



Mental Health and Schools: Best Practices to Support Our Students

Implications for Policy, Systems, and Practice

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ABSTRACT

It is well documented that one in five children will experience a diagnosable behavioral health concern, and half of all lifetime mental illnesses begin by age 14.¹ Strikingly, as few as 50% of these children will receive any kind of treatment and even fewer receive evidence-based treatments.² Schooling is a legal requirement until age 16. As a result, schools encounter the vast majority of children ages 5 to 17, and are therefore a highly impactful setting to ensure children's behavioral health needs are identified and met as quickly as possible – either through school-based supports and services or through links to services in the broader community. Multi-Tiered Systems of Support (MTSS) built upon effective, culturally and linguistically responsive interventions are the most promising strategy for achieving positive student behavioral health outcomes. When well designed and implemented, these systems function harmoniously with existing academic and social-emotional learning structures, working together to facilitate positive outcomes for students. This report highlights the current strengths and barriers related to promoting healthy outcomes for students living with mental health concerns, and provides actionable recommendations and strategies to ensure that all children and families have access to the services and supports they need in order to thrive.

For a full exploration of COVID-19 and its impact on children and families, see the Evidence-Based Policy Institute's reports [Spotlight On: Impact of the COVID-19 Pandemic on Children, Youth and Families](#) and [Spotlight On: The "New Normal" and Life Beyond COVID-19](#).

Report Development

This report was developed using a structured methodology drawing upon existing quantitative data and best practice literature, as well as qualitative strategies engaging multiple stakeholder informants. Data collection methods included a review of relevant school-based behavioral health literature, input from key stakeholders and experts, a review of current school behavioral health practices in Massachusetts, and a review of national best practices. More than twenty stakeholders were engaged in semi-structured in-person or Zoom virtual interviews. Interviews were conducted with partners from Boston Children's Hospital and the Children's Mental Health Campaign, using questions developed collaboratively between The Baker Center's Evidence-Based Policy Institute (EBPI) and Boston Children's Hospital.

Interviewees expanded on topics based on their areas of focus and expertise. Initial interviewees were identified by

their areas of expertise and connection to Massachusetts schools at the policy, systems or practice levels.

Snowball sampling was used to identify key informants with knowledge of the current system and best practices. Data was compiled via written notes and/or audio recording and analyzed to extract themes. These themes were incorporated into the narrative of the report along with the literature review and quantitative data that was surveyed to develop an overview of Massachusetts school-based behavioral health systems, to identify best practices nationally and locally, and to develop actionable recommendations for system enhancement and reform. Select expert and stakeholder editors were given the chance to review and respond to this report before its publishing.

¹ Takkunen & Zlevor, 2018

² Whitney & Peterson, 2019; Bruns, et al., 2015

Introduction

Massachusetts consistently ranks among the top states in the nation for its high quality kindergarten through grade twelve education programs.³ This notable accomplishment is both an opportunity to celebrate our state's educational system and the remarkable work happening across the Commonwealth, as well as develop strategies to ensure that Massachusetts leads the way for generations to come. While Massachusetts as a whole boasts high achieving and successful schools, significant inequities exist within the Commonwealth. This is especially relevant in the context of school-based behavioral health. While COVID-19 has exacerbated behavioral health needs among youth and families, there has long been an established need for behavioral health services and supports. Before the pandemic, one in five children routinely experienced behavioral health challenges, many of whom have gone unidentified and under-supported.⁴ These rates are often even higher in our urban and underserved areas. The Commonwealth has an opportunity to build on its strong foundation to ensure that every school in Massachusetts has the tools and resources to identify and respond to student behavioral health needs, and that students have access to the best mental and behavioral healthcare and supports possible.

The effects of the pandemic on children, youth and families will be felt long after the crisis ends. In the wake of an unprecedented adverse experience that has impacted all families, it is more important now than ever that our schools and communities are equipped to identify and respond to the needs of youth and families, and that those strategies are equity-driven and rooted in research. Evidence-based decisions at the policy, systems and practice levels can have a broad-reaching, positive impact on our Commonwealth's students and families. This will likely lead not only to better behavioral health outcomes for students, but also improved academic achievement in schools, higher utilization and access to quality care, more effective and efficient use of resources, significant return on investment and mid- to long-term cost savings.⁵ As research shows, by addressing the negative consequences of adverse childhood experiences, we can see long-lasting outcomes well into adulthood in multiple domains of functioning including academic achievement, social adjustment, employment, emotional wellbeing and physical health.⁶ Addressing the behavioral needs of children and adolescents in our schools is vital for the health and wellbeing of this generation.

Historically, many children experiencing behavioral health challenges have gone unidentified or under-supported.⁴



³McCann, 2020

⁴Substance Abuse and Mental Health Services Administration, 2019

⁵Substance Abuse and Mental Health Services Administration, 2019

⁶Monnat & Chandler, 2015



Varying Perspectives: “Behavioral Health” vs “Mental Health”

School-based behavioral health is a broad term, referring to mental health, substance use, social-emotional learning (SEL), and social determinants of health.⁷ This report intentionally uses “behavioral health” as the umbrella term, aligning with terminology used by the Substance Abuse and Mental Health Services Administration (SAMHSA). Stakeholder testimony gathered during report development revealed that school-based professionals sometimes differ in their use of this terminology. For some, the terms “mental health” and “behavioral health” are interchangeable, referring to the complex intermingling of biological, psychological and environmental factors that lead to a child’s emotional well-being. Others consider “mental health” and “behavioral health” to be overlapping but distinct, with “mental health” referring to psychological and emotional wellbeing, and “behavioral health” referring to a student’s physical, displayed behaviors.

⁷ Center for Health and Healthcare in Schools, School-Based Health Alliance, National Center for School Mental Health, 2020

Behavioral Health Needs in Schools

Why Schools?

Research shows half of all lifetime mental illness cases begin by age 14.⁸ Strikingly, as few as 50% of these youth will receive any kind of treatment and even fewer receive evidence-based treatments.⁹ Nationally, and here in Massachusetts, there is an array of challenges to accessing community-based behavioral health services. These barriers include geographic distance to access providers, long-standing systemic and structural inequities, and inadequate funding to support behavioral health interventions. Early identification and preventative/proactive interventions are the hallmarks of effective behavioral healthcare.¹⁰ Since attendance in schools is a legal requirement until age 16, schools serve the vast majority of children and are the ideal setting to identify needs, address access challenges, and ensure children, youth and families receive high-quality, evidence-based care.

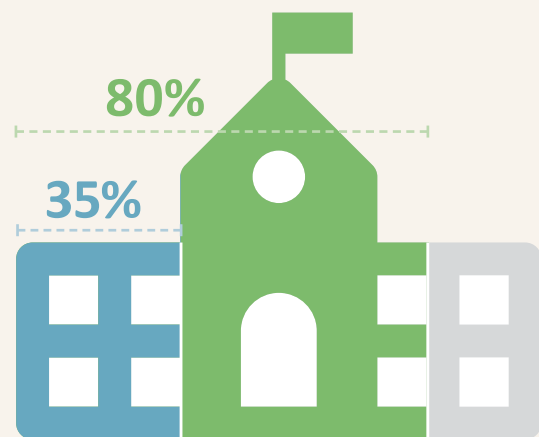
Nationally, nearly 93% of 5- and 6-year olds, 97% of 7- to 13-year olds, and about 96% of 14- to 17-year

olds are enrolled students.¹¹ These numbers are similar in Massachusetts (see page 35). When schools are adequately equipped to identify and address the behavioral health needs of students, they can ensure that our children and youth who need services and supports receive them in an effective and timely manner. Research has found that up to 80% of behavioral health services are delivered within the school setting and 35% of children receiving services do so exclusively within the school setting.¹² Students from low income, racial and ethnic minority communities and other historically underserved populations are more likely than other student populations to depend on schools for their behavioral health supports. Therefore, providing behavioral healthcare in schools helps to address inequities in access to care. We must further ensure that the services being offered in schools are able to address the needs within our communities and that high quality, evidence-based services and supports are available to all students in need.

Of students who access behavioral health services, as many as 80% do so within the school setting. 35% receive services exclusively within the school setting.¹²



It is well documented that one in five youth will experience a diagnosable behavioral health concern, and half of all lifetime mental illness begins by age 14.



⁸Takkunen & Zlevor, 2018

⁹Whitney & Peterson, 2019; Bruns, et al., 2015

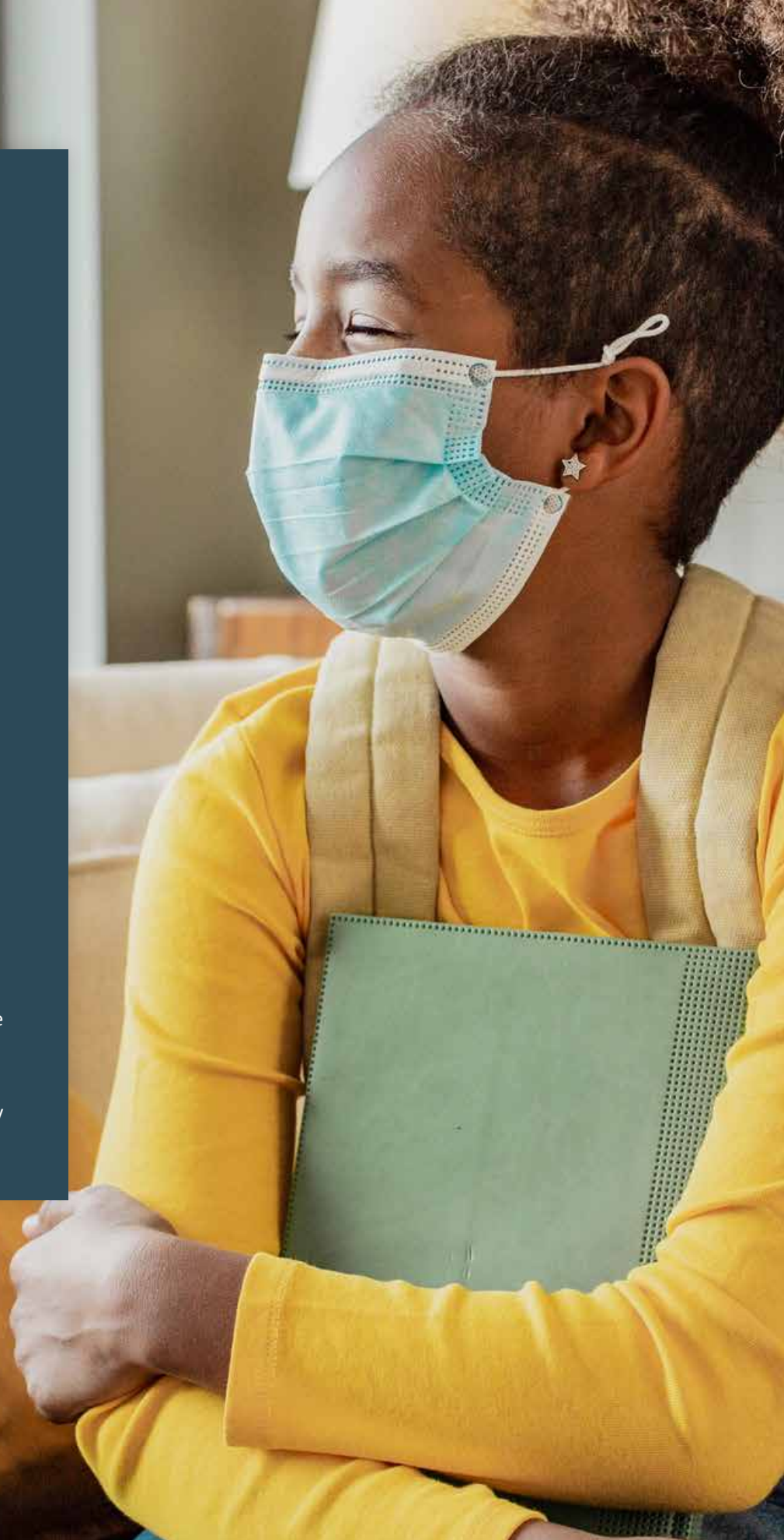
¹⁰Substance Abuse and Mental Health Services Administration, 2019

¹¹United States Census Bureau, 2018

¹²Hoover, et al., 2019; Ali et al., 2019

The Impact of COVID-19

On March 10th, 2020, the COVID-19 pandemic was declared a state of emergency in Massachusetts.¹³ Schools and child care programs were closed, and a stay-at-home advisory was issued.¹⁴ In the months that followed, the need for physical distancing meant youth were kept at home and away from their peers, unable to attend school for in-person K-12 education. The full impact of quarantine, remote learning, social isolation, and the pandemic on child behavioral health outcomes remains to be seen. However, preliminary research and anecdotal observations are showing marked increases in challenges such as anxiety, depression, eating disorders and substance use. Recent research has shown that rates of childhood maltreatment and abuse during the pandemic may have also increased. If unaddressed, these adverse experiences and trauma will likely lead to long-term challenges that negatively impact all areas of a child's life from school performance to social functioning to future professional success. Many experts are especially concerned with the pandemic's impact on youth suicide, which was already on the rise pre-pandemic.



¹³ Office of Governor Charlie Baker and Lt. Governor Karyn Polito, n.d.

¹⁴ Office of Governor Charlie Baker and Lt. Governor Karyn Polito, n.d.



Understanding the School and Community Context: Capacities and Needs

Successful strategies to address student behavioral health needs must consider the local school and community context. When designing a comprehensive school behavioral health system that will effectively identify and meet the behavioral health needs of students, there is no single approach that will work in all settings. Partnerships between the local school district, community behavioral health providers, and universities are an essential component of effective, comprehensive school behavioral health by connecting students to care in the community when the supports and services present within the school are not preferred or adequate to meet their needs.

Extreme differences can exist between neighboring school districts, and even between schools within the same district. Because schools are largely funded by the local tax base, there may be wide differences in school districts that are just a few miles apart. Because of this, significant differences may exist in regard to what resources are available and what capacity the local school has to address the needs of families in the community. One of the greatest contradictions of our existing system is that often schools with the most limited resources have the greatest needs. This inequity of resources disproportionately impacts historically overlooked communities such as communities of color.¹⁵

Therefore, when designing a system of supports, we must consider the local context including the available resources in both the school and community and ensure that there are adequate resources to meet the community's needs.

When school-based resources and the capacity of the school district are limited, increased community collaboration is necessary to meet the needs of students and families. Additionally, strategies must balance leveraging community-based services with internal capacity building and professional development in schools so that school professionals who are already positioned to provide needed services are adequately trained and empowered to do so.

¹⁵ Duncombe, 2017; O'Connell, Boat, & Warner, 2009

Understanding Risk and Resiliency

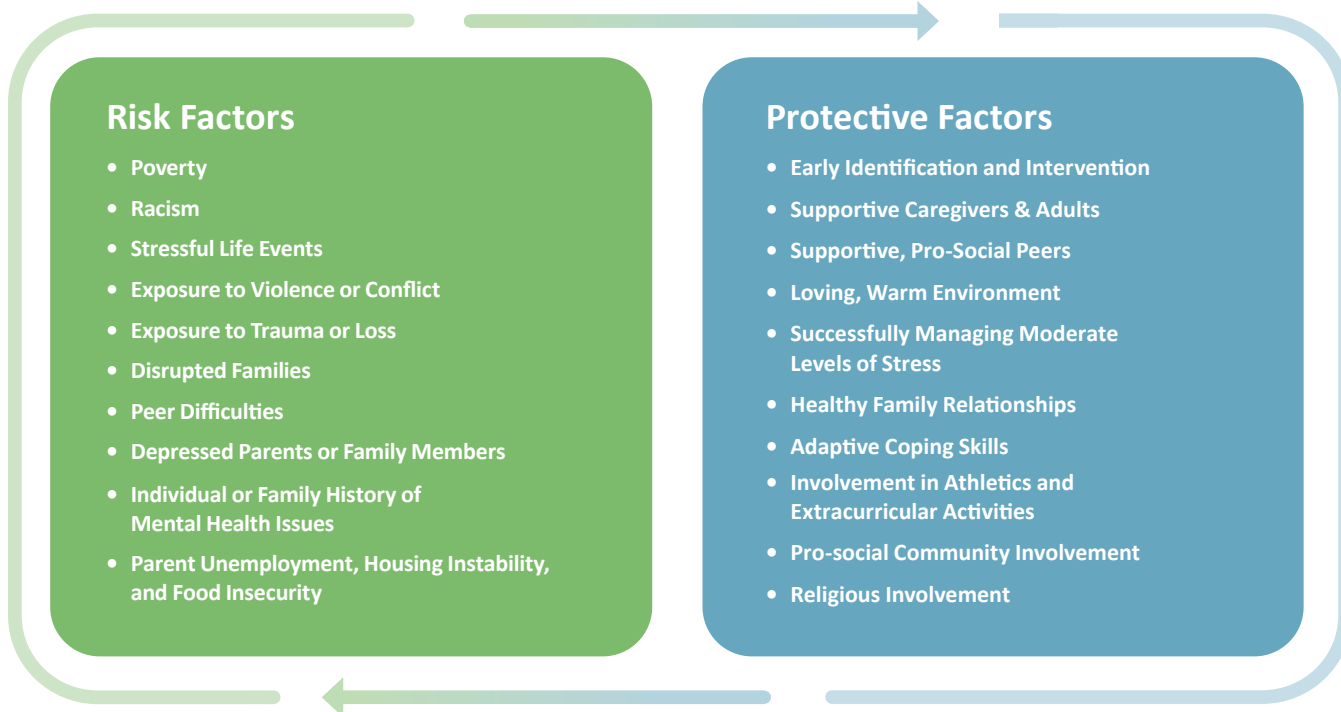
In order to promote best possible outcomes for students and families, it is essential to understand the interplay between risk factors, protective factors and resiliency, and how issues of equity contribute to student wellbeing. Risk factors are those characteristics that make children more vulnerable or more likely to experience a potentially negative outcome. Risk factors can include adversities such as poverty, family history of behavioral health challenges, and/or exposure to domestic or community violence.¹⁶ Protective factors are those characteristics that can help counter risk factors, protect children and help them to stay on a healthy developmental track, despite the challenges and adversities they may experience. Protective factors can include relationships with supportive caregivers and adults, growing up in a loving and warm environment, or engagement in prosocial activities and a supportive community.¹⁷ Both protective and risk factors can include characteristics that exist within the child, family, school and community.

Resiliency occurs when children develop in a healthy trajectory despite the presence of one or more risk factors. Resiliency can contribute to why some children and families do well and even thrive while facing similar adversities to other children who experience negative outcomes.¹⁸

Strategies to promote positive outcomes for youth should consider how to promote resiliency and help families build upon their own strengths and capacities. There are certain qualities that help to build resiliency in the face of adversity, such as positive self-esteem, academic achievement, coping resources, extracurricular involvement, and having a positive orientation toward the future. Other characteristics that foster resilience include connection to a religious or spiritual group or cultural affiliation. It is also protective to grow up in a positive environment with available and engaged adults who can help children mitigate potentially harmful external environments and experiences.¹⁹

While children and youth at every socioeconomic level experience risk and adversity to some degree, children of color, children living in poverty and those from historically marginalized and disadvantaged communities are especially at risk for experiencing negative outcomes.²⁰ A key element to ensuring healthy development in children is an equity-focused, strengths-based, resiliency-promoting approach. Schools can aid in promoting resiliency through fostering school connectedness, creating a nurturing and embracing climate, and creating policies focused on keeping children and youth in school.²¹

Risk Factors and Protective Factors



¹⁶ O'Connell, Boat, & Warner, 2009

¹⁷ O'Connell, Boat, & Warner, 2009

¹⁸ Lee, Cheung, & Kwong, 2012

¹⁹ Lee, Cheung, & Kwong, 2012

²⁰ O'Connell, Boat, & Warner, 2009

²¹ Centers for Disease Control and Prevention, 2009



Impact of COVID-19: Building Supportive Environments for Children and Youth

During the COVID-19 pandemic, children have been at higher risk of experiencing prolonged feelings of loss, social isolation, loneliness, anxiety, depression, separation from family members (especially if a member of their family contracts the virus), among many other stressors. Strategies to mitigate these and other stressors, and leverage protective factors to build resilience should be evidence-informed and developed in active collaboration with communities. Children and families would benefit from opportunities to express their feelings and reactions to the pandemic in safe and supportive settings. Strategies should promote affiliation and connection amongst children and their families as well as providing younger children with the means to play and engage in age-appropriate activities in order to help foster a sense of safety and security and facilitate healthy development.

Social Determinants of Health

The relationship between schools and the broader community are further influenced by the various social, cultural and environmental conditions that impact youth development and contribute to how they interact with school systems. These “social determinants of health,” sometimes referred to as “social influencers of health,” are conditions that exist in the environments in which people are born, live, learn, work, and play; and impact health, functioning, prevalence of risk, and quality-of-life outcomes.²² Social determinants of health may be positive and protective, such as reliable social supports, access to healthcare services, and availability of community-based resources.²³ Likewise, social determinants such as poverty, poor education or employment, unsafe neighborhood conditions, and exposure to community violence may negatively affect individuals.²⁴

Social determinants of health can be particularly impactful for the growth, development, and well-being of children and adolescents.²⁵ Research indicates that these factors not only have an impact on health, they can also influence educational outcomes for children and youth.²⁶ Examples of social determinants of health that may impact a child’s ability to succeed in the school setting include housing instability and homelessness, food insecurity, trauma and adverse childhood experiences, and poor access to health-related services and supports.²⁷ Risk factors such as these can cause distress that, if unaddressed, can increase the likelihood that behavioral health challenges will develop.²⁸

²² Healthy People 2020, n.d.; Center for Health and Healthcare in Schools, School-Based Health Alliance, National Center for School Mental Health, 2020

²³ Healthy People 2020, n.d.

²⁴ Thornton, et al., 2016

²⁵ Braveman & Gottlieb, 2014

²⁶ American Public Health Association, 2019

²⁷ Center for Health and Healthcare in Schools, School-Based Health Alliance, National Center for School Mental Health, 2020

²⁸ Center for Health and Healthcare in Schools, School-Based Health Alliance, National Center for School Mental Health, 2020

Impact of COVID-19 on Children and Families

The pandemic derailed the daily lives of youth across the country. The need for social distancing, school closures and other interrupted routines introduced a host of potentially harmful stressors. Caregivers too were asked to wear many hats: parent, employee, teacher, nanny, spouse; all while facing increased social, financial, and professional stressors themselves. Further, as communities endured lockdowns or other physical distancing mandates, protective factors such as family gatherings, death and grieving rituals, access to religious supports, or community activities were interrupted or canceled. The decline in case numbers, deaths and case severity following the introduction of highly effective COVID-19 vaccines has many feeling optimistic that the end of the COVID-19 crisis is near. While these are major milestones to be celebrated, we must not overlook the psychological and emotional impact COVID-19 has had. Between April 2020 and June 2021, more than 140,000 children in the United States under the age of 18 lost a caregiver due to COVID-19.²⁹ This number has increased in the months since the study was completed and may now have reached as high as 175,000 children.³⁰ These children's traumatic experience of losing a caregiver, coupled with the universally felt stressors experienced by children and families across the country means it is likely the fallout from this crisis will persist for months or even years. Strategies to mitigate these and other stressors should be designed in active collaboration with children and families themselves, as well as professionals such as child psychiatrists, psychologists, social workers, pediatricians, and other behavioral health experts.

As we consider implementing policies and programs to support positive outcomes for children, a fundamental understanding of the interplay between risk, protective factors and resiliency is important. We must determine whether the potential adversities our children face overwhelm their available coping mechanisms and available protective factors. We cannot always control the risk factors to which children and families are exposed, but we can try to identify children who may be at risk of negative outcomes or are already experiencing the negative impacts

of exposure to adversity. By building their protective factors and resiliency through policies, systems and services that promote health and wellbeing, and by identifying and intervening early with prevention and intervention services and supports, we can create healthier outcomes for even our most vulnerable children. This strategy is at the heart of tiered systems of supports which utilizes identification, prevention, and intervention services and supports to create a comprehensive school system of care.

What is Comprehensive School Mental Health?

This report defines Comprehensive School Mental Health Systems (CSMHS) as “school-district-community-family partnerships that provide a continuum of evidence-based mental health services to support students, families and the school community.”

Essential elements of a CSMHS include:³¹

- Providing a full array of tiered behavioral health supports and services.
- Including a variety of collaborative school and community partnerships.
- Using evidence-based services and supports.



²⁹ Caregiver is defined as parent, custodial grandparent, or grandparent caregiver who provided a child's home and basic needs; National Institutes of Health, 2021

³⁰ National Institutes of Health, 2021; Chatterjee & Wroth, 2021

³¹ Hoover, et al., 2019

Tiered Systems of Support: A Comprehensive Approach to Meeting Students' Behavioral Health Needs in Schools

What are Tiered Systems of Support?

The Institute of Medicine (IOM) first proposed that supports and services can be categorized into three distinct tiers: Universal, Selective and Indicated.³² “Universal” prevention programs are those supports and services designed to benefit everyone in a given population. “Selective” prevention and early intervention programs target a specific sub-set of a population who are at higher risk for certain negative outcomes. “Indicated” interventions for identified individuals are supports and services designed to address the needs of individuals struggling with identified behavioral health challenges.³³

This framework has since become the foundation for similar models across a number of domains, including education; notably Multi-Tiered Systems of Support (MTSS), the tiered model most commonly associated with school-based behavioral health.

What are Multi-Tiered Systems of Support?

Multi-Tiered Systems of Support (MTSS) is a three-tiered model to help schools to organize and deliver their educational and behavioral health services, supports, and systems designed for students with a variety of needs.³⁴ When effectively utilized, MTSS promotes positive behavioral health outcomes for students.³⁵ The interventions and supports that make up the multi-tiered school-based behavioral health system can promote positive social, emotional, and behavioral skills in addition to the general well-being of all students regardless of risk for or presence of behavioral health diagnoses.³⁶

When implemented with a high degree of fidelity, MTSS enables schools to embed supports within the school environment and ensure that they can be readily accessed by faculty, staff, and most importantly by students and families. MTSS must be culturally responsive and meet

What sets MTSS apart from other school-based initiatives is its emphasis on a comprehensive infrastructure and four essential elements:

- 1 Universal screening to identify levels of need for individual students.
- 2 Progress monitoring to guide the intensiveness of intervention moving forward.
- 3 Assessment methods and data strategies to govern use of data in decision-making.
- 4 Tiered interventions increasing in intensity to effectively identify and respond to the unique needs of each student.³⁷

the unique needs of school communities. As a model, the MTSS tiers build upon one another, with increasing levels of intensity of the intervention (frequency, dosage, and duration) based on students' unique needs. The three tiers include: Tier 1 “Universal”; Tier 2 “Targeted”; and Tier 3 “Intensive.” As a model, the MTSS tiers build upon one another, with increasing levels of support based on students' unique needs. Within the MTSS framework, all students receive primary, universal supports at Tier 1, and small groups of students with identified needs receive more targeted supports at Tier 2. When student needs cannot be met by the supports and services at Tiers 1 and 2, individual students receive unique and intensive supports at Tier 3; however, this is not to the exclusion of the continued participation in services at Tiers 1 and 2.³⁸ Further, access to services at different tiers is not exclusive or necessarily sequential. One student may receive Tier 1 services in one area, and Tier 2 or 3 services in another; and a student can move between tiers, accessing services at the appropriate tier as needed. For example, moving immediately to Tier 3

³² O'Connell, Boat, & Warner, 2009; National Institute on Drug Abuse, 2003; Department of Health and Human Services Nevada Division of Public and Behavioral Health, 2014

³³ Department of Health and Human Services Nevada Division of Public and Behavioral Health, 2014

³⁴ McIntosh, Goodman, & Bohanon, 2010

³⁵ Adamson, McKenna, & Mitchell, 2019; Batsche et al., 2005

³⁶ NCSMH, 2020a

³⁷ Doll, 2019

³⁸ Yamaguchi & Hall, 2016

if an acute need is identified, or transitioning from lower to upper tiers, or vice versa, based upon the identified need. MTSS is most effective when appropriate, evidence-based practices (EBPs) are implemented at each tier.³⁹

MTSS Characteristics

Tier 1: Universal Supports & Universal Screening

Tier 1 supports and prevention strategies are provided to all students, regardless of need. Tier 1 is focused on prevention and proactive strategies, rather than strategies that are deployed after a specific difficulty has been identified. Tier 1 supports are fully embedded within daily programming and are provided universally throughout the entire school, in specific grades, or in individual classrooms. For example, a Tier 1 prevention strategy could be direct instruction focused on the teaching and practicing of school-wide expectations,⁴⁰ working with teachers and school administration to create trauma sensitive classrooms, implementing positive discipline practices, or using a validated curriculum to teach behavioral health literacy or social-emotional learning.⁴¹ When implemented in a coordinated way, these Tier 1 strategies build a foundation for the success of all students – psychologically, socially and academically.⁴² It is expected that approximately 80% of students receiving Tier 1 supports will respond successfully to them and require no additional intervention.⁴³

Universal screening within an MTSS model can be described as, “a systematic tool or process to identify the strengths and needs of students” through the use of a validated approach.⁴⁴ Identifying student need and intervening at the earliest possible point serves to: a) identify when Tier 2 or Tier 3 supports and services are needed, b) provide upstream supports to mitigate the need for Tier 2 and Tier 3 services and crisis response, and c) make more effective and efficient use of limited resources by selecting the appropriate supports for children in need at the right time. Likewise, screening results help schools tailor prevention and intervention strategies, as well as identify concerns specific to particular groups of students, such as certain grades. If screening identifies needs of students that the existing system cannot address, it also can serve to highlight the need for additional capacity building or workforce development and training needs, and/or strong partnerships with community-based providers.

The effectiveness of this approach relies on the screening of all students, not only specific groups of students.⁴⁵ Therefore, along with universal prevention efforts, screening can be seen as an integral and essential element of Tier 1 supports and can help identify additional needs of students that can be further served by Tier 2 and Tier 3 interventions. By asking all students about their social-emotional strengths, as well as their psychological distress, screening may also reduce stigma surrounding youth behavioral health, enhance students’ sense of empowerment, and provides valuable information about student needs school-wide.⁴⁶ It is important to note that schools are one of the only systems that are positioned to provide universal screening and prevention services to large populations of children and are therefore essential in ensuring that vulnerable children are identified.

It should also be acknowledged that universal screening can be a controversial topic. The challenge of conducting universal screening in a school setting is that it raises a variety of issues including privacy concerns, how the information is used, how emergent needs will be addressed, and what to do if the identified needs exceed the capacity of the school and community.⁴⁷ Screening alone is not enough to address behavioral health needs. While universal screening is a critical element in the implementation of an MTSS framework, it is only the first step in a multi-layered process. Once screening occurs, the results need to be interpreted and an appropriate system needs to be in place to meet the identified needs.⁴⁸ For example, if universal screening reveals that a large percentage of the student population has experienced trauma and is demonstrating signs of traumatic stress, does the system have adequate resources to further assess the needs of the students and the capacity to provide appropriate (ideally evidence-based) services and supports to address this need? If a majority of students are demonstrating a common concern, such as traumatic stress, a Tier 1 (universal) or Tier 2 (targeted) approach may be warranted. This can put schools in a challenging position if there isn’t sufficient capacity or a trained workforce to meet these needs.⁴⁹ Further, what happens when a student is identified through screening to have certain risks or symptoms, but that child’s family refuses services to address the identified need? If a student is identified through screening to pose a danger to self or others, their parent or guardian must be notified. As mandated reporters, schools can be put in a difficult position with families and this can be a breach of trust. Ideally, once screening is conducted, a well-developed MTSS will be

³⁹ For a partial list of EBPs appropriate for school settings, see Appendix A, Page 54

⁴⁰ All students need to be explicitly taught the behavioral expectations of the school across all contexts (classroom, cafeteria, hall, etc.).

This concept challenges underlying assumptions that students should inherently know the expectations. Simply put, they don’t without adequate and clear instruction.

⁴¹ NCSMH, 2020b

⁴² Massachusetts Department of Elementary and Secondary Education, 2019

⁴³ OSEP, 2014

⁴⁴ NCSMH, 2020a

⁴⁵ NCSMH, 2020b

⁴⁶ NCSMH, 2020a

⁴⁷ Sicheloff, Bradley, & Flory, 2017

⁴⁸ SAMHSA, 2019

⁴⁹ SAMHSA, 2019

positioned to address the identified needs. However, for many schools, screening might only highlight challenges for which there are no easy solutions.

While schools and communities may be reluctant to screen because they feel they lack sufficient capacity to address these concerns, it is ethically our responsibility to screen all students to identify children at risk. Screening is intended to identify need, not to diagnosis children.

Tier 2: Targeted

All students within a fully implemented MTSS framework should receive Tier 1 supports. However, when a child has identified needs beyond those that can be addressed at the universal level, Tier 2 or Tier 3 interventions may be considered based on the identified needs of the student and the level of intensity of supports needed. Tier 2 early intervention supports are well suited to students who have been identified as experiencing mild or moderate behavioral health, or social-emotional needs, or are considered to be at-risk for developing certain behavioral health challenges.⁵⁰ These services may include small group interventions for students who have similar needs including mentoring, classroom supports, and brief, less intensive individualized interventions for students with mild to moderate challenges. For example, a group of students who witness a car crash while waiting at a bus stop may be referred to a Tier 2 group intervention to help them cope with the trauma and prevent further distress. Other examples of Tier 2 services include cognitive behavioral therapy groups focused on anxiety and/or depression, social skills groups, and topical, psychoeducational groups designed to improve students' understanding and navigation of a specific presenting challenge, or "Check-in/Check-out," a targeted practice that provides students with increased adult support and monitoring throughout the school day.⁵¹

These interventions may rely upon existing resources at the school level or, when necessary, may require specialized professional development, clinical expertise or resources.⁵² Tier 2 interventions are intended to develop student skills quickly and efficiently, allowing a student to progress such that Tier 1 supports are again sufficient. It should again be noted that movement between MTSS tiers is fluid, and a child may immediately access these higher tier services as soon as the need is identified without needing to pass through the lower tiers first. Within the three-tiered MTSS framework, it is expected approximately 15% of students will require and respond successfully to Tier 2 supports.⁵³

Tier 3: Intensive

When a student has an identified need that cannot be addressed through Tier 1 or Tier 2 supports and services, or when a student is receiving but not responding to lower tier services, the more intensive and individualized interventions at Tier 3 may be considered. Interventions provided at this level are unique to an individual student and are tailored to best meet their needs.⁵⁴ These services often include engaging in therapeutic services both with school-based behavioral health professionals and/or services and supports in the community. These therapeutic services may include more intensive individual, group or family therapy. Ideally, once an assessment has been made, the child will be referred for evidence-based treatment (EBT) to address his or her presenting concerns. For example, a child suffering from significant traumatic stress symptoms that are interfering with their ability to function in a classroom setting might be referred to a clinician either in the school or community who has been trained in an EBT such as Cognitive Behavioral Intervention for Trauma in Schools (CBITS) or Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). This level of support may also require additional assessment and the coordination of additional service providers such as board certified behavioral analysts, occupational therapists, speech and language pathologists, child psychiatrists or well-trained community-based therapists.

The defining characteristic of Tier 3 interventions is the level of intensity required to support a student's needs. Tier 3 supports should be tailored to the individual child and whenever possible, evidence-based. For example, Tier 3 behavioral interventions could consist of a Functional Behavioral Assessment that results in an individualized Behavior Support Plan meant to help individual students learn and apply new skills and behaviors that will facilitate their success in school and social settings, allowing them to succeed and thrive.⁵⁵ And again, students may access Tier 3 services immediately once a need has been identified. Interventions that fall within Tier 3 are expected to be necessary for approximately 5% of students.⁵⁶

It is worth noting that while some students may receive services as part of their Individual Education Plan (IEP), the MTSS strategy is meant to make services available to all students who demonstrate need, whether or not that have an Individualized Education Program. Further, Tier 2 and Tier 3 supports, and behavioral health supports in general, are not reserved solely for those who carry an official diagnosis. Behavioral health support can benefit all students, and embedding this understanding in daily practices will increase access for those who do not have an official diagnosis yet still need the support.

⁵⁰ NCSMH, 2020c

⁵¹ Reinke, et. al., 2013

⁵² Oakes, et al., 2012

⁵³ OSEP, 2014

⁵⁴ Young, et al., 2012

⁵⁵ Scott, et. al., 2010

⁵⁶ OSEP, 2014

Massachusetts Snapshot: Positive Behavior Interventions and Supports

In an effort to create proactive behavioral health supports, Positive Behavioral Interventions and Supports (PBIS) has emerged as a leading evidence-based framework to enhance behavioral supports in schools nationally, and here in Massachusetts.⁵⁷ PBIS mirrors the overall structure of MTSS by providing a three-tiered approach to behavior with an emphasis on prevention and data-based decision making.⁵⁸

Across all tiers of PBIS, significant attention is given to the selection of EBPs. Among the most common Tier 1 interventions are: school-wide behavioral expectations taught through direct instruction, rewards for appropriate behavior, a continuum of consequences for problem behavior, and school-wide classroom management practices.⁵⁹ Tier 2 interventions frequently consist of interventions such as: targeted direct instruction in areas of need, increased structure in daily routines, and increased frequency of adult feedback.⁶⁰ Tier 3 interventions are reserved for students with individualized need. Interventions at this level of behavioral support include: functional behavior assessment, intensive instruction, and self-management.⁶¹ PBIS is one of a number of EBPs that the Massachusetts Department of Elementary and Secondary Education (DESE) have identified as a choice intervention, and worked to implement in the state. For a partial list of this and other EBPs appropriate for school settings see Appendix A on page 54.



⁵⁷ Cook, et. al., 2015
⁵⁸ Horner, et. al., 2010

⁵⁹ Horner, et. al., 2010
⁶⁰ Horner, et. al., 2010

⁶¹ Horner, et. al., 2010

What does MTSS in schools look like?

Again, movement between the three tiers is fluid and supports at each level can be accessed immediately once need has been determined.⁶² Not every student will need or receive clinical services. However, in schools implementing MTSS, all students should receive Tier 1 supports that foster healthy social, emotional and academic health. As has been stated, it is expected the majority of students will need no supports beyond those found at Tier 1. For students with identified behavioral health needs that cannot be addressed through Tier 1, access to Tier 2 services (for students identified as at risk for a negative behavioral health outcome) and Tier 3 services (for students who are symptomatic) is driven by acuity of need, and severity of the symptoms, with students accessing the tier that is best suited to meet their needs. It is also important to note that students are not labeled within an MTSS framework; rather their need in various domains is seen within the context of the tiered model.⁶³ For example, a student may benefit from Tier 1 supports in the classroom, such as a comprehensive social-emotional curriculum, and Tier 2 supports during recess, such as a “point sheet” to provide positive reinforcement by awarding points for healthy prosocial behaviors. The student is never labeled a “Tier 1, 2, or 3 student.” Instead their level of need in specific contexts is identified and responded to with appropriate supports.

Tier 3

Intensive

for students with moderate to severe challenges

Tier 2

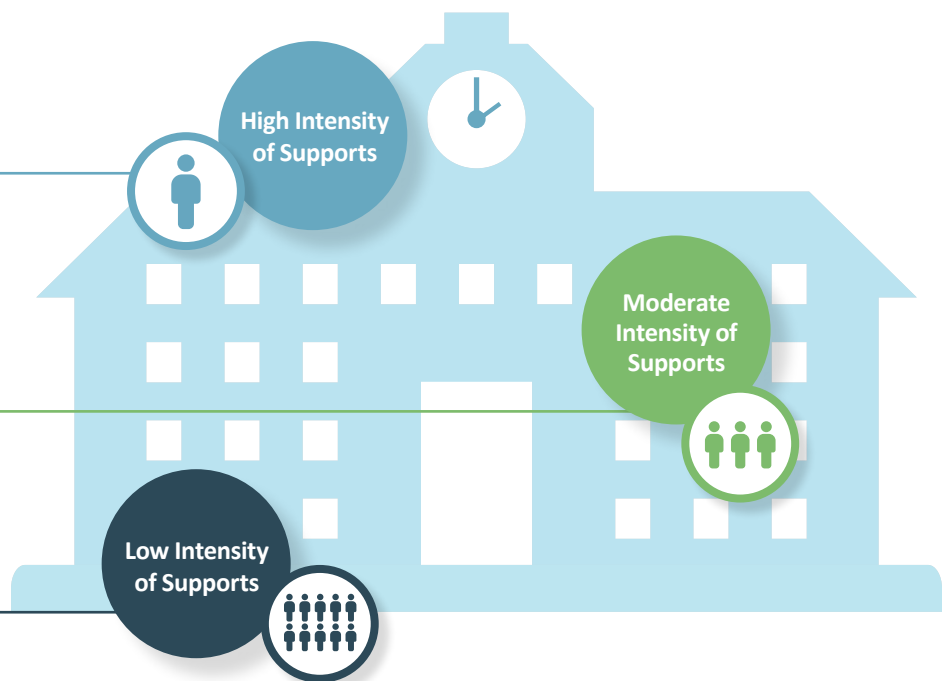
Targeted

for students identified as at risk for a negative behavioral health outcome or who are experiencing mild to moderate concerns

Tier 1

Universal Support and Universal Screening

for all students



Measuring Outcomes

For practices and systems to be fully leveraged, they must support progress monitoring and measurable outcomes that can demonstrate social, emotional, behavioral, and academic success. These outcomes ideally should utilize standardized criteria, but also should consider the unique context and culture of each school in order to make them meaningful and relevant. For example, while academic outcomes may include improved reading scores, behavioral outcomes could be defined as a decrease in out of school suspension, a measured reduction in symptom presentation, or increase in reported social-emotional competence. Students may only need interventions for a limited time. Ideally, as symptoms are reduced, students will eventually no longer need ongoing services. The underlying foundational element that should drive decision making at every level is data.⁶⁴ The right data will help schools identify needs, guide the selection of interventions, and identify areas where additional supports must be developed and capacity must be strengthened. When a range of services and supports are developed based upon sound data that measures both identified need and outcomes of existing services, MTSS can best be utilized and the full potential of the framework can be harnessed. A fully implemented multi-tiered system can lead to documented improved and sustainable outcomes for children, families, and school communities as a whole.

⁶² Averill & Rinaldi, 2011

⁶³ Massachusetts Department of Elementary and Secondary Education, 2019

⁶⁴ OSEP, 2019

Massachusetts Snapshot: Boston Public Schools’ “Lighthouse” Model⁶⁵

Boston Public Schools (BPS) is considered a national leader in school-based behavioral health, in part due to its homegrown Comprehensive Behavioral Health Model (CBHM). The “Lighthouse” model, as it is commonly called, provides a system-wide framework for schools to implement data-driven, evidence-based behavioral health interventions and supports. Part of what makes the model so successful is its focus on professional development at the school level and partnering with community behavioral health agencies in addition to its three-tiered MTSS model. For all students, Tier 1 includes social-emotional learning, universal screening and Positive Behavior Interventions and Supports (PBIS). For students with elevated risk or identified need, Tier 2 interventions provided by general education teachers in the classroom, and group counseling provided by behavioral health personnel. Tier 3 services including individualized interventions provided by licensed clinical staff, or a community partner, as well as crisis response and management.⁶⁶

As of 2021, CBHM has been implemented in at least 85 out of the 125 BPS schools. According to BPS,⁶⁷ schools who have implemented CBHM have seen:



Improved academic outcomes



Increased supports to families



Increased teacher knowledge of behavior and trauma



Greater coordination of supports and services



Improved positive behaviors



Decreased negative behaviors



Decreased school discipline



Decreased need for Tier 3 services



Decreased risk for challenges such as conduct issues, negative affect, or cognitive attention

One notable example is Brighton High School, one of the earliest adopters of the Lighthouse model. After the first year, Brighton High decreased student suspensions by 44% and both students and teachers reported a more positive school environment.⁶⁸ Further, reports published by BPS suggests that students who have needs identified and responded to early experience and sustain significant improvement; and that those improvements are similarly experienced by students across different racial and ethnic groups.⁶⁹

⁶⁵ CBHM Research Committee, 2020; CBHM, 2020

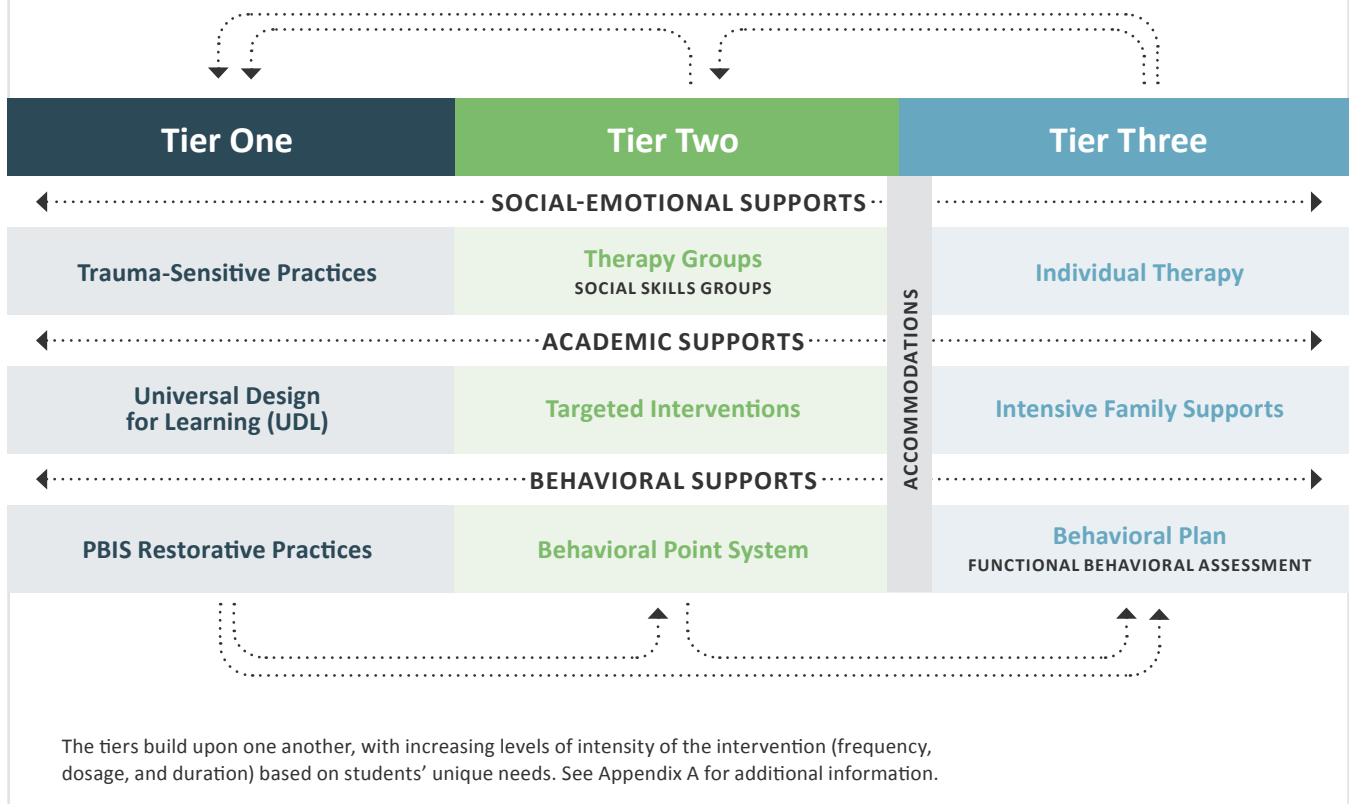
⁶⁶ Rennie Center, 2019

⁶⁷ Boston School-Based Behavioral Health Collaborative, 2021

⁶⁸ Amador, 2017
⁶⁹ CBHM Research Committee, 2020

How do all of these interconnected systems of support fit together?⁷⁰

MULTI-TIERED SYSTEMS OF SUPPORT FOR BEHAVIORAL HEALTH



Through universal screening student strengths and needs are identified, and students are immediately funneled into the appropriate tiered service or support to promote their health and wellbeing. While typically students flow from one tier to the next (e.g. Tier 1 ► Tier 2), in certain circumstances when there is a clearly identified need, students may move from Tier 1 directly to Tier 3.

At the Tier 1 level, school-based behavioral health consists of interventions (both curriculum and practices) that are focused on education, school climate, and behavioral health literacy, fostering use of coping skills, stigma reduction and social-emotional learning.⁷¹

Within the higher intensity levels of Tiers 2 and 3, behavioral health supports provided by both clinical and non-clinical staff become increasingly targeted. Students who have been identified as experiencing mild or moderate distress, mildly or moderately impaired

functioning or at-risk for a given problem or concern are ideal candidates for Tier 2 supports, delivered by teachers in classroom settings, or clinicians.⁷² Supports may include small-group, evidence-based interventions delivered by trained clinicians, mentoring, daily report cards, teacher check-ins, or short term individual counseling home-school notes.⁷³ For students who continue to demonstrate more significant need, Tier 3 supports provide individualized treatment. Behavioral health supports at Tier 3 consist of services such as individual, family, or group therapy ideally using evidence-based therapeutic modalities provided by school or community-based behavioral health professionals,⁷⁴ programmatic general or special education services facilitated by a team of staff members, and crisis interventions. Ongoing progress monitoring is used to determine when a student's needs can be fully met with a lower intensity of supports in Tiers 1 and 2.

⁷⁰ Branching Minds, 2022
⁷¹ NCSMH, 2020b

⁷² NCSMH, 2020c

⁷³ NCSMH, 2020c
⁷⁴ NCSMH, 2020c

National Best Practice: Designing and Implementing MTSS in Schools

Research and expert testimony suggest that MTSS is the most effective strategy to promote student health and wellbeing.⁷⁵ For schools and districts seeking to implement a tiered approach, there are several best-practice guidelines to consider.

Needs and Capacities Assessment

One of the first steps to develop an appropriate system of supports is to conduct a community needs and capacities assessment. This assessment can provide a strong foundation to help identify unique needs and challenges, such as high rates of community violence or levels of unemployment, while also identifying the strengths and capacities already present in the school and the community. For example, perhaps the school has a limited tax base and therefore very limited funding to invest in support services for students including a behavioral health team;⁷⁶ however, there may be several community-based providers that can help fill the gap and address the need. In some cases, the existing services and supports in a community are not well coordinated, nor do they have the necessary infrastructure (such as data sharing, efficient referral mechanisms, or memorandums of understanding with community mental health providers) needed to maximize outcomes for families. In some cases, barriers exist that impede school and community partners working collaboratively and effectively together – such as lack of designated space for outside clinicians to provide services in schools, not giving students necessary time off from academics to receive behavioral health supports, or funding barriers.⁷⁷ By first identifying the needs and capacities of the local system in order to better understand the local context, an inventory of local services and supports can be identified as well as identifying where there may be gaps. On a school level, needs assessment and resource mapping help schools understand staff capacity and readiness to implement EBPs.⁷⁸ A needs assessment should also include rates of both family and community risk factors, as well as prevalence rates of behavioral health challenges. For example, in communities where trauma exposure is high, there would be a high need for trauma-informed services and supports such as screening, assessment and evidence-based trauma-focused interventions to be developed in the school and community.

A comprehensive needs assessment can inform capacity building as well as school and district professional development planning and staffing needs. Once the gaps between needs and capacity are identified, schools and communities need access to the right resources and tools to build the needed capacity, close identified gaps and effectively meet the behavioral health needs of students. Only then can a comprehensive, equity-informed multi-tiered strategy that is developed using evidence-based approaches be designed and implemented effectively.

Resource: The SHAPE System⁷⁹

The School Health Assessment and Performance Evaluation (SHAPE) System is a free online platform for school, district, and state teams. The SHAPE System supports districts in understanding the quality of their comprehensive school mental health system and informs the creating of an action plan to address gaps and leverage what is already going well. This resource includes tools to conduct needs assessments and resource mapping to identify and build upon community-based and school-based behavioral health supports and services. Schools can search for screening or assessment tools that fit their specific school needs by focus area (academic, school climate, or social/emotional/behavioral), assessment purpose, student age, language, reporter, and cost. Every measure has been carefully reviewed and includes a brief summary with direct links to copies of the instrument and scoring information.

The SHAPE System can be found at:
<https://www.theshapesystem.com/>

A partial list of screening and assessment resources can be found in Appendix B on page 72.

⁷⁵ NCSMH, 2020a

⁷⁶ The four clinical Specialized Instructional Support Personnel (SISP) roles in Massachusetts include school counselors, school psychologists, school social workers, and adjustment counselors

⁷⁷ Shriberg, 2013; Hoover et al., 2019

⁷⁸ Substance Abuse and Mental Health Services Administration, 2019

⁷⁹ The SHAPE System: <https://www.theshapesystem.com/>

Screening⁸⁰

Screening can be used to identify both the needs and strengths of students. Best practice is to conduct screening universally, rather than only for students considered to be at risk. This might mean screening an entire school, or a smaller subset, such as a specific grade level.⁸¹ When implementing school behavioral health screening, it is essential to select an appropriate, validated screening instrument and to use it effectively. For a partial list of validated screeners see Appendix B on page 72. It is also essential that students and families be actively engaged and kept informed throughout the process of designing and implementing screening procedures and protocols, and that those procedures and protocols include clearly articulated processes for responding to screening results. All screening procedures must be Family Educational Rights and Privacy Act (FERPA) compliant and parents always retain the right to be informed.⁸² Districts may adopt active or passive consent procedures. If a district seeks active consent, parents must provide explicit written consent to allow the screening to occur. Districts using passive consent procedures alert families to the administration of screening and provide opportunities for families to opt out of screening. Results of the screening process may identify students in need of follow-up assessments and potential referral to culturally and linguistically responsive, evidence-based services and supports.

COMMUNICATION GUIDANCE AND EXAMPLE

Effectively communicating with parents and the broader community is essential to providing the highest quality of care possible to students. The Massachusetts School Mental Health Consortium provides tools and resources to assist with this communication. Learn more at:

https://docs.google.com/document/d/1zOOTrU5P5n4Z5X-wSZyAOPE9v4JJoI_Gxh7cE6uSif0/edit

An example from the CDC regarding COVID-19 testing can be found here:

<https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/letters-for-schools.html>

It is important to restate that screening is a first step in identifying students in need. For example, screening may indicate that a student has many potential risk factors, but

a more comprehensive assessment by a behavioral health professional would be necessary to determine if the student was suffering from any behavioral health challenges requiring intervention. Effective universal screening also requires that the data be tracked and regularly reported to identify trends and needs, and ensure children and families are having their needs met.⁸³ For example, this may include: number of students enrolled in school, formally screened in the absence of known risk factors, identified as being at-risk, are already experiencing a behavioral health challenge, or referred to behavioral health services following identification. Additionally, schools should document how many students were screened for specific concerns, such as anxiety, depression, suicidality, substance use, trauma and other behavioral health needs. Again, screening cannot diagnose these concerns, only identify students who may be at risk. Once identified through screening, additional assessment is needed to identify specific behavioral concerns or diagnoses. Screening is universal; assessment is targeted.

Resource: Designing and Implementing Effective Screening

For more information, and additional resources to assist schools in designing and implementing effective universal screening practices, see the National Center for School Mental Health's (NCSMH) resource: School Mental Health Quality Guide – Screening (link in footnote below).⁸⁴



⁸⁰ NCSMH, 2020a

⁸¹ For example, in Massachusetts Screening, Brief Intervention and Referral to Treatment (SBIRT) is used to screen for substance use in two grades, typically 8th and 10th grade. For a more thorough exploration of SBIRT in Massachusetts, see page 36

⁸² In rare instances, external providers may be engaged to conduct screening. If outside providers are being leveraged or involved in screening, appropriate consent and confidentiality procedures should be considered based on their licensing; for example, compliance with the Health Insurance Portability and Accountability Act (HIPAA).

⁸³ NCSMH, 2020a; Substance Abuse and Mental Health Services Administration, 2019

⁸⁴ School Mental Health Quality Guide – Screening; <http://www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Quality-Guides/Screening-1.27.20.pdf>

Impact of COVID-19 on Community Needs

The COVID-19 pandemic has exacerbated existing community needs, and introduced new challenges. As our nation moves past the current public health crisis, administering community needs assessments can be an effective strategy to inform program design and the allocation of resources to address common trends and student needs in the months and years to come. Developing or adapting existing surveys to collect data related to families' social-emotional needs, concerns related to social determinants of health, impact of remote learning, and perspectives on returning to more typical school environments will be an important step toward ensuring the voices of students and families are considered, and that needs are identified and met. This information can further serve to ensure the resources and systems developed to support students and families align well with what they actually want and need. Similarly, staff-related data needs can be collected to (1) better understand the experiences of staff in order to address mental health needs of staff, mitigate the effects of burnout and adjust policies and practices to improve morale and the effectiveness of instruction/service delivery and (2) understand the needs of students and families through the lens of the educators who have firsthand experience with students. Finally, school teams should have a process for reviewing the status of students who were not engaged in remote learning experiences during the period of school closure as this may be an indicator of the need for additional social-emotional supports.

Initial Assessment

Regardless of a district's readiness to engage in universal behavioral health screening, psychosocial data can still be collected to inform intervention and/or treatment on an individual basis. Students identified through more traditional methods, such as teacher/parent referral, self-referral, or identification through review of attendance, academic, disciplinary or behavioral data may benefit from a more comprehensive assessment to determine additional areas of need or intervention.⁸⁵ Administering psychosocial measures to identify social-emotional concerns can serve as an effective practice to ensure students are referred to the most appropriate services, and that their strengths, needs and cultural and linguistic considerations are accounted for prior to intervention. Psychological assessments, standardized student self-report measures, teacher/parent/guardian-completed measures or observations, student and parent interviews, as well as a review of associated data that was not a part of the initial referral (for example, attendance data) can produce a clearer picture of students' needs, resulting in a more comprehensive approach to addressing those needs.

Tier 1: Universal Interventions⁸⁶

Tier 1 interventions and instruction serve many purposes, including promoting healthy child development, decreasing stigma about behavioral health, promoting well-being for students and teachers alike, identifying risk factors and the potential need for multi-tiered services and supports, and reducing the need for more intensive services and thus saving on costs.⁸⁷ Schools and districts seeking to implement effective Tier 1 services should focus first on assessing and improving the school climate to facilitate positive, nurturing and accepting school environments. This may further serve to decrease teacher and staff stress and burnout.⁸⁸ Effective Tier 1 interventions can be achieved through implementing school-wide Social-Emotional Learning (SEL) curricula, using trauma-informed classroom practices to foster a safe and supportive learning environment, implementing universal programs such as PBIS, setting classroom and school-wide expectations surrounding positive behavior, implementing positive reinforcement systems that promote such behavior, reducing exclusionary discipline practices,⁸⁹ promoting inclusiveness, and implementing strategies that foster a sense of community. Behavioral health literacy and social-emotional learning opportunities for students further integrate skills for understanding and managing emotions,

⁸⁵ NCSMH, 2020a

⁸⁶ NCSMH, 2020b

⁸⁷ NCSMH, 2020b

⁸⁸ Grayson & Alvarez, 2008

⁸⁹ While exclusionary practices are potentially harmful for all children, research shows children from communities of color are disproportionately exposed to such practices, and their negative consequences.

Tier One All Students

Tier Two Students at Risk or With Mild To Moderate Impairment

Tier Three Students with Significant Distress and Functional Impairment



setting and achieving positive goals, demonstrating empathy for others, and making responsible decisions.

Mental Health First Aid is an example of one such program designed to provide teachers and other school staff with tools to recognize warning signs and risk factors for various mental health conditions such as depression, anxiety, trauma, or substance use disorder, and to connect students to needed care.⁹⁰ As is true at all tiers, Tier 1 supports and services should ideally be evidence-based, delivered with fidelity and responsive to the unique needs and strengths of the school community. There are a number of proven effective Tier 1 interventions (see Appendix A on page 54).

Because teachers are experts at instruction, the focus of Tier 1 supports on skills building and fostering a healthy school environment can make teachers and other non-clinical staff the ideal professionals to deliver these supports and services.⁹¹ Preparing and empowering non-clinical staff requires administration and other non-clinical decision makers to be educated on how best to utilize the staff they have available and to facilitate ongoing professional development. By adequately balancing the roles and responsibilities of clinical and non-clinical staff, schools can ensure that clinical workers are being efficiently dispatched to deliver higher tier services, knowing that interventions happening at those higher tiers is reinforced by the Tier 1 universal supports being practiced school-wide. School administration and support staff, in consultation with behavioral health experts, are ultimately responsible for designing and implementing strategies to address students' behavioral health needs. However, the decision process will likely be strengthened when informed by diverse stakeholder perspectives including students and parents themselves, clinicians, teachers, and individuals with implementation expertise.

Resource: Tier 1 Services and Supports

For more information, and additional resources to assist schools in designing and implementing effective Tier 1 strategies, see the National Center for School Mental Health's (NCSMH) resource: *School Mental Health Quality Guide – Mental Health Promotion Services and Supports (Tier 1)* (link in footnote below).⁹²



⁹⁰ National Council for Mental Wellbeing, 2022
⁹¹ Hoover, et al., 2019

⁹² School Mental Health Quality Guide – Mental Health Promotion Services and Supports (Tier 1); <http://www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Quality-Guides/Tier-1-Quality-Guide-1.29.20.pdf>

Resource: CASEL⁹³

CASEL Program Guides⁹⁴ provide guidance for educators about specific programs to choose and implement.

The CASEL District Resource Center also has a team self-assessment for districts⁹⁵ to gauge their capacity and readiness for SEL implementation.

Tier 2 and 3 Interventions

Effective Tier 2 and 3 services are delivered by trained, licensed clinicians ideally using culturally and linguistically responsive, evidence-based practices. The Tier 2 and 3 services differ by level of intensity of the intervention and both can be delivered in small groups or individually. Again, school administrators and staff are ultimately responsible for identifying, planning and implementing appropriate Tier 2 and Tier 3 supports and services. However, the process of doing so will likely be strengthened by actively engaging diverse community stakeholder perspectives. Tier 3 services are individualized, and individual goals should be developed in partnership with the student, caregivers, and school staff to foster the student's success. Further, schools should implement a systematic protocol for addressing behavioral health crisis situations and ensure that school staff are trained in crisis prevention and de-escalation strategies. Effective Tier 2 and 3 services require data to be collected, analyzed and used to improve policies and procedures, using appropriate assessment tools to continuously monitor implementation fidelity, individual students' and school-wide progress across tiers, and to inform collaborative decision-making about altering services and supports.

Resource: Tier 2 and 3 Services and Supports

For more information, and additional resources to assist schools in designing and implementing effective Tier 2 and Tier 3 strategies, see the National Center for School Mental Health's (NCSMH) resource: School Mental Health Quality Guide – Early Intervention and Treatment Services and Supports (Tiers 2 & 3)*.⁹⁶

**Link in footnote below.*



Resource: Selecting an Evidence-Based Practice

Evidence-based practices (EBPs)⁹⁷ are defined as interventions which have consistently demonstrated intended results and positive outcomes.⁹⁸

The "Selecting Evidence-Based Programs guide" provides detailed, practical information about EBP selection in schools. It includes worksheets and tools schools can use to assess prospective or currently implemented EBPs. Domains include: relevance to the school's student population, intervention target, tier of service, mode of delivery, readiness, and impact evaluation capacity.

Additionally, evidence-based practices require effective implementation to ensure that models are delivered with integrity and fidelity to the model. There are an array of strategies and best practices that can be utilized to ensure programs are implemented effectively. Schools and districts seeking to implement and/or sustain evidence-based practices would benefit from the implementation resources available through programs such as the National Implementation and Research Network, or other community-based programs that specialize in evidence-based practice implementation.

⁹³ NCSMH, 2020b

⁹⁴ CASEL Program Guides: <https://casel.org/guide/>

⁹⁵ CASEL Self-assessment Guide: <https://drc.casel.org/>

⁹⁶ School Mental Health Quality Guide – Early Intervention and Treatment Services and Supports (Tiers 2 & 3): [http://www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Quality-Guides/Early-Intervention-and-Treatment-Services-Guide-\(Tiers-2-and-3\)-2.18.pdf](http://www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Quality-Guides/Early-Intervention-and-Treatment-Services-Guide-(Tiers-2-and-3)-2.18.pdf)

⁹⁷ Selecting Evidence-Based Programs: <https://dm0gz550769cd.cloudfront.net/shape/76/76f9570a074986a6b22b1d6c69289eea.pdf>

⁹⁸ Morris, Day, Schoenwald, 2010

Resource: Evidence-Based Practices (EBP) Registries⁹⁹

For more information about EBPs, and additional information such as individual practice's evidence base, features, training requirements, and cost, see:

**Institute of Education Sciences:
What Works Clearinghouse:**
<https://ies.ed.gov/ncee/wwc/>

Blueprints for Healthy Youth Developments:
<https://www.blueprintsprograms.org/about/>

Model Programs Guide:
<https://www.ojjdp.gov/mpg>

**Society of Clinical Child and
Adolescent Psychology:**
<https://effectivechildtherapy.org/therapies/>

**A partial list of EBPs appropriate for school settings is included in Appendix A of this report.*

Resource: Implementing Evidence-Based Practices in School Settings Checklist¹⁰⁰

Steps include:

1. Develop a plan to track implementation of core components of the EBP.
2. Monitor adaptations to EBP to check fidelity.
3. Ensure that quantitative and qualitative data are obtained to monitor fidelity.
4. Develop a plan to address low-fidelity adherence.

**Linked in the footnote below is a brief checklist to support schools in planning and teaming processes*

Resource: The Fidelity Monitoring Checklist¹⁰¹

A useful tool for fidelity monitoring planning, including:

- Identification of fidelity monitoring tools
- Determining the frequency of fidelity measurement
- Establishing benchmark for acceptable levels of fidelity
- Monitoring adaptations

**reference link in footnote*



⁹⁹ NCSMH, 2020b

¹⁰⁰ Implementing EBP Checklist: <https://dm0gz550769cd.cloudfront.net/shape/49/49ee77b9836c0b0162339153e5a77e65.pdf>

¹⁰¹ Fidelity Monitoring Checklist: <https://dm0gz550769cd.cloudfront.net/shape/6a/6ace1f979015ac4593afa1281ec7361d.pdf>

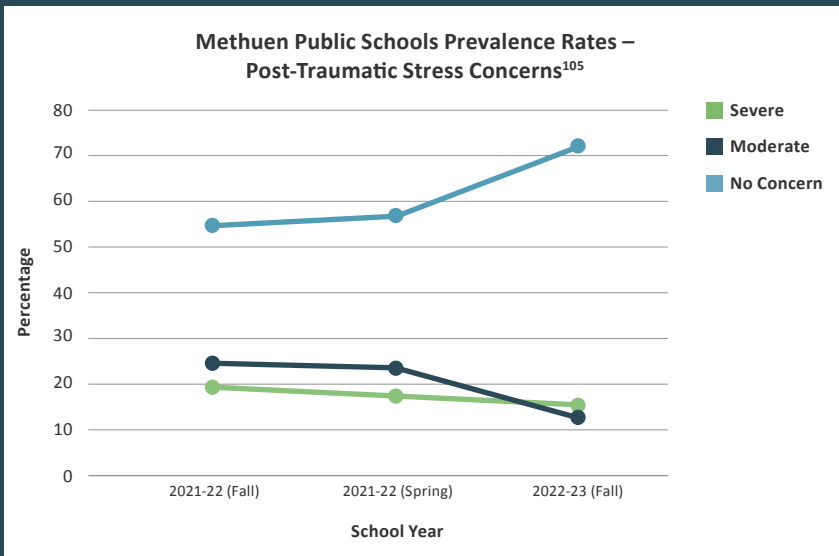
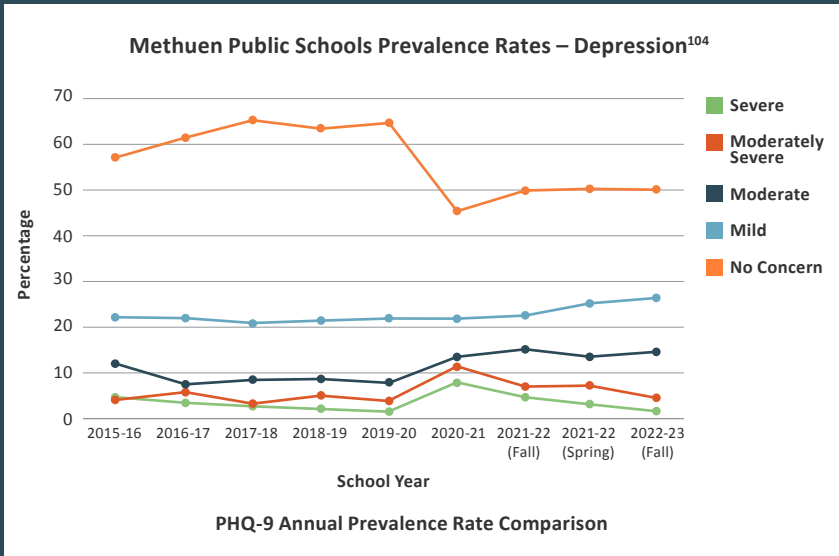
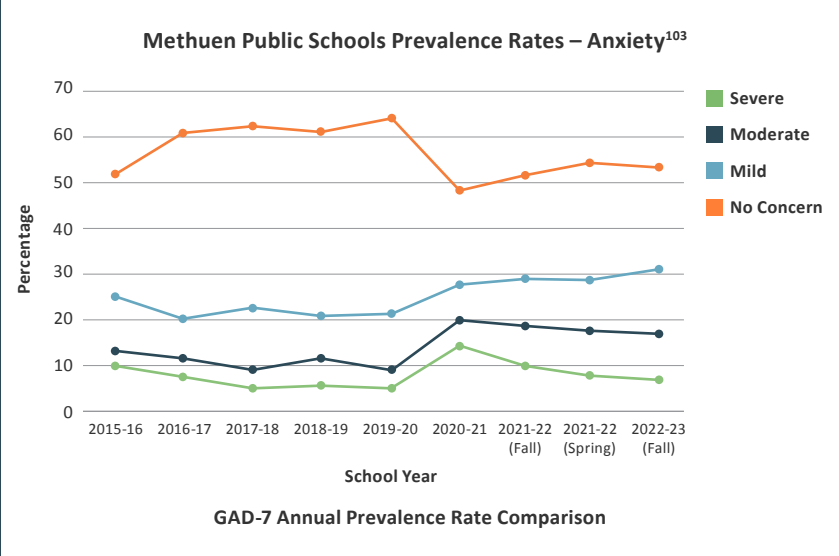
Massachusetts Snapshot: Methuen Public Schools

Methuen Public Schools (MPS) has been recognized as a state and national leader for their work to implement a comprehensive school mental health system (CSMHS), including universal behavioral health screening in grades K-12 that focuses primarily on internalizing concerns (anxiety, depression, trauma etc.) and multi-tiered behavioral health supports for all students. MPS has provided professional development to all staff to ensure Tier 1 supports are universally implemented in the areas of PBIS, trauma-sensitive classroom practices, and SEL. Group-based and individual therapeutic services are informed by the extensive professional development that MPS mental health staff have received in the areas of cognitive behavioral therapy, treatment planning, measurement-based care practices (collection and use of psychosocial and behavioral data), and crisis management. MPS also leverages partnerships with community-based mental health providers, resulting in a 14% increase in available services for students at no cost to the district.¹⁰²

Screening was first piloted while Methuen engaged in the National Quality Initiative Collaborative Improvement and Innovation Network (NQI CoIIN) for Comprehensive School Mental Health Systems (CSMHS), a project led by the National Center for School Mental Health (NCSMH) that engaged districts across the country in work to implement school behavioral health. As Methuen worked to implement screening, the CoIIN team engaged in rapid cycle micro-tests to work through the pilot phase of screening, which helped to determine which measures matched their population's needs, how best to manage consent procedures, how the collected data informed therapeutic practice, and how best to administer a large scale screening and plan for follow up with hundreds of students at once. Between 2015 and 2020, Methuen has seen a reduction in several behavioral health concerns including anxiety and depression:



¹⁰² Calculated from data collected internally by Methuen Public Schools, provided by report co-author John Crocker



The data shows prevalence rates for Methuen Public Schools specifically, which the authors use as a point of comparison for experiences around the Commonwealth. Addressing mental health in schools was a priority for districts across Massachusetts prior to the COVID-19 pandemic. There is reason to believe rates of anxiety and depression in some districts (such as Methuen) were beginning to decline and have since increased again due to the stress and strain brought on by the COVID-19 pandemic. School districts state-wide have taken steps to address the increase in behavioral health needs, however additional measures will be needed in the coming months and years to ensure persistent pandemic-related behavioral health challenges are identified and met as quickly as possible. Methuen has developed a strategic plan that explicitly prioritizes social emotional learning and mental health, priorities that were championed prior to the pandemic and that have been increasingly supported and memorialized in the district's vision for improvement.

¹⁰³ Data collected and analyzed in-house in Methuen Public Schools. Measure used was GAD-7

¹⁰⁴ Data collected and analyzed in-house in Methuen Public Schools. Measure used was PHQ-9

¹⁰⁵ Data collected and analyzed in-house in Methuen Public Schools. Measure used was UCLA Brief COVID-19 Trauma Screen

Promoting Equity

Dismantling long-standing racial and ethnic disparities is an essential component of effective school-based behavioral health. School-based systems of support must address equity and be tailored and customized so that all students, irrespective of race, ethnicity, language or economic status, have access to a comprehensive array of effective services and supports to address their needs. Despite notable advancement across the state and country, research shows that students of color still disproportionately experience negative educational outcomes and punitive reactions to common child behavior.¹⁰⁶ According to the National Center for Education Statistics, in the 2018-2019 school year, the national graduation rate for public high school students was 86%. Asian/Pacific Islander students had the highest rate at 93%, followed by White at 89%, Hispanic at 82%,

Black at 80% and American Indian/Alaskan Native at 74%.¹⁰⁷ Further, while white students tend to be identified and referred to behavioral health services – in the school or in the community – students of color are more likely to receive punitive action including exclusionary discipline, diversion from mainstream classes, or arrest.¹⁰⁸ This contributes to negative outcomes including being held back a grade, school dropout, and perpetuates the “school-to-prison pipeline;” a term to describe the well documented connection between trouble at school leading to a student coming into contact with the juvenile justice system (often referred by the school or a School Resource Officer embedded in the school), and subsequent involvement with the criminal justice system later in life.¹⁰⁹

NATIONAL MODEL SPOTLIGHT: THE CONNECTICUT SCHOOL-BASED DIVERSION INITIATIVE¹¹⁰

There have been notable efforts made across the Northeast region aimed at eliminating the school-to-prison pipeline. One such model is Connecticut’s *School-Based Diversion Initiative* (SBDI). SBDI, developed by the Child Health and Development Institute of Connecticut (CHDI), is designed to reduce student referral to the juvenile justice system by preparing schools to identify and appropriately intervene when students experience behavioral health needs, instead of referring them to law enforcement. To date, SBDI has served dozens of schools across Connecticut. Reported outcomes include a 35% reduction in court referrals, and 47% more students being connected to behavioral health services. SBDI has been identified as a Substance Abuse and Mental Health Services Administration (SAMHSA) best practice.

Previous hypotheses have suggested that perhaps students of color may have learned and exhibit behaviors that more often manifest through emotional dysregulation¹¹¹ because they have been subjected to greater adversity, thus leading to higher rates of disciplinary action.¹¹² However, this is not the case. For example, research on behavior, race, and discipline have found no significant differences in behavior between Black and White students.¹¹³ National research further suggests that Black students receive harsher punishment for less serious behavior than other students, like the subjective offenses of disrespect or loitering.¹¹⁴ These outcomes are driven, in part, by persistent social and structural issues including racial bias and systemic racism. For example, the disparities in school funding in districts that predominantly serve students of color. Nationally, a large portion of public school funding (approximately 35%) is derived from property taxes, which are generally lower in communities of color. This practice has led to Black, Indigenous, and other non-Black students of color to attend schools that are more likely to be under-funded and under-resourced.¹¹⁵

¹⁰⁶ Rovner, 2016

¹⁰⁷ National Center for Education Statistics, 2021

¹⁰⁸ Colman, Kim, Mitchell-Herzfeld, & Shady, 2008

¹⁰⁹ Nelson and Lind, 2015

¹¹⁰ Child Health and Development Institute of Connecticut, 2021

¹¹¹ Emotional regulation and dysregulation refer to the ability of a person to manage their emotional and behavioral responses when under stress.

¹¹² Skiba et al., 2011

¹¹³ Wallace, Goodkind, Wallace, & Bachman, 2008

¹¹⁴ Skiba et al., 2011

¹¹⁵ Chatterji, 2020



Behavioral Health Workforce in Schools and the Community

Schools and communities have a variety of professionals and community members that can attend to the behavioral health needs of students. Commonly, school districts experience insufficient access to school psychologists, social workers and counselors, and this shortage is especially evident in our urban areas. One school psychologist may be responsible for serving thousands of students in a large school system. Nationally, it is estimated that the ratio of students per school psychologist may be as high as 1,233 to 1. The recommended ratio is 500 to 1.¹¹⁶ While Massachusetts fairs better in this area than many other states, there is still a shortage of behavioral health professionals, including but not limited to school psychologists, in Massachusetts schools.¹¹⁷ Statewide, the ratio in Massachusetts is 734 students to one.¹¹⁸ Districts, such as Boston Public Schools, have successfully hired additional school psychologists to meet the National Association of School Psychologists recommended ratio. Given the tremendous need in Boston and other school settings it needs to be assessed whether meeting this ratio alongside other school behavioral health providers is sufficient to address the needs of students. The resources of the school and community also dictate the availability of care. Resource rich schools that are embedded in wealthier communities may have exponentially higher student to service provider ratios than their urban, less resourced counterparts despite those neighboring urban and/or rural communities having much greater needs.

Behavioral health services are provided by a range of professionals and paraprofessionals in the school and community all with their individual levels of training and expertise. In school-based settings, school districts typically employ school psychologists, social workers, counselors and other masters level clinicians. Rarely, schools might employ a consulting psychiatrist to provide support for children with significant needs. In addition, a range of bachelor's level support staff, paraprofessionals and parent aides might also be utilized to provide a range of behavioral health supports to students and their families. Given that many schools are under-resourced, it is imperative that workforce development issues be a primary consideration in developing a comprehensive MTSS plan to ensure that available clinicians have the appropriate training to meet the needs of the school community and deliver effective care.



Often, the behavioral health resources in a school system are insufficient to meet the needs of students, so partnerships and linked services with community-based providers (including psychologists, psychiatrists, social workers, counselors and other licensed masters level clinicians) are necessary. These professionals may provide services in the school through school-linked or embedded services through a partnership with the school or district, or the services may be provided in the community after the child is identified and referred by the school. Where the child receives services will depend on the capacity and expertise of the behavioral health workforce in the school and community; with school-based evidence-based care likely providing optimal access for students. The capacity and expertise of this workforce can vary greatly. Workforce development and training is critical to ensure the community-based providers have adequate capacity and expertise. It is also vital to ensure that there is a comprehensive system to ensure adequate communication and collaboration between school-based clinical and educational staff, and community-based providers. Issues such as referral mechanisms, data sharing, consultation and outcome monitoring should be developed as part of a MTSS system in the school and community.

The shortage of clinical professionals in general is often exacerbated by in-school role confusion, creating a potential barrier to effective, evidence-based care at a practice level, and to expanding and improving school behavioral health across Massachusetts. A variety of different licenses exist for school-based behavioral health staff (school counselors, adjustment counselors, school psychologists, and school social workers). As has been stated, these staff members are not always utilized consistently between districts and schools. Staffing models in which domains of need (academic, behavioral, and social-emotional domains) are parsed out to different staff members in an attempt to facilitate greater focus on a single problem area are often employed. The result is often fractured service delivery that places students in a position of receiving care from numerous staff members and confusion regarding who is

¹¹⁶ National Association of School Psychologists, 2021

¹¹⁷ National Association of School Psychologists, 2021

¹¹⁸ Massachusetts School Mental Health Consortium, n.d.

responsible for what.¹¹⁹ Frequently, school-based behavioral health staff are dispatched to narrowly defined tasks, such as testing, or used inefficiently to manage responsibilities that are outside of the scope of their training, rather than providing clinical supports and consultation.

In addition to staff availability, training, licensure and usage vary between districts and often between schools in the same district. Providing comprehensive care to students in an efficient manner that accounts for their unique needs, challenges and strengths is of paramount importance. Yet, stakeholder testimony suggest that current staffing models often have built-in inefficiencies and are structured in a manner that does not translate well to how students require care.

One potential cause of this inefficient utilization of school-based behavioral health staff may be the fact that many schools and districts are operating with limited clinical leadership and outdated definitions, understanding, and expectations regarding the ways in which school-based behavioral health staff can support and provide services to students. This may be due to the persistence of an outdated staffing model or the adherence to a job description for counseling staff that does not reflect the significant improvements to training programs that have occurred over the past 10-15 years. Advancements in recent years especially serve to enhance the readiness of school-based behavioral health staff in providing evidence-based behavioral health services.

Examples of Common School-Based Mental Health Roles:

The authors have included this chart in an attempt to introduce common roles you might find providing school-based behavioral health services. It is important to highlight that these roles often overlap and coordination is key. Further, the individuals who fill these positions and the way that schools combine and/or deploy these roles may vary greatly between schools and districts. All roles listed are important in supporting school mental health services and promoting positive student outcomes, and can be filled by an array of trained, qualified behavioral health professionals.

SCHOOL COUNSELORS	Role description: School counselors provide individual and group interventions and supports and create school counseling programs based on three sets of standards. These standards are ASCA Mindsets and Behaviors for student success, K-12 College, and Career Readiness for every student. ¹²⁰
	Degree/level of training: Typically requires a master's degree in a helping profession such as social work or education. School Counselors are required to engage in trainings held throughout the year to maintain the most relevant and new information. ¹²¹
ADJUSTMENT COUNSELORS	Role description: School adjustment counselors carry the role of fostering therapeutic relationships between the school, family, and other constituents regarding a student's mental health status or needs.
	Degree/level of training: Typically, a master's degree in school counseling or social work is required. Massachusetts requires graduate students to have 900 practicum hours and 450 hours working in an educational setting. ¹²²
SCHOOL PSYCHOLOGISTS	Role description: School psychologists provide behavioral health support and deliver clinical interventions to students, as well as support teachers, families, and other school employed social workers.
	Degree/level of training: Typically requires a master's or doctoral degree in clinical or school psychology. ¹²³ Degree/level of training: Typically requires a specialist degree (1 year past a master's degree) or doctoral degree in clinical or school psychology.
SCHOOL SOCIAL WORKERS	Role description: Among other duties, school social workers provide clinical supports and services to address students with mental health concerns, behavioral concerns, provide positive academic and classroom support, consult with teachers, parents, and administrators as well as provide individual and group counseling/therapy. ¹²⁴
	Degree/level of training: School social workers are licensed mental health professionals typically with a master's degree in social work and related clinical credentials (which may vary from state to state).

¹¹⁹ Holman, Nelson, & Watts, 2019

¹²⁰ American School Counselor Association, n.d.a

¹²¹ The Best Schools Staff, 2021

¹²² Lesley University, n.d.a

¹²³ National Association of School Psychologists, n.d.a

¹²⁴ School Social Work Association of America, n.d.

Evidence-Based Practices in School-Based Behavioral Health

In recent years, we have made great progress in designing and implementing effective multi-tiered systems to support the behavioral health needs of students. When implemented correctly, MTSS is an ideal model to facilitate the implementation of evidence-based practices and programs, leveraging the expertise of both clinical and non-clinical staff. By implementing an effective continuum of services in schools, from universal curriculums delivered by teachers and non-clinical school staff, to highly individualized interventions delivered by trained, licensed clinicians,¹²⁵ schools can design evidence-based systems that effectively meet the behavioral health needs of all students, and facilitating strong, collaborative school-community partnerships.

For a partial list of EBPs appropriate for school settings, see Appendix A on page 54. Evidence-based school-based interventions fall into three main categories:

1. EBPs designed and tested for use in school settings.
2. EBPs adapted for school settings that show positive outcomes.
3. EBPs with promise for adaptation in school settings and address a need.

There are many EBPs that are routinely provided in outpatient and community-based settings that may also be delivered in schools. What is most important is assessing the needs of the school and community, selecting appropriate interventions that can address those needs, and determining how best to deliver those services in the school or community. Many EBPs can be successfully delivered in a school setting, and others may be more appropriate to deliver as school-linked services in the community. However, when building an effective system of care, it must be recognized that capacity to deliver effective services needs to be built in both the school and community. Upfront investment in training and implementation of EBPs must be included as part of the planning process. This will likely require providing additional training and coaching to ensure school and community-based clinicians are equipped to deliver EBPs effectively.

As schools develop their MTSS systems and the needs of the school and community are identified, evidence-based interventions can be selected that can best meet those needs. As identified above, an important part of this process is doing an inventory of the strengths, capacities and deficits of the school and community system of care. For example, if a school community demonstrates high rates of children who are exposed to and experience traumatic stress symptoms, then the MTSS should be designed to offer trauma-informed identification, prevention and interventions at multiple levels in both the school and community.

Traumatic stress can significantly interfere with a child's ability to learn in school and can impact their interpersonal and social relationships, as well as their overall wellbeing. Traumatic stress symptoms, if not properly identified, can be misdiagnosed or mislabeled as behavior problems, ADHD, learning difficulties and other problems. If not properly treated, traumatic stress can lead to even greater problems for children both in and out of school.¹²⁶ When children suffering from or at risk of traumatic stress are identified through a MTSS system, children can be identified and referred to trauma-focused interventions both through school-linked services in the community, as well as through services provided directly in the school by either well-trained school clinical staff or by community clinicians working in the schools. Examples of trauma-focused services that have been offered successfully in school-based settings include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Cognitive Behavioral Intervention for Trauma in Schools (CBITS), among others. These models have been demonstrated to be highly effective to treat the symptoms of traumatic stress and provide students with the necessary skills to cope both within and outside of the school setting.

¹²⁵ For example, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) or Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems (MATCH)

¹²⁶ Miller, n.d.

Intervention Spotlight: Modular Approach for Treatment for Children for Anxiety, Depression, Trauma and Conduct problems (MATCH-ADTC)

In addition to traumatic stress, a range of other behavioral challenges can impact children in school settings such as anxiety, depression, ADHD, behavior/conduct problems and developmental disorders. There are a range of evidence-based practices that can be utilized to address these challenges both through school-based and community-based services. One evidence-based treatment that holds promise as an effective intervention in schools is the Modular Approach for Treatment for Children for Anxiety, Depression, Trauma and Conduct problems (MATCH-ADTC). This modular approach integrates other well established evidence-based practices and treats over 80% of the problems that children typically encounter. MATCH has been used successfully in school-based settings, but like other EBPs requires initial extensive training of the clinicians delivering the service to be provided properly with good outcomes.

Training of the clinicians who will deliver services is important for any EBP. Typically, training should include not only skills-based didactics, but also role playing and practice of the evidence-based skills with adequate coaching and supervision of the clinician by a qualified trainer/consultant until full competence is achieved. Training should include attention to local adaptations of the model to the school and community setting, as well as ensuring that the services are culturally and linguistically competent. EBPs also require fidelity monitoring to ensure that they are being delivered properly, as well as outcome monitoring to ensure that the children receiving services are having successful outcomes. While the training, coaching, fidelity monitoring and outcome assessment using EBPs requires some initial and ongoing investment, research has shown that in the end schools and communities actually save money by identifying and treating the problems early and getting children back on a healthy developmental track leading to better long-term positive outcomes that require less intervention and higher levels of care.¹²⁷

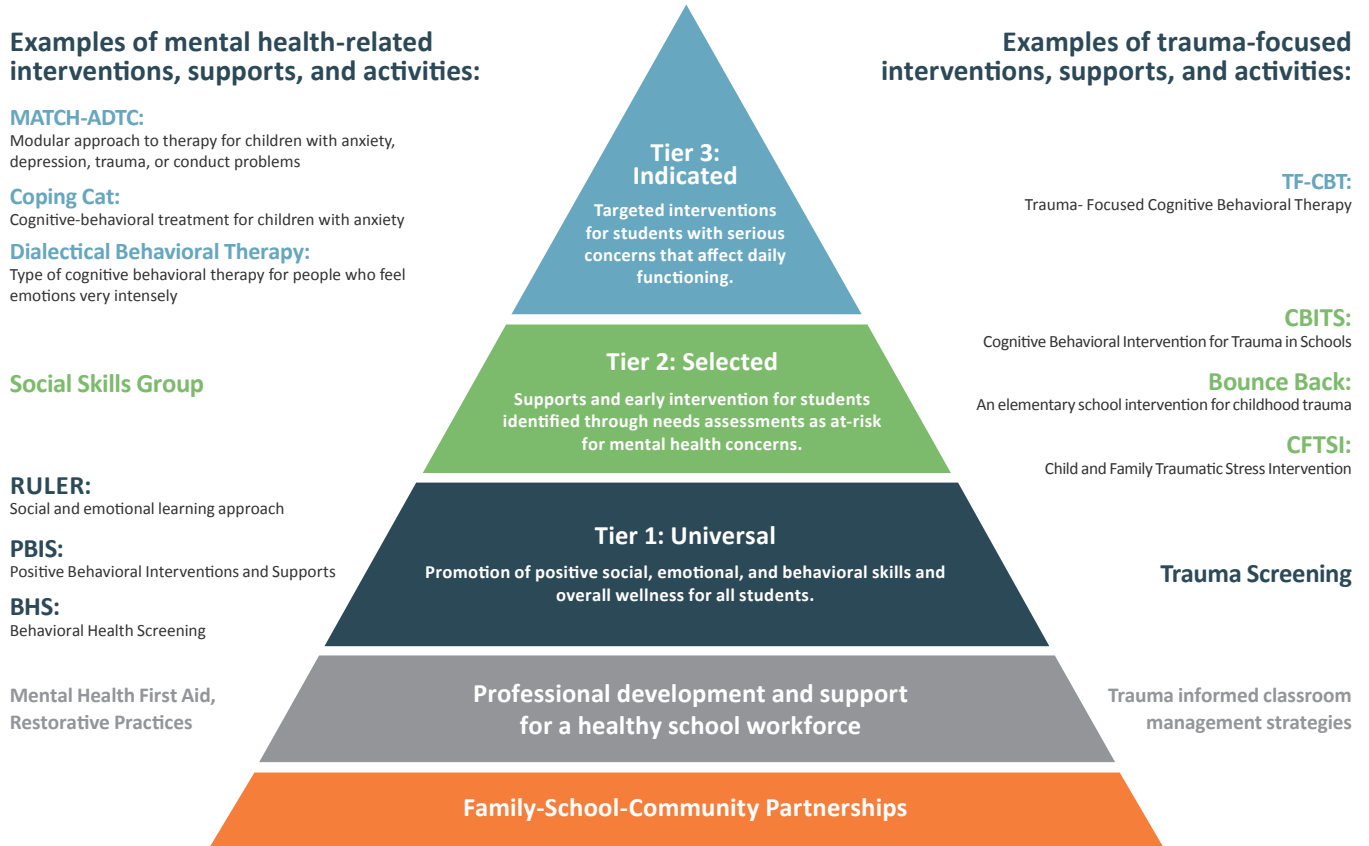
Some challenges to providing EBPs in school-based settings include reimbursement issues (third party payers will often not reimburse clinicians working out of a community agency to provide services in schools), training issues (many school-based clinicians have not received adequate training or supervision in delivering EBPs), as well as challenges surrounding the structure of the school day (scheduling services during the school day presents a logistical issue for many schools and may require dedicated scheduling efforts). Parent and caregiver engagement is often a central component to the delivery of effective services and this can also sometimes be a challenge in school-based settings. Despite these challenges and concerns, with the appropriate planning, training and attention to developing an effective MTSS system, these issues can be overcome and schools remain the best place for children to access effective care. The investment in building a comprehensive school and community-based system utilizing EBPs to treat identified needs is a vital aspect of building a successful MTSS and will produce a long-term return on the initial investment.

¹²⁷ Washington State Institute for Public Policy, 2011

Evidence-Based Practices and MTSS

The Child Health and Development Institute of Connecticut (CHDI) visualized the MTSS pyramid beginning with a foundation of strong “family-school-community partnerships” and adequate professional development and supports for school-based professions upon which the typical tiers 1 through 3 rest. CHDI also identified several evidence-based practices that may exist at each tier. It should be noted that some of these interventions may be applicable to more than one tier. For example, Cognitive Behavioral Therapy (CBT) may be used as a Tier 2 or Tier 3 intervention depending on the scope and intensity of services.¹²⁸

Trauma-Informed Multi-Tiered System of Supports for School Mental Health¹²⁹



Evidence-Based Practices to respond to COVID-19

Strategies to address the impact of COVID-19 must focus on making evidence-based, culturally and linguistically responsive behavioral healthcare accessible to children and youth. Available data is showing a concerning rise in a number of behavioral health concerns and many experts expect this need will persist for many months or even years. It is essential that the services used to address this need be rooted in research and evidence-based approaches. School systems in particular should take advantage of existing infrastructure to provide students with access to high quality, evidence-based care, including tele-health. Supports and services should also be mindful to identify and respond to the unique needs of diverse communities, paying particular attention to historically marginalized and underserved populations, especially communities of color. At the policy level, legislative and funding priorities should be targeted specifically toward implementing EBPs across the Commonwealth.

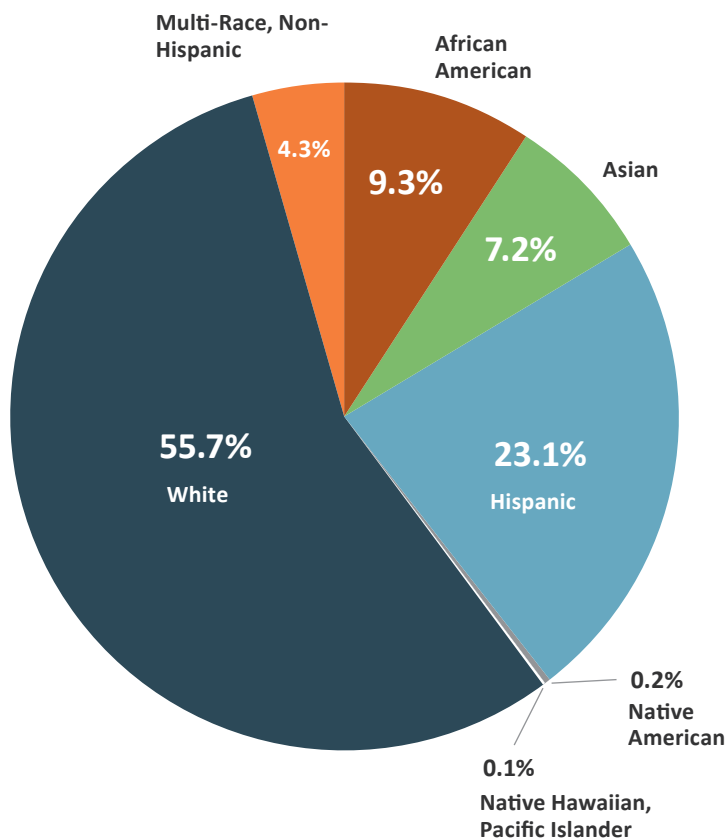
¹²⁸ Cockroft, 2019

¹²⁹ Child Health and Development Institute of Connecticut, 2018

Implications for Massachusetts

In Massachusetts, there are 1,840 public schools across 400 districts.¹³⁰ Roughly 14.4% of the population is between ages 5 and 18, amounting to nearly one million children residing in the state.¹³¹ In 2018-2019, approximately 92% of these children were enrolled in K-12 public programs.¹³² The remaining 8% were enrolled in in-state private and parochial schools, out of state private and parochial schools, or homeschooled.¹³³ In the 2020-2021 school year, there were 911,529 students enrolled in Massachusetts public schools, a 3.9% decrease from the 2019-2020 school year.¹³⁴ During the same year, the student body in Massachusetts consisted of a diverse racial and ethnic representation.¹³⁵

Enrollment by Race/Ethnicity (2021–2022)



Source: Massachusetts Department of Elementary and Secondary Education.¹³⁷

Children in Massachusetts experience an array of behavioral health needs. According to the Massachusetts Association of Mental Health, 38.5% of youth aged 0-17 in Massachusetts experienced at least one form of trauma, abuse, or significant stress in the last year, and 15% experienced multiple traumas.¹³⁶

Policy

Despite the notable efforts by the legislature (such as school-focused funding decisions during the COVID-19 pandemic), the Department of Early and Secondary Education (DESE; such as statewide work to create Comprehensive School Mental Health Systems, hereafter referred to as “CSMHS”) and the dedication of countless families, professionals, community members, advocates and policy makers, there is still need for, and opportunity to develop, a fully unified district-level or state-wide approach to ensure schools and communities are equipped to identify and respond to the behavioral health needs of students. While some districts demonstrate national leadership, others struggle to unify under a common goal or strategy. Massachusetts has a long history of investing political, financial and social capital in strategies to improve outcomes for school-age children and their families. Recent examples of note at the policy, systems and practice levels include (though are not limited to):

¹³⁰ School and District Profiles, 2020a

¹³¹ United States Census Bureau, 2019

¹³² United States Census Bureau, 2019 School and District Profiles, 2020b

¹³³ School and District Profiles, 2020b

¹³⁴ Massachusetts Department of Education, n.d.; Hanson, 2020

¹³⁵ Massachusetts Department of Elementary and Secondary Education, n.d.

¹³⁶ Massachusetts Association of Mental Health, 2022

¹³⁷ Massachusetts Department of Elementary and Secondary Education, n.d.

Legislative Initiatives

STUDENT OPPORTUNITY ACT & ADDRESSING BARRIERS TO CARE (ABC) ACT

In the fall of 2019, the Legislature passed the Student Opportunity Act.¹³⁸ This groundbreaking legislation included plans to invest \$1.4 billion over the next seven years, with some districts receiving over \$1.5 million annually. The money was intended to be used for an array of initiatives including improving academic outcomes, dropout prevention, and workforce development, before and after school support for students, as well as improving social-emotional supports in schools and through community partnerships. However, there was no specific guidance about how the money should be spent; only that funding should go toward “addressing persistent disparities” among students.¹³⁹ Since the passage of this bill, Massachusetts school districts have begun receiving allocated funds and documenting the progress of addressing district-specific disparities and gaps in the service array. The bill is built on four key elements:

1. Implementing evidence-based programs to reduce disparities among student subgroups,
2. Clearly articulating how funds will be used, with particular attention paid to supporting English language learners and low-income students,
3. Establishing targets and outcome measures for addressing persistent disparities in achievement among student subgroups, and

4. Specifying ongoing plans to effectively engage families and measure family engagement. Recognizing the historic gap between needs and resources, the legislation allocates more money for the districts with the most need. About 80% of the dollars will go to the 37 districts determined to have the greatest need.¹⁴⁰

Another act of note is 2022’s An Act Addressing Barriers to Care for Mental Health (ABC Act). The ABC Act is designed to improve the behavioral health outcomes for families and communities in Massachusetts by bolstering its mental health systems.¹⁴¹ This legislation amends the guidance for school leaders when determining consequences for student behavior, and specifically mentions the necessity of positive behavioral interventions and supports and trauma-sensitive learning models in school.¹⁴²

DUAL LICENSURE

Largely supported by the Legislature’s Joint Committee on Education, education and school-based behavioral health is routinely a top priority among legislators, policymakers, and other leaders at the policy level. There are several ongoing legislative efforts exploring the role of school psychologists being licensed to work outside of schools, as well as funding paid internships for mental health positions in schools. One policy effort of note intended to advance the school behavioral health workforce and reduce barriers to dual licensure for school counselors is bill H.351, An Act Expanding Licensure Opportunity for School Counselors, sponsored

by Rep. Linda Dean Campbell. This legislation proposed several changes to the current language outlining licensure requirements for individuals seeking to secure a licensed mental health counselor (LMHC) license in Massachusetts. Specifically, the bill would (1) allow school counselors to use their graduate coursework secured in pursuit of a DESE license toward the education requirements for a LMHC license, (2) designate schools as approved sites to secure supervision hours for a LMHC license for work conducted that aligns with the approved activities for supervision (e.g. provision of evidence-based group and individual therapeutic care) and (3) provide access for school counselors to take the LMHC licensing exam. The proposed changes also sought to advance cross-collaboration between schools and community-based mental health agencies, increase the available workforce during non-school hours, and increase schools’ ability to reimburse for Medicaid eligible services, without reducing the education or supervision requirements to secure an LMHC. To date, only certain licenses are eligible to bill Medicaid for clinical services provided. Limitations around which clinical professionals can and cannot bill Medicaid have historically limited access to care.

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)

On March 14, 2016, An Act Relative to Substance Use, Treatment, Education and Prevention (STEP) was signed into law.¹⁴³ The STEP Act required annual

¹³⁸ For guidance materials, including evidence-based program examples and funding requirements, please see: <https://www.doe.mass.edu/commissioner/spec-advisories/soa.html>

¹³⁹ Massachusetts Department of Elementary and Secondary Education, 2020b; For a full description of the Student Opportunity Act please visit: <https://malegislature.gov/Laws/SessionLaws/Acts/2019/Chapter132>

¹⁴⁰ Massachusetts Department of Elementary and Secondary Education, 2020b

¹⁴¹ Alicante, 2022

¹⁴² Massachusetts Legislature, 2022

¹⁴³ Massachusetts General Law chapter 71, section 96

Impact of COVID-19: Funding for School-Based Behavioral Health

COVID-19 initially inhibited the State's ability to follow-through with the promised funding. In March of 2020, school districts were granted an extension to the April 2020 deadline for submitting their budgets under the Student Opportunity Act.¹⁵⁰ Available information and stakeholder testimony suggest that this program was delayed due to money being diverted to purchase Personal Protective Equipment (PPE) and address other COVID-19 response needs. School districts were asked to submit a 3-year, evidence-based, plan for addressing disparities in educational achievement by January 15, 2021. At the time of writing this report, Governor Baker has announced that in the 2022 fiscal year budget, the Commonwealth has increased public school funding by \$1.6 billion, and plans to fully fund the first year of the Student Opportunity Act.¹⁵¹

in-person substance use screening of adolescents in two grades in all public schools. The recommended grades are 8th and 10th grade; however, schools do have some autonomy to designate different grades.¹⁴⁴ In schools, the Screening, Brief Intervention, and Referral for Treatment (SBIRT) process begins by using a validated screening tool¹⁴⁵ intended to identify substance use risk behaviors and current use, followed by opportunity for trained school professionals and students to engage in one-on-one conversations to foster trusting relationships focused on education and support related to substance use.¹⁴⁶ In some cases, this may lead to referring students with more frequent or

dangerous substance use for further assessment or treatment. Although the SBIRT model has existed for several decades,¹⁴⁷ it did not become a mandated screening in schools until 2016.¹⁴⁸

Districts and schools are required to develop policies on substance use prevention. According to guidance provided by DESE, policies should include:

- Clearly defined goals,
- Involvement of parents, teachers, students, and the community,
- Strategies to encourage communication,

- Implementation of an evidence-based substance use prevention curriculum;
- Prohibitions against and discipline provisions for substance use,
- Opportunities for intervention and treatment, and
- A timeline for review and revision of the policy.¹⁴⁹ As of December 2017, 99% of Massachusetts school districts had submitted their substance use prevention policies to DESE.¹⁵²

Executive Branch Initiatives

BUDGETARY PRIORITY

School-based behavioral health has also been a priority in the state budget, even while navigating the COVID-19 pandemic. FY21 budget amendments funded strategies to guide and support statewide implementation of behavioral health promotion, prevention and intervention services in all school districts. The budgetary process was delayed significantly due to the COVID-19 crisis, but was ultimately passed on December 11, 2020. The budget included items such as \$950,000 for Mental Health Advocacy Program (MHAP) for Kids,¹⁵³ \$350,000 for Bridge (BRYT; further explained below) Programs,¹⁵⁴ and \$50,000 in seed funding to begin work developing a School Behavioral Health Technical Assistance Center.¹⁵⁵ The budget also increased Chapter 70 education aid by \$108 million, and recognizes over \$442 million in new federal supports for K-12 schools to support the education of students during the pandemic.¹⁵⁶

In July 2021, Governor Baker signed the budget for fiscal year 2022, which included funding for improving

¹⁴⁴ SHIELD & MASBIRT-TTA, 2019

¹⁴⁵ Currently, CRAFFT-II is the only approved screening tool; however, the law allows districts to select another screening tool if they provide the department with a written description of the program and an explanation as to why the approved screening tool is not appropriate for their district; SHIELD & MASBIRT-TTA, 2019

¹⁴⁶ SHIELD & MASBIRT-TTA, 2019; MASBIRT-TTA, 2020

¹⁴⁷ SAMHSA, 2011

¹⁴⁸ As part of the STEP Act, parents/guardians are required to be notified about the screening prior to the start of the school year and must have the opportunity to opt out.

¹⁴⁹ Massachusetts Department of Elementary and Secondary Education, 2020a

¹⁵⁰ Massachusetts Department of Elementary and Secondary Education, 2021a

¹⁵¹ Office of Governor Charlie Baker and Lt. Governor Karyn Polito, & Governor' Press Office, 2022

¹⁵² Massachusetts Department of Elementary and Secondary Education, 2018

¹⁵³ For more information, see MHAP's website: <https://www.healthlawadvocates.org/initiatives/mhapforkids>

¹⁵⁴ Children's Mental Health Campaign, 2020

¹⁵⁵ Children's Mental Health Campaign, 2020

¹⁵⁶ Office of Governor Charlie Baker and Lt. Governor Karyn Polito, 2020

education and behavioral health access and quality. Specifically, the 2022 budget increased Chapter 70 funding for state public schools to \$5.5 billion, and additional funding for special education services, charter schools and early education. The state’s financial investments to support improved outcomes for children goes beyond schools as well, with \$84 million being allocated to MassHealth to address issues of quality and accessibility of behavioral health treatment, and \$952 million will go to the Department of Mental Health to continue addressing the behavioral health needs of children and families across Massachusetts.¹⁵⁷

DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION’S MTSS BLUEPRINT

The Massachusetts Department of Elementary and Secondary Education (DESE) promotes Multi-Tiered Systems of Support (MTSS) to advance the well-being of students – academic and behavioral. One recent iteration of this commitment is its MTSS Blueprint, which organizes services and supports in a manner consistent with the standard definition of MTSS.¹⁵⁸

Student needs are defined across three domains: 1) academic, 2) behavioral, and 3) social-emotional, which can be supported through implementation of frameworks grouped under the title “Inclusive Practices.” Inclusive practices include social-emotional learning (SEL), universal design for learning (UDL), and Positive Behavioral Interventions and Supports (PBIS).¹⁵⁹ DESE has supported districts in adopting the MTSS Blueprint

through the provision of professional development, coaching, and technical assistance. Notably, the MTSS Academies (described further below) have served as one of the primary offerings that DESE has utilized to engage districts in establishing teams to support MTSS implementation.

DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION (DESE) GRANTS

The COVID-19 pandemic, along with the heightened national awareness of racial injustice, has increased the focus on social-emotional and behavioral health programs and supports for students, staff, and families. To further support their commitment to school mental health, DESE has introduced the Supporting Students' Social Emotional Learning, Behavioral & Mental Health, and Wellness grants. These grants are too expansive to fully detail in this report. One prominent example is DESE’s FY23 allocation of over \$5.8 million for schools to bolster multi-tiered systems of support, create and sustain partnerships with community-based providers, and pilot universal mental health screening systems. Individual applicants may receive up to \$100,000. Priority will be given to districts and schools experiencing chronic performance challenges, those with limited access to behavioral health supports, limited financial resources, and those serving communities where at least 45% of students are identified as low-income. These efforts are in support of broader priorities of bolstering racial equity and cultural responsiveness, increasing access to evidence-based care, and building sustainable systems and partnerships.¹⁶⁰

PROMOTE – PREVENT COMMISSION

The Special Commission on Behavioral Health Promotion and Upstream Prevention was signed into law in 2016, and was tasked with investigating evidence-based practices, programs and systems to prevent behavioral health disorders and promote overall behavioral health.¹⁶¹ Considerations made by the Commission included what is working well in regards to behavioral health promotion and prevention, how adequate funding can be used to build upon existing supports and services, and articulated expected outcomes if adequate funding is received. The Promote-Prevent Commission formally began its work in 2017. Of particular concern to the Commission was a consideration of the full behavioral health continuum of care.¹⁶² The Commission released its final report and recommendations in 2018, in which it identified barriers and solutions to foster investments in promotion and prevention programs and system changes to address behavioral health needs in the Commonwealth.¹⁶³ Of note for schools, one of the six recommendations provided by the Commission was to promote behavioral health in schools including social-emotional learning, and incorporating behavioral health promotion education in school health curriculums.

SAFE AND SUPPORTIVE SCHOOLS COMMISSION

The Safe and Supportive Schools Commission was created as part of the Safe and Supportive Schools Framework Law¹⁶⁴ through An Act Relative to the Reduction of Gun

¹⁵⁷ Office of Governor Charlie Baker and Lt. Governor Karyn Polito, Governor’s Press Office, & Executive Office for Administration and Finance, 2021

¹⁵⁸ Massachusetts Department of Elementary and Secondary Education, 2020e

¹⁵⁹ Massachusetts Department of Elementary and Secondary Education, 2020e

¹⁶⁰ Massachusetts Department of Elementary and Secondary Education, 2022

¹⁶¹ Massachusetts General Laws, Section 193, Chapter 133 of the Acts of 2016

¹⁶² Promote Prevent, n.d.

¹⁶³ Promote Prevent, 2018

¹⁶⁴ Massachusetts General Laws, Chapter 69, Section 1P

Violence in 2014.¹⁶⁵ The Commission, in part, is responsible for working with DESE at a policy level to create school environments that effectively meet the academic and non-academic needs of students.¹⁶⁶ This includes promoting positive behavioral health outcomes through integrated behavioral health supports and services, social-emotional learning, bullying prevention, and trauma sensitivity, among other areas of focus.¹⁶⁷

The Commission makes annual recommendations to DESE and the legislature. Schools and education-oriented entities may also find these recommendations instructive. The Commission's FY23 report articulates three recommendations: 1) Continue to fund the safe and supportive schools line item, 2) Advance racial and ethnic equity, and 3) Promote and strengthen safe and supportive schools. The commission's work is further supported through stakeholder consultation.¹⁶⁸ Teams have continued to be funded to implement the Safe and Supportive Schools framework and recently updated tool designed to a) document current practices that support students' behavioral health and b) to explore, understand and refine the roles of various school-based professionals who are providing these supports.¹⁶⁹

Systems

There are a number of statewide initiatives designed to promote the best possible outcomes for students, any one of which could be the subject of a full report. For the purpose of this section, the authors have selected a few choice examples which effectively highlight the concepts discussed throughout this report. However, the authors acknowledge that this is only a partial list and commend the many dedicated districts, schools,

professionals and communities across the state working to improve behavioral health supports and services for students.

Training and Professional Development

COMPREHENSIVE SCHOOL MENTAL HEALTH SYSTEMS (CSMHS)

The Massachusetts Department of Elementary and Secondary Education (DESE) is working to establish Comprehensive School Mental Health Systems (CSMHS) in Massachusetts by implementing trainings and convenings both in-person and virtually "to foster cross-collaboration between districts, highlight best practices for school mental health implementation, and support teams in developing and implementing action plans that are supported by continuous quality improvement practices."¹⁷⁰

District teams were provided with access to professional development, technical assistance, and ongoing coaching as they work to pilot practices to support the establishment of a CSMHS. Staff from National Center for School Mental Health, in conjunction with DESE and the Massachusetts School Mental Health Consortium (MASMHC), facilitated convenings (in-person and virtual) to foster cross-collaboration between districts, highlight best practices for school mental health implementation, and support teams in developing and implementing action plans that are supported by continuous quality improvement practices. District teams also received training and coaching in conducting a formal needs assessment to determine priority areas of growth and relative strengths using assessments and processes that have proven results.¹⁷¹

DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION'S STATE "COIIN"

Another system of support that is advancing school mental health implementation in Massachusetts is an effort co-led by the Department of Elementary and Secondary Education (DESE) and the Massachusetts School Mental Health Consortium. The Collaborative Improvement and Innovation Network (COIIN) is a multi-state learning collaborative facilitated by the National Center for School Mental Health (NCSMH) focused on providing professional development, collaborative learning, resource sharing, coaching, and technical assistance to both state teams and selected districts. The COIIN supported two cohorts of districts after DESE and MASMHC successfully applied to engage in this work during the 2021 and 2022 school years. District teams worked to pilot practices to support the establishment of a CSMHS with support from NCSMH, DESE, and MASMHC staff. The state leadership team, in conjunction with NCSMH staff, facilitates convenings to foster cross-collaboration between districts, highlight best practices for school mental health implementation, and support teams in developing and implementing action plans that are supported by continuous quality improvement practices. District teams also received training and coaching in conducting a formal needs assessment to determine priority areas of growth and relative strengths using assessments and processes that have proven results. State team planning members include representatives from the Departments of Mental Health, Public Health, and Children and Families (DMH, DPH, and DCF), parent and youth leaders, and others.¹⁷²

¹⁶⁵ Chapter 284 of the Acts of 2014.

¹⁶⁶ Massachusetts Department of Elementary and Secondary Education, n.d.

¹⁶⁷ Massachusetts General Laws, Chapter 69, Section 1P: <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXII/Chapter69/Section1P>

¹⁶⁸ Massachusetts Department of Elementary and Secondary Education, 2021

¹⁶⁹ Massachusetts Department of Elementary and Secondary Education, 2022b

¹⁷⁰ Massachusetts Department of Elementary and Secondary Education, n.d.

¹⁷¹ Massachusetts Department of Elementary and Secondary Education, n.d.

¹⁷² Massachusetts Department of Elementary and Secondary Education, 2021b

MTSS ACADEMIES

DESE provides school districts with professional development opportunities in part through their MTSS Academies, including Academies for PBIS, Social-Emotional Learning/Mental Health, and Culturally Responsive Practice, among others. Through the MTSS Academies, district teams are engaged in a variety of opportunities to enhance their knowledge of MTSS and the framework that is the focus of implementation for the specific academy. Teams are supported in developing knowledge and skills related to MTSS, action plans and piloting practices and policies to enhance their implementation of the framework. The Social-Emotional Learning/Mental Health Academy supports school districts through professional development, technical assistance, and coaching. The Academy establishes teams to support implementation, a dynamic action plan to coordinate the development of systems and practices, and services within a social-emotional/mental health multi-tiered system of support.

MASSACHUSETTS SCHOOL MENTAL HEALTH CONSORTIUM (MASMHC)

The Massachusetts School Mental Health Consortium (MASMHC) was established in 2018 to support school behavioral health implementation across the Commonwealth through resource sharing, training, technical assistance, and direct coaching for district teams. Since its inception, MASMHC has grown to include hundreds of school mental health staff and educators across 170 districts to foster school behavioral health implementation. Sponsorship of the consortium has grown to include institutions of higher education, regional/national mental health advocacy agencies, state entities, and community-based service providers.

Early sponsorship of the consortium by Representative Linda Dean Campbell and Senator Kathleen O'Connor Ives translated into a legislative earmark that supported MASMHC during the 2018-2019 school year in designing programs to foster school behavioral health implementation. One such example, the MASMHC Mini-Grant Program, was an attempt at providing a small amount of funding to foster school behavioral health implementation, which ultimately supported the larger membership by sharing best practices and lessons learned from the implementation through project presentations required of grantees.

BOSTON CHILDREN'S HOSPITAL NEIGHBORHOOD PARTNERSHIPS (BCHNP)

Boston Children's Hospital Neighborhood Partnerships (BCHNP) is a behavioral health program that places social workers, psychologists, and psychiatrists in schools and community health centers throughout Boston Public Schools to provide an array of services to children and adolescents. According to their website and stakeholder testimony, these supports include social, emotional and behavioral health services for children, as well as professional development, consultation, and capacity building services for school personnel. The goals of BCHNP are to increase access to children's behavioral health services and promote social-emotional development; to build the sustainability and capacity of partner organizations and promote systemic change in behavioral health service delivery; and to provide services that achieve a high degree of satisfaction with all stakeholders.¹⁷³ As part of these efforts, BCHNP offers The Training and Access Project (TAP), a community-based program that provides high-quality professional development and consultation services

to Boston schools. Each year, TAP partners with five schools to help build capacity to address students' social, emotional and behavioral health needs. Over the course of the two years that TAP is involved with a school, participants learn best practices across schools and receive a total of 33 hours of professional development designed to meet the specific needs of the school.¹⁷⁴

Statewide Initiatives

THRIVING MINDS: BUILDING COMPREHENSIVE SCHOOL MENTAL HEALTH SYSTEMS

The Rennie Center, the Massachusetts School Mental Health Consortium, and Bridge for Resilient Youth in Transition (BRYT) partnered with the DESE to develop Thriving Minds, a series of learning opportunities centered on supporting districts in building comprehensive school mental health systems that address the holistic needs of their students. The foundation for these learning opportunities is a series of professional development workshops on the fundamental components of a comprehensive school mental health system—data, systems, and practices—all presented with a racial equity lens. To date, Thriving Minds has delivered a variety of professional development and coaching opportunities focused on building comprehensive school mental health systems sponsored by DESE and a focused series of trainings on supporting trauma-responsive systems and practices in schools, sponsored by the newly minted Center for Child Wellbeing and Trauma (CCWT).

SCHOOL MENTAL HEALTH LEADERSHIP INSTITUTE

One pressing challenge facing Massachusetts is the need for additional clinical leadership in schools. As previously identified, access to

¹⁷³ Boston Children's Hospital Neighborhood Partnerships, n.d.a

¹⁷⁴ Boston Children's Hospital Neighborhood Partnerships, n.d.b



clinical implementation leadership and clinical supervision appears to be a barrier for many school districts. Without appropriate clinical leadership and an expert perspective to guide the development of support services guidance schools and districts are left without sufficient direction to effectively develop and implement comprehensive systems of support and improve practice, and places undue burden on non-clinical staff and school leaders to be responsible for clinical needs and decisions. To partially address this issue, MASMHC in partnership with the Rennie Center is co-leading the School Mental Health Leadership Institute, a project funded and facilitated by Massachusetts Partnerships for Youth (MPY). This program trains participants to develop the capacity to act as both clinical and mental health leaders and change agents to build comprehensive mental health systems in their district. Through a series of trainings and cohort-based discussions, participants acquire and exercise a new set of skills to help them set and enact a vision for change.

SUPPORTING STAFF TO SUPPORT STUDENTS (S2S): COLLABORATING TO DEVELOP GROUP MENTAL HEALTH SERVICES IN SCHOOLS

The Department of Mental Health (DMH) in partnership with

Massachusetts School Mental Health Consortium (MASMHC), the International Trauma Center (ITC), Boston Children's Foundation, and the National Child Traumatic Stress Network (NCTSN) is creating an opportunity for schools and districts to engage in a learning collaborative to support the establishment of group-based services. Fifteen districts were selected for participation in this pilot project. Selected schools/districts provided free professional development, coaching, and resources to support school based mental health staff (school counselors, school psychologists, and adjustment counselors/school social workers) in developing skills and gaining knowledge and resources to facilitate group-based services using evidence-based therapeutic modalities.

The training and coaching afforded to schools/districts allowed for students to receive access to care in the short term and school-based mental health staff to build capacity to run groups utilizing specific evidence-based counseling approaches over the course of the project, specifically: Cognitive Behavioral Therapy (CBT), and Compassion Care Coping Groups (CCCG). Schools/districts selected which approaches they would work to implement over the course of the project.

BRIDGE FOR RESILIENT YOUTH IN TRANSITION (BRYT)

A distinctly Tier 3 support, the Brookline Center for Community Mental Health's BRYT Team partners with schools and districts to provide the tools, framework, and ongoing consultation to help them define, structure, and launch school-based Bridge (or BRYT) programs. Bridge programs work with young people who have missed significant amounts of school due to a mental health crisis, hospitalization, or serious medical problem (e.g., concussion, or cancer). Some programs also serve students who come to school more often but are in need of support to prevent a crisis. BRYT supports students as they catch up academically and reintegrate into school life through clinical and coping support, academic case management, family support and care coordination. Bridge programs empower schools to support children with mental health needs by enabling reintegration to the classroom at their own pace. The only consistent program model of its type in the United States,¹⁷⁵ over the past several years BRYT has rapidly become a trusted and highly utilized resource for many public high schools across Massachusetts, and is increasingly being replicated in middle and elementary schools. Currently over 140 schools throughout the Northeast offer programs based on BRYT.¹⁷⁶ BRYT boasts significant success including

¹⁷⁵ Marrassini, Lee & Chin, 2019

¹⁷⁶ Brookline Center for Community Health, n.d.a

up to 90% of students successfully returning to school and completing the school year, on track for graduation.¹⁷⁷ Further, school systems benefit; districts utilizing the BRYT model save money through decreased use of out-of-district placements, while simultaneously improving practices and culture around understanding and addressing the behavioral health needs of students.¹⁷⁸

Education and Advocacy Efforts

MASSACHUSETTS ASSOCIATION FOR MENTAL HEALTH (MAMH), SEL4MA & EXSEL NETWORK

Advocacy efforts centered on social-emotional learning (SEL) and behavioral health abound in Massachusetts. Organizations such as SEL4MA and the Massachusetts Association for Mental Health (MAMH) have significantly contributed to shaping policy and systems advancement to improve access to mental health services and reducing stigma associated with mental health. These organizations have also significantly advanced the knowledge base associated with implementation of preventative services and supports, championing Tier 1 practices and an awareness campaign that normalizes help seeking behavior and the adoption of a mindset that schools can and should engage in work to support students' well-being. The Excellence through Social-Emotional Learning (exSEL) Network similarly brings together districts from across Massachusetts to elevate understanding about integrating SEL district-wide and assist with the implementation of effective SEL practices.¹⁷⁹

THE BEHAVIORAL HEALTH INTEGRATED RESOURCES FOR CHILDREN (BIRCh) PROJECT

The BIRCh Project represents another major effort underway in

Massachusetts to advance school mental health implementation. A partnership between UMass Boston and UMass Amherst, and funded by Boston Children's Hospital, the BIRCh Project has enhanced the state's understanding of the available and needed resources for the provision of school mental health services.¹⁸⁰ This research represents a significant contribution by focusing attention on both the available school-based behavioral health staff to engage in evidence-based work as well as the state resources to enhance these efforts. The project aims to improve access and efficient utilization of preventive and responsive behavioral health resources as well as to promote the collaboration between schools and community health agencies. More recently, the BIRCh Project received funding from the Department of Mental Health, to take inventory of the available school- and community-based services available across Massachusetts, and to plan a statewide school-based behavioral health technical assistance center. This initiative, grounded in an Interconnected Systems Framework, provides schools and community agencies with professional development resources, professional learning communities, and district coaching to build capacity of public schools to implement and sustain effective behavioral health supports and services.¹⁸¹

CHILDREN'S MENTAL HEALTH CAMPAIGN

The Children's Mental Health Campaign (CMHC) has a long history of advocating for reforms to better support the behavioral health needs of children, youth and families. The CMHC advocated for many prominent provisions in the ABC Act, which was highlighted previously in this report. This included the elimination of preschool suspension and expulsion, the requirement for school-based emergency response plans to replace

disciplinary or police interventions with behavioral health crisis response teams, and the creation of a statewide technical assistance center to help schools implement school-based behavioral health services.¹⁸² The Children's Mental Health Campaign is co-leading a collaborative initiative which includes educators, school leaders, advocates, caregivers, students, and leaders in the field of school-based behavioral health in order to make equity-informed recommendations for multi-tiered service implementation.¹⁸³

Practices

While developing this report and conducting a thorough exploration of Massachusetts school-based behavioral health policies, systems, and practices, two of the most salient themes to emerge were 1) schools and school-based professionals are passionate about their work and heavily invested in promoting the best possible outcomes for the children in their care, and the decision making at a district and school level, as a rule, reflect that intention; and 2) specific practices, approaches, and even foundational philosophies regarding school-based behavioral health can vary greatly from district to district and even from school to school. While evidence-based practices such as Positive Behavior Interventions and Supports (PBIS) have been identified by DESE and gained traction in the state, a, and Multi-Tiered Systems of Support (MTSS) may be widely-used organizational framework, the specific practices and approaches selected to populate that framework vary greatly. The reasons for this are many, ranging from buy-in at the leadership and/or staff level, financial limitations, access to behavioral health resources in the school or surrounding community, varying perspectives on topics such as evidence-based practices or the

¹⁷⁷ White, LaFleur, Houle, Hyry-Dermith, & Blake, 2017

¹⁷⁸ Brookline Center for Community Mental Health, 2018

¹⁷⁹ Rennie Center, 2020

¹⁸⁰ University of Massachusetts Boston, 2022

¹⁸¹ University of Massachusetts Boston, n.d.

¹⁸² Children's Mental Health Campaign, 2022

¹⁸³ Children's Mental Health Campaign, 2022

fundamental role of schools in the behavioral health service continuum, among others. As a result, it is very difficult to sufficiently summarize the current “Practice” landscape in Massachusetts. As one stakeholder put it, “If you’ve seen one school, you’ve seen one school.” This variation may manifest in the specific strategies and interventions present within schools, in the partnerships present or not present with community-based service providers, staffing and staff training or credentialing, and the way those school-based staff are utilized to identify and address the behavioral health needs of students. In Massachusetts there are a wide array of specific practices utilized and many notable examples, a number of which have already been highlighted in this report. Massachusetts is in a strong position to build off the notable areas

of success in the state to hone future efforts and rally around state- and district-wide strategic plans and goals.

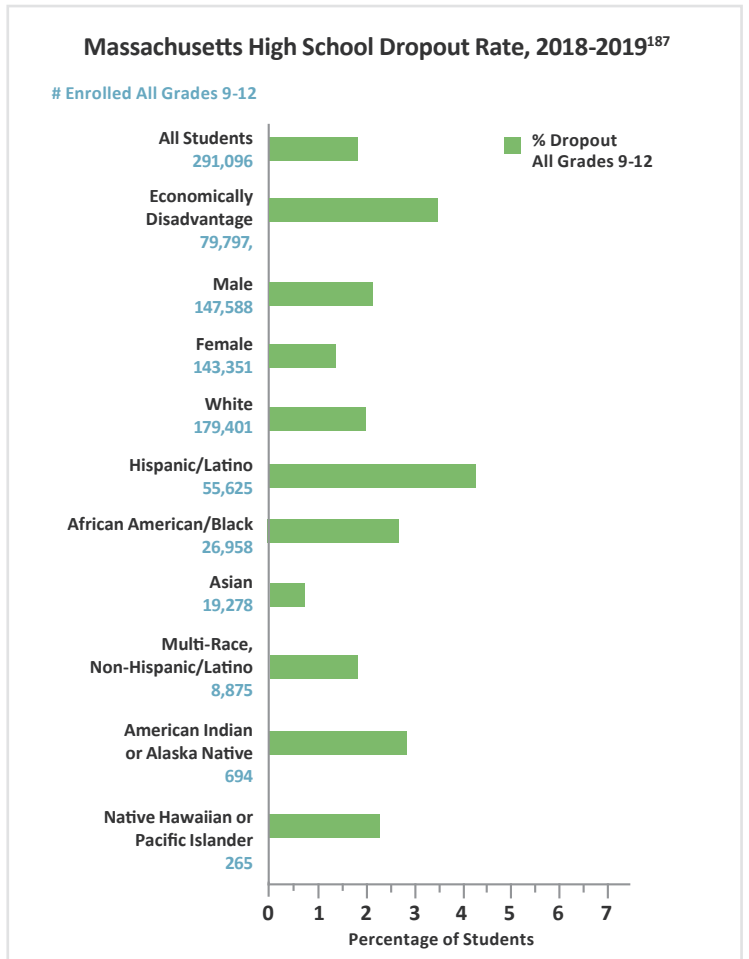
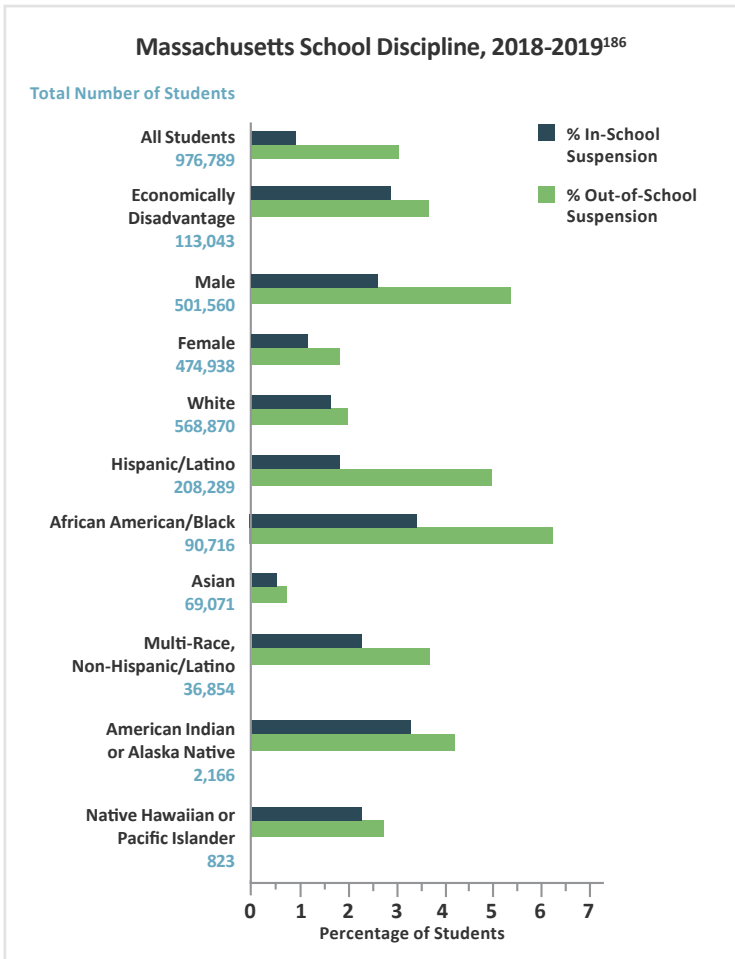
For a list of practices that may be appropriate in school settings see Appendix A.

Equity

While Massachusetts is a national leader in K-12 education, and there are a number of notable schools and school districts who demonstrate national leadership, the Commonwealth continues to see a disproportionate number of children of color receiving exclusionary discipline, harsh punishment, contact with the juvenile justice system and dropping out of high school as shown below.¹⁸⁴ According to the U.S. Commission on Civil Rights, practices like “zero tolerance” policies, test-based ranking of schools, presence and use of School Resource Officers in schools, and

uncoordinated school and community partnerships can potentially lead to negative outcomes for students of color.¹⁸⁵ Further, stakeholder testimony gathered during this report development suggests that discipline data collection and reporting may be inconsistent across the state, and that data collection gaps likely suggest an inaccurate picture of disciplinary experiences of students across the Commonwealth.

It should be noted that these issue are long-standing systemic trends that transcend any one teacher, school district, or state. Individuals who dedicate their lives and careers to education do so out of a passion and commitment to help children and youth grow to become healthy, happy individuals. Moving forward we must all share the collective responsibility to confront and address biases, systemic inequities, and dismantle structural racism wherever it exists in our schools and society.



¹⁸⁴ School and District Profiles, 2019b
¹⁸⁵ U.S. Commission on Civil Rights, 2019

¹⁸⁶ School and District Profiles, 2019a;
 School and District Profiles, 2020c

¹⁸⁷ School and District Profiles, 2019b



Conclusion and Implications

This report summarizes the various efforts that are currently underway, both in Massachusetts and across the country, to create comprehensive school behavioral health systems to promote children’s wellbeing. Implementing school-based behavioral health programs can be challenging yet it is critical to the health of our country. Inherent in the design of the United States’ educational system are wide differences between schools, school districts and states in terms of available resources and the capacity of schools to address the social-emotional and behavioral health needs of their students. While there are some fundamental recommendations and cross-cutting strategies that can be applied universally at the policy, systems and practice levels, approaches to promote comprehensive school behavioral health should adapt chosen strategies for the local community, based upon identified needs, capacities and available resources. Efforts must also strive to create fair and equitable access to services and meet the behavioral health needs of students in all communities throughout the Commonwealth.

This report has established the important role schools play in identifying and addressing student behavioral health needs, and why evidence-based practices implemented through comprehensive, Multi-Tiered Systems of Support (MTSS) are the most effective strategy to promote positive student outcomes. This report has further identified national best practices and resources, reviewed considerations for effectively designing and implementing MTSS, explored the importance of evidence-based practices, identified several evidence-based practices appropriate for school settings, and reviewed a number of notable efforts in Massachusetts. Moving forward, Massachusetts has an opportunity to build upon its reputation as a national leader to ensure that an effective, evidence-based continuum of behavioral health services and supports are available to students and families across the state regardless of race, ethnicity, identity or zip code. At the policy level in the wake of the COVID-19 pandemic, evidence-based behavioral healthcare for children and families must be a statewide priority.

At the policy level, Massachusetts would benefit from prioritizing resources to invest in building a community-based behavioral health system of care that focuses on early identification, early intervention and an effective continuum of treatment for all families in need, utilizing evidence-based, culturally responsive practices. Massachusetts would benefit from developing a plan

to implement MTSS across districts statewide. The plan will require, in part, inventorying and integrating already existing but often siloed services and supports currently available across the state. The statewide plan should articulate a comprehensive strategy that includes goals, objectives, and benchmarks to monitor and report implementation and outcomes.

The Commonwealth could further support the health and wellbeing of students by identifying and addressing behavioral healthcare financing and reimbursement issues that are barriers to school-based care. Issues such as licensure requirements and third-party reimbursement constraints can prevent children from accessing the care they need in school-based settings. The Hopeful Futures Campaign is a resource that specifies policies that support school mental health, with recommendations for how to improve.¹⁸⁸ Every effort should be made at the state and local level to ensure equitable access to behavioral healthcare. All policy level initiatives should prioritize equity, recognize and work to dismantle structural racism, and seek to address other long-standing structural inequities.

At the systems level, the Commonwealth would benefit from inventorying services, supports and resources available to each community and school, assessing the level of evidence supporting these services, and developing strategies to allocate needed resources to address identified gaps in the service array. Services should be proven effective, high-quality and, when possible, evidence-based. Further, systems level initiatives would be strengthened through investments in infrastructure for workforce development, training, quality improvement and outcome monitoring to ensure the services families receive are of the highest quality and are demonstrating positive outcomes.

In addition to a comprehensive statewide plan, Massachusetts would benefit from creating mechanisms that allow for plan adaptation and specialization at the local level. Local implementation plans should be based on community strengths and needs that guide policy and practice, and ensure children have access to a continuum of school- and community-based behavioral health services and supports.

Further, it is important for the Commonwealth to build comprehensive systems and supports to close the gap between needs and available resources.

¹⁸⁸ Hopeful Futures Campaign (2022). <https://hopefulfutures.us/>

This may include implementing systematic screening and assessment, training professionals in the school and community in evidence-based practices and programs, building an infrastructure that allows for data sharing and addressing barriers to quality care.¹⁸⁹

At the practice level, the most effective community-level strategies will ensure children and families have access to high quality services and supports that are in alignment with broader state-wide goals and objectives. These strategies should include evidence-based services that meet the needs of the community and are culturally and linguistically competent. Several examples in Massachusetts have been highlighted throughout this report.

At the local level, services and programs can be organized under a MTSS framework to leverage school-based and community-based resources. The work being conducted in Boston Public Schools and Methuen Public Schools (among others) are examples of local initiatives that are working to bring comprehensive, evidence-based services to school districts in the Commonwealth. While these initiatives are promising, there continues to be a lack of consistently implemented strategies to identify and address the behavioral health needs of students. Moving forward, Massachusetts communities would benefit from implementing new school district-level strategies, built on the MTSS framework, that promote healthy child development and respond to the behavioral health needs of students through strong partnerships with community-based providers. Community-based strategies should leverage areas in which schools already excel and build additional capacity in the school and community to address identified gaps and needs.

Massachusetts has long been a national leader in both public education and children’s behavioral health services. In fact, the Boston Public Health Commission recently created the first-ever Chief Behavioral Health Officer. The Commonwealth is in a strong position to build upon this foundation by ensuring that vulnerable children and families have access to needed behavioral health services and supports in their schools and communities. By designing and implementing an evidence-based, state-wide strategy to build upon the unique strengths and needs of each community, the Commonwealth can create a comprehensive system of care that ensures that all children in Massachusetts thrive.

At the national level, the recommendations included in this report could be helpful to any state or jurisdiction that is looking to improve outcomes for children and families in schools.



¹⁸⁹ Child Health and Development Institute of Connecticut, 2018





Recommendations for Policy, Systems, and Practice Development

As Massachusetts and other states across the nation consider how to support students and their families through and after the COVID-19 pandemic, the following recommendations are proposed to improve outcomes at the policy, systems and practice levels.

1

Develop, implement, and sustain a comprehensive statewide and district-level school behavioral health strategic plan that identifies and responds to the behavioral health needs of students, fills gaps in prevention, promotion and intervention services, builds upon existing state and local initiatives, and is responsive to individual community strengths and needs.

- a. Develop a **strategic framework** including a timetable with clear goals, objectives and benchmarks that can be monitored and reported;
- b. Develop an **annual public reporting** system that monitors strategy implementation at the local and state level, including creating a **statewide data infrastructure** that tracks and monitors progress and outcomes for all children and families receiving care;
- c. **Inventory** the existing array of services, supports, and capacity at the state and local level to identify strengths and capacities as well as needs and gaps in the current system;
- d. Support the implementation of a **Multi-Tiered System of Support** in school districts across Massachusetts, including mechanisms for early identification and screening, strong partnerships with community-based providers and model adaptation to address the local community strengths and needs.

2

Increase access to comprehensive, evidence-based, and culturally and linguistically responsive behavioral health supports and services in communities across Massachusetts;

- a. Identify and respond to behavioral health needs resulting from, or exacerbated by, the COVID-19 pandemic;¹
- b. Build capacity of community-based providers to increase access to care and deliver high quality, evidence-based behavioral health services;
- c. Explore telehealth as a strategy to deliver high-quality care to students across Massachusetts.
- d. Provide more opportunities for parents and youth to become engaged partners.

3

Partner with schools, behavioral health entities, families and state leaders to reform staffing guidelines and policies to increase access to mental health services and supports in schools.

- a. Clearly articulate school mental health workforce roles and responsibilities and ensure clear procedures are in place to connect students to needed care and maintain school safety;
- b. Develop and implement staffing models that ensure schools have adequate access to behavioral health supports;
- c. Design a plan to ensure that all Massachusetts schools meet or exceed the recommended number of mental health providers (e.g., school psychologists, school-based social workers, and counselors) per number of students.
- d. Decrease silos between school-based professionals and right-size the roles of school mental health workforce staff, ensuring all individuals have clear roles and responsibilities that align with their training and with the needs and strengths of students;
- e. Develop and implement support structures to ensure all school-based staff are adequately trained and equipped to deal with behavioral health issues, crises and matters of school safety.
- f. Create a continuum of supports through peer counselors, mentors, health educators, and community volunteers.

¹ (For additional information and recommendations regarding the impact of COVID-19 on children and families, see the [Evidence Based Policy Institute's reports Spotlight On: The Impact of the COVID-19 Pandemic on Children, Youth and Families, and, Spotlight On: The "New Normal" and Life Beyond COVID-19](#)).

4

Develop, implement, and fund a robust workforce development strategy to ensure school-based staff, including teachers, administrators, behavioral health providers and school resource officers are well prepared to identify and respond to routine behavioral health needs, crises, and/or potentially dangerous situations which threaten school safety.

- a. Partner with national, state and local experts and stakeholders to expand and diversify the behavioral health workforce and identify professional development needs in each community;
 - i. Incentivize educational opportunities in behavioral health;
 - ii. Identify opportunities for individuals to work in behavioral health at multiple levels and create opportunities for advancement;
 - iii. Streamline the credentialing process for providers.
- b. Survey available trainings and workforce development offerings at the local and national levels to select or design an appropriate strategy;
- c. Invest in professional development strategies and training to improve competencies and skills (especially training in evidence-based practices and programs);
 - i. Include opportunities for ongoing support and consultation to reinforce and refine knowledge and skills;
 - ii. Provide ongoing quality assurance to maintain fidelity to practice models and ensure quality of care;
- d. Assess and redesign supervision and professional development structures to ensure that all school mental health staff are provided the support they need, including potential post-secondary trauma and burnout among staff.
- e. Provide effective training and workforce development strategies to increase knowledge and skills related to:
 - i. Child and adolescent development;
 - ii. Evidence-based behavioral health practices;
 - iii. Trauma-informed practices;
 - iv. Culturally and linguistically appropriate services;
 - v. Diversity, equity, and inclusion;
 - vi. School safety;
 - vii. Strategies that reduce reliance on suspension and expulsion, link children to appropriate services, and work to maintain children in their schools and communities.

5

Identify strategies to elevate equity, advance multicultural frameworks and dismantle long-standing structural inequities and systemic racism in student-focused policies, systems and practices.

6

Raise public and professional awareness about the importance of understanding and addressing the behavioral health needs of all students.

- a. Continue implementing strategies to destigmatize behavioral health, and utilize strengths-based approaches to promote healthy child development – biologically, psychologically and socially;
- b. Educate stakeholders about the impact of trauma and adversity on child development, school success and future life outcomes;
- c. Raise awareness about the importance of high-quality prevention, promotion, and behavioral health care including the effectiveness of evidence-based practices and programs;
- d. Utilize a range of public awareness and media strategies.

7

Develop financial strategies and incentives to implement, support, and sustain evidence-based, culturally and linguistically responsive services and supports in schools and communities across Massachusetts.

- a. Examine existing policies and funding streams, and reform as needed to promote access to effective behavioral health care in schools and communities;
- b. Identify and address funding barriers and reimbursement issues that impede access to school and community-based behavioral health care;
- c. Identify opportunities for cross-system, multi-agency collaboration, cost-sharing and blended funding;
- d. Develop public and philanthropic partnerships to support and sustain implementation of a comprehensive school-based behavioral health plan at the state and local level;
- e. Reform reimbursement structures to ensure school-based clinical licenses (including: school counselors, adjustment counselors, school psychologists, and school social workers) can bill for services provided;
- f. Build the school workforce pipeline and broaden the staffing array that can be funded by Medicaid.
- g. Ensure that evidence-based practices (EBPs) are sufficiently reimbursed to incentivize and increase access to effective, high quality behavioral health services for children and families.

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Appendix A: Partial List of Evidence-Based Practices for Schools

This appendix focuses on practices and programs that have been specifically designed or adapted for use in schools, which have an established evidence-base and proven efficacy in addressing the behavioral health needs of children. Each category is further sub-divided by Multi-Tiered Systems of Support (MTSS) tier.



Developed for Schools

The below programs were designed specifically for use in schools. These evidence-based interventions can be utilized by teachers, school staff, and/or clinicians to identify and address students' behavioral health needs and facilitate healthy development.

Tier 1		
4Rs	Caring School Community	Family History and Ourselves
<p>Description: The 4Rs (Reading, Writing, Respect & Resolution) curriculum engages the imagination and creativity of children to help develop critical skills including empathy, community building, and conflict resolution. The program takes place over 35 period-long class sessions, and includes explicit skills instruction, academic integration strategies for English/ language arts, and opportunities to practice social and emotional skills.</p> <p>Modality: Individual</p> <p>Target population: Ages 5-15, targeting Black and Hispanic students.</p> <p>Who delivers the program: Teachers in the classroom.</p> <p>Program cost: The program costs about \$175 per student each year for the first three years, but becomes more cost effective the more years the program is offered, as some materials do not have to be repurchased regularly.</p> <p>Implementation considerations: Implementation information is provided in the leader guide. Assessment tools for monitoring implementation (via self-report) and measuring student behavior are included.</p> <p>Outcomes: Improved academic performance and positive social behavior, and reduced contact problems and emotional distress.</p> <p>Website to learn more: https://www.morningsidecenter.org/4rs-program</p>	<p>Description: Caring School Community is a comprehensive, social and emotional learning (SEL) program that builds school-wide community, develops students' social skills and SEL competencies, and provides an alternative stance on discipline. This program promotes positive behavior by teaching responsibility, empathy, and cooperation, creating settings where students feel heard and cared for.</p> <p>Modality: Individual</p> <p>Target population: Ages 5-11, targeting Black and Hispanic students.</p> <p>Who delivers the program: Teachers in the classroom.</p> <p>Program cost: A teacher package is \$200 per grade, which can be reused.</p> <p>Implementation considerations: Implementation is assisted by academic integration strategies that are provided with the teacher guide. The Center for the Collaborative Classroom provides remote guidance designed to support teachers.</p> <p>Outcomes: Improved academic performance, increased positive social behavior, reduced contact problems, and reduced emotional distress.</p> <p>Website to learn more: https://www.collaborativeclassroom.org/programs/caring--school-community/</p>	<p>Description: Facing History and Ourselves is an educational program that uses teaching practices to promote students' social and emotional learning. These practices are infused in an academic curriculum that focuses on historical periods of intergroup conflict that involved racism and prejudice. Through this content, the program promotes awareness and respect of diversity.</p> <p>Modality: Individual</p> <p>Target population: Ages 12-18, targeting Black, Hispanic, and Multiracial students.</p> <p>Who delivers the program: Teachers in the classroom and families at home.</p> <p>Program cost: For training and curriculum costs, organizations must reach out directly.</p> <p>Implementation considerations: The program recommends beginning with an intensive training model, followed up with on site coaching, and virtual support. Digital supports include videos and documentaries, micro sites focused on core content, and other resources.</p> <p>Outcomes: More prosocial behavior, greater ability to empathize, better classroom climate, greater civic self-efficacy, greater "political tolerance", better academic achievement, and fewer conduct problems at post-test.</p> <p>Website to learn more: https://www.facinghistory.org</p>

Get Real: Comprehensive Sex Education that Works	I Can Problem Solve	LifeSkills Training
<p>Description: Get Real is a sex education curriculum with a foundation in SEL competencies, with an emphasis on self-awareness, social awareness, relationship skills, and responsible decision-making. Materials include lessons on expressing and respecting boundaries, handling bullying, sexual and reproductive anatomy, gender and sexual identity, sexually transmitted infections, and defining and maintaining abstinence.</p> <p>Modality: Individual</p> <p>Target population: Ages 12-14</p> <p>Who delivers the program: Teachers in the classroom and families at home.</p> <p>Program cost: Training costs about \$1,000 per participant. Middle school classroom materials cost \$550 and high school classroom materials cost \$300, all of which can be reused.</p> <p>Implementation considerations: The Get Real Training Institute provides professional development for teachers implementing Get Real. This includes participation in a 10-12 hour, self-guided online course followed by participation in a two-day, skill-building, in-person training. In addition, teachers are provided two follow-up support sessions when they begin teaching Get Real in the classroom and receive ongoing online support through the special interactive Teacher Resources area of the Get Real website.</p> <p>Outcomes: Significantly lower implied likelihood of sexual debut by 8th grade.</p> <p>Website to learn more: https://www.getrealeducation.org/</p>	<p>Description: The I Can Problem Solve program teaches students how to generate alternative solutions, anticipate consequences, and effectively solve problems. Instruction introduces central concepts, which is then followed by explicit skill instruction in SEL competencies. Initial training for the program is required and a train-the-trainer system is available to support sustainability.</p> <p>Modality: Individual</p> <p>Target population: Ages 5-11</p> <p>Who delivers the program: Teachers in the classroom and families at home.</p> <p>Program cost: Cost for curriculum is \$50 per grade, and can be reused. The two-day training is designed for implementers and includes either on-site or off-site coaching. Organizations must reach out directly to inquire about training prices.</p> <p>Implementation considerations: Implementation strategies are outlined in the curriculum.</p> <p>Outcomes: Increased concern/awareness for others in distress, increased ability to make friends and get along with others, decreased aggression, decreased over-emotionality and inability to cope with frustration, decreased social withdrawal, and gains in academic achievement scores.</p> <p>Website to learn more: http://www.icanproblemsolve.info/community/</p>	<p>Description: LifeSkills Training is a classroom-based universal prevention program designed to prevent adolescent tobacco, alcohol, marijuana use, and violence. Major program components teach students personal self-management skills, social skills, and information and resistance skills specifically related to drug use. Skills are taught using instruction, demonstration, feedback, reinforcement, and practice.</p> <p>Modality: Individual</p> <p>Target population: Ages 12-14</p> <p>Who delivers the program: Teachers and other school staff.</p> <p>Program cost: Facilitators attend a training to familiarize themselves with the program and its rationale, receive an overview of evaluation research, and to learn and practice the skills needed to successfully implement the prevention program. The cost of the training is \$1,000 per participant. Price does not include curriculum materials.</p> <p>Implementation considerations: Ongoing technical assistance and Training of Trainer workshops are available. Additional resources available on the LST website include unit quizzes, lesson support slides, fidelity checklists, program evaluation tools (pre-and post-test), and activities and self-checks designed for students.</p> <p>Outcomes: Reduced alcohol use, delinquency and criminal behavior, illicit drug use, sexual risk behaviors, tobacco use, and violence, and increased emotional regulation.</p> <p>Website to learn more: https://www.lifeskillstraining.com</p>

Lions Quest: Skills for Adolescence	Michigan Model for Health	Promoting Alternative Thinking (PATHS)
<p>Description: Lions Quest Skills for Adolescence is a skills promotion program for middle school students, implemented over three years. The activities and instructions provide coverage for self-awareness, social awareness, relationship skills, and responsible decision-making. Skills for Adolescence is designed to establish a caring, participatory, and well-managed learning environment.</p> <p>Modality: Individual</p> <p>Target population: Ages 12-14</p> <p>Who delivers the program: Teachers in the classroom and families at home.</p> <p>Program cost: Initial trainings are provided on site or through regional. Sponsored workshops are \$2700–\$3500 total, while regional trainings are \$500 per participant. Teacher’s kits cost \$150 per grade. Workbooks are \$5 per student.</p> <p>Implementation considerations: Resources are offered online to support implementation, including sample lessons, implementation guidelines, consulting sessions, and possible funding sources. The program creates a leadership team for planning, offers a separate workshop for administrators, and provides guidelines for developing positive school climate.</p> <p>Outcomes: Lower levels of drug use, more positive self-perceptions of self-efficacy to refuse drugs and alcohol, and more positive perceptions of social skills.</p> <p>Website to learn more: https://www.lions-quest.org/explore-our-sel-curriculum/</p>	<p>Description: The program facilitates sequential learning through lessons that include a variety of teaching and learning techniques, skill development and practice, and emphasizes positive lifestyle behaviors in students and families. Learning centers on knowledge, skills, self-efficacy, and environmental support for healthy behaviors.</p> <p>Modality: Individual</p> <p>Target population: Ages 5-18</p> <p>Who delivers the program: Teachers in the classroom.</p> <p>Program cost: Classroom materials for each grade can be purchased for \$265 as a “digital bundle”, which includes HTML lessons that are mobile-friendly with links to online teacher resources such as student worksheets, family resource sheets, assessments, etc.</p> <p>Implementation considerations: Strategies and recommendations are provided online, as well as in the classroom curriculum. Organizations must reach out to Michigan School Health Coordinators Association through their website to inquire about training opportunities and costs.</p> <p>Outcomes: The major program goal of the Michigan Model for Health is to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors while creating a partnership between homes, schools, communities and government.</p> <p>Website to learn more: https://www.michiganmodelforhealth.org</p>	<p>Description: PATHS is a comprehensive program for promoting emotional and social competencies and reducing aggression and behavior problems. Five conceptual domains, integrated in a hierarchical manner, are included in PATHS lessons at each grade level: self-control, emotional understanding, positive self-esteem, relationships, and interpersonal problem-solving skills. Throughout the lessons, a critical focus of PATHS involves facilitating the dynamic relationship between cognitive-affective understanding and real-life situations.</p> <p>Modality: Individual</p> <p>Target population: Ages 5-11</p> <p>Who delivers the program: Teachers in the classroom and families at home.</p> <p>Program cost: The cost for the two-day workshop is \$5,000, while curriculum materials are about \$500 per classroom.</p> <p>Implementation considerations: Strategies are included in the training and classroom materials.</p> <p>Outcomes: Improved academic performance and emotional regulation, and reduced antisocial-aggressive behavior, conduct problems, and delinquency and criminal behavior.</p> <p>Website to learn more: https://pathsprogram.com/</p>

Peace Works: Peacemaking Skills for Little Kids	Positive Action	Project Towards No Drug Abuse
<p>Description: The Peace Works: Peacemaking Skills for Little Kids promotes conflict resolution skills in young children. It teaches lessons on cooperation, diversity, recognizing and managing emotions, and taking responsibility for our actions. The program focuses on violence prevention, social-emotional learning, conflict resolution, mediation skills, character and values, bullying prevention.</p> <p>Modality: Individual</p> <p>Target population: Ages 5-11</p> <p>Who delivers the program: Teachers in the classroom and families at home.</p> <p>Program cost: Classroom materials can be purchased for \$25 per classroom, and will need to be purchased again each year. Training on how to implement the program is offered, but organizations must reach out directly to inquire.</p> <p>Implementation considerations: Strategies are included in the classroom materials.</p> <p>Outcomes: Decreases disruptive disorders and behaviors, decreases internalizing problems, increases social competence, and increases social connectedness.</p> <p>Website to learn more: https://peaceeducation.org/</p>	<p>Description: Positive Action includes school-wide climate change and a detailed curriculum with scripted, age-appropriate lessons. The program focuses on positive actions for the physical, intellectual, social and emotional areas.</p> <p>Modality: Individual</p> <p>Target population: Ages 5-18</p> <p>Who delivers the program: Teachers and other school staff.</p> <p>Program cost: Trainings costs vary depending upon the time of training selected, ranging from \$550 per individual participant to \$3000 per day (plus travel expenses) to bring a trainer to the organization. Curriculum materials cost \$400-\$500 per classroom for initial purchase, followed by the \$175 purchase of a “refresher kit” to replace consumed materials.</p> <p>Implementation considerations: Strategies for implementation are provided in the curriculum materials, as well as through online resources.</p> <p>Outcomes: Increased positive social behavior and reduced emotional distress in the following areas: academic performance, alcohol, antisocial-aggressive behavior, anxiety, bullying, conduct problems, delinquency and criminal behavior, depression, emotional regulation, illicit drug use, internalizing, obesity, physical health and well-being, positive social/prosocial behavior, sexual risk behaviors, tobacco, truancy, school attendance, violence.</p> <p>Website to learn more: https://www.positiveaction.net/</p>	<p>Description: Project Towards No Drug Abuse is a drug prevention program for high school youth. The current version of the curriculum contains twelve 40-minute interactive sessions taught by teachers or health educators over a 3-week period. Sessions provide instruction in motivation activities to not use drugs; skills in self-control, communication, and resource acquisition; and decision-making strategies.</p> <p>Modality: Individual</p> <p>Target population: Ages 15-18</p> <p>Who delivers the program: Teachers and other school staff.</p> <p>Program cost: Teacher training consists of 1-2 day workshops, each day lasting 6-7 hours. The cost for training ranges from \$1200-\$2100 per day, depending on the location of the training. Teacher manuals are \$90 each, while student workbooks are \$60 for a set of 5.</p> <p>Implementation considerations: The objectives of the training workshop are to provide teachers with an understanding of the theoretical basis, content, instructional techniques, and objectives of the program. In addition, the training is designed to build the skills that teachers need to deliver the lessons with fidelity.</p> <p>Outcomes: Reduced alcohol use, illicit drug use, sexual risk behaviors, tobacco use, violence, and violent victimization.</p> <p>Website to learn more: https://tnd.usc.edu/</p>

Resolving Conflict Creatively Program	Responding in Peaceful and Positive Ways	School-Based Diversion Initiative
<p>Description: The Resolving Conflict Creatively Program includes sequenced, skill-building, classroom lessons designed to foster the creation of caring, peaceable school learning communities for prekindergarten through eighth grade. Lessons emphasize building relationships, understanding feelings, developing empathy, managing emotions, and developing social responsibility.</p> <p>Modality: Individual</p> <p>Target population: Ages 5-14, targeting Black and Hispanic students.</p> <p>Who delivers the program: Teachers in the classroom and families at home.</p> <p>Program cost: Initial training for the program typically lasts 24-30 hours and is required. The program offers a train-the-trainer system to support sustainability. Organizations must reach out directly regarding cost of training and program materials.</p> <p>Implementation considerations: The intervention prioritizes training and coaching of teachers to support them in implementing the curriculum. Implementation recommendations are provided in the training and coaching process.</p> <p>Outcomes: Reduced contact problems, emotional distress, and racial/ethnic/gender put-downs in the classroom.</p> <p>Website to learn more: https://pg.casel.org/resolving-conflict-creatively-program-rccp/</p>	<p>Description: Responding in Peaceful and Positive Ways is a violence prevention program that uses free-standing lessons to promote students' SEL. The program places a heavy emphasis on teaching social problem-solving and conflict-resolution skills. The program emphasizes practice within the classroom and includes strategies for calming down.</p> <p>Modality: Individual, Group</p> <p>Target population: Ages 12-14</p> <p>Who delivers the program: Trained school staff.</p> <p>Program cost: Organizations must reach out directly to inquire about training costs.</p> <p>Implementation considerations: Professional development is designed for a designated program specialist who delivers the curriculum to all students in the school. Coaching involves a monthly phone call to check in and offer technical assistance.</p> <p>Outcomes: Less drug use (4 months after baseline); fewer interpersonal problems (4 months and 21 months after baseline); less victimization (12 months after baseline), and fewer conduct problems (4 months, 7 months, and 21 months after baseline). Additionally, significant program impact was sustained at follow-up for life satisfaction (both 4 months after post-test).</p> <p>Website to learn more: https://pg.casel.org/resolving-conflict-creatively-program-rccp/</p>	<p>Description: The Connecticut School-Based Diversion Initiative (SBDI) is a model school-level initiative that incorporates juvenile justice reforms and school mental health concepts. SBDI promotes positive outcomes for youth at risk of arrest due to emotional or behavioral health challenges, and increases the likelihood that students are appropriately linked to existing networks of services and supports.</p> <p>Modality: Individual, Group</p> <p>Target population: Ages 12-18</p> <p>Who delivers the program: Teachers and other school staff.</p> <p>Program cost: Training requests can be made by contacting local community-based service providers. Providers will often present to schools free of charge or at minimal cost.</p> <p>Implementation considerations: The SBDI toolkit provides a guide for implementing some of the core principles and activities of the program. There are self-assessment questions listed at the beginning of each section of the toolkit to determine the school's level of need and readiness.</p> <p>Outcomes: Reduced frequency of expulsions, out-of-school suspensions, and discretionary school-based arrests; linkage of students who are at risk of arrest to services and supports; and increased knowledge and skills among school staff to recognize and manage behavioral health crises, and access services.</p> <p>Website to learn more: https://www.chdi.org/our-work/mental-health/school-based-mental-health/sbdi/</p>

Second Step	Second Step: Middle School	Student Success Skills
<p>Description: The Second Step Program is a skills promotion program that provides a fully integrated framework for protecting elementary school students and promoting their social, emotional, and academic success. The program also focuses on bullying prevention to improve school climate and child abuse prevention.</p> <p>Modality: Individual, Group</p> <p>Target population: Ages 5-11</p> <p>Who delivers the program: Teachers in the classroom and families at home.</p> <p>Program cost: Requires purchase of a license, as well classroom kits. Cost varies depending on the number of teachers providing Second Step and the number of student participants.</p> <p>Implementation considerations: The program provides highly structured and directive training. Optional professional development opportunities are offered for diverse stakeholders, as well as checklists and observational tools to monitor the fidelity of implementation. Online resources are also available to support planning, implementation, and sustainability.</p> <p>Outcomes: Increased positive social behavior, reduced contact problems, and reduced emotional distress.</p> <p>Website to learn more: https://www.secondstep.org/elementary-school-curriculum</p>	<p>Description: The middle school version uses free-standing lessons to promote students' social and emotional learning. The program uses a variety of interactive strategies that include direct instruction, video modeling, partner and group discussion, behavioral skill practice, and interactive homework assignments. Every lesson includes videos that are visually appealing to youth and support program delivery. The program includes lessons on bullying prevention and substance abuse prevention.</p> <p>Modality: Individual, Group</p> <p>Target population: Ages 12-14</p> <p>Who delivers the program: Teachers in the classroom and families at home.</p> <p>Program cost: Requires purchase of a license, as well classroom kits. Cost varies depending on the number of teachers providing Second Step and the number of student participants.</p> <p>Implementation considerations: The program provides highly structured and directive training. Optional professional development opportunities are offered for diverse stakeholders, as well as checklists and observational tools to monitor the fidelity of implementation. Online resources are also available to support planning, implementation, and sustainability.</p> <p>Outcomes: Increased positive social behavior, reduced contact problems, reduced emotional distress, and lower levels of physical aggression.</p> <p>Website to learn more: https://www.secondstep.org/</p>	<p>Description: Student Success Skills is a skills promotion program that uses teaching practices to support students' SEL. Lessons provide students with strategies for setting goals, monitoring progress, and sharing success; building a caring, supportive, and encouraging environment; developing and practicing memory and cognitive skills; calming anxiety and managing emotions; and developing healthy optimism. The stress reduction techniques include mindfulness strategies.</p> <p>Modality: Individual</p> <p>Target population: Ages 12-18</p> <p>Who delivers the program: Teachers in the classroom and families at home.</p> <p>Program cost: For information on training costs, organizations or individuals must reach out directly to inquire. Classroom manuals are available for purchase for \$85 each.</p> <p>Implementation considerations: A one-day training is recommended and can be provided on site or regionally. Each teacher receives a classroom manual as part of the training. Supports include consultations with district leaders before and after training, consultation for an implementation evaluation, and coaching. The program offers rating scales and observational tools to monitor fidelity.</p> <p>Outcomes: Students who participated in the program achieved higher standardized test scores in reading and math as well as more positive perceptions of their own social and emotional skills.</p> <p>Website to learn more: https://studentsuccessskills.com/</p>

The Incredible Years Series	Too Good for Violence	Tools of the Mind
<p>Description: The Incredible Years is a series of three separate, multifaceted, and developmentally based curricula for parents, teachers, and children. This series is designed to promote emotional and social competence; and to prevent, reduce, and treat behavior and emotional problems in young children. The parent, teacher, and child programs can be used separately or in combination.</p> <p>Modality: Individual, Family</p> <p>Target population: Ages 5-11</p> <p>Who delivers the program: Teachers in the classroom and families at home.</p> <p>Program cost: About \$1,500-\$2,000 per day to have a trainer come to the school to train teachers (15+), plus travel, lodging and meals. \$550 for an individual teacher to receive training. Curriculum is purchased separately for \$400-\$1500.</p> <p>Implementation considerations: Implementation supports include consultations, webinars, video reviews, and certification fidelity check. There are protocol checklists, process checklists, self-evaluations, self-reflection checklists, and more available on the website or in the leader manuals.</p> <p>Outcomes: Prevention, reduction, and treatment of early onset conduct behaviors and emotional problems; Promotion of child social competence, emotional regulation, positive attributions, academic readiness, and problem solving; Prevention of academic underachievement, delinquency, violence, and drug abuse.</p> <p>Website to learn more: http://www.incredibleyears.com/</p>	<p>Description: Too Good for Violence develops and applies SEL skills for conflict resolution, bullying prevention, anger management, and respect for self and others. In middle school, students learn the negative consequences of aggressive behavior and practice healthy methods to manage stress and frustration. Each grade level curriculum builds on the previous by continually developing skills and addressing common problems faced in middle school like teaching students how to manage situations in a positive and healthy way. Additional concepts in the program supplement and reinforce the SEL skill concepts and are tailored to the intellectual, cognitive, and social development of the student.</p> <p>Modality: Individual</p> <p>Target population: Ages 5-14</p> <p>Who delivers the program: Teachers and school staff, and families at home.</p> <p>Program cost: Program training costs \$345–\$545 depending on how far in advance participants register. Classroom materials cost approximately \$250-\$300 per grade.</p> <p>Implementation considerations: Implementation strategies are provided in the classroom materials, and implementation workshops are offered at the time of initial training.</p> <p>Outcomes: Increased positive social behavior.</p> <p>Website to learn more: https://toogoodprograms.org/collections/too-good-for-violence</p>	<p>Description: Tools of the Mind is a research-based early childhood model combining teacher professional development with a comprehensive innovative curriculum that helps young children to develop the cognitive, social-emotional, self-regulatory, and foundational academic skills they need to succeed in school and beyond.</p> <p>Modality: Individual, Group</p> <p>Target population: PreK-K, targeting Hispanic students</p> <p>Who delivers the program: Teachers in the classroom and families at home.</p> <p>Program cost: Program training costs \$3750. The first workshop is two sequential days with a focus on Tools’ theory and practice that takes place near the beginning of the school year. Each of the remaining three workshops is a one-day session. Each workshop builds on the one before it, and teachers attend all of the workshops as part of their Year One Core training. Other classroom materials are available for separate purchase.</p> <p>Implementation considerations: The four-workshop series is supplemented by a personal staff member assigned to each program to support implementation, Technical Assistance support for programs with 3 or more registered classrooms, and school-year subscriptions to eTools with iScaffold, an innovative app-based learning system, for each registered staff member.</p> <p>Outcomes: Reduced conduct problems, improved academic behaviors and school climate.</p> <p>Website to learn more: https://toolsofthemind.org/</p>



OT AN EXIT

Tier 2		
Blues Program	Coping Cat	Support for Students Exposed to Trauma: School Support for Childhood Trauma (SSET)
<p>Description: The Blues Program (Cognitive Behavioral Group Depression Prevention) is intended to actively engage high school students with depressive symptoms or at risk of onset of major depression, includes six weekly one-hour group sessions and home practice assignments. Weekly sessions focus on building group rapport and increasing participant involvement in pleasant activities, learning and practicing cognitive restructuring techniques, and developing response plans to future life stressors. In-session exercises require participants to apply skills taught in the program. Home practice assignments are intended to reinforce the skills taught in the sessions and help participants learn how to apply these skills to their daily life.</p> <p>Modality: Individual, Group</p> <p>Target population: Ages 15-18</p> <p>Who delivers the program: Clinicians in the school.</p> <p>Program cost: 4-6 hour training programs for groups of therapists costing about \$1,000 per day plus travel expenses.</p> <p>Implementation considerations: Training consists of reading key outcome papers and the prevention intervention manual, discussion of intervention rationale, modeling and role play of all key intervention components, discussion of process issues, and review of crisis response plans.</p> <p>Outcomes: Reduced depression and illicit drug use.</p> <p>Website to learn more: https://www.blueprintsprograms.org/blues-program/</p>	<p>Description: Coping Cat is a cognitive-behavioral treatment for children with anxiety. The program incorporates recognizing and understanding emotional and physical reactions to anxiety, clarifying thoughts and feelings in anxious situations, developing plans for effective coping, and evaluating performance and giving self-reinforcement.</p> <p>Modality: Individual</p> <p>Target population: Ages 7-13</p> <p>Who delivers the program: Clinicians in the school.</p> <p>Program cost: Treatment manuals for therapists and student workbooks can be purchased online for \$24 each. Training is obtained virtually through DVDs for purchase.</p> <p>Implementation considerations: Implementation support is available through supervisory phone consultations. Goals and targets are included with each session in the therapist manual. When evaluating fidelity, tapes of sessions are listened to in order to check that the goals/targets for the session were addressed. The fidelity form also has places for the supervisor to rate the therapist on several dimensions. The form is not publicly available.</p> <p>Outcomes: Reduced anxiety.</p> <p>Website to learn more: https://www.copingcatparents.com</p>	<p>Description: SSET is an evidence-based intervention focused on managing the distress that results from exposure to trauma. SSET is designed for children who have experienced events such as witnessing or being a victim of family, school, or community violence, being in a natural or man-made disaster, being in an accident or fire, or being physically abused or injured, and who are experiencing moderate to severe levels of post-traumatic stress symptoms.</p> <p>Modality: Group</p> <p>Target population: Ages 10-16</p> <p>Who delivers the program: Teachers and/or clinicians in the school.</p> <p>Program cost: Training consists of reading background materials and the manual, attending an in-person training, and then receiving ongoing consultation. The manual can be purchased for \$32. Organizations must reach out directly, as cost of training varies.</p> <p>Implementation considerations: Recommendations are provided during training and in the manual.</p> <p>Outcomes: Reduced PTSD and depression symptoms.</p> <p>Website to learn more: https://www.nctsn.org/interventions/support-students-exposed-trauma-school-support-childhood-trauma/</p>

Tier 2 & 3		Tier 3
<p>Bounce Back: An Elementary School Intervention for Childhood Trauma</p>	<p>Cognitive Behavioral Intervention for Trauma in Schools (CBITS)</p>	<p>Trauma-Focused Coping in Schools (TFC)</p>
<p>Description: Bounce Back is a cognitive-behavioral, skills-based, group intervention to teach children exposed to stressful and traumatic events skills to cope with and help recover from their experiences. It is often used with children who experienced or witnessed violence, or who have been involved in natural disasters, or traumatic separation from a loved one due to death, incarceration, deportation, or child welfare placement. It includes group sessions where children learn and practice feelings identification, relaxation, courage thoughts, problem solving, and conflict resolution, and build positive social support.</p> <p>Modality: Individual, Family, Group</p> <p>Target population: Ages 5-11</p> <p>Who delivers the program: Clinicians in the school.</p> <p>Program cost: Training often consists of trainees reading the manual, attending an in-person training, and then receiving ongoing supervision. Program materials are provided during training. Cost of training varies.</p> <p>Implementation considerations: Recommendations are provided during training.</p> <p>Outcomes: Reduced PTSD, depression, and anxiety symptoms.</p> <p>Website to learn more: https://www.nctsn.org/interventions/bounce-back-elementary-school-intervention-childhood-trauma</p>	<p>Description: CBITS is a skills-based, child group intervention that is aimed at relieving symptoms of Post Traumatic Stress Disorder, depression, and generalized anxiety among children exposed to multiple forms of trauma. CBITS has been used with students who have witnessed or experienced traumatic life events such as community and school violence, accidents and injuries, physical abuse and domestic violence, and natural and man-made disasters.</p> <p>Modality: Individual, Family, Group</p> <p>Target population: Ages 10-18</p> <p>Who delivers the program: Teachers in the classroom.</p> <p>Program cost: Training is tailored to the organization/individual being trained, with costs varying.</p> <p>Implementation considerations: Recommendations are provided during training, as are instruments to measure delivery.</p> <p>Outcomes: Improvement in Post-Traumatic Stress Disorder (PTSD) and depressive symptoms, and overall functioning.</p> <p>Website to learn more: https://traumaawareschools.org/index.php/learn-more-cbits/</p>	<p>Description: Coping Cat is a cognitive-behavioral treatment for children with anxiety. The program incorporates recognizing and understanding emotional and physical reactions to anxiety, clarifying thoughts and feelings in anxious situations, developing plans for effective coping, and evaluating performance and giving self-reinforcement.</p> <p>Modality: Individual</p> <p>Target population: Ages 7-13</p> <p>Who delivers the program: Clinicians in the school.</p> <p>Program cost: Treatment manuals for therapists and student workbooks can be purchased online for \$24 each. Training is obtained virtually through DVDs for purchase.</p> <p>Implementation considerations: Implementation support is available through supervisory phone consultations. Goals and targets are included with each session in the therapist manual. When evaluating fidelity, tapes of sessions are listened to in order to check that the goals/targets for the session were addressed. The fidelity form also has places for the supervisor to rate the therapist on several dimensions. The form is not publicly available.</p> <p>Outcomes: Reduced anxiety.</p> <p>Website to learn more: https://www.copingcatparents.com</p>

Tier 1 to 3

Positive Behavioral Interventions and Supports (PBIS)	TRAILS Programs
<p>Description: PBIS is an implementation framework for maximizing the selection and use of evidence-based prevention and intervention practices at every level of a multi-tiered continuum. All students develop and learn social, emotional, and behavioral competence, supporting their academic engagement. All educators develop positive, predictable, and safe environments that promote strong interpersonal relationships with students through teaching, modeling, and encouragement.</p> <p>Modality: Individual, Group</p> <p>Target population: Can be utilized for all student ages.</p> <p>Who delivers the program: Teachers, school staff, and clinicians.</p> <p>Program cost: Schools must identify if there is a funded project in the state or district that coordinates PBIS activities and supports PBIS trainings. Refer to www.pbis.org for further information on locating available training.</p> <p>Implementation considerations: Guidelines are provided through the PBIS website.</p> <p>Outcomes: Reductions in major disciplinary infractions, antisocial behavior, and substance abuse; reductions in aggressive behavior and improvements in emotional regulation; improvements in academic engagement and achievement; improvements in perceptions of organizational health and school safety; reductions in teacher and student reported bullying behavior and victimization; improvements in perceptions of school climate; and reductions in teacher turnover.</p> <p>Website to learn more: https://www.pbis.org/</p>	<p>Description: TRAILS Programs offers improved access to evidence-based mental health services through training, materials and implementation support with three tiers of programming. Programs include TRAILS Social and Emotional Learning (SEL) (Tier 1), TRAILS CBT and Mindfulness (Tier 2) and TRAILS Suicide Prevention and Risk Management (Tier 3). TRAILS Programs train school mental health professionals in effective practices, such as social and emotional learning, cognitive behavioral therapy, mindfulness, and suicide prevention. Coaches are paired with their local TRAILS-trained school professionals and co-facilitate school-based skills groups focused on reducing students' symptoms of depression and anxiety.</p> <p>Modality: Individual, Group</p> <p>Target population: All students in schools.</p> <p>Who delivers the program: Clinicians in the school and other trained school staff.</p> <p>Program cost: Organizations must reach out directly regarding training and associated costs.</p> <p>Implementation considerations: Recommendations are provided during training, as well as through the trained coaches who are made available.</p> <p>Outcomes: Increased access to mental and behavioral health services to students, and reduced symptoms of anxiety, depression, and post-traumatic stress disorder.</p> <p>Website to learn more: https://trailstowellness.org/</p>

Adapted for Schools

The below programs were originally developed for home, community, or outpatient settings, but have since been adapted and validated for use in schools. These evidence-based interventions can be utilized by teachers, school staff, and/or clinicians to identify and address students’ behavioral health needs and facilitate healthy development.

Tier 1
<p>There are limited programs or practices available. DBT Skills in Schools offers the first non-clinical application of DBT skills for designed to be taught at the universal level in grades 6–12.</p> <p>Website to learn more: https://www.dbtinschools.com/dbt-steps-a</p>

Tier 2	
Child Adult Relationship Enhancement (CARE)	Motivational Interviewing (MI)
<p>Description: CARE is a trauma-informed set of skills that can be used by any adult in any setting who interacts with children and teens who have experienced trauma. It may complement mental health treatments, but is not a therapy program. It has been used in a wide-variety of settings with varied audiences, including health, mental health, and allied health professionals, family members, and lay professionals.</p> <p>Modality: Family</p> <p>Target population: Can be utilized for all ages.</p> <p>Who delivers the program: Teachers and school staff.</p> <p>Program cost: Training cost varies, but is typically \$100 per participant. No additional materials or equipment are required for purchase.</p> <p>Implementation considerations: Strategies for implementation are discussed during training.</p> <p>Outcomes: Overall improvement in positive parenting skills, decreased endorsement of corporal punishment, improved parent-child relationships, and improved behaviors.</p> <p>Website to learn more: https://www.nctsn.org/interventions/child-adult-relationship-enhancement</p>	<p>Description: Motivational Interviewing is a therapeutic strategy that seeks to motivate individuals who have expressed disinterest in addressing their problems. This approach is commonly implemented with individuals who are suffering with substance use disorders, eating disorders, or those who are unwilling to change or are hostile towards therapy. The focus is on empathy, self-efficacy, and optimism.</p> <p>Modality: Individual</p> <p>Target population: Can be utilized for all ages.</p> <p>Who delivers the program: Teachers, school staff, or clinicians. Anyone can be trained.</p> <p>Program cost: \$150 per training participant. Training can be provided on-site. Follow-up feedback and coaching can be delivered by telephone.</p> <p>Implementation considerations: Clinicians can utilize tools for implementation and continued fidelity, such as the Motivational Interviewing Treatment Integrity, which provides feedback that can be used to increase clinical skill in the practice of motivational interviewing.</p> <p>Outcomes: Enhance internal motivation to change, reinforce this motivation, and develop a plan to achieve change.</p> <p>Website to learn more: http://www.motivationalinterviewing.org</p>

Tier 2 & 3		
Applied Behavior Analysis	Behavior Therapy	Cognitive Behavioral Therapy (CBT)
<p>Description: Applied Behavior Analysis (ABA) uses learning principles to teach socially significant behaviors in real-life settings. If a behavior is followed by a reward or reinforcement, it is more likely to be repeated. This individualized intervention addresses communication, social skills, self-management, cognition, and pre-academic skills such as imitation, matching, letter, and number concepts. When used with younger children, ABA interventions are often referred to as “early intensive behavioral interventions”. ABA is considered an effective treatment for autism spectrum disorder.</p> <p>Modality: Individual</p> <p>Target population: Can be utilized for all ages.</p> <p>Who delivers the program: Clinicians</p> <p>Program cost: Training is tailored to the organization/individual being trained, with costs varying.</p> <p>Implementation considerations: Recommendations are provided during training, as are instruments to measure delivery.</p> <p>Outcomes: Established and enhanced socially important behaviors.</p> <p>Website to learn more: https://effectivechildtherapy.org/therapies/what-is-applied-behavior-analysis/</p>	<p>Description: Behavioral therapies for children and adolescents vary widely, but they all focus primarily on how some problematic thoughts or negative behaviors may unknowingly or unintentionally get “rewarded” within a young person’s environment. These rewards or reinforcements often contribute to an increase in the frequency of these undesirable thoughts and behaviors. Behavioral therapy encourages children and adolescents to try new behaviors, rewards desired behaviors, and allows unwanted behaviors to “extinguish”.</p> <p>Modality: Individual</p> <p>Target population: Can be utilized for all ages.</p> <p>Who delivers the program: Clinicians</p> <p>Program cost: Training is tailored to the organization/individual being trained, with costs varying.</p> <p>Implementation considerations: Recommendations are provided during training, as are instruments to measure delivery.</p> <p>Outcomes: Increased engagement in positive or socially reinforcing activities.</p> <p>Website to learn more: https://effectivechildtherapy.org/</p>	<p>Description: Cognitive Behavioral Therapy (CBT) for children and adolescents usually are short-term treatments that focus on teaching children and/or their parents’ specific skills. CBT differs from other therapy approaches by focusing on the ways that a child or adolescent’s thoughts, emotions, and behaviors are interconnected, and how they each affect one another. These treatments have been proven to be effective in treating many psychological disorders among children and adolescents, such as anxiety, depression, post-traumatic stress disorder (PTSD), behavior problems, and substance abuse.</p> <p>Modality: Individual</p> <p>Target population: Can be utilized for all ages.</p> <p>Who delivers the program: Clinicians</p> <p>Program cost: Training is tailored to the organization/individual being trained, with costs varying.</p> <p>Implementation considerations: Recommendations are provided during training, as are instruments to measure delivery.</p> <p>Outcomes: Increased self-awareness and emotional intelligence, increased understanding of how distorted perceptions and thoughts contribute to painful feelings, increased self-control, reduction in symptoms by examining and solving current problems, and prevention of future episodes of distress.</p> <p>Website to learn more: https://effectivechildtherapy.org/therapies/cognitive-behavioral-therapy/</p>

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	Family Therapy	Organizational Skills Training
<p>Description: TF-CBT is a treatment that helps children and adolescents recover after trauma. TF-CBT is a structured, short-term treatment model that effectively improves a range of trauma-related outcomes in sessions with the child and caregiver. TF-CBT has proved successful with children and adolescents who have significant emotional problems related to traumatic life events. TF-CBT can also improve the participating caregiver’s personal distress about the child’s traumatic experience, and increase effective parenting skills, and supportive interactions with the child.</p> <p>Modality: Individual, Family, Group</p> <p>Target population: Can be utilized for all ages.</p> <p>Who delivers the program: Clinicians in the school.</p> <p>Program cost: Training costs approximately \$1,000 per participant. For TF-CBT certification information, please see: https://tfcbt.org/tf-cbt-certification-criteria/</p> <p>Implementation considerations: Expert consultation should be regularly received, and fidelity monitoring should occur using fidelity checklist and at least one standardized instrument to assess progress pre and post treatment.</p> <p>Outcomes: Reduced PTSD, depression, and anxiety symptoms, reduced child and caregiver distress.</p> <p>Website to learn more: https://tfcbt.org/</p>	<p>Description: Family therapy is a form of treatment that views psychological problems and their treatment in terms of the interactions among family members. Families are seen as an integrated, interconnected unit in which psychological functioning is influenced by each family member individually and collectively as an entire system. In family therapy, there is no traditional identified patient; the focus is on relationship patterns and communication among family members. During family therapy, therapists avoid blaming any individual family member for the problem, and instead help the family interact in new, different ways that may improve functioning.</p> <p>Modality: Family</p> <p>Target population: Can be utilized for all ages.</p> <p>Who delivers the program: Clinicians</p> <p>Program cost: Training is tailored to the organization/individual being trained, with costs varying.</p> <p>Implementation considerations: Recommendations are provided during training, as are instruments to measure delivery.</p> <p>Outcomes: Develop and maintain healthy boundaries, facilitate cohesion and communication, promote problem-solving by better understanding family dynamics, build empathy and understanding, and reduce conflict within the family.</p> <p>Website to learn more: https://effectivechildtherapy.org/therapies/what-is-family-therapy/</p>	<p>Description: Organizational skills training focuses on training children with attention-deficit/hyperactivity disorder (ADHD) to overcome their difficulties in organizing school materials. This intervention teaches children and adolescents organizational, time management, and planning skills. These are especially helpful for children with ADHD who often struggle with these skills. A lack of organizational skills can have a negative impact on school performance, friendships, and can cause issues at home.</p> <p>Modality: Individual</p> <p>Target population: Ages 5-18</p> <p>Who delivers the program: Clinicians</p> <p>Program cost: Training is tailored to the organization/individual being trained, with costs varying.</p> <p>Implementation considerations: Recommendations are provided during training, as are instruments to measure delivery.</p> <p>Outcomes: Improved organizational skills, improved academic performance, improved behaviors, decreased emotional distress.</p> <p>Website to learn more: https://effectivechildtherapy.org/therapies/organizational-skills-training/</p>

Tier 3		
Alternatives for Families- A Cognitive Behavioral Therapy (AF-CBT)	Integrative Treatment of Complex Trauma for Adolescents (ITCT-A)	Integrative Treatment of Complex Trauma for Children (ITCT-C)
<p>Description: AF-CBT is a trauma-informed treatment designed to improve the relationships between children and caregivers in families involved in arguments, frequent conflict, physical force or discipline, child physical abuse, or child behavior problems. It is appropriate for use with physically coercive/abusive parents and their school-aged children.</p> <p>Modality: Individual, Family</p> <p>Target population: Ages 5-18</p> <p>Who delivers the program: Clinicians in the school.</p> <p>Program cost: The cost for a one-year, learning community in AF-CBT may vary, as it is based on an individualized training program plan and depends upon the total number of trainees, booster session modality (on site vs. video conference), inclusion of reviews of session audio files, and travel requirements. A training manual (session guide that includes topical content and worksheets/handouts) is provided as part of an approved training program in AF-CBT.</p> <p>Implementation considerations: Strategies are provided during training and in relevant materials.</p> <p>Outcomes: Improved caregiver parenting practices and distress/abuse potential, reduced children's behavioral and emotional problems, and improved family functioning.</p> <p>Website to learn more: https://www.nctsn.org/interventions/alternatives-families-cognitive-behavioral-therapy</p>	<p>Description: ITCT-A is a component-based, assessment-driven, multimodal treatment for traumatized adolescents and their families. The ITCT model is based on developmentally appropriate, culturally adapted approaches and involves collaboration with multiple community agencies. ITCT-A addresses challenges specifically associated with complex trauma and includes separate treatment manuals addressing substance use as well as “acting out” or self-injurious behaviors.</p> <p>Modality: Individual, Family</p> <p>Target population: Ages 12-21</p> <p>Who delivers the program: Clinicians in the school.</p> <p>Program cost: Organizations must reach out directly regarding training, which is provided at no cost. Materials are available for download at no cost.</p> <p>Implementation considerations: Strategies are provided during training and in relevant materials.</p> <p>Outcomes: Reduced trauma and depression symptoms.</p> <p>Website to learn more: https://www.nctsn.org/interventions/integrative-treatment-complex-trauma-adolescents</p>	<p>Description: ITCT-C is an assessment-driven, multimodal treatment for children, with interview and/or standardized trauma-specific measures administered at 2-3 month intervals to identify particular symptoms and issues requiring focused clinical attention. ITCT-C is based on developmentally appropriate, culturally adapted approaches that involves collaboration with multiple community agencies. ITCT-C has been particularly adapted for economically disadvantaged and culturally diverse children and families.</p> <p>Modality: Individual, Family</p> <p>Population: Ages 5-12</p> <p>Who delivers the program: Clinicians in the school.</p> <p>Program cost: Training is \$4,000-\$8,000 depending on time-frame, plus associated travel expenses. Follow-up consultations virtually or in person can also be contracted with the trainer for an additional fee. Materials are available for download at no cost.</p> <p>Implementation considerations: Strategies are provided during training and in relevant materials.</p> <p>Outcomes: Reduced trauma and depression symptoms.</p> <p>Website to learn more: https://www.nctsn.org/interventions/integrative-treatment-complex-trauma-children</p>

Managing and Adapting Practice (MAP)	Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)	Trauma and Grief Component Therapy for Adolescents (TGCT-A)
<p>Description: The MAP system is designed to improve the quality, efficiency, and outcomes of children’s mental health services by giving clinicians easy access to the most current scientific information and by providing user-friendly measurement tools and clinical protocols. Using an online database, the system can suggest evidence-based programs to fit a specific child’s characteristics. The program’s primary aim is for professionals to develop proficiency in the selection, organization, and delivery of common practices used in evidence-based treatments.</p> <p>Modality: Individual</p> <p>Target population: Can be utilized for all ages.</p> <p>Who delivers the program: Clinicians in the school.</p> <p>Program cost: Organizations must reach out directly regarding training and associated costs. Courses, resource subscriptions, continuing education can all be accessed online.</p> <p>Implementation considerations: MAP offers consultation to assist organizations in implementing the program.</p> <p>Outcomes: Clinicians are better able to identify and adapt services to meet the needs of clients, build individualized treatment plans, and evaluate client progress.</p> <p>Website to learn more: https://www.practicewise.com/Community/MAP</p>	<p>Description: MATCH-ADTC is a coordinated, component-based approach that uses theory, performance feedback, and clinical reasoning to adapt treatment to address the complex needs and characteristics of children. The MATCH-ADTC intervention emphasizes building childrens’ skills and capacities, with the goal of improving their abilities to manage symptoms and enhance functioning. This intervention addresses not only anxiety, depression, trauma-related issues, or conduct problems, but also related issues or challenges that may emerge during therapy.</p> <p>Modality: Individual</p> <p>Target population: Ages 6-15</p> <p>Who delivers the program: Clinicians in the school.</p> <p>Program cost: Organizations must reach out directly regarding training and associated costs.</p> <p>Implementation considerations: Recommendations are provided during training, as are instruments to measure delivery.</p> <p>Outcomes: Decrease in symptoms of anxiety and depression, increased ability to cope with trauma experiences, and reduced conduct problems.</p> <p>Website to learn more: https://crimesolutions.ojp.gov/programdetails?id=607&ID=607#pd</p>	<p>Description: TGCT-A is a manualized group or individual treatment program for trauma-exposed or traumatically bereaved older children and adolescents. It is a modularized, assessment-driven, flexibly tailored treatment manual and accompanying children workbook that includes detailed instructions for conducting individual or group sessions. Specific treatment modules are selected, prioritized, sequenced, and emphasized based on clients’ specific needs, strengths, circumstances, and informed wishes.</p> <p>Modality: Individual, Group</p> <p>Target Population: Ages 12-20</p> <p>Who delivers the program: Clinicians in the school.</p> <p>Program cost: Training cost varies, as training can be customized according to the specific needs of the participants. The treatment manual is available for purchase.</p> <p>Implementation considerations: Strategies are provided during training and in relevant materials. To ensure successful implementation, support should be obtained from the school principal and vice-principals, teachers who will participate in risk screening and referrals, and caregivers.</p> <p>Outcomes: Improved distress reactions, improved school behavior and academic performance, and increased group cohesion.</p> <p>Website to learn more: https://www.nctsn.org/interventions/trauma-and-grief-component-therapy-adolescents</p>

Interpersonal Psychotherapy (IPT)	Interpersonal Psychotherapy for Adolescents (IPT-A)
<p>Description: Interpersonal Psychotherapy (IPT) is a short-term treatment that is effective in treating depression in children. It is based on the idea that depression occurs in the context of an individual's relationships. The IPT model identifies four general areas in which a person may be having relationship difficulties: grief after the loss of a loved one, conflict in significant relationships, difficulties adapting to changes in relationships or life circumstances, and difficulties stemming from social isolation. In IPT, therapists help the child to identify areas in need of skill-building to improve his or her relationships and decrease their depressive symptoms.</p> <p>Modality: Individual</p> <p>Target population: Can be adapted for all ages, but typically utilized for teenage youth and older.</p> <p>Who delivers the program: Clinicians in the school.</p> <p>Program cost: Training is tailored to the organization/individual being trained, with costs varying.</p> <p>Implementation considerations: Recommendations are provided during training, as are instruments to measure delivery.</p> <p>Outcomes: Increased understanding of link between changes in mood and things happening in relationships, increased ability to communicate feelings and expectations for relationships, and increased problem-solving skills.</p> <p>Website to learn more: https://effectivechildtherapy.org/therapies/what-is-interpersonal-psychotherapy/</p>	<p>Description: IPT has been adapted for the treatment of depressed adolescents (IPT-A) to address developmental issues most common to teenagers, such as separation from parents, development of romantic relationships, and initial experience with death of a relative or friend. IPT-A helps the adolescent identify and develop more adaptive ways of dealing with the interpersonal issues associated with the onset or maintenance of their depression. The therapy primarily involves individual sessions with the teenager, although parents are asked to participate in a few sessions to receive education about depression, to address any relationship difficulties that may be occurring between the adolescent and his/her parents, and to help support the adolescent's treatment.</p> <p>Modality: Individual, Group</p> <p>Target population: Ages 12-18</p> <p>Who delivers the program: Clinicians in the school.</p> <p>Program cost: Training costs vary based on availability. Upon request, experts may be willing to provide informal consultation and supervision, but trainings are not set up as a regular offering.</p> <p>Implementation considerations: Recommendations are provided during training, as are instruments to measure delivery.</p> <p>Outcomes: Improved communication and problem solving skills.</p> <p>Website to learn more: https://effectivechildtherapy.org/therapies/what-is-interpersonal-psychotherapy/</p>



Appendix B: Partial List of Screening and Assessment Resources

The following appendix is a partial list of validated screening tools. While these tools can help schools identify student behavioral health needs, it is again important to note that screening alone is not sufficient. Students and families must also have access to high quality, evidence-based and culturally and linguistically responsive care. Additionally, screening is only one step in the process to identify and respond to the behavioral health needs of youth. Further evaluation is required for youth who screen positive for a particular concern.

Screening Tools		
Center for Epidemiological Studies Depression Scale for Children (CES-DC)	Child and Adolescent Disruptive Behavior Inventory (CADBI)	CRAFFT 2.0: Substance Abuse Screener
<p>Description: CES-DC is a 20-item self-report depression inventory measure to assess for depressive symptoms in children, adolescents, and young adults. The CES-DC was modified from the CES-D, an adult depression inventory.</p> <p>Modality: Individual, Group</p> <p>Target population: 6-18+ years</p> <p>Focus Area: Depression/Mood</p> <p>Reporter: Student</p> <p>Estimated Completion Time: 5-10 minutes</p> <p>Cost: Free</p> <p>Languages: English, Spanish, Other</p> <p>For more information see: https://www.theshapesystem.com/wp-content/uploads/2019/09/CES-DC_FINAL_11.29.17.pdf</p>	<p>Description: CADBI is a 25-item parent and teacher questionnaire designed to assess a range of problem behaviors that often occur in childhood and adolescence.</p> <p>Age Range: 3-18 years</p> <p>Focus Area: Defiant Behavior, Inattention, Hyperactivity</p> <p>Reporter: Caregiver, Educator</p> <p>Estimated Completion Time: 5 minutes</p> <p>Cost: Free</p> <p>Languages: English, Spanish, Other</p> <p>For more information see: https://www.psychtools.info/cadbi/</p>	<p>Description: The CRAFFT 2.0 is a behavioral health screening tool that measures high-risk alcohol and other drug use behaviors for adolescents. The CRAFFT 2.0 enhances sensitivity of the original CRAFFT. CRAFFT is a mnemonic acronym of the first letters of key words in the six screening questions.</p> <p>Age Range: 12-18 years</p> <p>Focus Area: Substance Use</p> <p>Reporter: Student, Clinician</p> <p>Estimated Completion Time: 5 minutes</p> <p>Cost: Free</p> <p>Languages: English, Spanish, Other</p> <p>For more information see: https://dm0gz550769cd.cloudfront.net/shape/b5/b5461fea4c0d6de1856707e259d5bd77.pdf</p>

Generalized Anxiety Disorder 7-item Screening (GAD-7)	Patient Health Questionnaire (PHQ-9)	Pediatric Symptom Checklist (PSC)
<p>Description: The GAD-7 screening tool measures symptoms of anxiety in older adolescents and adults. The Severity Measure for Generalized Anxiety Disorder—Child Age 11-17 complements the GAD-7 in assessing anxiety in youth and adolescents.</p> <p>Modality: Individual, Group</p> <p>Target population: 11-18+ years</p> <p>Focus Area: Anxiety, Trauma</p> <p>Reporter: Student</p> <p>Estimated Completion Time: 5 minutes</p> <p>Cost: Free</p> <p>Languages: English, Spanish, Other</p> <p>For more information see: https://dm0gz550769cd.cloudfront.net/shape/15/15d9e8b78438e72dea21f1418406d787.pdf</p>	<p>Description: PHQ-9 was initially designed to facilitate the recognition and diagnosis of depressive disorders in primary care. The PHQ-9 was modified for adolescents (Severity Measures for Depression – Child Age 11-17) and to better assess for suicide risk and dysthymia in adolescents (PHQ-9-A).</p> <p>Age Range: 11-18+ years</p> <p>Focus Area: Depression/Mood</p> <p>Reporter: Student</p> <p>Estimated Completion Time: 5 minutes</p> <p>Cost: Free</p> <p>Languages: English, Spanish, Other</p> <p>For more information see: https://dm0gz550769cd.cloudfront.net/shape/fe/fe39333188563f2ffa4f2df3b75d1b2c.pdf</p>	<p>Description: PSC is a screening tool intended to identify a wide range of psychosocial concerns. Originally utilized in primary care, the PSC’s application has also been expanded to school and community health and behavioral health settings.</p> <p>Age Range: 3-18 years</p> <p>Focus Area: Anxiety, Depression/Mood, Disruptive Behavior, Global Functioning, Hyperactivity, Inattention</p> <p>Reporter: Student, Caregiver</p> <p>Estimated Completion Time: 5 minutes or less</p> <p>Cost: Free</p> <p>Languages: English, Spanish, Other</p> <p>For more information see: https://dm0gz550769cd.cloudfront.net/shape/dd/dd941b00e7f9aa7249cea4379455702f.pdf</p>
Penn State Worry Questionnaire for Children (PSWQ-C)	Revised Children's Anxiety and Depression Scale (RCADS)	Strengths and Difficulties Questionnaire (SDQ)
<p>Description: PSWQ-C assesses generalized worry in students. High scores on the PSWQ-C are more indicative of generalized anxiety than specific anxiety disorders. The measure was adapted from the Penn State Worry Questionnaire (PSWQ) for adults.</p> <p>Age Range: 7-18 years</p> <p>Focus Area: Anxiety</p> <p>Reporter: Student</p> <p>Estimated Completion Time: 5 minutes</p> <p>Cost: Free</p> <p>Languages: English, Danish, Other</p> <p>For more information see: https://dm0gz550769cd.cloudfront.net/shape/fe/fe74a225ba43d268d1fd7951441b2e04.pdf</p>	<p>Description: RCADS assesses DSM-defined anxiety and depression for students. The RCADS anxiety items were derived from the Spence Children’s Anxiety Scale (SCAS).</p> <p>Age Range: 8-18 years</p> <p>Focus Area: Anxiety, Depression/Mood</p> <p>Reporter: Student, Caregiver</p> <p>Estimated Completion Time: 5-10 minutes</p> <p>Cost: Free</p> <p>Languages: English, Spanish, Other</p> <p>For more information see: https://dm0gz550769cd.cloudfront.net/shape/8b/8b4f653df7862d2ace05df37f7df72d1.pdf</p>	<p>Description: SDQ assesses positive and negative psychological attributes across emotional, behavioral, and social dimensions. All versions are offered with an optional impact supplement, to assess functional impairment, and a follow-up version, to assess change over time.</p> <p>Age Range: 2-18+ years</p> <p>Focus Area: Anxiety, Depression/Mood, Disruptive Behavior, Global Functioning, Hyperactivity, Social Skills</p> <p>Reporter: Student, Caregiver</p> <p>Estimated Completion Time: 5-10 minutes</p> <p>Cost: Free</p> <p>Languages: English, Spanish, Other</p> <p>For more information see: https://dm0gz550769cd.cloudfront.net/shape/26/26ce077a03b33f595f34d319001550e6.pdf</p>



Student Engagement Instrument (SEI)	UCLA Brief COVID-19 for Child/Adolescent PTSD
<p>Description: SEI assesses a student's level of engagement at school and with learning. Specifically, the SEI measures "higher-inference" types of student engagement, including cognitive and affective (psychological) engagement.</p> <p>Age Range: 8-18 years</p> <p>Focus Area: Academic</p> <p>Reporter: Student</p> <p>Estimated Completion Time: 20-30 minutes</p> <p>Cost: Free</p> <p>Languages: English</p> <p>For more information see: https://dm0gz550769cd.cloudfront.net/shape/c9/c98089252f7ae1af38602b56b085dbfe.pdf</p>	<p>Description: The UCLA Brief COVID-19 Screen is used to screen for PTSD risk and address the impact of the coronavirus pandemic on children, adolescents, and their families.</p> <p>Age Range: 6-18 years</p> <p>Focus Area: Trauma</p> <p>Reporter: Student</p> <p>Estimated Completion Time: 5-10 minutes</p> <p>Cost: Free</p> <p>Languages: English, Spanish</p> <p>For more information see: https://istss.org/getattachment/Clinical-Resources/Assessing-Trauma/UCLA-Posttraumatic-Stress-Disorder-Reaction-Index/UCLA-Brief-COVID-19-Screening-Form-English-4-13-20.pdf</p>

Other Screening Tools

Child and Youth Resilience Measure (CYRM)	Child PTSD Symptom Scale (CPSS-5)	Children's Hope Scale
<p>Description: The CYRM is a screening tool designed to capture children's individual, relational, communal, and cultural resources that bolster individuals' resilience.</p> <p>Target population: 5-18+ years</p> <p>Focus Area: Resilience</p> <p>Reporter: Student</p> <p>Estimated Completion Time: 20 minutes</p> <p>Cost: Free</p> <p>Languages: 23 available</p> <p>For more information see: https://dm0gz550769cd.cloudfront.net/shape/7e/7eb30adffb72a80e2c769949686ba51f.pdf</p>	<p>Description: The CPSS-5 was developed to screen and assess the severity of DSM-5 post-traumatic stress disorder (PTSD) in children and adolescents exposed to trauma. There is a self-report (CPSS-SR-5) version, which includes an optional trauma screen to identify frightening or stressful events.</p> <p>Age Range: 8-18 years</p> <p>Focus Area: Trauma</p> <p>Reporter: Student, Clinician</p> <p>Estimated Completion Time: 10-20 minutes</p> <p>Cost: Free</p> <p>Languages: English, Spanish, Other</p> <p>For more information see: https://dm0gz550769cd.cloudfront.net/shape/b4/b4b34cb0683375db5200a127bb9de16d.pdf</p>	<p>Description: The Children's Hope Scale is a measure designed to assess hope within children and youth.</p> <p>Age Range: 8-16 years</p> <p>Focus Area: Life Satisfaction, Quality of Life, Hope</p> <p>Reporter: Student</p> <p>Estimated Completion Time: Less than 5 minutes</p> <p>Cost: Free</p> <p>Languages: English</p> <p>For more information see: https://dm0gz550769cd.cloudfront.net/shape/8d/8de19b2483b12586110cc3fe11205589.pdf</p>
School Academic Optimism Scale (SAOS)	School Climate Measure (SCM)	
<p>Description: The SAOS assesses three characteristics to provide an overall sense of academic optimism: collective efficacy, faculty trust in students and parents, and academic emphasis. School staff rate school performance and teacher performance at the elementary and secondary school levels.</p> <p>Age Range: 8-16 years</p> <p>Focus Area: Academic, School Climate</p> <p>Reporter: Educator</p> <p>Estimated Completion Time: 10-15 minutes</p> <p>Cost: Free</p> <p>Languages: English</p> <p>For more information see: https://dm0gz550769cd.cloudfront.net/shape/d1/d18a82301d36ca04d681d8ba69669252.pdf</p>	<p>Description: The SCM assesses multiple dimensions of organizational school climate based on perceptions of middle and high school students. The SCM was constructed by combining and evaluating five well-regarded school climate measures, to produce a briefer, more refined battery of school climate.</p> <p>Age Range: 12-18 years</p> <p>Focus Area: Academic, School Climate, Social Skills</p> <p>Reporter: Student</p> <p>Estimated Completion Time: 15 minutes</p> <p>Cost: Free</p> <p>Languages: English</p> <p>For more information see: https://dm0gz550769cd.cloudfront.net/shape/b5/b5fe12b57bdc720bd2e16c5524ce0ec8.pdf</p>	
	<p>Additional Resources:</p> <p>SHAPE Screening and Assessment Library https://www.theshapesystem.com/assessmentlibrary/</p> <p>Trauma ScreenTIME https://www.traumascreentime.org/</p> <p>The Behavior Intervention Monitoring Assessment System (BIMAS-2™) is a measure of behavioral functioning and social, emotional skills in children and adolescents ages pre-k to 18 years. It can be useful for universal screening, progress monitoring, outcome assessment, and program evaluation. https://edumetris.com/bimas-2/</p>	

Appendix C: Specific Recommendations for Implementing Multi-Tiered Systems of Support (MTSS)

As part of the statewide school-based behavioral health strategy mentioned in Recommendation 2, Massachusetts would benefit from a statewide initiative to implement Multi-Tiered Systems of Support in every school district across Massachusetts. Specific considerations for implementing MTSS across Massachusetts include:

1. Conduct School and Community Needs and Capacities Assessments in every district in Massachusetts:¹⁸⁸

- a. Prioritize communities identified as having high needs.
- b. Engage community stakeholders, including parents/ caregivers, students, and educators, and identify appropriate data sources to assess community strengths and needs.
- c. When warranted, collect and analyze new sources of data to complete a comprehensive needs and capacities assessment.
- d. Assess common risk and stress factors faced by students and families, and the degree to which universal screening for behavioral health and trauma concerns is being implemented.
- e. Evaluate existing school behavioral health staffing and community services in place and identify any gaps.
 - i. Assess staffing patterns to determine if sufficient behavioral health resources exist in schools to meet student needs.
 - ii. Evaluate whether community-based services and resources are available, and whether those supports are equipped to meet the identified student and family needs. Inventory existing supports and services.
 - iii. Assess workforce capacity and expertise to address identified needs in the community including availability of any evidence-based practices and programs and the degree to which available services are culturally and linguistically competent.
- f. Assess school staff professional development activities; including the frequency, quality, and content of training and development activities.
- g. Assess existing school processes and procedures that are designed to link students and families to community-based behavioral health services when in-school services are insufficient; develop necessary referral and linkage mechanisms and track access to and utilization of available services.

- h. Evaluate whether desired outcomes are being achieved through the existing services and supports, and identify strategies to monitor, track and improve outcomes.

2. Cultivate strong school-community partnerships to fill identified gaps in school services and supports:

- a. Inventory existing behavioral health supports and services in the community.
- b. Engage in Memorandums of Understanding (MOU) with local providers to detail how the partnership will be leveraged to support children.
- c. Ensure children and families have access to effective, evidence-based care.

3. Implement effective screening practices to identify student needs and strengths:¹⁸⁹

- a. Identify potential at risk areas to be assessed in student population.
- b. Use an appropriate and validated screener.
- c. Actively engage students and families when developing screening, planning and implementation strategies, ensuring students and families are well-informed of screening procedures, what will happen if their child has a positive screen, and have the opportunity to consent or opt out. Include consultation with legal advisors to ensure consent is done correctly.
- d. Develop clearly articulated procedures to process and respond to screening results, such as identifying the specific supports or services available to students at each tier, designing and implementing additional assessment processes for students who need Tier 2 and 3 services, or responding to students who display risk of harm to self or others.

¹⁸⁸ Child Health and Development Institute of Connecticut, 2018

¹⁸⁹ NCSMH, 2020a

- e. Make sure screening process and follow-up is culturally and linguistically responsive.
- f. Immediately respond to risk of harm to self or others.
- g. Track and report data.¹⁹⁰
- h. Develop a clearly articulated administration process including: who will be screened, when screening will occur, who will administer the screen, staff training and support needs, and additional resources needed (e.g. providing school staff with scripts to read to students).
- i. Consider potential barriers students, families, school staff and community partners may face, and develop a plan to overcome barriers accordingly.

4. Implement Tier 1 supports across Massachusetts:

- a. Assess and improve school climate.
- b. Assess and improve teacher and staff well-being.
- c. Utilize national evidence-based practice registries and research literature to inform selection of services and supports.
- d. Tailor interventions to the unique strengths and needs of students and families.
- e. Ensure implementation is reinforced by adequate resource capacity, such as staffing, finances, and existing supports within the school.
- f. Set school-wide expectations surrounding positive behavior, implement positive reinforcement systems that promote such behavior, and reduce exclusionary discipline practices.
- g. Prevent and address conflict by implementing classroom and school-wide strategies to foster a sense of community, engage in restorative practices, promote inclusiveness, and encourage problem solving.
- h. Reduce or eliminate exclusionary discipline practices.
- i. Increase behavioral health literacy and social-emotional learning opportunities for students.
- j. Provide school staff with interactive trainings and opportunities for professional development to support implementation.
- k. Prioritize the use of Tier 1 evidence-based practices.
- l. Monitor fidelity of services and supports by assessing how programs are implemented in daily practice.

5. Implement Tier 2 and 3 supports¹⁹¹ across Massachusetts:

- a. Create Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) intervention goals with the student, caregivers, and school staff.
- b. Engage the intervention selection committee to identify, plan and implement appropriate Tier 2 and 3 supports and services.
- c. Prioritize the use of evidence-based Tier 2 and Tier 3 practices, choosing practices that are best suited to the unique needs and experiences of the school community.
- d. Implement a systematic protocol for addressing behavioral health crisis situations and ensure that school staff are trained in crisis prevention and de-escalation strategies.
- e. Utilize data sources and assessment tools to continuously monitor implementation fidelity, individual students' and school-wide progress across tiers, and to inform collaborative decision-making about altering services and supports.
- f. Provide schools and districts with adequate resources and capacity, and support staff training and professional development to implement Tier 2 and 3 evidence-based programs.



¹⁹⁰ Collecting, storing, reporting and using data while also protecting student confidentiality, and ensuring collected data is only used to design and implement more effective services, not for punitive reasons; in compliance with legal and ethical standards.

¹⁹¹ NCSMH, 2020c

Appendix D: Abbreviations Used in this Report

ABA	Applied Behavior Analysis	CoIIN	Collaborative Improvement and Innovation Network
ADHD	Attention-Deficit/Hyperactivity Disorder	CPSS-5	Child PTSD Symptom Scale
AF-CBT	Alternatives for Families: A Cognitive Behavioral Therapy	CRAFFT-II	Substance Abuse Screener
ASCA	American School Counselor Association	CSMHS	Comprehensive School Mental Health Systems
BCHNP	Boston Children’s Hospital Neighborhood Partnerships	CYRM	Child and Youth Resilience Measure
BHS	Behavioral Health Screening	DBT	Dialectical Behavioral Therapy
BIRCh	Behavioral Health Integrated Resources for Children Project	DCF	Department of Children and Families
BPS	Boston Public Schools	DESE	Massachusetts Department of Elementary and Secondary Education
BRYT	Bridge for Resilient Youth in Transition	DMH	Department of Mental Health
CADBI	Child and Adolescent Disruptive Behavior Inventory	DPH	Department of Public Health
CARE	Child Adult Relationship Enhancement	DSM	Diagnostic and Statistical Manual of Mental Disorders
CASEL	Collaborative for Academic, Social, and Emotional Learning	EBP	Evidence-Based Practice
CBHM	Comprehensive Behavioral Health Model	EBPI	Evidence-Based Policy Institute
CBITS	Cognitive Behavioral Intervention for Trauma in Schools	EBT	Evidence-Based Treatment
CBT	Cognitive Behavioral Therapy	exSEL	Excellence through Social Emotional Learning
CCCG	Compassion Care Coping Groups	FERPA	Family Educational Rights and Privacy Act
CCWT	Center for Child Wellbeing and Trauma	FY21	2021 Financial Year
CDC	Center for Disease Control	FY22	2022 Financial Year
CES-DC	Center for Epidemiological Studies Depression Scale for Children	GAD	Generalized Anxiety Disorder
CFTSI	Child and Family Traumatic Stress Intervention	GAD-7	Generalized Anxiety Disorder 7-Item Screening
CHDI	Child Health and Development Institute of Connecticut	ITCT-A	Integrative Treatment of Complex Trauma for Adolescents
		ITCT-C	Integrative Treatment of Complex Trauma for Children
		IEP	Individualized Education Program

IOM	Institute of Medicine	PTSD	Post-Traumatic Stress Disorders
IPT	Interpersonal Psychotherapy	RCADS	Revised Children’s Anxiety and Depression Scale
IPT-A	Interpersonal Psychotherapy for Adolescents	SAMHSA	Substance Abuse and Mental Health Services Administration
ITC	International Trauma Center	SAOS	School Academic Optimism Scale
LMHC	Licensed Mental Health Counselor	SBDI	Connecticut’s School-Based Diversion Initiative
LST	Life Skills Training	SBIRT	Screening, Brief Intervention, and Referral to Treatment
MAMH	Massachusetts Association for Mental Health	SCAS	Spence Children’s Anxiety Scale
MAP	Managing and Adapting Practice	SCM	School Climate Measure
MASMHC	Massachusetts School Mental Health Consortium	SDQ	Strengths and Difficulties Questionnaire
MATCH-ADTC	Modular Approach for Treatment for Children for Anxiety, Depression, Trauma, and Conduct problems	SEI	Student Engagement Instrument
MHAP	Mental Health Advocacy Program	SEL	Social-Emotional Learning
MI	Motivational Interviewing	SHAPE	School Health Assessment and Performance Evaluation
MOU	Memorandums of Understanding	SMART	Specific, Measurable, Achievable, Relevant, and Time-bound
MPS	Metheun Public Schools	SSET	Support for Students Exposed to Trauma
MPY	Massachusetts Partnerships for Youth	STEP	Substance Use, Treatment, Education and Prevention
MTSS	Multi-Tiered Systems of Support	S2S	Supporting Staff to Support Students
NCSMH	National Center for School Mental Health	TAP	Training and Access Project
NCTSN	National Child Traumatic Stress Network	TFC	Trauma-Focused Coping in Schools
NQI CoIIN	National Quality Initiative Collaborative Improvement and Innovation Network	TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
PATHS	Promoting Alternative Thinking	TGCT-A	Trauma and Grief Component Therapy for Adolescents
PBIS	Positive Behavioral Interventions and Supports	UCLA	University of California, Los Angeles
PHQ-9	Patient Health Questionnaire	UDL	Universal Design for Learning
PPE	Personal Protective Equipment		
PSC	Pediatric Symptom Checklist		
PSWQ-C	Penn State Worry Questionnaire for Children		



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