school-based and community mental health resources.
- Coordinate health services with medical & mental health professionals in the community.

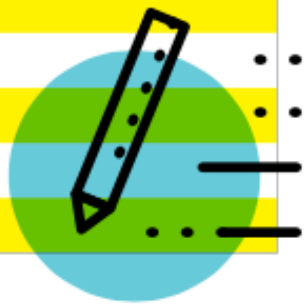
Resource Mapping & Needs Assessment

School Assessment Tool: A Checklist

After reading the **What works?** *section of this toolkit, reach out to your school champion and/or a school or district administrator to assess needs.* For each of these best practices, determine with your team or among your core leadership (which may vary depending on how you are addressing mental health in your district or school) which score best matches to your progress in each of the 10 best practices and write this score next to each practice.

1—We are not implementing this
2—We are not formally implementing this, but have some related efforts
3—We have a plan in place to implement this, and have had some success
4—We have a plan in place to implement this and feel that it has been successful
5—We have policies in place to implement and evaluate this and it is sustainable

Assessment Score (1–5)	Best Practice
	A school wellness team, or other effort to make mental wellness part of an overall wellness strategy
	An established process for mental health, suicide, or substance use screenings and referrals
	Social emotional learning programs
	School-based mental health and substance use services
	Active partnerships with community mental health professionals
	Teacher wellness programs and support
	Stigma reduction programs
	Positive behavioral intervention and supports
	A trauma-informed program or approach
	A suicide prevention program



IN ADDITION, ASK THE SCHOOL OFFICIALS:

1. What do you consider the biggest mental health or social emotional learning needs in your school/district?

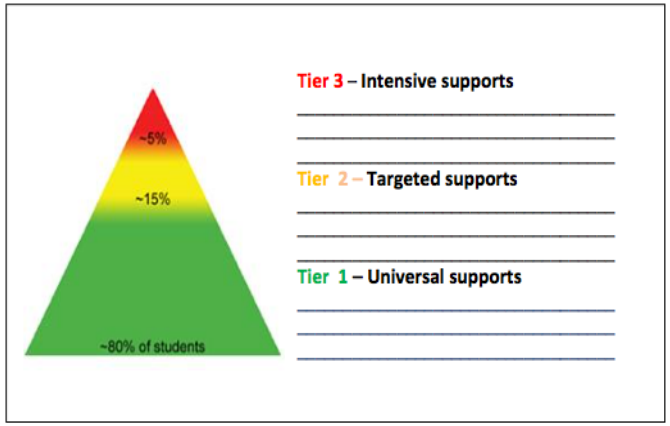
2. What kind of funding needs do you have?

3. What does your school/district need the most help with to improve or increase mental health services?

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

CSMH
Center for School Mental Health

Resource Mapping in Schools and School Districts: A Resource Guide



Suggested Citation: Lever, N., Castle, M., Cammack, N., Bohnenkamp, J., Stephan, S., Bernstein, L., Chang, P., Lee, P, & Sharma, R. (2014). *Resource Mapping in Schools and School Districts: A Resource Guide*. Baltimore, Maryland: Center for School Mental Health.

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

SHAPE

School Mental Health

Improving the quality of mental health in schools, districts, and states

The School Health Assessment and Performance Evaluation (SHAPE) system **(www.theSHAPEsystem.com)** is a free platform for schools and districts to:

- **map** your school mental health system's needs and resources
- measure school mental health **quality** and **sustainability**
- obtain **customized progress reports**
- access **targeted resources** to support quality improvement
- **be included** on the **national map** of school mental health

School Mental Health Matters

3/4 Of youth who receive mental health services, **70-80%** access these services in schools.

Positive school climate integrated with social emotional learning **improves school safety** and decreases bullying.

SAFE SCHOOL ZONE

Students who participate in social emotional learning programs **improve academic performance by 11 percentile points.**

Youth are **8x more likely** to complete mental health treatments in schools than in other community settings.

8x

he SHAPE System is hosted by the National Center for School Mental Health (NCSMH).

he NCSMH mission is to strengthen policies and programs in school mental health to nprove learning and promote success for America's youth.

CSMH funding is provided, in part, by the Maternal and Child Health Bureau (MCHB), ivision of Child, Adolescent and Family Health, Adolescent Health Branch of the Health esources and Services Administration (HRSA) of the U.S. Department of Health and Human ervices (HHS).

NCSMH

NATIONAL CENTER FOR SCHOOL MENTAL HEAL

www.schoolmentalhealth.org

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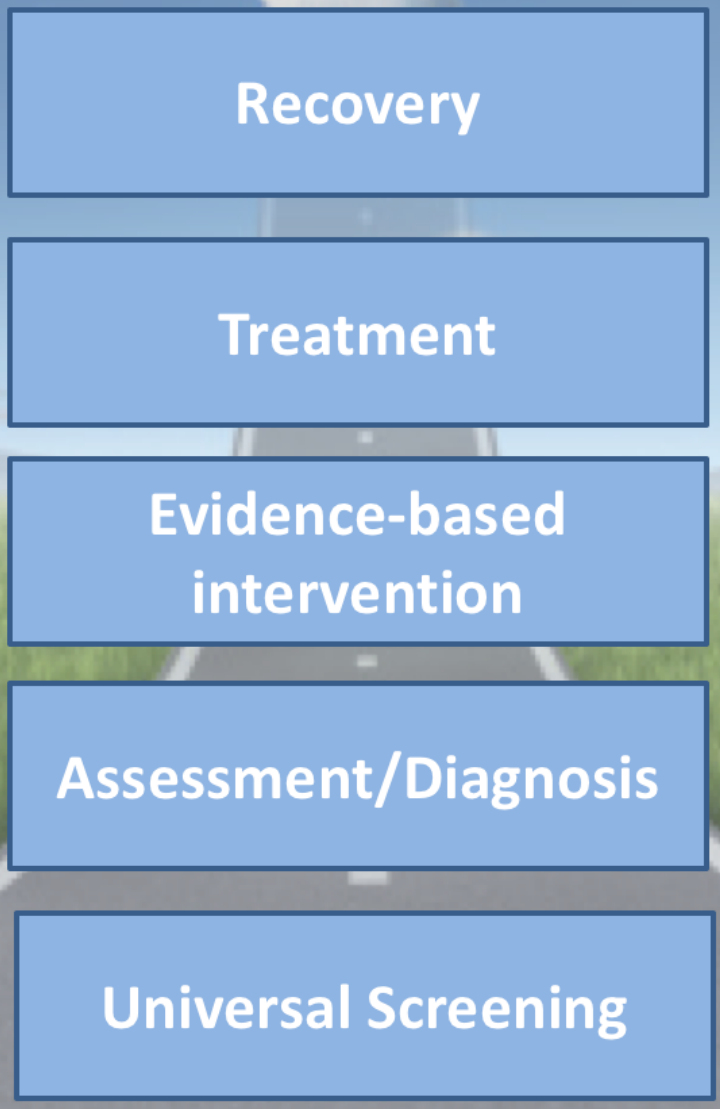
Core Elements of School-based Mental Health

Mental Health Assistance Allocation

Core Elements of SBMH Services



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Universal Screening

Mental health screening is a foundational element of a comprehensive approach to behavioral health prevention, early identification, and intervention.

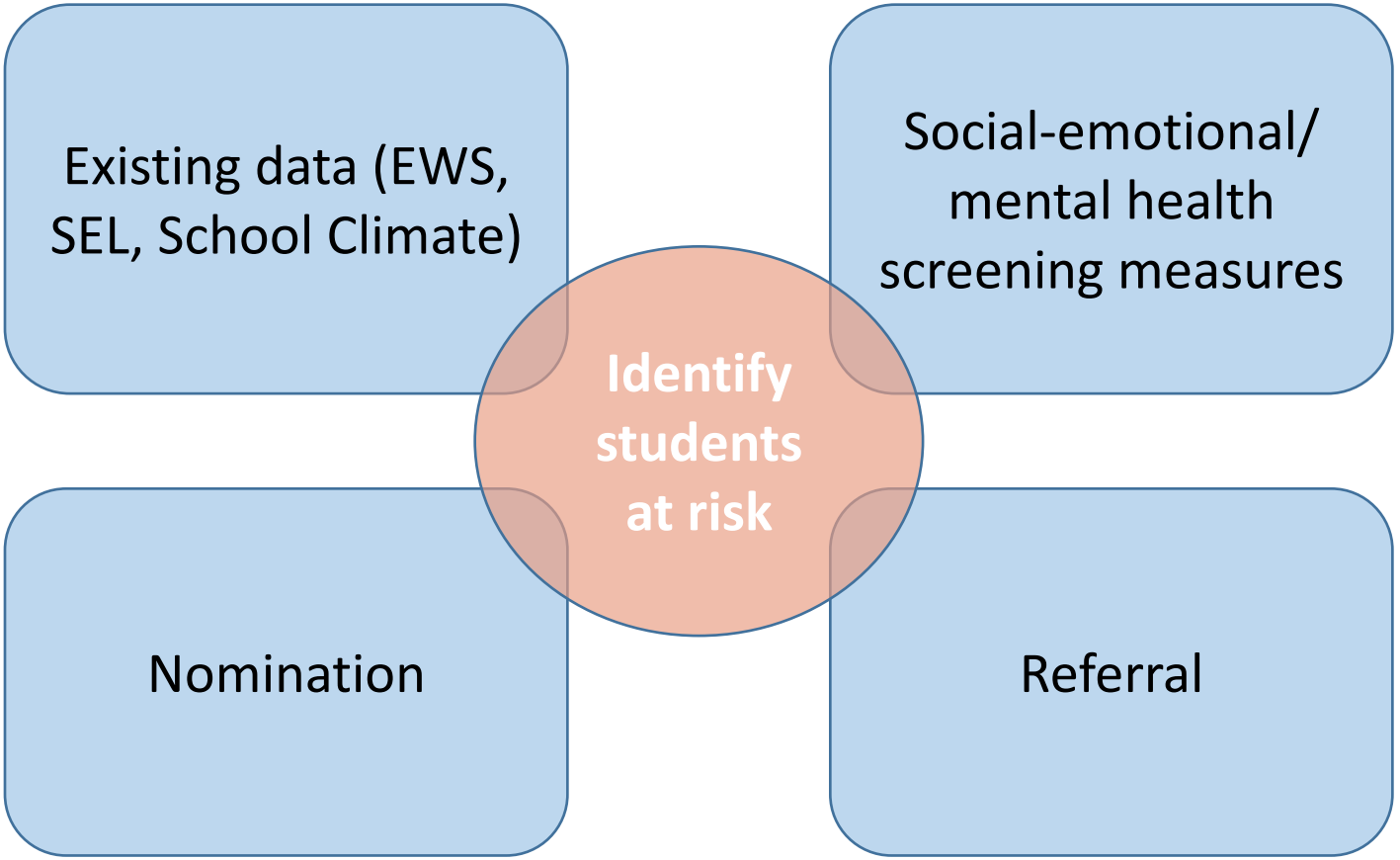
CSMH Mental Health Screening Playbook

Purposes of universal mental health screening

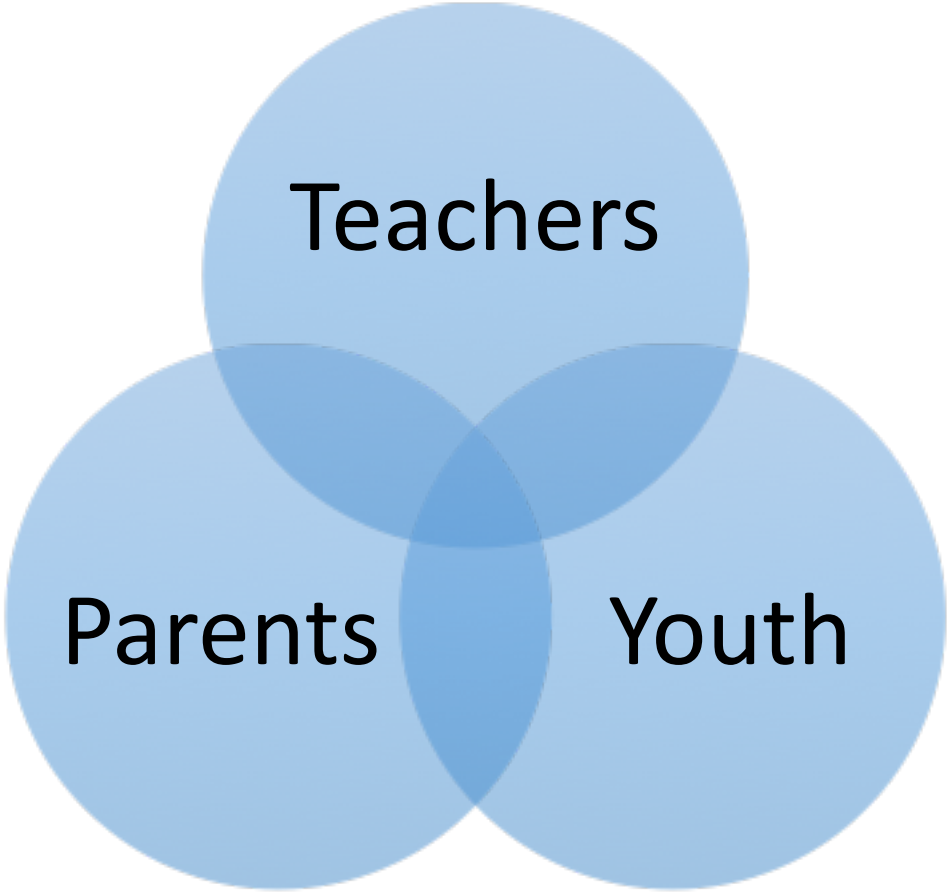
- Assess effectiveness of universal social/emotional/ behavioral programs, interventions, and supports.
- Identify students at risk of academic, behavioral, social, and mental health problems.
- Identify personal strengths/wellness as well as risk factors/emotional distress.

CSMH School Mental Health Screening Playbook

Screening Methods



Informants



Screening Recommendations

- Select screening instrument and informants.
- Include measure of wellness (strength-based)
- Inform parents about screening and rights, and obtain consent when needed (Active or Passive).
- Screen for mental health, behavior, and substance abuse
  - Assess overall level of risk present in school
  - Identify students needing intervention
- Provide intervention support for identified students.
- Monitor impact of mental health supports & interventions.
- Build capacity of school staff to recognize social-emotional and behavioral barriers to learning.

Screening issues/concerns

- Consent
- Right to privacy/Family Rights (PPRA/FERPA)
- Confidentiality
- Overidentification (false positives)
- Capacity to provide intervention/treatment (duty to respond)
- Community Acceptance

Chafouleas et al., (2010). Ethical Dilemmas in School-Based Behavioral Screening.

Consent for mental health screening

- Consent requirements vary depending on the informant & funding source.
- "Active" or "Passive" consent required when student is the informant of "protected" information.
  - "Active" consent – parent must provide a signed, dated, written consent before his or her child can participate in a survey.
  - "Passive" consent – consent is assumed after a parent is notified and given the opportunity to opt their child out of participating in a survey.
- Parental right to be notified of & provided opportunity to review student surveys of protected information.
- Consent not required for teacher completed screenings.

When is active parental consent required?

- The Protection of Pupil Rights Amendment (PPRA) requires written parental consent for student participation in ED-funded survey, analysis, or evaluation that reveals protected information including mental & psychological problems.
- ESSA (Section 4001) requires written, informed parental consent for minor to participate in any mental-health assessment or service that is funded under this title.
- Both PPRA and ESSA require written notification of survey.
- PPRA gives parents the right to inspect materials that will be used in connection with an ED-funded survey or evaluation.

https://studentprivacy.ed.gov/topic/protection-pupil-rights-amendment-ppra

When is passive parental consent permitted?

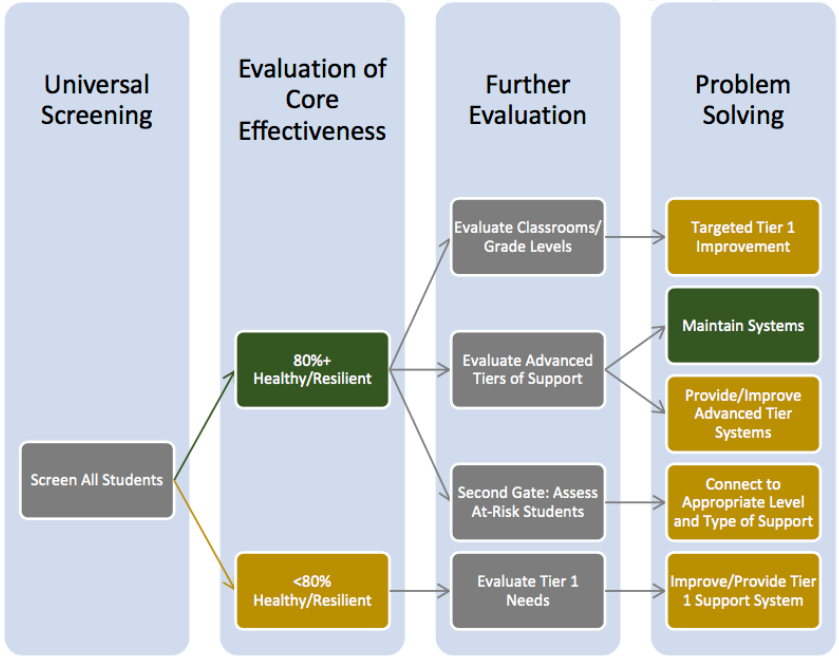
- The Protection of Pupil Rights Amendment (PPRA)
  - For surveys that are administered by an LEA, PPRA requires that the LEA "directly" notify parents of students who are scheduled to participate in order to provide them with an opportunity to opt their children out of participation ("passive" consent).
  - For surveys that ask questions concerning one or more of the eight protected areas but that do *not* require students to participate or are *not* part of a program administered by the Department, the LEA should utilize the "passive" consent requirement.
  - FPCO Model Notice and Consent/Opt Out form

Florida AWARE
Advancing Wellness and Resiliency in Education

Universal Screening Planning Packet

Universal screening for mental health involves the systematic assessment of *all students* within a given unit (e.g., school, district) on social-emotional indicators that youth, family, school/district and community partners agree are important. Universal screening data drives decision-making for (a) determining if improvements are needed in the educational environment and social-emotional curriculum and instruction (i.e., Tier 1), and (b) who may require additional supports. The figure below depicts the problem-solving logic of implementing universal screening within a multi-tiered system of support.

Universal Screening Problem-Solving Logic



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A Sample of Broadband, Empirically-Developed Screening Instruments

Below is a list of the screening instruments displayed in the table, along with examples of validation studies.

Acronym	Full Instrument Name
BASC-3 BESS	BASC-3 Behavioral and Emotional Screening System
	Kamphaus, R. W., DisStefano, C., Dowdy, E., Eklund, K., & Dunn, A. R. (2010). Determining the presence of a "problem": Comparing two approaches for detecting youth behavioral risk. *School Psychology Review, 39*, 395-407.
BIMAS	Behavior Intervention Monitoring Assessment System
	Meier, S. T., McDougal, J. L., & Bardos, A. (2008). Development of a change-sensitive outcome measure for children receiving counseling.*Canadian Journal of School Psychology, 23*(2), 148-160.
DESSA-Mini	Devereux Students Strengths Assessment – Mini
	Naglieri, J. A., LeBuffe, P., & Shapiro, V. B. (2011). Universal screening for social-emotional com- petencies: A study of the reliability and validity of the DESSA-mini. *Psychology in the Schools, 48*(7), 660-671.
SAEBRS	Social, Academic, and Emotional Behavior Risk Screener
	Kilgus, S. P., Sims, W. A., Nathaniel, P., & Taylor, C. N. (2016). Technical Adequacy of the Social, Academic, and Emotional Behavior Risk Screener in an Elementary Sample. *Assessment for Effective Intervention.*
SDQ	Strengths and Difficulties Questionnaire
	Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology, Psychiatry, and Allied Disciplines, 38* (5), 581-586.
SEARS-Short	Social Emotional Assets and Resilience Scales – Short
	Nese, R. N., Doerner, E., Romer, N., Kaye, N. C., Merrell, K. W., & Tom, K. M. (2012). Social Emotional Assets and Resilience Scales: Development of a strength-based short-form behavior rating scale system. *Journal for Educational Research Online, 4*(1), 124.
SEHS	Social and Emotional Health Survey System
	Furlong, M. J., You, S., Renshaw, T. L., Smith, D. C., & O'Malley, M. D. (2014). Preliminary development and validation of the Social and Emotional Health Survey for secondary school students. *Social Indicators Research, 117*(3), 1011-1032.
SIBS & SEBS	Student Internalizing/Externalizing Behavior Screeners
	Cook, C. R., Volpe, R., & Gresham, F. M. (in press). Technical adequacy, classification accuracy and social validity of the student externalizing behavior screener. *Assessment for Effective Intervention.*
	Cook, C. R., Rasetshwana, K. B., Truelson, E., Grant, S., Dart, E. H.Collins, T. A. (2011). Development and validation of the "Student Internalizing Behavior Screener": Examination of reliability, validity, and classification accuracy. *Assessment for Effective Intervention, 36*(2): 71–79.
SRSS-IE	Student Risk Screening Scale – Internalizing/Externalizing
	Lane, K. L., Oakes, W. P., Harris, P. J., Menzies, H. M., Cox, M., & Lambert, W. (2012). Initial evidence for the reliability and validity of the Student Risk Screening Scale for internalizing and externalizing behaviors at the elementary level. *Behavioral Disorders*, 99-122.
SSIS-PSG	Social Skills Improvement System – Performance Screening Guide
	Lane, K. L., Oakes, W. P., Common, E. A., Zorigian, K., Brunsting, N. C., & Schatschneider, C. (2015). A Comparison Between SRSS-IE and SSiS-PSG Scores Examining Convergent Validity. *Assessment for Effective Intervention, 40*(2), 114-126.
SSBD (2nd Ed.)	Systematic Screening for Behavioral Disorders
	Caldarella, P., Young, E. L., Richardson, M. J., Young, B. J., & Young, K. R. (2008). Validation of the Systematic Screening for Behavior Disorders in middle and junior high school. *Journal of Emotional and Behavioral Disorders, 16*(2), 105-117.

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A Sample of Broadband, Empirically-Developed Screening Instruments

Below is a sample of instruments that were (a) developed for the purpose of screening, (b) validated with large samples of children, (c) and are broadband, or assess a range of social-emotional indicators.

Instrument	Authors	Who to screen?				What to screen?					Who completes it?					How feasible and practical is the use of the instrument?										How do you access the instrument?	
		Preschool	Elementary (K-5)	Middle (6-8)	High (9-12)	Internalizing/Emotional Problems	Externalizing/Conduct Problems	Social Problems	Academic Problems	Adaptive Behavior/Strengths	Parent	Teacher	Youth	Spanish	Other Languages	Initial Expense	Cost	Annual Subscription	Number of Items	Time to Complete (Minutes)	Flex-Monitoring	Intervention	Online Scoring	Online Database	Software	Publisher	Website
BASC-3 BESS	Reynolds & Kamphaus	✔	✔	✔	✔	O	O		O	O	✔	✔	✔	✔		$247-321	$1.25/use	$170-256	19-30	5-10/5	✔	✔ (+$)	Review360	Review360		Pearson	http://bit.ly/1Rsev7k
BIMAS	McDougal, Bardos, & Meier		✔	✔	✔	◉	◉	◉	◉	◉	✔	✔	✔	NR	NR	$99	$2-4/child	N/A	34	5-10/5	✔	NR	✔	✔		MHS	http://bit.ly/1xTkF4
DESSA-Mini	Naglieri, LeBuffe, & Shapiro		✔	✔				O		O		✔		✔		$105	$0.64/use	$2.50/child	32	5-10/5		✔	✔	✔		Apperson	http://bit.ly/1QVGcLr
SAEBRS	Kilgus et al.		✔	✔	---	◉		◉	◉	O		✔				Free	Free	$6/child	19	1-3/5		NR	✔	✔		FastBridge	http://bit.ly/1QTYR2F
SDQ	Goodman	✔	✔	✔	✔	◉	◉	◉		◉	✔	✔	✔	✔	✔	Free	Free	N/A	25	5-10/5		NR	✔		✔		http://www.sdqinfo.com/
SEARS-Short	Merrell		✔	✔	✔					◉	✔	✔	✔	✔		$59	$.92/use	N/A	12	3-5/5		NR			✔	PAR	http://bit.ly/1RubNy4B
SEHS	Furlong		✔	✔	✔					◉			✔	✔	✔	Free	Free	N/A	20-36	5-10/5		NR					http://bit.ly/1Twfs04
SIBS & SEBS	Cook, Volpe, & Gresham		✔			O	O					✔				Free	Free	N/A	14	10-20/C		NR	Review360	Review360		Pearson	
SRSS-IE	Drummond; Lane et al.		✔	✔	✔	O	O					✔				Free	Free	N/A	12	10-20/C		NR					http://bit.ly/1UVJY2Q
SSIS-PSG	Elliott & Gresham	✔	✔	✔	✔				◉	◉		✔				$116	$47.50/10 classes	N/A	4	20-30/C		✔ (+$)	Review360	Review360		Pearson/AIMSweb	http://bit.ly/1RRN75x
SSBD (2nd. Ed)	Walker, Severson, & Feil	✔	✔	✔	9th	O	O					✔				$225	$.30/use	N/A	23	<60/C		NR	✔			Pacific Northwest	http://bit.ly/1QGxLQU

O Domain in Overall Score
◉ Domain Score Produced

Initial Expenses: manuals, forms, etc.
Annual Subscription: web-based account

/S: per student
/C: per class

(+$) Additional Cost
Flex Monitoring: a flexible range of items may be selected for progress-monitoring

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FOUR STEPS AT A GLANCE

Refer to the following pages for detailed steps.

STEP 1: ASK THE TWO AGE-SPECIFIC SCREENING QUESTIONS

- *One about friends' drinking*
- *One about patient's drinking frequency*

Does the patient drink?

NO

STEP 2: GUIDE PATIENT

For patients who DO NOT drink alcohol

- Reinforce healthy choices.

If friends drink:

- Explore your patient's views about this.
- Ask about his or her plans to stay alcohol free.
- Rescreen at next visit.

If friends don't drink:

- Praise the choice of nondrinking friends.
- Elicit and affirm reasons for staying alcohol free.
- Rescreen next year.

Screening complete for patients who do not drink

YES

STEP 2: ASSESS RISK

For patients who DO drink alcohol

- Identify **Lower**, **Moderate**, or **Highest** risk level using the age-specific risk chart on page 10.
- Use what you already know about your patient, and ask more questions as needed.

STEP 3: ADVISE AND ASSIST

LOWER RISK

- Provide brief advice to stop drinking.

MODERATE RISK

- Provide brief advice or, if problems are present, conduct brief motivational interviewing.
- Arrange for followup, ideally within a month.

HIGHEST RISK

- Conduct brief motivational interviewing.
- Consider referral to treatment.
- Arrange for followup within a month.

STEP 4: AT FOLLOWUP, CONTINUE SUPPORT

- Ask about alcohol use and any related consequences or problems.
- Review the patient's goal(s) related to alcohol and his or her plans to accomplish them.
- Offer support and encouragement.
- Complete a full psychosocial interview, if not done at the previous visit.

SBIRT IN SCHOOLS
Screening and Brief Intervention Protocols

MA SBIRT TTA
Asking questions. Improving health.

Introduce screening

I am going to ask a few health screening questions about alcohol and other drug use that we are asking all students in your grade.

Address confidentiality

There is no written record of this screening that includes information that specifically identifies you. Anything you tell me will be kept as confidential as possible. One reason why this information would not be kept confidential is if something you say indicates that there is an immediate risk to your safety or someone else's safety. Additionally, you, your parent, or your guardian, could request the information we discussed today. In any case, we would figure out next steps for support together. Do you understand?

Define substances

By alcohol we mean beer, wine, wine coolers, or liquor. By drugs we mean anything that one might use for the feeling it causes including: marijuana, heroin, prescription drugs like OxyContin, etc.

Ask permission to ask questions

Is it okay to ask you these questions?

CRAFFT-II Screen

During the past 12 months on how many days did you...

1	Drink more than a few sips of beer, wine, or any drink containing alcohol?
2	Use any marijuana (e.g., weed, oil, or hash by smoking, vaping, or in food) or "synthetic marijuana" (e.g.,"K2" or "Spice")?
3	Use a prescription medication or pill that was NOT prescribed to you or MORE than was prescribed to you (e.g., prescription pain pills or ADHD medications)?
4	Use anything else to get high? (e.g., other illegal drugs, over-the-counter medications, and things that you sniff, huff, or vape)?
C	Have you ever ridden in a **CAR** driven by someone (including yourself) who was high or had been using alcohol or drugs?

If no days of use, then STOP here. ⬇ If any days of use, ASK ALL ?'s BELOW.

R	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?
A	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?
F	Do you ever **FORGET** things you did while using alcohol or drugs?
F	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
T	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

Brief Intervention

S3

Build Rapport	I'd like to learn a little more about you... What are important things/hopes/goals in your life now? **OR** What is a typical day like for you? How does your use of [X] fit in?
Explore Pros & Cons	What do you enjoy/like about using [X]? What do you enjoy less or regret about using [X]? **Explore problems mentioned in CRAFFT:** You mentioned... Can you tell me more about that? So, on the one hand you said [PROS], and on the other hand you said [CONS]. **Emphasize CONS.**
Provide Feedback	What do you know about the risks of using [X]? Would you mind if I shared some health/safety information about [X]? **Provide 1-2 salient substance specific health/safety effects.** What are your thoughts about that?
Use Readiness Ruler	On a scale of 1-10, how ready are you to change any aspect of your [X] use? Why did you choose a [X] and not a lower number like a 1 or 2? **If "1":** What would need to happen to consider a change? **Reflect back student's reasons for change.**
Negotiate Action Plan	Given our discussion, what might you do? On a scale of 1-10, how confident are you that you could meet this goal? What might help you to get to a higher number? What helped you succeed with changes in the past? What obstacles do you anticipate? **When/if making suggestions, use Elicit-Provide-Elicit.** **Summarize plan. Thank student.**

HOW READY ARE YOU? NOT AT ALL 1 2 3 4 5 6 7 8 9 10 EXTREMELY **HOW CONFIDENT ARE YOU?**

Referrals: MA Substance Use Helpline · 800-327-5050 · helplinema.org

Resources: www.masbirt.org/schools · https://massclearinghouse.ehs.state.ma.us

The CRAFFT-II Questionnaire - SBIRT in Schools

DURING THE PAST 12 MONTHS, ON HOW MANY DAYS DID YOU...

1	Drink more than a few sips of beer, wine, or any drink containing alcohol?	PUT 0 IF NO USE
2	Use any marijuana (for example, weed, oil, or hash by smoking, vaping, or in food) or "synthetic marijuana" (for example "K2" or "Spice")?	PUT 0 IF NO USE
3	Use a prescription medication or pill that was NOT prescribed to you or MORE than was prescribed to you (for example, prescription pain pills or ADHD medications)?	PUT 0 IF NO USE
4	Use anything else to get high (for example, other illegal drugs, over-the-counter medications, and things that you sniff, huff, or vape)?	PUT 0 IF NO USE
C	Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	YES / NO

STOP

If no days of use, then STOP here.

If any days of use, ASK ALL CRAFFT ?s BELOW.

R	Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	YES / NO
A	Do you ever use alcohol or drugs while you are by yourself, or ALONE?	YES / NO
F	Do you ever FORGET things you did while using alcohol or drugs?	YES / NO
F	Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	YES / NO
T	Have you ever gotten into TROUBLE while you were using alcohol or drugs?	YES / NO

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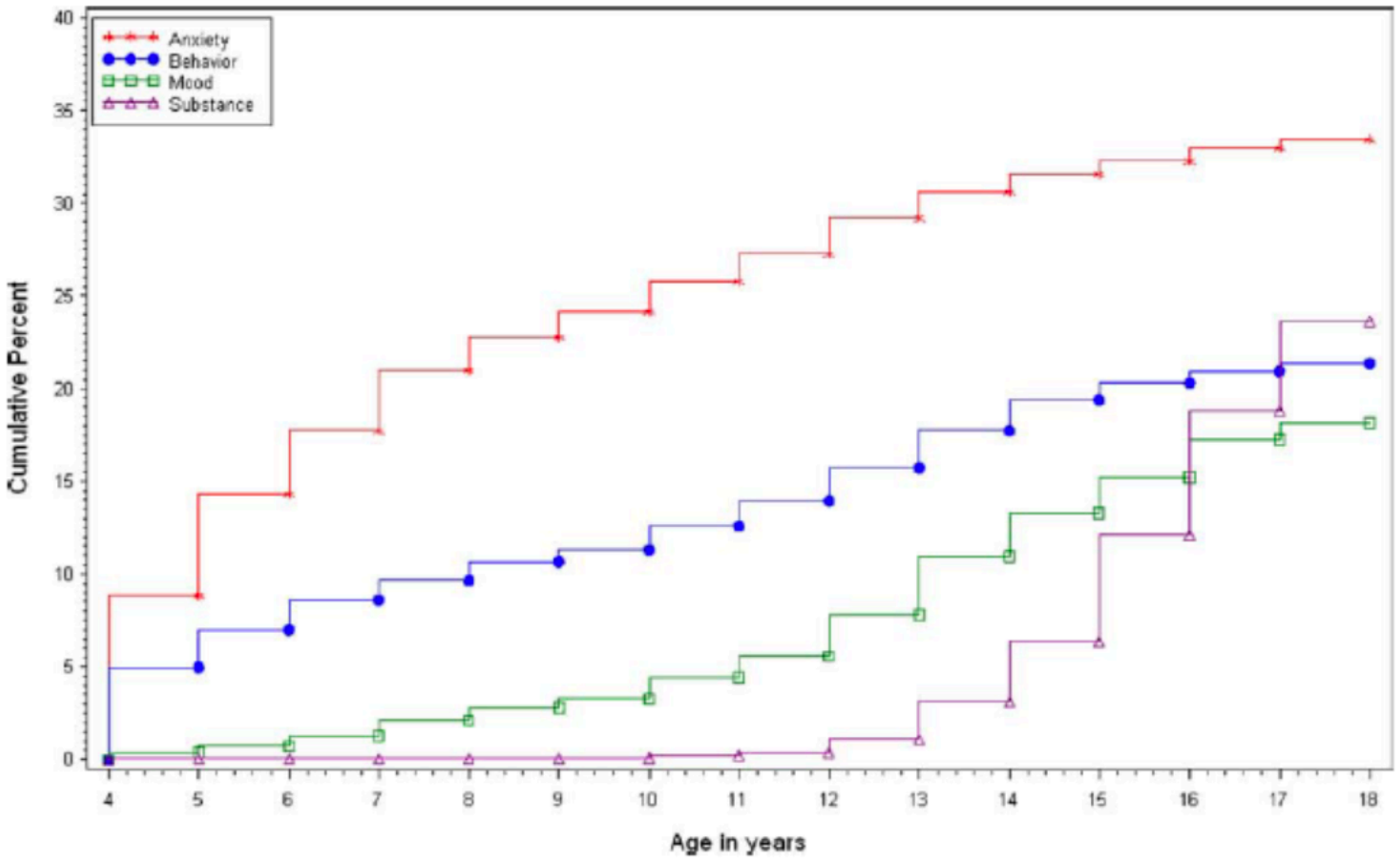
Assessment & Diagnosis

Diagnose? Can we diagnose?

Purpose of mental health assessment & diagnosis

- Provide a more comprehensive/in-depth understanding.
  - Includes input from student.
  - Distinguish true positives from false positives.
- Identifies the specific type of mental health problem the students is experiencing (diagnose).
- Inform intervention/treatment.
- Monitor progress/impact of intervention.

Cumulative lifetime prevalence of major classes of *DSM-IV* disorders among adolescents (N = 10,123).



- Merikangas, He, Burnstein, et al., 2010

Screening (Tier 1)

- Universal
- Identify which students are at risk
- General
- 1st gate
- Broad band scales
- Strength/wellness based
- Monitor of system effectiveness

Assessment (Tier 2/3)

- Targeted/individual
- Identify what disorder students are at risk for (Dx)
- Specific
- 2nd gate
- Narrow band scales
- Symptom/disorder based
- Monitor intervention effectiveness

Mental Health Assessment/Monitoring Tools

- BASC3 – BESS
- Conners Comprehensive Rating Scales
- Achenbach
- APA Online Assessment – DSM5 (cross cutting symptom measures
- NIH Toolbox (Emotion scales)
- PROMIS
- Peabody Treatment Progress Battery

Cross-cutting symptom measures - APA

- "Emerging" measures that may aid in a comprehensive mental status assessment by drawing attention to symptoms that are important across diagnoses. They are intended to help identify additional areas of inquiry that may guide treatment and prognosis.
- Level 1 questions are a brief survey of 12 domains for child and adolescent patients.
- Level 2 questions provide a more in-depth assessment of certain domains (e.g., depression, anxiety, anger).
- Severity measures are disorder-specific, corresponding closely to criteria that constitute the disorder definition.

https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	❑ Yes			❑ No		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	❑ Yes			❑ No		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	❑ Yes			❑ No		
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	❑ Yes			❑ No		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	❑ Yes			❑ No		
	25.	Have you EVER tried to kill yourself?	❑ Yes			❑ No		

LEVEL 2—Anxiety—Child Age 11–17*

* PROMIS Emotional Distress—Anxiety—Pediatric Item Bank

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

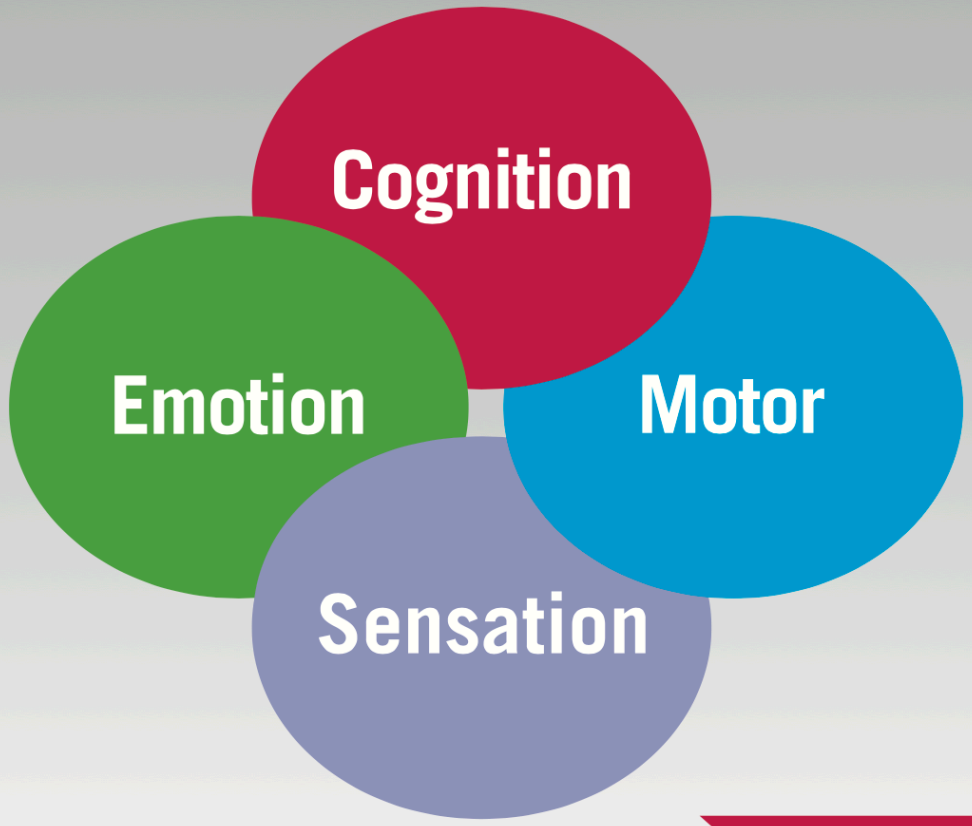
Instructions to the child: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you have been bothered by "feeling nervous, anxious, or scared", "not being able to stop worrying" and/or "not being able to do things you wanted to or should have done because they made you feel nervous" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Almost Never**	**Sometimes**	**Often**	**Almost Always**	
1.	I felt like something awful might happen.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt nervous.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt scared.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I felt worried.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I worried about what could happen to me.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I worried when I went to bed at night.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I got scared really easy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
8.	I was afraid of going to school.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
9.	I was worried I might die.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
10.	I woke up at night scared.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
11.	I worried when I was at home.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
12.	I worried when I was away from home.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
13.	It was hard for me to relax.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

*The PROMIS measure was developed for and can be used with children ages 8-17 but was tested in children ages 11–17 in the DSM-5 Field Trials.

For Assessment of Neurological and Behavioral Function®

NIH Toolbox® is a multi-dimensional set of brief, royalty-free measures to assess cognitive, sensory, motor and emotional function that can be administered in two hours or less across diverse study designs and settings.



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Four domain level batteries available in English and Spanish

Developed by more than 250 contributing scientists at 80 institutions

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Evidenced-based Intervention

An intervention with research/empirical evidence to support the intervention's effectiveness.

Benefits of Using EBPs

- Increases likelihood of success
- Offers implementation support
- Promotes efficient use of limited resources
- Helps facilitate stakeholder buy-in
- Helps provide justification for funding and resources
- Raises bar for types of programs that are implemented

National Resource Center for Mental Health Promotion and Youth Violence Prevention

Florida AWARE
Advancing Wellness and Resiliency in Education

Florida AWARE Guidance

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).

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This handout was developed under grant number 1H79SM061890-01 from SAMHSA, U.S. Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Accessing Existing Registries of Evidence-Based Mental Health Programs and Practices

Context: The Florida AWARE Program priorities include to support implementation of a multi-tiered framework of mental health supports across a variety of organizations and providers. In particular, the Program aims to support implementation of tested and proven to be effective mental health practices designed to meet the needs of diverse populations (see http://sss.usf.edu/resources/floridaaware/index.html for more information).

Purpose: This guidance document orients school leadership teams, mental health service providers, and other stakeholders (e.g., administrative supervisor, teachers, and families) to resources for (1) identifying mental health programs and practices, and (2) accessing summaries of research conducted to determine the extent to which a particular intervention is effective in achieving its goals.

Key Terms:

Culturally Responsive: The incorporation of culturally-relevant strategies into evidence-based practices (EBP) to improve community and youth engagement. Cultural responsiveness can entail the modification of EBPs to enhance relevancy and the alignment of services with the needs and cultural perspective of the specific youth, family, and community participating in the intervention.

Evidence-Based: Amount of empirical support for a given intervention. Professional organizations agree that the extent of the evidence merits a judgement on a continuum, but have not come to consensus on what type and level of evidence is sufficient for deeming an intervention "evidence-based." For example, below are terms used to describe the level of an intervention's evidence base, as offered by two organizations:

Level of Evidence	California Department of Social Services (CDSS) Office of Child Abuse Prevention, in cebc4cw.org	Society of Clinical Child and Adolescent Psychology (SCCAP), in effectivechildtherapy.org
Many Positive Effects	Well supported by research evidence	Well-established ("Works Well")
	Supported by research evidence	Probably efficacious ("Works")
Some Positive Effects	Promising research evidence	Possibly efficacious ("Might Work")
No or Negative Effects	Evidence fails to demonstrate an effect	Questionable ("Does Not Work/Tested but Did Not Work")
	Concerning practice	
Not Yet Studied	NR- Not able to be rated	Experimental ("Unknown/Untested")

Intervention: Programs or specific practices that are provided in an effort to promote well-being, or prevent or reduce mental health problems. Interventions can be referred to as Tier 1 – Tier 3 or universal – intensive/individualized. Levels:

Criteria for level of evidence base

Level of Evidence	California Department of Social Services (CDSS) Office of Child Abuse Prevention, in cebc4cw.org	Society of Clinical Child and Adolescent Psychology (SCCAP), in effectivechildtherapy.org
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Florida AWARE Guidance document, 2018

Registries

- Evidence-based Module Series https://healthysafechildren.org/learning-module-series/evidence-based-module-series
- PracticeWise Evidence-Based Services (PWEBS) Database and "Blue Menu www.practicewise.com
- Evidence-based Practices Resource Center https://www.samhsa.gov/ebp-resource-center
- Blueprints Programs https://www.blueprintsprograms.org
- California Evidence-Based Clearinghouse for Child Welfare (CEBC) http://www.cebc4cw.org/
- Evidence-Based Therapies https://effectivechildtherapy.org
- Searchable guide of resources and programs http://www.sprc.org/resources-programs

Evidence-based interventions

- Cognitive Behavior Therapy (CBT)
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH ADTC)
- Dialectical Behavior Therapy (DBT)
- Motivational Interviewing
- Brief Intervention for School Clinicians (BRISC)
- SBIRT (Screen, Brief Intervention, Referral, Treatment)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Good Behavior Game

Blue Menu of Evidence-Based Psychosocial Interventions for Youth

This report is intended to guide practitioners, educators, youth, and families in developing appropriate plans using psychosocial interventions. It was created for the period October 2018 – April 2019 using the PracticeWise Evidence-Based Services (PWEBS) Database, available at www.practicewise.com. This report updates and replaces the "Blue Menu" originally distributed by the Hawaii Department of Health, Child and Adolescent Mental Health Division, Evidence-Based Services Committee from 2002–2009. Looking for the American Academy of Pediatrics (AAP) Evidence-Based Child and Adolescent Psychosocial Interventions tool? It is available on the AAP website.

Problem Area	Level 1- BEST SUPPORT	Level 2- GOOD SUPPORT	Level 3- MODERATE SUPPORT	Level 4- MINIMAL SUPPORT	Level 5- NO SUPPORT
Anxious or Avoidant Behaviors	Attention Training, Cognitive Behavior Therapy (CBT), CBT and Medication, CBT for Child and Parent, CBT with Parents, Education, Exposure, Modeling	Assertiveness Training, Attention, CBT and Expression, CBT and Parent Management Training (PMT), CBT with Parents Only, Cultural Storytelling, Family Psychoeducation, Hypnosis, Mindfulness, Relaxation, Stress Inoculation	Contingency Management, Group Therapy	Behavioral Activation and Exposure, Biofeedback, Play Therapy, PMT, Psychodynamic Therapy, Rational Emotive Therapy, Social Skills	Assessment/Monitoring, Attachment Therapy, Client Centered Therapy, Eye Movement Desensitization and Reprocessing (EMDR), Peer Pairing, Psychoeducation, Relationship Counseling, Teacher Psychoeducation
Attention and Hyperactivity Behaviors	Biofeedback, Contingency Management, PMT, Self Verbalization, Working Memory Training	Behavior Therapy and Medication, Behavioral Sleep Intervention, CBT, CBT and Medication, CBT and PMT and Medication, CBT with Parents, Education, Motivational Interviewing (MI) /Engagement and PMT, Parent Psychoeducation, Physical Exercise, PMT and Classroom Behavior Management and Executive Functioning Training, PMT and Medication, PMT and Problem Solving, PMT and Teacher Psychoeducation, Relaxation and Physical Exercise, Social Skills and Education, Social Skills and Medication	Biofeedback and Medication	Executive Functioning Training, PMT and Parent Responsivity Training, PMT and Social Skills, Relaxation, Self Verbalization and Contingency Management, Social Skills	Attention Training, Client Centered Therapy, CBT and Anger Control, CBT and PMT, Family Therapy, Parent Coping/Stress Management, Play Therapy, PMT and Self-Verbalization, Problem Solving, Psychoeducation, Self Control Training, Self Verbalization and Medication, Skill Development
Autism Spectrum Disorders	CBT, Intensive Behavioral Treatment, Intensive Communication Training, Joint Attention/Engagement, PMT, Social Skills	Family Psychoeducation, Imitation, Peer Pairing, PMT and Medication, Theory of Mind Training	None	Massage, Peer Pairing and Modeling, Play Therapy	Attention Training, Biofeedback, Cognitive Flexibility Training, Communication Skills, Contingent Responding, Eclectic Therapy, Executive Functioning Training, Fine Motor Training, Modeling, Parent Psychoeducation, Physical/Social/Occupational Therapy, Sensory Integration Training, Social Skills and Peer Pairing, Structured Listening, Working Memory Training
Delinquency and Disruptive Behavior	Anger Control, Assertiveness Training, CBT, Contingency Management, Multisystemic Therapy, PMT, PMT and Problem Solving, Problem Solving, Social Skills, Therapeutic Foster Care	CBT and PMT, CBT and Teacher Training, Communication Skills, Cooperative Problem Solving, Family Therapy, Functional Family Therapy, Mindfulness, PMT and Classroom Management, PMT and Medication, PMT and Social Skills, Rational Emotive Therapy, Relaxation, Self Control Training, Transactional Analysis	Client Centered Therapy, Moral Reasoning Training, Outreach Counseling, Peer Pairing	CBT and Teacher Psychoeducation, Exposure, Physical Exercise, PMT and Classroom Management and CBT, PMT and Self-Verbalization, Stress Inoculation	Behavioral Family Therapy, Catharsis, CBT with Parents, Education, Family Empowerment and Support, Family Systems Therapy, Group Therapy, Imagery Training, Play Therapy, PMT and Peer Support, Psychodynamic Therapy, Self Verbalization, Skill Development, Wraparound
Depressive or Withdrawn Behaviors	CBT, CBT and Medication, CBT with Parents, Client Centered Therapy, Family Therapy	Attention Training, Cognitive Behavioral Psychoeducation, Expression, Interpersonal Therapy, Motivational Interviewing (MI)/Engagement and CBT, Physical Exercise, Problem Solving, Relaxation	None	Self Control Training, Self Modeling, Social Skills	CBT and Anger Control, CBT and Behavioral Sleep Intervention, CBT and PMT, Goal Setting, Life Skills, Mindfulness, Play Therapy, PMT, PMT and Emotion Regulation, Psychodynamic Therapy, Psychoeducation

Blueprints
FOR HEALTHY YOUTH DEVELOPMENT

ABOUT US | ASSESS NEEDS | BLUEPRINTS CRITERIA | VIEW ALL PROGRAMS | PROGRAM SEARCH | NOMINATE PROGRAM | RESOURCES

Blueprints Programs = *POSITIVE YOUTH DEVELOPMENT*

BLUEPRINTS PROGRAMS
WHO WE ARE

BLUEPRINTS FOR HEALTHY YOUTH DEVELOPMENT helps you easily identify evidence-based programs that help young people reach their full potential. Get ahead of serious challenges that influence children's success with programs that have the highest standards for promoting prosocial behavior, academic success, emotional well-being, physical health and positive relationships. More about evidence-based programs here.

EVIDENCE-BASED PROGRAMS
REVIEWED BY BLUEPRINTS PREVENT:

BULLYING IN SCHOOLS
YOUTH VIOLENCE
TEEN SUBSTANCE ABUSE
ANTISOCIAL, AGGRESSIVE BEHAVIOR
CHILDHOOD OBESITY
SCHOOL FAILURE
DELINQUENCY
YOUTH DEPRESSION/ANXIETY

LEARN MORE ABOUT BLUEPRINTS
VIEW VIDEOS

WHY
USE BLUEPRINTS

HOW
BLUEPRINTS HELPS

Selecting Evidence-Based Programs

NATIONAL RESOURCE CENTER FOR
MENTAL HEALTH PROMOTION & YOUTH VIOLENCE PREVENTION

https://healthysafechildren.org/learning-module-series/evidence-based-module-series

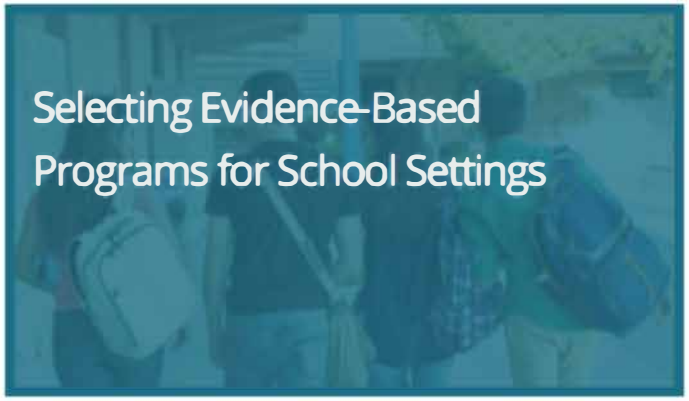
Selecting & Implementing an EBP

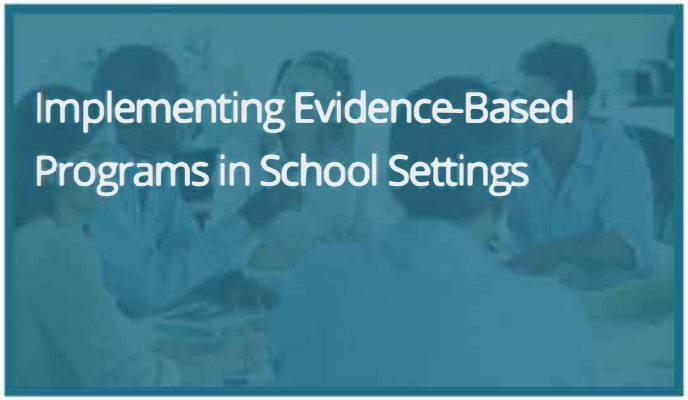
- Assess & analyze data
- Engage & inform stakeholders
- Assess readiness
- Assess existing programs
- Review EBP registries
- Explore EBPs
- Determine fit
- Monitor impact & fidelity

Evidence-Based Module Series

A series of interactive, self-paced learning modules on selecting, preparing for, and implementing evidence-based programs (EBPs) in school settings.

Since the publication of Module 1, SAMHSA has phased out the NREPP website. In April 2018, SAMHSA launched the **Evidence-Based Practices Resource Center** (Resource Center) that aims to provide communities, clinicians, policy makers, and others in the field with the information and tools they need to incorporate evidence-based practices into their communities or clinical settings.





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Treatment

BRIDGING **MENTAL HEALTH & BASIC NEEDS** BY BUILDING COMMUNITY PARTNERSHIPS

SAMHSA PROJECT AWARE

What are basic needs?

Basic needs are things that are needed in order to survive and be mentally and physically healthy. They include elements like shelter/housing, clothing, food, water, safety, a sense of belonging, and love.

How prevalent is the inability to meet basic needs in the U.S.?

The inability to meet the basic needs of youth in our country is widespread—**45% of Americans are not able to meet basic needs.**[1] In order to meet basic needs, families are believed to need an income that is twice the official poverty level. Approximately **15% of Americans and 22% of American children live in poverty.** Family income also impacts student eligibility for free or reduced school lunch; over 31 million students receive free or reduced school lunch.[2] In a recent survey, 84% of school principals have reported seeing students come to school hungry.[3]

What happens when basic needs are not met?

When families are unable to meet basic needs, youth can experience negative behavioral, social, and academic outcomes.[4] For example, food insecurity is associated with impaired social skills and academic performance in youth.[5] Poverty has been consistently connected with low academic achievement. Youth who face homelessness and poverty are more likely to experience mental illness.[6,7]

Why is it important for schools to address basic needs when trying to support student mental health?

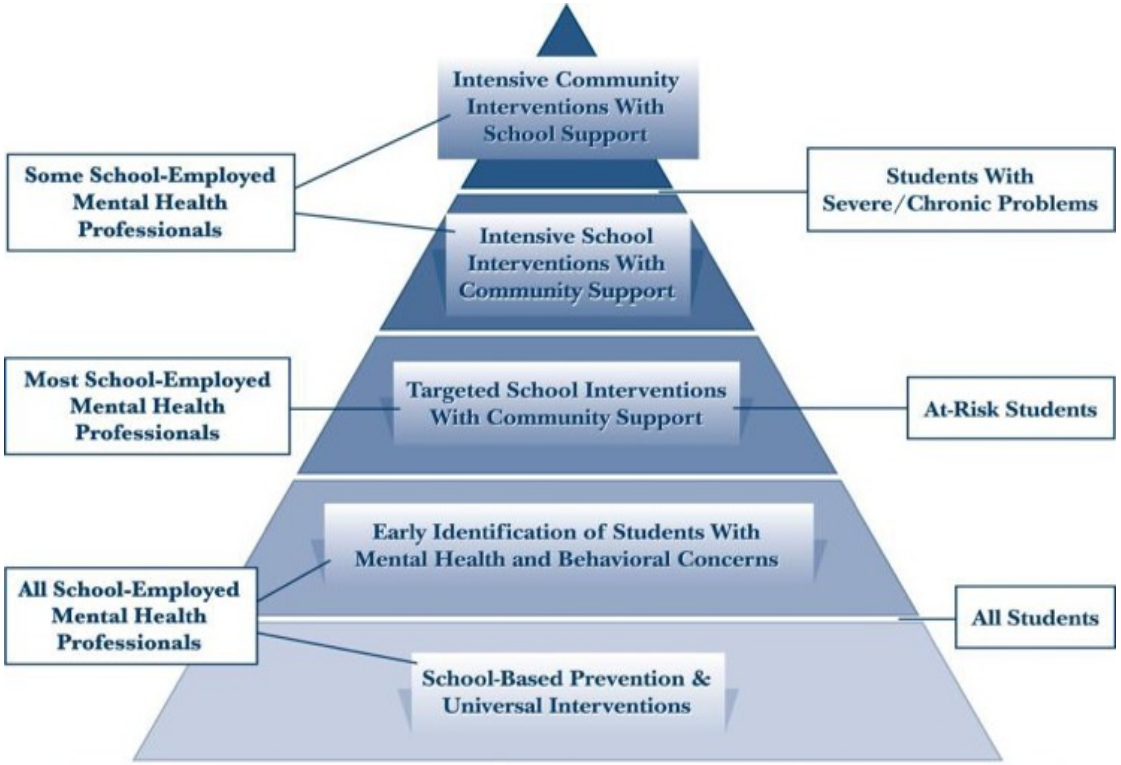
If students are struggling to meet basic needs, they may have less energy to devote to mental health and overall wellness. In addition, basic needs-related challenges, like lack of transportation, health insurance, or stable housing, may make it impossible for students to engage in mental health services and supports that they are connected with at school.

How can schools work with community partners to promote mental health and wellness in students whose basic needs are not being met?

The priority for these students should be connecting them with services that help to meet basic needs. Mental health supports alone are unlikely to achieve desired outcomes if students are struggling to meet basic needs. To help these students, schools can serve as an access point or "one stop shop" for meeting both mental health and basic needs. Partnerships with community organizations and providers that can help youth and families meet basic needs are essential.

Mental Health Treatment in Schools

- Reduces barriers to access mental health services
- Allows for treatment to occur in natural settings when possible
- Provides schools with a wider range of resources and supports to meet the mental health needs
- Provides for smoother transitions between levels of care (Tiers of Support)



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.

How can Schools & Community Providers Partner Effectively

- Defining Roles and Responsibilities
- Sharing Information and Monitoring Progress across systems
- Coordinating & Planning

Defining Roles and Responsibilities

- Any Preexisting Relationships
- Cross Purposes
- Different Levels of Partnership
- Different Terminology
- Different Rules for Confidentiality and Information Sharing

Sharing Information and Monitoring Progress Across Systems

- Timely dissemination of Information
- Family Education Rights and Privacy Act (FERPA)
- Health Information Portability and Accountability Act (HIPAA)
- Signed Parental Consent for Release of Information
- Electronic Student Tracking Systems
- Monitor Treatment Progress with Partners

Coordinating & Planning Care on Reentry

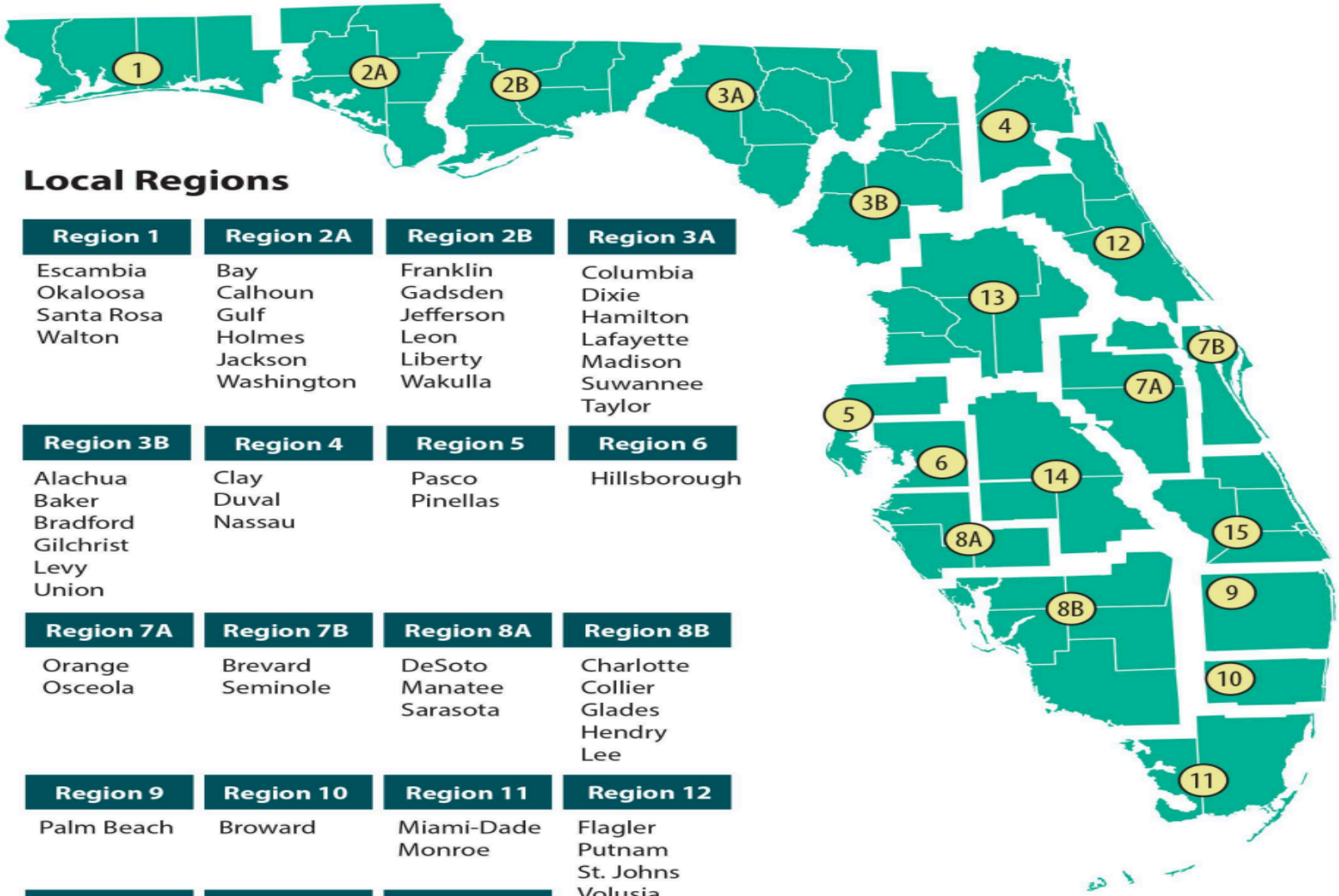
- School and Partners Plan for Reentry
- Monitor and Follow up after Reentry
- Educate School Community on Supports
- Designate a go to Person for the Student Returning
- Follow recommendations from Outside Provider
- Train School Staff on Signs of Relapse
- Adjust Educational Plan as Needed

Multiagency Network for Students with Emotional/Behavioral Disabilities (SEDNET)

- Statewide Discretionary Project (FDOE)
- Created by FL Legislature
- Works with other agencies to create and facilitate a network to provide quality care to children with or at risk of E/BD
- 19 SEDNET regions

www.sednetfl.info

Florida Department of Education SEDNET Regions



Local Regions

Region 1	Region 2A	Region 2B	Region 3A
Escambia	Bay	Franklin	Columbia
Okaloosa	Calhoun	Gadsden	Dixie
Santa Rosa	Gulf	Jefferson	Hamilton
Walton	Holmes	Leon	Lafayette
	Jackson	Liberty	Madison
	Washington	Wakulla	Suwannee
			Taylor

Region 3B	Region 4	Region 5	Region 6
Alachua	Clay	Pasco	Hillsborough
Baker	Duval	Pinellas	
Bradford	Nassau		
Gilchrist			
Levy			
Union			

Region 7A	Region 7B	Region 8A	Region 8B
Orange	Brevard	DeSoto	Charlotte
Osceola	Seminole	Manatee	Collier
		Sarasota	Glades
			Hendry
			Lee

Region 9	Region 10	Region 11	Region 12
Palm Beach	Broward	Miami-Dade	Flagler
		Monroe	Putnam
			St. Johns
			Volusia

Region 13	Region 14	Region 15
Citrus	Hardee	Indian River
Hernando	Highlands	Martin
Lake	Polk	Okeechobee
Marion		St. Lucie
Sumter		

Multiagency Network for Students with Emotional/Behavioral Disabilities

- Collaborates with local agencies and provides direct support to school districts in expanding school based mental health services, internally, and from community agencies and providers
- Assists with coordinating services at the local, regional and state levels of the Interagency Review teams, Florida System of Care, and Court Circuit.
- Information, interventions, community supports and agencies identified within the local systems of care are shared with schools and families to ensure access to appropriate evidence-based services and programs for families and students with emotional/behavioral disabilities.

SEDNET Services

- Local Resource Guides
- Community and Systems of Care facilitation
- Data review and recommendations
- Interagency Collaboration
- Student Suicide Prevention
- Youth Mental Health First Aid
- DJJ Re-entry Team Support
- Access to System of Care: Wrap-around Services
- Family Assistance and Resources
- Participate in Interagency State, Regional and Local Review Teams

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Recovery


Recovery
Support
Community
Growth
Skills
Peer
Hope
Person
Empower

Working Definition of Recovery

- A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Four Dimensions that Support Recovery

- **Health**—overcoming or managing symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and making informed, healthy choices that support physical and emotional well-being.
- **Home**—having a stable and safe place to live.
- **Purpose**—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and participating in society.
- **Community**—having relationships and social networks that provide support, friendship, love, and hope.

SAMHSA

10 Guiding Principles of Recovery

1. Recovery emerges from hope.
2. Recovery is person-driven.
3. Recovery occurs via many pathways.
4. Recovery is holistic.
5. Recovery is supported by peers and allies.
6. Recovery is supported through relationships and social networks.
7. Recovery is culturally-based and influenced.
8. Recovery is supported by addressing trauma.
9. Recovery involves individual, family and community strengths and responsibility.
10. Recovery is based on respect.

SAMHSA Evidence-Based Practice Resource Center

- Collection of scientifically-based resources for a broad range of audiences, including Treatment Improvement Protocols, toolkits, resource guides, clinical practice guidelines, and other science-based resources.
- Designed with an easy to use point-and-click system to enable users to quickly identify the most relevant resources for their particular needs.
- https://www.samhsa.gov/ebp-resource-center

What can recovery look like in schools?

- Create a Reintegration Plan
  - Facilitate supports identified in the recovery plan created with the therapist or physician (if applicable)
  - Identify a school-based mental health professional to coordinate, monitor and follow up with the mental health services being provided.
  - Create and monitor short and/or long term goals with time frames when appropriate (academic, attendance, behavioral, etc.)
  - Help student to identify things that help them stay "healthy" (i.e. exercise, medication, listening to music, etc.)
  - Create a safe place(s) for the student to go if needed
  - Identify the student's role and responsibility within the plan (self help, etc.)
  - Identify a "support team" of trusted individuals inside and outside of school the student can check in/out with (health care professionals, therapist, family, peers, faith leaders, etc.)

Wellness Recovery Action Plan

- Wellness Toolbox
- Daily Maintenance Plan
- Identifying Triggers and an Action Plan
- Identifying Early Warning Signs and an Action Plan
- Identifying When Things Are Breaking Down and an Action Plan
- Crisis Planning
- To learn more about the **WRAP program** visit http://www.mentalhealthrecovery.com/index.php.

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Building Capacity and Skills

Professional Development & Learning

Training formats

- Face-to-Face PD
- Webinars
- Community of practice (PLCs)
- Partner training/workshops
  - National training resources (CSMH)
  - University trainers
  - Professional organization
- Agency trainings
- District-developed trainings

Online Trainings

- Boston Children's Hospital https://www.childrenshospital.org/TAPonline
- NITT TA Center https://www.samhsa.gov/nitt-ta/distance-learning-videos/project-aware
- UMD Behavioral Health http://mdbehavioralhealth.com
  - Youth Co-Occurring Disorders Training
  - Mental Health Training Intervention
  - Community Partnered School Behavioral Health Intervention
  - Supporting Hospital to School Transitions
- National Center for Healthy Safe Children https://healthysafechildren.org/learning-portal
- UCLA Center for School Mental Health http://smhp.psych.ucla.edu/summit2002/toolbox.htm
- Teach Mental Health https://www.teachmentalhealth.org

SEDNET Supported Training

- Emotional Disabilities
- Trauma Informed Care
- Behavior Management
- Crisis De-escalation
- Self Regulation
- Restorative Practices
- Compassion Fatigue
- Resiliency
- Youth Mental Health First Aid

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