NEW JERSEY COMPREHENSIVE SCHOOL-BASED

Mental Health Resource Guide

February 2022

Updated June 2022

FOREWORD

By New Jersey Acting Commissioner of Education

Angelica Allen-McMillan, EdD

I am thrilled to present the New Jersey Comprehensive School-Based Mental Health Resource Guide (Guide) to help districts address the mental health needs of students, educators, and school staff. In 2020, recognizing the widespread and increasing mental health needs of our school communities, Governor Phil Murphy called upon the New Jersey Department of Education to lead a statewide youth mental health work group to develop resources, including best practices for school and mental health provider collaboration to support student needs. This extensive Guide will provide schools with a roadmap for developing, implementing, and evaluating mental health supports and services in our schools.

The safety and well-being of students are among our top priorities in New Jersey, and we have seen a growing need for holistic mental health supports for students and educators. We know that even before the COVID-19 pandemic, 16.5% of young people between ages 6 to 17 had a mental illness, but only about a half received any kind of treatment. While our students, educators, and families have shown extraordinary resilience throughout these challenging times, the COVID-19 pandemic unquestionably exacerbated the need for increased social, emotional, psychological, and behavioral student supports. We have received anecdotal reports from our

sister agencies and community partners that are in alignment with the CDC's national findings that mental health-related visits to hospital emergency departments increased sharply from mid-March 2020 and continued into October 2020. The CDC reported that mental health-related visits to hospital emergency departments increased 24% among children ages 5 to 11 years and 31% among adolescents ages 12 to 17 years, compared with the same period in 2019. Data from the New Jersey Hospital Association's Center for Health Analytics, Research, and Transformation found that a higher percentage of youth presented with a mental, behavioral, or drug/substance use disorder diagnosis during the pandemic, compared to prior years.

Such realities require our agency to be responsive and to provide tangible supports for districts and educators so they may support their students and staff. This Guide combines the expertise of more than 50 stakeholders, including psychologists, school counselors, teachers, physicians, parents, researchers, and many mental health experts, who collaborated throughout 2020 and 2021 to produce this comprehensive document of rich resources and practical guidance for developing comprehensive school-based mental health systems.

The importance of providing a physically and mentally safe learning environment has never been greater. I applaud the stakeholders who advanced this effort by contributing their time and expertise. I thank the Northeast & Caribbean Mental Health Technology Transfer Center at Rutgers University for their partnership on this effort. I applaud the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration for issuing the grant that made this initiative possible. Most importantly, I commend the tireless efforts of the many educators who demonstrate a relentless commitment to providing their students with the mental health supports needed for them to be successful. When students feel physically and mentally safe, they are more likely to reach their greatest potential in school and beyond.

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This guide was developed with support from the Northeast & Caribbean Mental Health Technology Transfer Center with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA)– Cooperative Agreement 3H79SM081783.

HOW TO USE THIS GUIDE

Composed of a group of more than 50 stakeholders representing a variety of school districts, mental health service providers, clinicians, parents, and state agency partners, the goal of the statewide Mental Health Work Group was to identify key topics and essential components to be included in this Guide. The invaluable input and diverse viewpoints expressed by the members of the Mental Health Work Group resulted in a comprehensive outline of the eleven chapters presented in the pages of this document, as well as a list of "must have" resources to share with educators across New Jersey.

The authors of each chapter, working in tandem with committees of the New Jersey Department of Education (NJDOE) staff and other subject matter experts, used these outlines to produce content that is clear, relevant, and practical for school personnel, as well as to provide a comprehensive overview of the New Jersey Tiered System of Supports for mental health. These pages are intended to inform, guide, provoke additional discussion, and provide connections to more detailed and specific resources for educators and mental health professionals alike. For additional information on members of the statewide Mental Health Work Group, chapter authors, and review committees, please see the "Acknowledgments" section of this Guide.

The NJDOE understands that one challenge that may result from publishing an extensive guide with dozens of resources is implementation capacity, particularly given the extraordinary demands posed by COVID-19 on districts' and educators' bandwidth. With that in mind, this document was designed to be used by several potential audiences:

The COVER-TO-COVER reader: If a reader chooses to read this Guide from cover to cover, they will observe that the Guide flows from one topic to the next, starting with an introduction to the use of a multi-tiered system of supports to address the mental health needs of all students, and concluding with resources and information on how to fund these supports. Along the way, the "deep dive" reader will see that each chapter includes a School Spotlight to provide real examples of how schools in New Jersey apply these concepts. Also, resources are linked throughout the document to guide the reader to additional information and citations.

The SELECTIVE reader: As an alternative to reading the Guide from cover to cover, another approach may be to focus on topical areas of interest that may have been identified as a need within the school or community in which the reader lives

or works. This approach may start with the Table of Contents and Chapter Summaries to identify the topics of interest, and conclude with selective reading of the most relevant chapters. Again, school exemplars and resources will be accessible and provided on the selected topic(s).

The RESOURCE reviewer: In some cases, the reader may already be familiar with some of the topics addressed in this Guide and may be looking to add to their collection of resources, discover new information, or search for helpful graphics to assist stakeholders in enhancing their efforts towards building comprehensive mental health supports in their respective districts. In this case, the resources are contained and organized within each chapter and, in some cases, sample documents are provided to assist schools with the implementation of the concepts presented.

Whatever approach is taken in utilizing this document, the information that follows can assist in the initial planning, development, implementation and/or enhancement of a tiered system of supports to address the mental health needs of all students and educators.

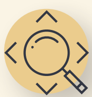
Chapter Key

As you use this Guide you will notice that each chapter has a similar structure. This structure includes key requirements to help you implement comprehensive school-based mental health services and supports. The key requirements have corresponding icons to help you navigate the guide easily. The chapter key requirement icons can be found in the upper right hand corner of each page throughout the guide. A brief description of each chapter key requirement icon is available below:

WHAT YOU NEED TO KNOW provides critical information to support the implementation of a comprehensive mental health framework in schools;

INTEGRATION describes how the chapter topic fits into the multitiered systems of support framework and other New Jersey school mental health initiative;

TEAMING offers practical guidance for school mental health teams to support implementation efforts;



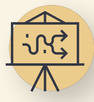
SPOTLIGHT features schools across New Jersey that are implementing aspects of a comprehensive school mental health framework;

COMMUNITY, STUDENT, AND FAMILY ENGAGEMENT outlines strategies and practices for successful partnerships;

CULTURAL CONSIDERATIONS provide recommendations for how to incorporate culturally responsive practices into your school-based mental health framework;

STAFF COMPETENCIES outline what skills and training staff need to effectively support the implementation of your comprehensive school mental health framework;

RESOURCES & LINKS provide additional information and tools to support your further development;



Lastly, the **CHAPTER SUMMARY** includes a set of reflection questions intended to prompt you and your school team to pause and plan actionable steps as you prepare for successful implementation.

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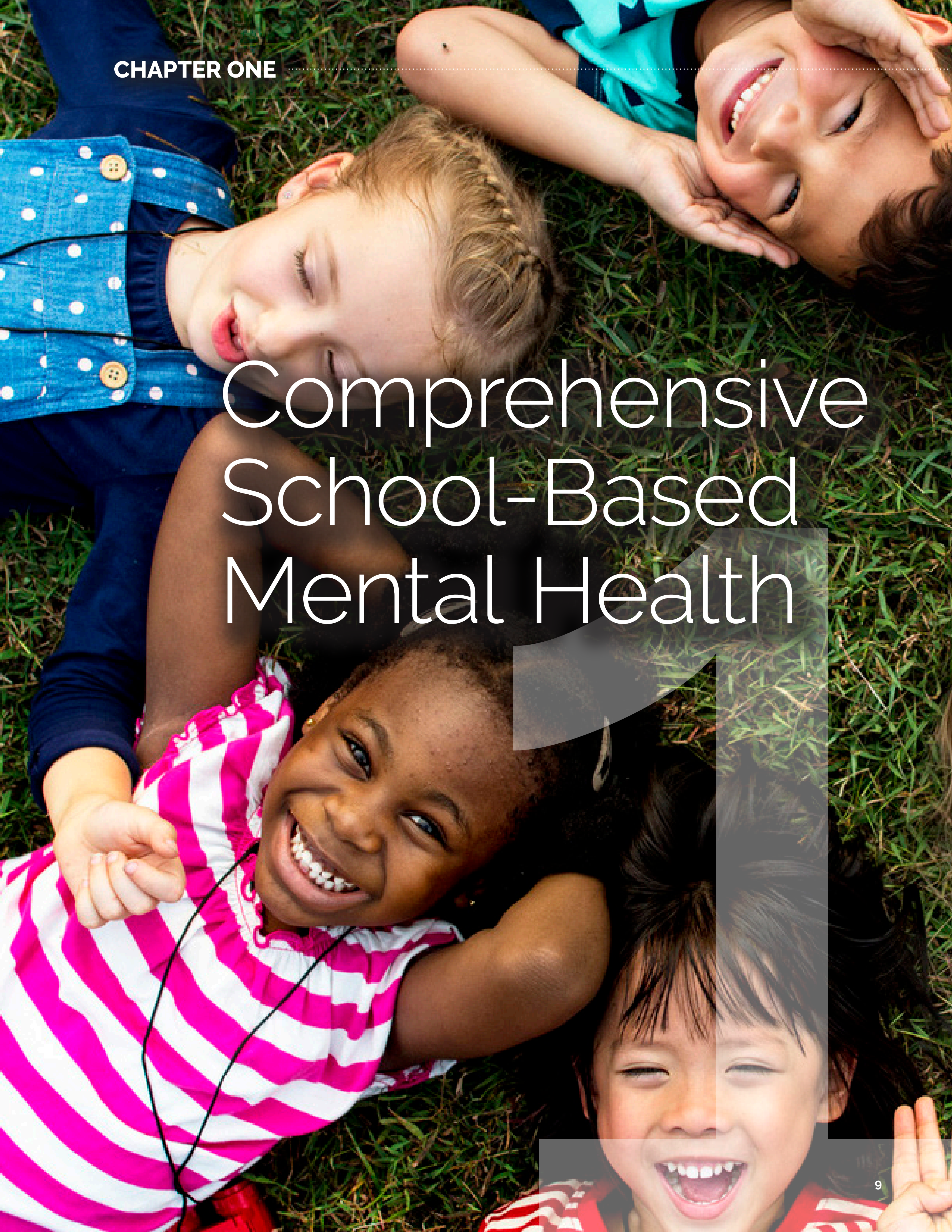


Comprehensive School-Based Mental Health

1

WHAT YOU NEED TO KNOW

The well-being of our children and youth is a top priority for every family, school and community. To successfully achieve this goal, we need to ensure the necessary foundations are in place for our children and youth to grow and thrive. These include: a) access to high quality education, b) good physical health, and c) positive mental health.

Mental health is defined as the overall social, emotional and psychological well-being of children and adults. Despite our best efforts, many students struggle to achieve healthy social, emotional and psychological development. In response, there is a growing movement across our nation to establish and support comprehensive, school-based mental health systems (CSMHS) to deliver much-needed services to students. School-based mental health services are broadly defined as any services, activities and supports that address the social, emotional, psychological and behavioral well-being of students and staff and are delivered through school.

This CSMHS implementation guide was developed to respond to the growing need for school-based mental health services throughout the state. This need has been further exacerbated by the COVID-19 pandemic, to the point where providing schools with a blueprint for implementing a comprehensive, school-based mental health system is a must. The guide was developed to support schools interested in implementing a CSMHS to: 1) develop a multi-tiered system of support (MTSS) framework that allows schools to implement a continuum of evidence-based practices to address the mental health needs of students and staff, 2) facilitate alignment of multiple initiatives using the MTSS framework, and 3) build capacity to promote implementation with high fidelity and sustainability of school-based mental health supports. The guide details the implementation of a multi-tiered system of support framework to address the mental health needs of students and staff. It focuses on practical examples at Tiers 1, 2, and 3 that will enable schools to make available a continuum of evidence-based supports to address those needs. This research-based guide offers 11 chapters, each focused on the fundamental practices needed to effectively serve the mental health needs of our students and staff.

Growing Need for School-Based Mental Health Programs and the Benefits of Promoting Mental Health in Schools

Research consistently points to a growing need for mental health support within schools, not only for our students but for our professional staff as well.[1,2,3,4] Mental health conditions remain a persistent and serious health issue affecting both children and adults in the U.S. According to the National Institute of Mental Health, approximately 20% of adults live with some form of mental illness that can be categorized into one of two broad groups: any mental illness (AMI), or serious mental illness (SMI).[5] AMIs vary in severity but include all recognized mental illnesses, while SMIs are a subset of the most serious and severe illnesses.[5]

Trends in data indicate that from 2008 to 2019, the percentage of young adults who are categorized as having AMI jumped from 18.5% to 29.4%, while the percentage of adults with SMI increased from 3.8% to 8.6%.[6] With the 2020 COVID-19 pandemic, these numbers have continued to rise, with one study suggesting that more than 40% of its 5,000+ respondents reported a mental health challenge during 2020 as a result of the pandemic.[7]

As for children in the U.S., these alarming trends continue, with various reports indicating that 10% to 25% of children are affected by mental illness.[2,8,9] In 2016, 16.5% of children ages 6 to 17 faced a mental health disorder of some sort, but only 50% of them received any kind of treatment.[9] Among the disorders most prevalent in children ages 2 to 17 are ADHD (9.4%), behavior-based mental illnesses (7.4%), anxiety (7.1%), and depression (3.2%).[10] About 5% of adolescents meet the criteria for a substance use disorder each year. Even more concerning, the consequences of not addressing mental health needs can be dire, with suicide listed as the third leading cause of death for adolescents ages 15 to 19.[8] (See page 4

> Research consistently points to **a growing need for mental health support within schools,** not only for our students but for our professional staff as well.

for the latest released statistics by the American Foundation of Suicide Prevention for the state of New Jersey.[11]) Suicide is also listed as the third leading cause of death for individuals ages 10 to 24.[11] Unfortunately, 30.2% of communities in New Jersey did not have sufficient mental health providers to serve their constituents in 2020.[11]

Suicide Data: New Jersey

Suicide is a public health problem and leading cause of death in the United States. Suicide can also be prevented – more investment in suicide prevention, education, and research will prevent the untimely deaths of thousands of Americans each year. Unless otherwise noted, this fact sheet reports 2019 data from the CDC, the most current verified data available at time of publication (January 2021).

14th leading cause of death in New Jersey

3rd leading
cause of death for ages 10-24

2nd leading
cause of death for ages 25-34

4th leading
cause of death for ages 35-44

5th leading
cause of death for ages 45-54

9th leading
cause of death for ages 55-64

20th leading
cause of death for ages 65 & older

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
New Jersey	**762**	**8.03**	**50**
Nationally	47,511	13.93	

See full list of citations at **afsp.org/statistics**.

30.2% of communities did not have enough mental health providers to serve residents in 2020, according to federal guidelines.

Over five times as many people died by suicide in 2019 than in alcohol related motor vehicle accidents.

The total deaths to suicide reflected a total of 14,188 years of potential life lost (YPLL) before age 65.

47.01% of firearm deaths were suicides.

22.70% of all suicides were by firearms.

afsp.org/statistics

Both prevalence of mental health issues and access to care for children in the U.S. fluctuate on a state-by-state basis. In 2020, Mental Health America published data for all 50 states (and the District of Columbia) across a variety of categories as they relate to youth mental health.[12] Vermont, Pennsylvania, and Washington, DC, lead the way with low prevalence and high access to mental health supports.[12] On the opposite end, Nevada (49), New Mexico (50), and Arizona (51) have the highest prevalence and least access to support.[12] Specifically for New Jersey, 11.17% of youth 12 to 17 years of age reported experiencing at least one major depressive episode (MDE) in the past year; 7% reported experiencing severe MDE; and 3.34% reported experiencing substance use disorder. Approximately 58% of youth experiencing MDE did not receive the mental health services they needed and only 30.4% of youth experiencing severe MDE reported receiving some outpatient treatment.[12] The rate of mental health providers (e.g., psychiatrists, psychologists, clinical social workers, counselors, family therapists and nurses specialized in mental health care) in New Jersey was reported to be 500:1, indicating little access to care compared to states such as Massachusetts, where the rate was reported to be 180:1.[12]

Psychological, behavioral, social and emotional health issues are a leading contributor to chronic absenteeism that in turn leads to academic risk and school dropout. Impoverished youth and youth of color have higher reported rates of depression and substance use and are at the highest

risk of not having regular access to health visits and services. Thus, they are at a higher risk for negative outcomes.[13,14,15] Negative consequences extend to adult life, affecting both physical and mental health and preventing individuals from engaging in opportunities leading to a life of quality.

In light of the need for mental health supports, and the grave consequences when these needs are left unattended, additional initiatives to support youth mental health are being adopted in New Jersey.[16] As of February 2020, the Department of Human Services and the National Council of Behavioral Health are working together to provide training for K–12 school employees.[16] Teachers and school personnel are uniquely positioned to identify, refer and provide support for students with mental health needs; thus, such initiatives are critically important.[17] Comprehensive school mental health systems can positively impact students who face mental health issues. Further, schools can reduce stigma and increase access to care by training teachers and parents on mental health literacy and help-seeking.

Given the staggering rates of mental illness beginning in childhood and continuing to increase in adolescents and young adults, the Substance Abuse and Mental Health Services Administration (SAMHSA) calls attention to the need for early intervention.[6] While school counselors, social workers and psychologists are trained to provide school-based mental health support, students nationwide still struggle to gain the assistance they need for a variety of reasons.[3,2] As a result, an estimated 80% of students do not receive the mental health support they need.[1]

Schools can play a critical role, both in identifying students' mental health needs and connecting students with appropriate services and supports. Schools offer a more accessible, less stigmatizing environment compared to traditional community-based settings. Unfortunately, too often schools lack the staff, resources and training to identify and address students' mental health needs, and as a result, shift the responsibility to the families. For example, when a student is identified as having potential mental health struggles, the

school will typically encourage families to seek treatment from professionals within the community.[2] Families referred to an outside practice may encounter certain barriers, such as inability to secure appointments or pay for services. Transportation issues also affect access to support. These barriers limit the family's ability to secure and maintain the services their children need.[2] Additionally, despite the increased awareness and recognition of mental illness, shame, embarrassment, fear of judgment and discrimination continue to fuel families' reluctance to seek help.[18]

Recognizing that barriers for families are abundant, districts increasingly take responsibility for providing the necessary support by creating school-community partnerships. Such comprehensive school mental health systems (CSMHS) focus on promotion and prevention, early identification and intervention, and treatment for students with mental health needs.[1] With trained professionals who spend a significant amount of time with students, schools are well-positioned to identify mental health problems and intervene early. Periodic universal screening for mental health problems could help schools identify students in need of support before their mental health needs become clinically significant. Children and adolescents are more likely to receive much-needed mental health support in their schools than in any other setting. Of the children and youth who obtain mental health care, 70% to 80% receive it in schools.[19,20,21] In spite of this, schools still face many challenges providing mental health services to the majority of children who need them.[22] Moreover, schools do not typically provide a full range of mental health services and the quality of services is often unverified.[23,24,25]

Reasons Why Comprehensive, School-Based Mental Health Systems Are Important

1. Learning is an intrinsically social and interactive process, and social, emotional and behavioral competence is essential for all kinds of learning.

Students are most successful academically when they can manage their behavior and emotions. Positive mental health allows students to think clearly, develop socially, and learn new skills. Having supportive and nurturing relationships with peers and adults helps students develop self-esteem, confidence, and a healthy emotional perspective on life. In addition, many mental health problems are triggered and maintained by educational demands (e.g., math and test anxiety) and the school environment (e.g., bullying, which leads to school avoidance). Thus, it is appropriate to treat the issues in the environments where they occur.

2. Building capacity in schools to address the diverse needs of all students and staff is a must.

It is crucial that mental health professionals working in schools have the necessary skills to effectively integrate evidence-based practices into the school by collaborating with other school professionals, families and community-based providers. According to the Annapolis Coalition on the Behavioral Health Workforce, the U.S. has a lack of trained mental health professionals.[26] Beyond school-based providers, a wide gap exists between the number of mental health providers (approximately 700,000) and the number of individuals needing mental health services (approximately 75 million).[27] Even if the numbers of providers doubled, it would not be sufficient to produce a notable effect for individuals in need. In addition, mental health providers are unequally distributed geographically, with higher numbers in lower need areas.[28]

3. Comprehensive school-based mental health systems provide an array of supports and services designed to promote positive school climate, social and emotional learning, and mental and physical wellness.[29]

It is the collective responsibility of educators, community mental health providers and families to share the common goal of building a wide set of skills that enable students to be productive citizens and live a life of quality. Such a comprehensive effort cannot be initiated and sustained solely by schools. As a result, partnerships need to be established between schools, families, and community agencies to offer a full continuum of effective mental health promotion, early intervention, and treatment services for our children and youth. It is critically important to engage families in meaningful ways. To do that, school professionals need to acknowledge parents' values and priorities and treat them as equal partners by recognizing their role as experts on their children and thus, relying on their input when developing and implementing supports for students. Not only do we need to support students, we also need to encourage families by providing them with a range of strategies they can utilize to help their children. In addition, schools have the unique advantage of engaging students to serve as mentors and advocates for their peers with mental health needs, thus strengthening the students' prosocial network of support, and normalizing mental health.

Define Comprehensive School-Based Mental Health Systems (CSMHS)

Effective comprehensive school-based mental health systems (CSMHS) provide a variety of services and supports that contribute to improved student and school outcomes, including improved academic success, reduced exclusionary discipline practices, reduced special education referrals and placement in restrictive settings, enhanced student engagement and feelings of connectedness to school, and higher graduation rates.[30,31,32,33,34,35] These systems are built on strategic partnerships between school professionals (e.g., administrators, educators, school psychologists, social workers, counselors, and nurses), students and their families, and community mental health partners. These systems assess and address the social and environmental factors that impact student and staff mental health.

A guidance monograph, "Advancing Comprehensive School Mental Health Systems—Guidance From the Field," was released by Hoover and colleagues in 2019.[36] The document emerged through a joint effort of a panel of experts on school mental health who examined national best practices and performance standards, local and state exemplars, and recommendations provided by federal/national, state, local, and private leaders in mental health. The report offers collective

insights and guidance to local communities and states to advance CSMHS. The core features of comprehensive school mental health systems have been described by Hoover and colleagues (2019) in this monograph as follows:[36]

1. A strong foundation of well-trained school and district professionals, including educators equipped with social and emotional skills and mental health literacy, and sufficient specialized instructional support personnel (e.g., school psychologists, school counselors, social workers, nurses, and occupational therapists) who are qualified to support the mental health needs of students in the school setting.

2. A strong foundation of family-school-community partnerships where school professionals, family members and community representatives work in teams and collaborate to promote student mental health. Students, families, schools, community partners, policymakers, funders and providers must work together to address the academic, social, emotional and behavioral needs of all students. The roles and responsibilities of school and community partners will differ based on unique resources and needs, but they need to complement each other. There are advantages to creating school-based teams such as internal staff who are familiar with dynamics of school staff and students and thus can address mutual influences and strategically capitalize on their strengths/weaknesses. Successful and sustainable school mental health systems use a collaborative, team-based approach to implementation, where members commit to problem-solve barriers that will arise in practice, coordinate resources, and integrate systems to respond to student needs. See details on team composition, functioning, and the Team-Initiated Problem Solving (TIPS) process described in Chapter 2.

3. A systematic assessment process that helps identify the school and student needs and map available resources to meet those needs, thus helping schools prioritize goals and develop action plans. Schools must conduct a needs assessment to identify school and student needs and strengths (e.g., school climate surveys, student/staff/family mental health surveys, review of office referrals, and exposure to risk factors), and use the data to determine priorities for planning and implementation. Resource mapping of school and community assets will inform team decisions about available supports and services, coordination of care, and access for students and families. For the greatest impact, needs assessment and resource mapping must be conducted by collaborative teams using a problem-solving approach that is representative of the community, school personnel, families and students.

4. Use of an MTSS framework to ensure that all students can access a full array of tiered, evidence-based practices that promote mental health and reduce the prevalence and severity of mental illness. A dominant framework in the field of school mental health (SMH), multi-tiered systems of support are heavily influenced by public health and prevention science. This framework should be used to organize the practices recommended in this guide. MTSS is the general framework; the reader might be familiar with the New Jersey Tiered System of Supports (NJTSS) terminology which describes the state's adaptation of the MTSS framework. MTSS outlines three tiers of support, representing a continuum of preventive and intervention services designed to address the diverse mental health needs of all students. Tier 1 focuses on activities promoting positive mental health, teaching and strengthening social, emotional, and behavioral skills, and supporting a positive school climate and staff well-being. Tier 2 focuses on early identification and prevention of problems by offering small group interventions, brief individualized interventions, mentoring, and low-intensity classroom support to students identified as at risk. Tier 3 focuses on individualized interventions that address more serious concerns and prevent worsening of symptoms. Many schools deliver instructional (e.g., Response to Intervention, or RtI) and behavioral interventions (e.g., Schoolwide Positive Behavioral Interventions and Supports, or SWPBIS) to students in varying intensities. RtI and SWPBIS are two examples of widely implemented multi-tiered systems of support designed to address the academic and behavioral concerns of all students. The number of tiers in an MTSS can vary, though many districts use a three-tiered model. Integrating multiple initiatives using the same MTSS framework will help schools align their efforts, strategize resources, and identify staff

who can be trained to collaborate and integrate evidence-based interventions across tiers.

5. Use of mental health screening and referrals to identify student needs early and connect students to services and support. Early identification and intervention lead to better outcomes for students. Screening can be conducted using a systematic tool or process with the entire school population or a selected group or grade level. Screening is only recommended when there is a team in place to promptly review the data and make necessary referrals for further assessment, services and support.

6. Use of evidence-based and emerging best practices within an MTSS framework increases the likelihood that students will be provided with quality services and support. Practices should not be directed solely at the students, but should also focus on strategies targeting social and environmental determinants of mental health, school climate, and staff wellness. Schools need to ensure that the practices are culturally relevant, supported by research, and acceptable to school staff. The implementation of these practices by school staff must be deemed feasible, and the staff must be appropriately trained. Ongoing coaching and supervision, organizational and administrative support, and data collection are needed to promote integrity of implementation and sustainability of selected practices.

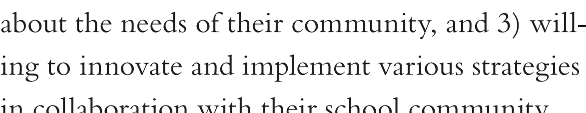
7. Comprehensive school mental health systems rely on data collection and analysis for decision-making to determine the effectiveness of the services and support. Schools need to track student level (e.g., academic, behavioral, psychosocial functioning, grades, attendance, behavioral referrals, engagement and connectedness with school, mental illness, risk behaviors, food and housing security) and school level (e.g., school climate, staff retention and well-being, discipline practices and family engagement) data to monitor student, staff and family needs and progress, assess quality of implementation, and evaluate the effectiveness of support and services provided. Schools need a system to organize and analyze such comprehensive data in order to enable teams to make data-based decisions about needs, progress and priorities.

8. To build and sustain a comprehensive school mental health system requires diverse sources of funding. Schools and districts must continuously seek new funding opportunities from federal/national, state and local sources, so adequate funding can be allocated at each tier. Schools and districts also need to examine what current practices are ineffective or repetitive and should be discontinued, so funds can be redirected towards implementation of effective practices. Evaluating and documenting the impact of practices is necessary for local financial decisions, but also to inform district and state level policies that impact funding and resource allocation.

Schools and their community partners implementing CSMHSs can access district and school assessments and resources at the School Health Assessment and Performance Evaluation System (SHAPE) site (www.theshapesystem.com), a free, private, web-based portal that provides a virtual work space for self-assessment of a CSMHS's level of quality implementation, based upon the National Indicators for School Mental Health.[37] SHAPE allows schools to document and track advances they make in their school mental health systems.

CULTURAL CONSIDERATIONS

Calls for transforming school-based mental health care for children and adolescents highlight the role that cultural responsiveness plays in providing appropriate, effective care.[38] Generating culturally appropriate approaches to mental health services and support for students requires a collaborative effort between school professionals, education and mental health researchers, community providers, and the families they serve. To effectively bridge the gap between an increasingly diverse student population and school professionals who predominantly identify with European-American, middle-class values and norms requires school professionals who are: 1) aware of themselves and others, 2) knowledgeable about the needs of their community, and 3) willing to innovate and implement various strategies in collaboration with their school community.



In the past, cultural responsiveness was associated solely with race and ethnicity. However, recent shifts in understanding have extended this to include gender, age, ability, economic status, immigration status, sexual orientation, gang affiliation, location (such as urban or rural) and community (such as the military).[39, 40, 41] When a school-based mental health system is culturally responsive, professionals implement programs that are applicable to the students they serve. For example, providing students with access to trained professionals who speak their native language

is a must when working with students whose primary language is not English. Black students have historically been the target of racial injustices and social inequalities, causing tension and a mistrust among students and school professionals. Knowing these facts, school professionals need to consider what it is like to be a Black student in a predominantly white school, or recognize the importance of developing interpersonal relationships with ethnic minority families as a means of engagement.[42] In addition to racial minorities, other populations, such as LGBTQ+ students and students with disabilities, also require culturally responsive mental health support. In response to reports of more than 60% of LGBTQ+ students feeling unsafe in school and nearly 85% verbally harassed,[43] culturally responsive interventions to support the mental health of these students should include bullying intervention, safe-haven spaces, and open discussions about sexual orientation.[44] For students with disabilities, open discussions about ability, difference, and acceptance are encouraged.[45]

It is important to remember that children in U.S. schools may be refugees, unaccompanied minors, or asylum seekers with a variety of backgrounds and experiences, including separation from family members, living in war zones, or struggling with PTSD, depression and anxiety. In this case, culturally responsive mental health needs to be centered around providing students and their families with a sense of community, meeting language needs, and helping navigate the legal processes associated with immigration.[46]

Cultural considerations need to be infused throughout all facets of school mental health work, from training school personnel, to assessments and interventions, to public policy initiatives.

While the aforementioned examples are just a few out of several populations that would benefit from culturally relevant, school-based mental health support, the need for a change is evident. The increasingly diverse student population requires professionals who are knowledgeable about the needs of their community and are willing to implement various supportive strategies. Being culturally responsive means creating and adapting support that attends specifically to the cultural values and norms representing the community served. Cultural considerations need to be infused throughout all facets of school mental health work, from training school personnel, to assessments and interventions, to public policy initiatives.

CHAPTER SUMMARY

Good mental health is critical for the success of our children and youth, both in school and post-school. It is critical to understand that mental health is not simply the absence of psycho-pathology, but also encompasses social, emotional, and behavioral well-being, the ability to cope with challenges, and satisfaction with life in general.[47]

> School-based teams must use a **collaborative, data-driven, problem-solving approach** to ensure implementation with high fidelity and sustainability of provided mental health services and supports.

Research demonstrates that students who receive social-emotional and mental health support achieve better academic outcomes. School climate, positive and productive classroom behavior, students' sense of connectedness with school and well-being also improve. Left unmet, mental health problems are linked to costly negative outcomes, including academic and behavior problems, dropping out, and delinquency.

There is a growing need for mental health services for children and youth. Schools are the ideal place to provide these services, due to easy access to care, the presence of trained professionals, and the removal of traditional barriers for families such as stigma and cost. Providing a full continuum of school-based mental health services is critical to effectively respond to the diverse needs of students and is dependent on the collaboration between schools and community mental health providers. An MTSS approach facilitates effective collaboration between all partners to ensure seamless and comprehensive service delivery. Key aspects of a CSMHS approach include: 1) evidence-based universal prevention efforts, 2) training school and community members to identify, refer and respond to early warning signs of mental health difficulties, and 3) provision of more intensive intervention services and support in response to identified student needs.

Comprehensive school mental health systems provide a full array of services at three tiers: 1) universal mental health promotion for all students and staff; 2) selective services for students identified as at risk for developing mental health concerns; and 3) individualized/targeted services for students who already experience an identified mental health concern. Services provided need to be evidence-based to the fullest extent possible and their need and effectiveness determined by regularly collected data. Such systems are possible only within a purposeful, planned, collaborative partnership between schools, families, and community partners. Key school and community partners, along with family members, come together to plan and implement a universal screening process, review needs, and identify supports and services. School-based teams must use a collaborative, data-driven, problem-solving approach to ensure implementation with high fidelity and sustainability of mental health services and supports.

Reflection Questions

What is your current understanding of comprehensive, school-based mental health supports and what are the mental health needs of your students, staff, and the community at large?

What is the impact, or lack thereof, of current mental health initiatives on your students and staff?

What is needed for your school to be the ideal place to deliver comprehensive mental health support for students?

Do you currently have an MTSS framework in place? How can you use it to align initiatives and ensure a continuum of supports for all your students?

If you currently do not have an MTSS framework in place, are you ready to learn more about it?

What strategies and supports do you use to ensure a meaningful partnership between your school, community providers and family stakeholders?

How are your mental health efforts in tune with the cultural values and norms of the students and community you serve?

RESOURCES & LINKS

1. NJ Department of Education—Quick Reference Mental Health Guide
2. SHAPE: The School Health Assessment and Performance Evaluation (SHAPE) system is a public access, web-based platform offering schools, districts, and states a workspace and targeted resources to support school mental health quality improvement.
3. National Center on Safe Supportive Learning Environments
4. Final Report of the New Jersey School Boards Association's Task Force on Mental Health Services in the Public Schools
5. Ocean City, New Jersey School District
   - General website
   - Parent resource guide
6. National Alliance on Mental Illness—website with links and resources related to mental health in New Jersey
7. Burlington County Mental Health Resource Guide
8. Montclair Public Schools—list of mental health resources available
9. A Guide for Incorporating Health and Wellness into School Improvement Plans
10. Toolkit for Mental Health Promotion and Suicide Prevention K–12
11. Supporting Student Mental Health: Resources to Prepare Educators
12. National School Mental Health Best Practices: Implementation Guidance Modules for States, Districts, and Schools
13. Advancing Comprehensive School Mental Health Systems: Guidance from the Field
14. University of Maryland—Policies on Cultural Responsiveness & Equity for School Mental Health
15. Culturally Competent Mental Health Services in Schools: Tips for Teachers—NASP

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CHAPTER TWO

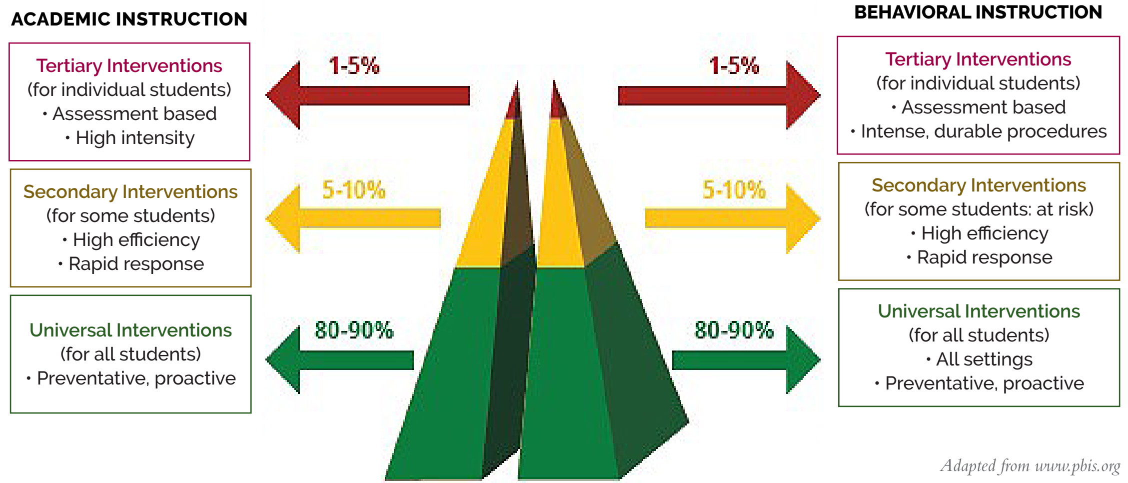
Developing an MTSS Framework

WHAT YOU NEED TO KNOW

Developing a comprehensive, school-based mental health system (CSMHS) requires a thorough understanding of how to organize services and supports to achieve the best outcomes. To address the needs of all students, schools should utilize a prevention- and promotion-based framework that includes data-based decision-making, team problem-solving, and a multi-tiered continuum of evidence-based practices. This multi-tiered system of support (MTSS) is the umbrella term describing an approach that addresses the academic, behavioral, and emotional needs of all students. Therefore, the MTSS framework provides the overall structure for a comprehensive school mental health program.[1]

Problem prevention and wellness promotion are the underlying principles for each of the tiers within the MTSS framework. It is important to match the full range of needs, so interventions are layered: from a universal approach to more specific and targeted interventions. This ensures that all students can access the continuum of services, starting with universal mental health supports. In addition to layered levels of support, MTSS systems should include a universal screener to identify which students have greater needs, matching evidence-based strategies to student need and using data to drive decision-making and monitor progress.[1,2]

Tier 1 (universal, primary prevention and promotion), designed for all students and staff, involves strengthening social, emotional and behavioral skills. Example activities at the Tier 1 level may include addressing school climate and staff well-being, teaching and acknowledging school-wide values, social-emotional learning (SEL) curriculum, and using evidence-based curriculum. It is helpful to have Tier 1 supports in place before implementing Tier 2 and Tier 3 services, to avoid

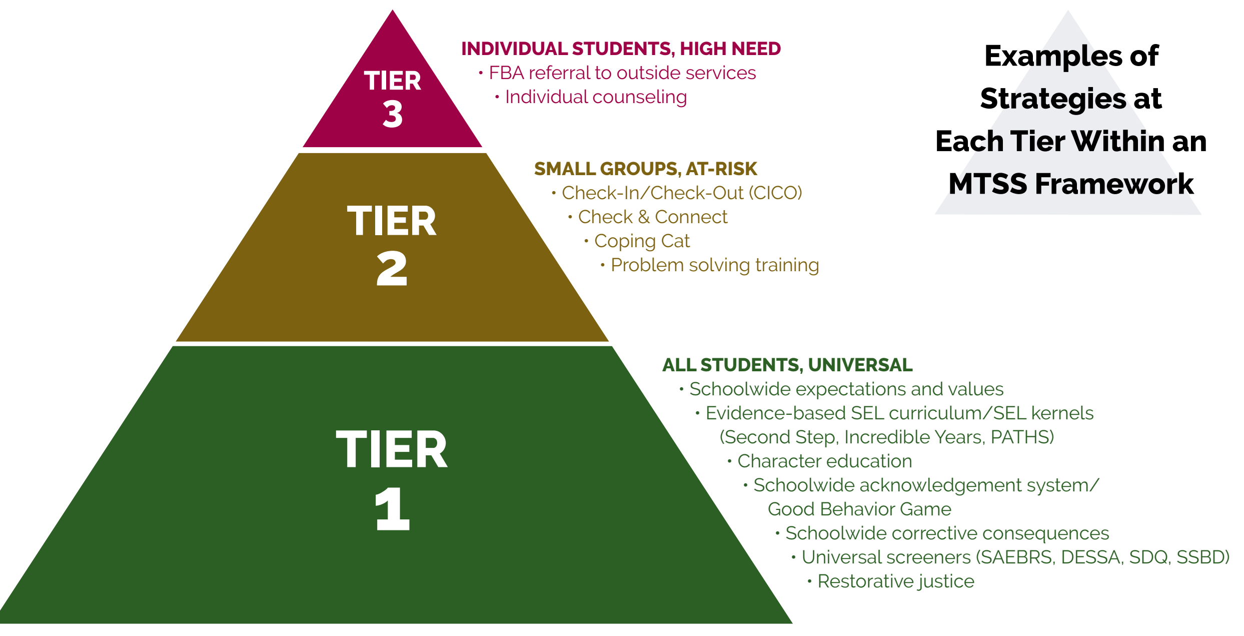


Adapted from www.pbis.org

taxing the system with student needs that may be met by Tier 1 supports.[3]

Tier 2 (selective, secondary prevention) is designed for the 10 to 15% of students who may not respond to the universal supports and are at risk for developing mental health concerns unless smaller-group, targeted interventions (e.g., anxiety and prevention groups) are provided. MTSS teams use data such as needs assessments, universal screeners and referrals to identify which students may be at risk. The team then problem-solves solutions, creating a plan to provide the student with extra support. Some examples include small group interventions, mentoring, classroom-based supports, and brief individualized strategies. Tier 2 supports may be provided by staff, teachers, or qualified community partners and should supplement and align with Tier 1 supports.[3]

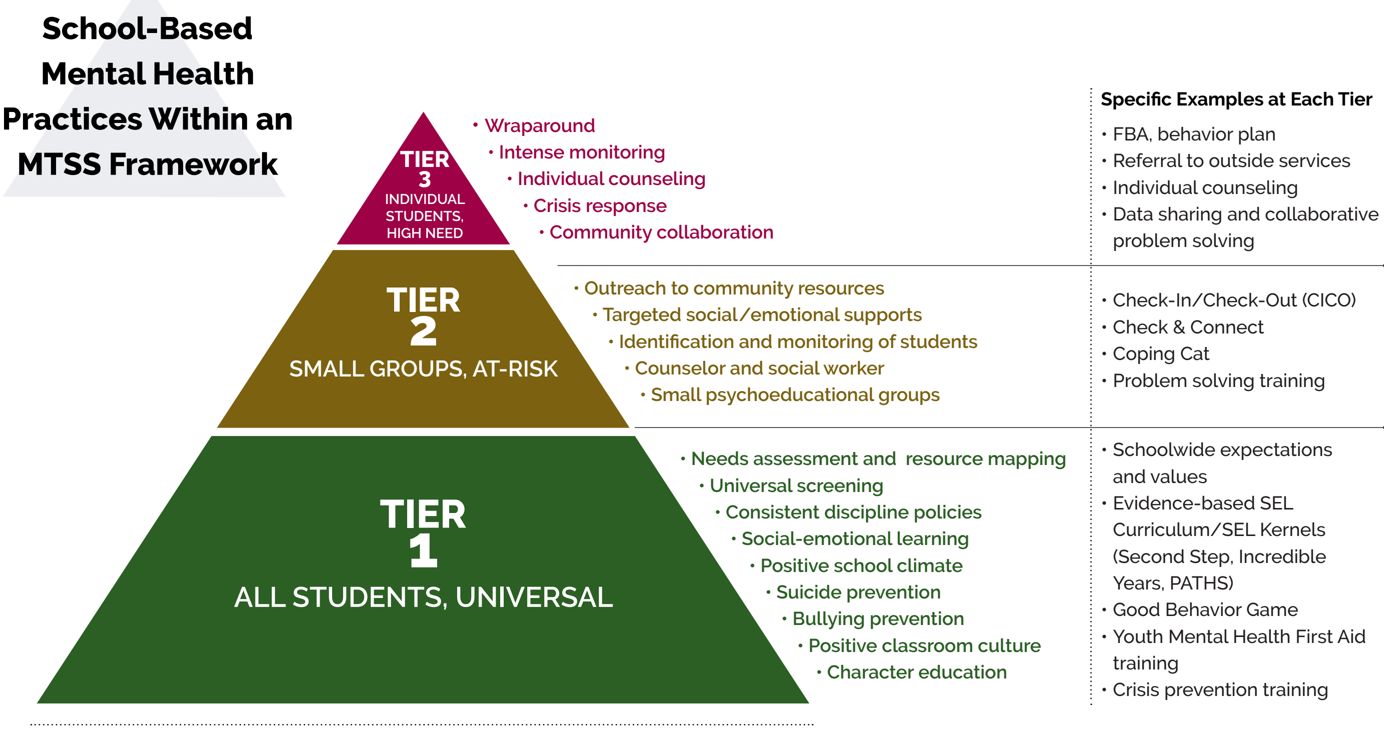
Tier 3 (targeted, tertiary prevention) responds to the individualized needs of the 5 to 10% of students who do not respond to primary and secondary supports and will need more intensive, individualized interventions. These may include individual, group, or family therapy;



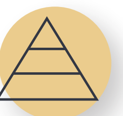
function-based problem solving to create individualized treatment plans; family and caregiver treatment; and collaboration with community service providers. A CSMHS employs this tiered approach while including a focus on school-community collaborations to provide mental health services across the tiers.

In addition to mental health providers, other systems of care are linked in an Interconnected Systems Framework (ISF). Schools may involve law enforcement, the faith community, physical health care providers, local businesses, government agencies and substance treatment providers.[12,3] Key aspects of this approach include a multi-tiered system of support, training educators and other personnel, collaborative teaming, needs assessment, resource mapping, and mental health screening (see Chapter 3), use of evidence-based practices and data-based decision making (Chapter 4 and Chapter 5), and securing funding (Chapter 11).[2]

> **Problem prevention and wellness promotion** are the underlying principles for each of the tiers within the MTSS framework



INTEGRATION



Integrating multiple initiatives that you may have within your school, using the same framework, will help align different efforts, strategize resources, and identify staff who can be trained to collaborate and utilize evidence-based interventions across tiers. Furthermore, services are enhanced by combining the advantages and focuses of each initiative and targeting multiple risk and protective factors under one program.[4] Conducting a needs assessment and resource mapping of services will help determine what supports exist and what are needed (see Chapter 3). Some common initiatives include Schoolwide Positive Behavior Interventions and Support (SWPBIS), Response to Intervention (RtI), New Jersey Tiered System of Supports (NJTSS), Schoolwide Social Emotional Learning (SEL), and Restorative Practices (RP).

If your school uses any of these approaches to address students' academic, behavioral, or social-emotional needs, you do not need to stop using them when developing a framework for a CSMHS. These initiatives have similar components that fit nicely within the overall umbrella of a MTSS framework. Aligning initiatives allows for the efficient use of resources while reducing load and maximizing sustainability of the system. In addition, integration improves collaboration and communication among stakeholders and contributes to enhanced outcomes by combining the most effective components of multiple approaches to target a variety of risk and protective factors. Therefore, schools are able to provide a full continuum of services from prevention and promotion to treatment and maintenance.[2]

Aligning and Interconnecting Our Work

	Social Emotional Learning	Mental Health	Equity	Positive Behavioral Interventions & Supports	Restorative Practices
TIER 3 INTENSIVE	• Individual social skills instruction	• Crisis counseling • Individual support teams/plans • Psychiatric care	• Youth friendly health clinics • Culturally responsive services • Community organizations	• Wraparound • Complex function-based problem solving/individualized behavior • Individual planning	• Family group conferencing • Circles to repair harm
TIER 2 STRATEGIC	• Targeted social skills instruction	• Group counseling/support groups • Staff and family • Coordinated referral process/progress monitoring	• Youth led groups, e.g., Gay Straight Alliance, Hip Hop Dance, American Indian Leaders, Hmong Club	• Brief function-based problem solving/individualized behavior • Check-In/Check-Out • Check & Connect • Social academic instructional groups	• Small group conferencing • Problem-solving circles • Conflict resolution • Restorative chats • IEP circles
TIER 1 UNIVERSAL	• SEL curriculum • School climate assessment	• Mental health screening • Prevention/wellness promotion	• Curriculum inclusion • Diversity/equity/sexuality training • Discussion processes	• Schoolwide behavior expectations • Acknowledge positive behaviors • Data-based planning	• Schoolwide/class values • Daily/weekly circles for students/staff • Data-based planning

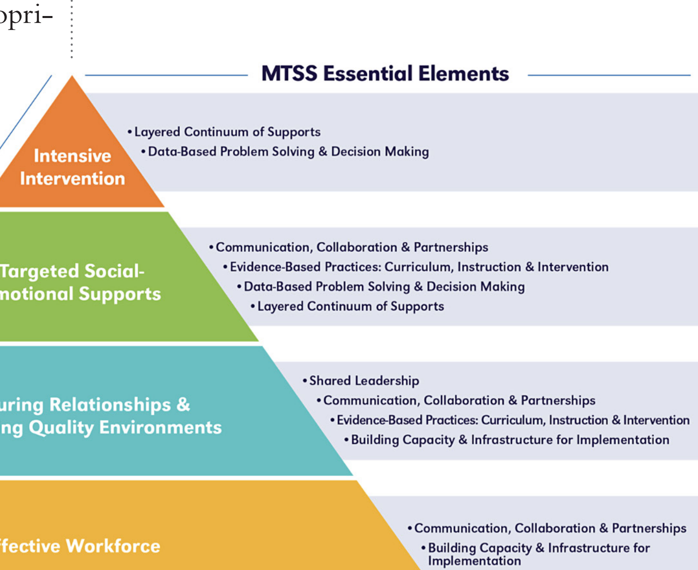
Adapted from Illinois Balanced and Restorative Justice (IBARJ)

Schoolwide Positive Behavior Interventions and Supports (SPBIS)

SPBIS uses the MTSS framework to organize behavioral supports for all students, taking into account the environmental factors that may impact functioning. There is no specific SPBIS curriculum. However, the team will develop specific systems to promote, teach and reinforce appropriate behavior in the form of expectations and rules. Students are explicitly taught what behaviors are expected through modeling, reinforcement of appropriate behaviors, and corrective feedback of misbehaviors. Behavioral data such as office referrals, attendance and grades are reviewed and used in problem-solving for students who need more intensive behavioral instruction and support.[5]

Pyramid Model

The Pyramid Model is a specific application of the SPBIS model to early childhood settings such as child care facilities, early childhood school programs and Head Start, incorporating a focus on healthy social-emotional development for children up to 8 years of age.[6]



https://nemtss.unl.edu/pyramid-model/

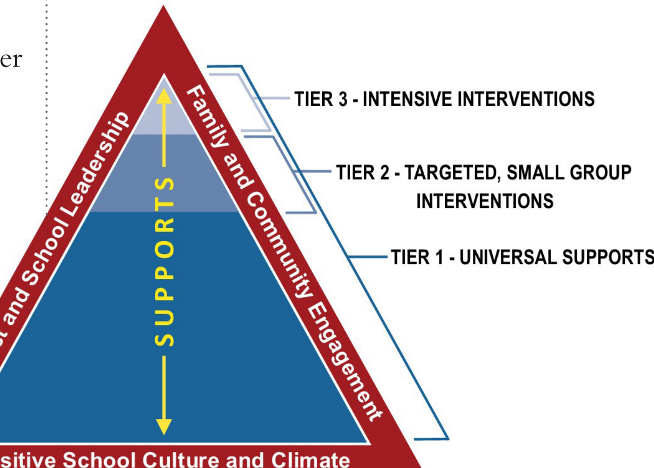
Response to Intervention (RtI)

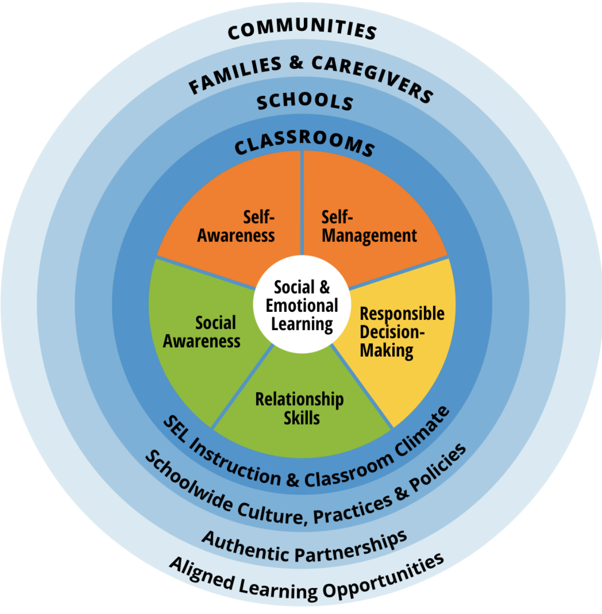
RtI is typically associated with academics, but it applies to any approach providing students with increasing levels of intervention intensity to accelerate learning, based on individual need. All students are provided with high-quality instruction and screened for difficulties. Progress towards skills is monitored through data. Students who do not respond or make progress receive more individualized interventions as needed. Some schools use an RtI approach to identify students who may qualify for special education services as having a "specific learning disability." If students do not make progress with high-quality instruction and evidence-based strategies, a referral may be initiated.

In the case of developing a CSMHS, RtI principles are applied so all students receive a high-quality universal system. For those students who still show signs of need (based on data), more targeted supports are provided. For example, students identified as at risk for mental health needs or those who have behavioral difficulties may also participate in small group counseling or activities targeted to specific needs (e.g., depression, problem-solving, anxiety, and grief). For students who exhibit need of additional support, a more individualized approach may be taken: for example, conducting a functional behavioral assessment (FBA), a systematic procedure used to identify problem behaviors and the circumstances under which those behaviors are likely to occur. Further steps could include creating an individualized behavior plan, referring to community partners, closely monitoring progress, or providing individual counseling. Receiving services at Tier 2 or 3 does not preclude students from receiving services at other levels, and all students should have access to universal programming at all times.

New Jersey Tiered System of Supports (NJTSS)

NJTSS utilizes the MTSS framework and RtI principles to organize a continuum of academic and behavior supports to promote student achievement and build on a foundation of positive school culture and climate, district and school leadership, and family and community engagement. Data-based decision-making is incorporated into the Intervention and Referral Services (I&RS) process to match student needs to appropriate supports.





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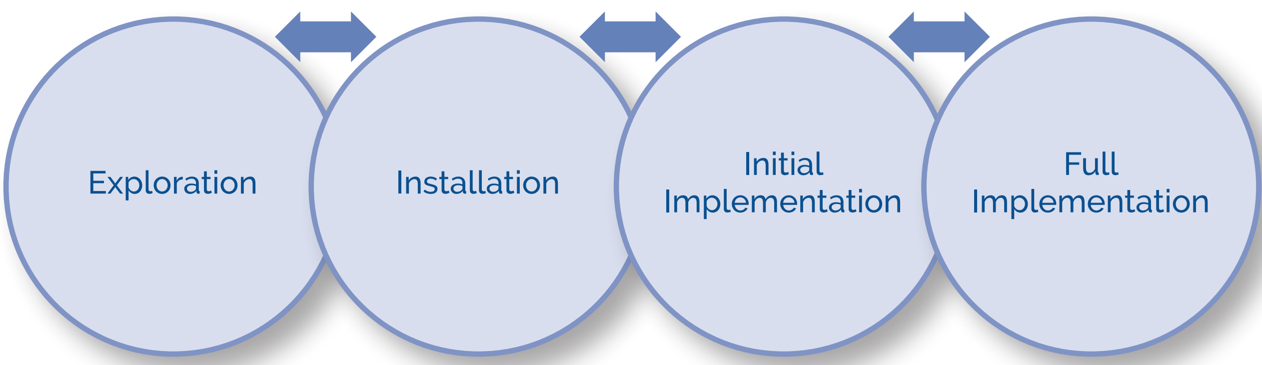
Schoolwide Social-Emotional Learning (SEL)

Schoolwide SEL is not a framework for organizing student supports but rather an enhancement to existing support systems. SEL is a process in which individuals learn and apply skills needed in five competency areas: 1) self-awareness; 2) self-management; 3) responsible decision-making; 4) relationship skills; and 5) social awareness. CASEL's (the Collaborative for Academic, Social, and Emotional Learning) schoolwide SEL framework systematically incorporates instruction of these competencies across all school contexts, involving the use of data for continuous improvement to promote equitable outcomes. In addition, family and community partnerships, adult SEL (for school staff and families), and schoolwide practices and policies (creating safe and supportive environments, instruction of skills, and data-based decision-making) are core components of this framework.

Restorative Justice (RJ)

RJ is a community-based approach to dealing with conflict and misbehavior by building, repairing and restoring relationships and holding individuals accountable by allowing them to reflect on how their actions impact themselves and their community. Restorative Practices (RP) are tools and strategies based on RJ principles that schools can build into their tiered model approach of addressing mental health needs. At the universal level, community and relationship building is the focus, and may include such strategies as establishing a safe and supportive environment and utilizing effective communication skills and community building circles. At Tier 2, harm and healing is addressed with restorative questioning, restorative circles, community service, peer juries or mediation. Depending on the nature of the conflict or behavior, students may spend extended time away from the typical school setting. Therefore, Tier 3 includes strategies to help students reintegrate and repair relationships, including community conferencing, problem solving training and re-entry planning.



Phases of Implementation

Developing and implementing a CSMHS is typically a five-year process occuring across multiple phases. It starts with an exploration and development phase in which teams are created and provided training. Schools conduct needs assessment and resource mapping and begin to plan out the components of the universal system. In the second year, schools begin to implement their universal program and may pilot it with a small group to prepare for a larger rollout. The following years move toward full implementation with the addition of advanced tiers and continuous improvement activities, with the goal of fully embedding the program into the school culture.[2] Perhaps it seems daunting to develop a three- to five-year plan, considering the prevalence of mental health concerns among our youth. However, there are still some evidence-based, cost effective/ low resource interventions that can be implemented to support students, families, and the larger community in the interim. These include: The Good Behavior Game, SEL Kernels, Mystery Motivators, Positive Peer Reporting (Tootling), and connection with community resources. See Intervention Central on the resources page for a link to information on many of these strategies.

YEAR ONE **Exploration and Development**	YEAR TWO **Kick-off and Universal Interventions**	YEAR THREE **Tier 2 System**	YEAR FOUR **Tier 3 System**	YEAR FIVE **Continuous Improvement**
Leadership and team training	Train staff and introduce program to students	Small groups	Individualized supports	Strong embedding into culture
Expectation/values and lesson plans	Kick-off event	Mental health/ SEL interventions	Functional behavioral assessments	Adding additional school goals
Systems of behavioral supports	Implement all universal components	Development of advanced tiers team	Intensive mental health interventions	Continuous improvement cycles
SEL program selection and planning	Baseline-universal screening			
Acknowledgement systems	Team-based problem solving			
Data-based problem solving procedures				
Developing relationships with partners				

TEAMING

A key aspect of the CSMHS is teaming. Establishing both district and school-based teams helps achieve the goal of providing a continuum of services. This process may start with a district team to help manage school implementation by providing the vision, structure and assistance in planning for logistics and technical support. The district team may take on the following tasks:

- **Planning meetings**
- **Team development**
- **Securing funding; resource mapping**
- **Getting buy-in and setting district priorities**
- **Community partner identification and partnership development**
- **Initial evaluation and goal-setting**
- **Creating a district road map**
- **Anticipating and addressing barriers**
- **District-level problem-solving**

The school team will collaborate to plan, implement, and evaluate evidence-based practices and make decisions regarding mental health initiatives using quality assessment and improvement activities. This interdisciplinary team will promote strong relationships among educators, students, and service providers and requires insight and feedback from students, families, school staff, and community service providers. Schools should look for existing opportunities to merge teams with similar goals. For example, schools that have school climate, safety, student support, mental health, or NJTSS teams may consider combining these efforts into a Tier 1 team to address universal programming and a Tier 2/3 team to address more targeted programming.

When recruiting team members, it is ideal to have representation from all stakeholders, as well as those playing various roles in the school, so the

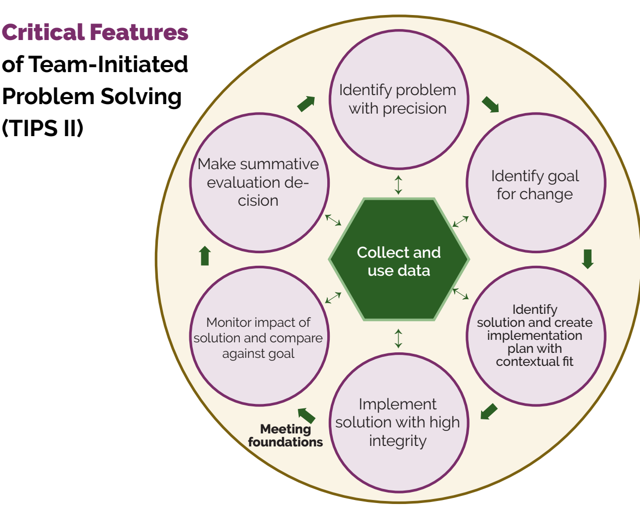
team accurately reflects the school community. The team should include strong administrative support as well as school personnel who have an understanding of social-emotional health programming (typically, a school counselor, social worker or school psychologist, special educator and nurse). It will also include teachers and assistants, student and family representatives, and community partners to collaborate in providing services (usually at the Tier 2/3 levels).

The school mental health teams will conduct resource mapping and a needs assessment to determine how best to address needs of the school community and to ensure the program aligns with the school's culture. Based on these results, the teams will select the programming at the universal level that fits their needs, which could include an SEL curriculum, schoolwide expectations and acknowledgements and/or consistent discipline. Further, schools may select a universal screener, or survey students' social-emotional functioning, in order to determine which students may need additional support beyond the universal level.

> **Working collaboratively** with family, student, and community partners in the problem-solving process is essential to best address student needs and ensure contextual fit of programming.

A main feature of school mental health teams will be data-based problem-solving. Schools may choose to examine a number of indicators of social, emotional, and behavioral health, including behavioral referrals, attendance, grades, progress monitoring and screening/survey results. The team will then create solutions and develop strategies based on the data collected. Working collaboratively with family, student, and community partners in the problem-solving process is essential to best address student needs and ensure contextual fit of programming.

Critical Features of Team-Initiated Problem Solving (TIPS II)



Preston, Cusumano, & Todd, 2015

Teams function most effectively when following these best practices:

- **Securing buy-in from staff and administration**
- **Defining roles and responsibilities**
- **Working collaboratively**
- **Establishing a team purpose and procedures**
- **Systematic problem-solving using data**
- **Professional development**
- **Evaluating team progress and effectiveness**

One model for effective teaming using data-based decisions is Team Initiated Problem Solving (TIPS II). The TIPS II model starts with establishing foundational elements of effective and efficient meetings, such as using meeting minutes to guide notes, consistent procedures, clearly defined roles and responsibilities, and guiding the team through the problem-solving process using a structured agenda form. See figure for the TIPS II process.[10a]

COMMUNITY, STUDENT, AND FAMILY ENGAGEMENT

In collaborating with key stakeholders, it is necessary to strategically plan how to engage community, student, and family members in this process. Strengthening connections and expanding the support network for students can help improve outcomes. Caregivers should be treated as collaborative partners and experts in their family culture. Families can provide valuable insights into their children and can continue working on strategies at home as an extension of what the children are learning in school. Family members should be part of the collaborative team and should be asked to provide input and share their expertise.

Partnering with youth can improve the relevance and effectiveness of programming. Students can provide their perspective on mental health issues, needs, supports and services. In addition, partnering reduces stigma around mental health issues and improves access to care. Schools may include a student representative on their team. For example, schools with a student council may choose to have the student council leader attend portions of the meetings to provide updates on student activities, needs, and desires, as well as feedback on current initiatives. Another approach may be to select a representative who is, or was, a disconnected or disaffected student. These students, often overlooked, may provide valuable perspective on factors leading to the need for Tier 2 and Tier 3 interventions.

Community partners can help augment services within the school setting while also linking students to outside services and supports. These partners can also support and advocate for schools with other key policymakers. It is important to establish the roles and responsibilities of partners up front, based upon the unique resources and services that can be provided.

To engage stakeholders, schools work as equal collaborative partners and value the perspective

each group brings to the team. Stakeholder groups may be surveyed about school climate, recommendations for programs and services, and preferences. These data can be reviewed by the team and should be taken into consideration when problem-solving and planning. Schools can create a communication plan that includes what information is to be communicated, how often, to which stakeholder groups, and who is responsible for sharing the information. This ensures that a system is in place to regularly update relevant parties. Further, stakeholders should be invited to key events as members of the school community.[2,3]

One useful tool to help schools strengthen family collaborations is the NJTSS Parent and Family Engagement Assessment Tool. This tool assesses which indicators of family engagement are in place and which features are absent. The team completes the assessment together, decides which items should be a priority, and develops an action plan. A link to this tool is listed in the resources section.

Consider the following tips to improve family and student engagement:

- **Schedule meetings** involving families and students at convenient times.
- **When inviting families to meetings,** consider transportation, child care, and other basic needs. Schools may choose to reimburse families or provide transportation, child care and food for attendees, if allowable. Offer virtual options to optimize flexibility.
- **Initiate contact** and invite students and families to share ideas, concerns, perspectives and feedback.
- **Utilize surveys** to determine which mental health topics are selected for parent workshops.
- **Ensure topics and materials** are easy to understand and provide adequate translation services if necessary.
- **Foster a respectful,** open and nonjudgmental environment.
- **Establish multiple pathways for communication** (emails, phone calls, websites, meetings, online programs, home school notes, daily report cards, etc.).

CULTURAL CONSIDERATIONS

In order to be truly comprehensive, inclusive, and sensitive to needs, the CSMHS must include culturally responsive practices. All school members should have equitable access to supports at the universal level and careful consideration should be given on how to meet the needs of the school's unique populations, including students with disabilities, students and staff of color, non-native speakers, asylum seekers, and the

LGBTQ+ population. School mental health teams should ensure that the supports and resources they intend to provide meet the needs of the school community. Unfortunately, many students and families needing support do not have access to high-quality services, due to language barriers, high costs, and a mismatch of cultural perceptions of mental health services. Thus, it is imperative for schools to foster a positive, culturally responsive and equitable environment and ensure equal access to mental health supports for all students. Many organizations provide information and recommendations that may be helpful to school teams, including Learning for Justice, the National Association of School Psychology (NASP), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Links to these organizations are provided in the resources section of this chapter.

Schools should encourage open and safe communication within school communities, allowing for stakeholders of all backgrounds to share their experiences regarding cultural differences. Additionally, schools can offer professional development opportunities to build cultural self-awareness and literacy by examining their own views and biases, learning about other cultures and consulting with professionals.

Cultural background is an important part of students' lives. Therefore, the curriculum and services provided to students should be responsive to background, values, and level of acculturation. Interventions and supports may need to be adapted to account for values, needs, choices, and perspectives. Providing materials and services in the native language and building connections by understanding diverse cultural values can help students and families become more comfortable and willing to accept services.

Teams may also consider culture when conducting assessments. When screening students and progress monitoring, developing and using local norms may help to more accurately identify students who are at risk and measure treatment effectiveness. Further, when conducting needs assessment and resource mapping, be sure to consider areas of strength in the surrounding community to determine potential partners and service providers.[11,12]

STAFF COMPETENCIES

To ensure that teams have the necessary skills to implement a comprehensive mental health framework, districts can recruit team members with knowledge in the following core competency skill areas:

1. **key policies and laws;**
2. **interprofessional and cross-systems collaboration;**
3. **provision of evidence-based academic, social-emotional and behavioral strategies;**
4. **data-based decision making;**
5. **personal and professional growth and well-being; and**
6. **cultural responsiveness.**

If team members lack these competencies, schools may consider providing training and coaching. At a minimum, team members should be invested and dedicated to implementing this framework. Further, the team's success depends on strong administrative backing and support. Team members providing services and interventions should be trained in manualized protocols and implementation procedures, and given suggestions on how to adapt the strategies to their school culture.

Professional development is not enough to sustain and support implementation efforts. It is essential to combine professional development with coaching to provide the necessary guidance.[2]

CHAPTER SUMMARY

MTSS provides the overall structure for the CSMHS, which includes the following core features: prevention-based framework, data-based decision-making, team problem-solving, multi-tiered continuum of evidence-based practices, and collaboration with families, students, and community partners. Existing initiatives target-

ing improvement of student well-being, such as NJTSS, the Pyramid Model, schoolwide PBIS or SEL, and RtI, may already be in place. These may be integrated within the MTSS system to enhance outcomes, communication, collaboration, and efficiency. Development of a CSMHS can be a multi-year, multi-phase process that typically begins with exploration, moving to full implementation.

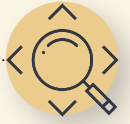
The CSMHS teams will play an integral role in development and execution of programming, working collaboratively with families, students, community partners, service providers and school staff to plan, implement and evaluate evidence-based practices using data. One model for effective teaming, TIPS II, includes meeting foundations and guided problem-solving.

Planning for collaboration with key stakeholders is imperative to obtain buy-in, strengthen engagement, and build connections. As team members, stakeholder groups can provide perspectives and feedback on development and implementation. Schools should foster a positive, culturally responsive and equitable environment and ensure access to support for all students.

Careful consideration should be given to selecting team members with knowledge of specific competency areas: key policies and laws, interprofessional and cross-system collaboration, evidence-based practices, data-based decision making, personal and professional well-being and cultural responsiveness. However, schools may provide training to staff who are invested in this process but have not had the opportunity to develop these competencies. Continuous coaching can be provided to build sustainability and capacity of the school community.

Schools should foster a positive, culturally responsive, and equitable environment and ensure access to supports for all students.

SPOTLIGHT



SPARTA TOWNSHIP PUBLIC SCHOOLS

School-Based Mental Health and Wellness Program

The school-based mental health and wellness program at Sparta Township Public Schools is committed to supporting the mental health and well-being of students and staff by providing an array of therapeutic and wellness services based on the principles of efficacy, education and empowerment. Using a tiered model, our school-based mental health and wellness program includes the following core features: counseling/psychological services/crisis intervention, parent/family/community services and outreach, after-school programming, psychoeducation/graduate clinical learning site, student/staff wellness activities, and mental/behavioral health screening and services.

Program Service Design Elements

- K-12 tiered, evidence-based, inclusive mental health and wellness practices, from schoolwide social-emotional education to secondary and tertiary interventions.
- K-12 mental and behavioral health screenings
- In-school student individual/group counseling
- Intensive after-school therapeutic counseling services (SMS/SHS)
- K-5 classroom behavioral support consultations
- K-12 family consultative support services
- Student and staff wellness activities (i.e., yoga, meditation, mindfulness)
- K-12 staff health and wellness program
- K-12 crisis intervention and emergency response
- K-12 psychoeducation: SEL curriculum, monthly mental health wellness information updates, Mental Health First Aid training, community/staff webinars, newsletters
- Pet therapy
- Alternative to suspension program (SMS/SHS)
- Community service outreach
- Externship learning site for graduate students (school psychology, clinical psychology, and clinical social work)
- Facilitation of referrals to community mental health services as appropriate

The director of student support services and K-8 school guidance counselors comprise the student support district team. The team develops multiple criteria for identifying at-risk students and determines appropriate services through implementation of a multi-tiered system of support. This approach provides a data-driven foundation for the assessment and implementation of supportive services.

Successes

- This year, we have seen a decline in referrals to the intervention and referral services team regarding student behavior in comparison to last year. This decline is based on our efforts to enhance the preventive supports provided to students.
- Our model also provides support to students as an alternative to suspension.
- We were able to stop outsourcing support for students with the most intensive needs by enhancing our district capacity to support these students through additional personnel FTEs and training opportunities.

Lessons Learned

All means all, so the recommendation is that districts work across departments in supporting the needs of students. Our model was developed as a cross-departmental effort between student services and special services. This has helped with implementation support and what we hope will be sustainability.

Reflection Questions

What initiatives and teams do you already have in place? How can they be integrated and aligned using a MTSS framework?

What needs to happen to allow your school to commit to a three- to five-year development and implementation effort?

What opportunities do you have to focus on specific enhancements related to one or more tiers to meet immediate/emerging needs while developing a longer-term implementation plan for a full MTSS?

How will you ensure that your initiative is team-driven and represents all key stakeholders?

How will administration ensure that the team has the resources, professional development, coaching, time and compensation to be successful?

What strategies and supports will you use to fully engage community, student and family stakeholders in the process of development and implementation?

How will you incorporate culturally responsive practices and ensure all students have access to high-quality mental health supports?

How will administration ensure that team members have the competencies needed to implement a comprehensive mental health framework and provide the necessary support where needed?

RESOURCES & LINKS

1. Center on Positive Behavioral Interventions & Supports
2. The Collaborative for Academic, Social, and Emotional Learning (CASEL)
3. MHTTC National School Mental Health Best Practices: Implementation Guidance Modules for States, Districts, and Schools
4. NJ Department of Education—Quick Reference Mental Health Guide
5. SHAPE: The School Health Assessment and Performance Evaluation (SHAPE) system is a public-access, web-based platform that offers schools, districts, and states a workspace and targeted resources to support school mental health quality improvement
6. PBIS Forum in Brief: Team-Initiated Problem-Solving TIPS
7. Getting Started with the New Jersey Tiered System of Supports (NJTSS)
8. National School Mental Health Best Practices: Implementation Guidance Modules for States, Districts, and Schools, Module Curriculum Supplementary Guide
9. Learning for Justice
10. Improving Cultural Competence: Treatment Improvement Protocol (TIP) Series, No 59 from SAMSHA
11. National Association of School Psychologists, Diversity and Cultural Competence
12. Intervention Central
13. NJTSS Parent and Family Engagement Assessment Tool

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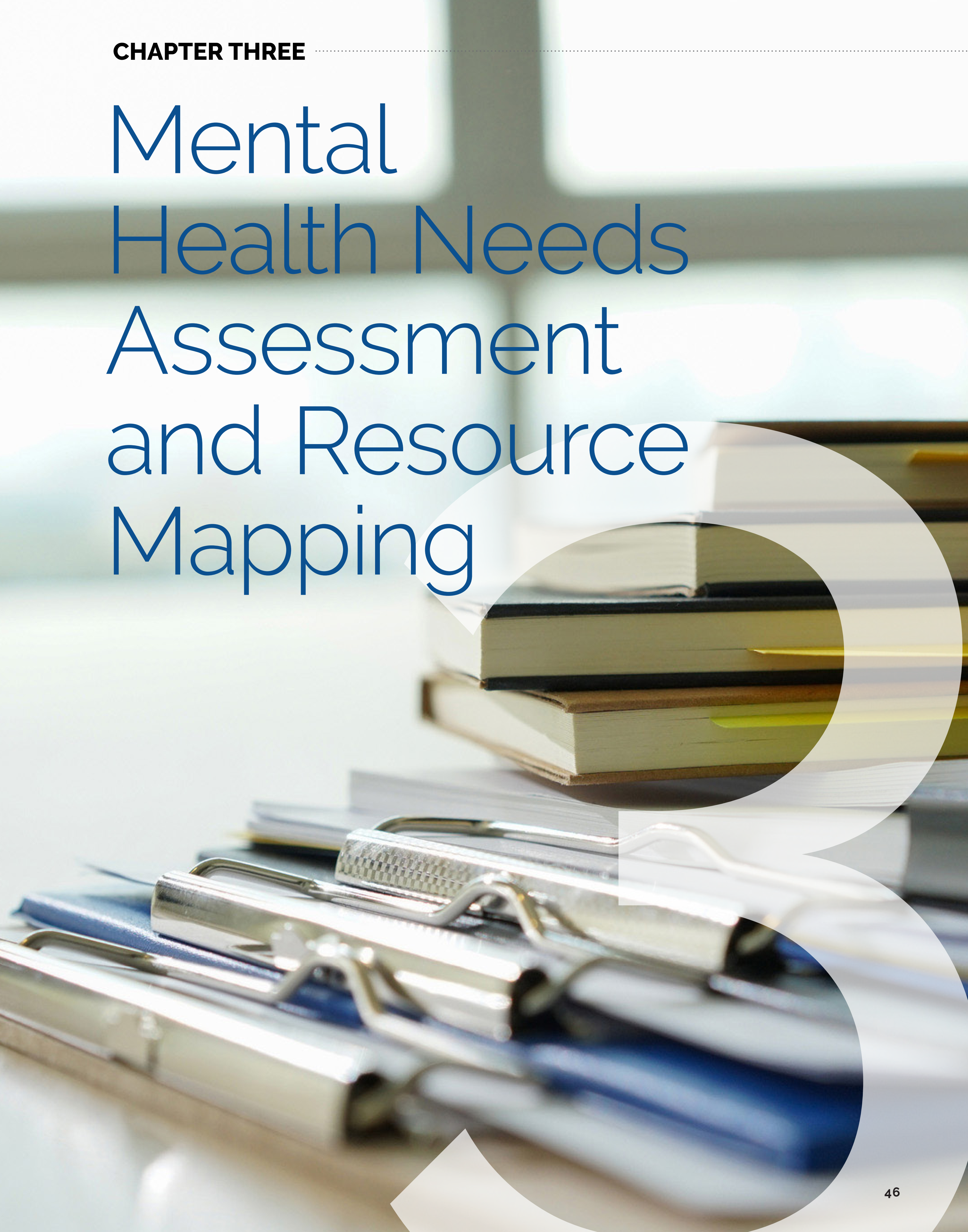


CHAPTER THREE

Mental Health Needs Assessment and Resource Mapping

WHAT YOU NEED TO KNOW

The previous two chapters covered a broad overview of comprehensive, school-based mental health systems (CSMHS) and the tiered framework (multi-tiered system of support, or MTSS) for implementation of comprehensive mental health supports in schools. This chapter will now turn to the first steps in the process of implementing a CSMHS: assessments. They cover two broad domains: 1) assessing the current status and needs (needs assessment), and 2) assessing the resources and capacity of the school to meet the needs (resource mapping).

As seen in the diagram at right, both tasks can be done at the same time and can inform each other (i.e., if a need is identified, resources can be assessed to see if the need can be appropriately addressed, or if existing resources can be reallocated to meet the need). Once these tasks are completed, the final step is to reorganize resources into an action plan to best meet the needs of students.

NEEDS ASSESSMENT

Needs assessments are a natural place to start. Knowing what the key needs are can guide the process of determining goals and deciding what resources will help the district or school achieve their goals. As such, the needs assessments are often seen as part of the "pre-mapping" process for resource mapping that the school mental health team will address.

Collaborative Needs Determination

The process of determining needs should involve collaboration of the school team and other school professionals (educators, specialists, etc.), as well as students, families/caregivers, and other relevant community stakeholders. This will ensure that "needs" are broadly defined from multiple perspectives and not just from one group, which is particularly important in light of increasing diversity and sensitivity to cultural differences. Additionally, comprehensive school mental health includes not just a focus on the needs of students, but also extends to adult mental health, including school professionals and families/caregivers.

Creating A Representative School Team

One of the best ways to accomplish a collaborative needs assessment is to strategically create a school team that will include diverse perspectives and expertise. These teams are an essential component of successful implementation of comprehensive school mental health programs. A team approach brings together people with different competencies and expertise, ensuring a broader skill set that will be essential for successful implementation of a CSMHS. (See table below for specific competencies needed.)

Perspectives/People to Include

District/school professionals
- Administrators
- General education teachers
- Special education teachers
- School psychologists
- Counselors
- Social workers
- Student assistance counselors (SACs)
- School nurses
- Occupational/physical therapists

Students
- Include student representation whenever possible (more difficulty with very young children)
- Ethnic and cultural diversity
- Students with disabilities, English language learners and other student subgroups should be represented

Family
- Not just parents, but extended family members or other caregivers
- Home-school association representatives
- Family advocacy groups

Community stakeholders
- Local businesses, volunteer organizations, etc.
- Religious groups
- Community advocacy groups

Note- this list is not exhaustive. If your school/community has additional members with a stake in the initiatives, they should be included.

Expertise and Competencies Needed

- **Facilitation**—individuals capable of organizing and running meetings, motivating team and maintaining focus
- **Data analysis**—individual(s) capable of collecting, analyzing and summarizing data in a usable format
- **Research**—determine if tools and programs have appropriate levels of evidential support
- **Meeting logistics and management**—includes tasks such as timekeeping, recording meeting minutes

Data Review and Collection Planning

Needs assessment can include a wide range of activities, depending on the local school context. It requires looking at existing and new data, along with other information.

- **Existing Data:** Gather and summarize existing data (e.g., discipline data, office referrals, survey data, grades, attendance).
- **New Data:** Conduct assessments to determine if there are needs beyond the existing data (e.g., administer an appropriate universal stress/anxiety assessment to all students).

Many factors can be assessed to determine school mental health needs. These areas include:

1. Assessing risk factors: exposure to stressful or adverse childhood events (e.g., violence in or out of school, substance abuse, neglect or abuse).

2. Assessing protective or resilience factors: factors that will offer protection from stress (e.g., the presence of positive adult relationships, access to services).

3. Assessing general needs. Ask if students have:

a. Basic needs met (food, shelter, safety)

b. Physical needs met (diet, exercise, sleep, access to health care)

c. Psychological/mental health needs met (access to school and community outpatient mental health services)

d. Social-relational needs met (family, friendships, school and community inclusion and belonging)

e. Academic needs met (basic reading and math, school success)

f. Activities of living needs met (participation in recreation, hobbies, arts, religious, intellectual and creative activities)

Depending on the goals of the school team, the focus of the assessment could be on all of the above or only on specific areas. This list is not comprehensive, so additional areas of need may be considered. The most important part of this step is to be clear about what needs will be the focus of the data collection and assessment process.

Scope of Needs

To further fine-tune the needs assessment process, determine if the assessment will focus on school, home, community, or a combination of all three. Since an integrated MTSS framework is recommended for comprehensive school mental health, school teams are advised to list needs across the three tiers, to determine what all students need (Tier 1), what some need in addition to Tier 1 (Tier 2), and what a few students will need on top of Tier 1 and 2 (Tier 3). Often, Tier 1 will serve to address broader needs, such as basic social-emotional competencies, while Tiers 2 and 3 focus on more targeted and intensive mental health topics. However, within an integrated needs assessment, each tier can include multiple areas of need. For example, Tier 1 can include needs for teaching basic social-emotional skills as well as mental health literacy or psychoeducation to help students gain basic knowledge of mental health.

The table below can be used as a way to organize needs across tiers.

Tier 1	Tier 2	Tier 3
Needs of all students	**Needs of some students beyond Tier 1**	**Needs of individual students for supports beyond Tiers 1 and 2**
Example: All students need strategies for basic social emotional competencies for their overall well-being.	*Example:* Small group counseling or social skills for students with more intensive and targeted needs.	*Example:* Individual cognitive behavioral therapy-based counseling for students who have experienced severe trauma.

For needs that may extend to homes and communities, a broader set of assessments may determine what concerns are present for students in these settings. These needs, like the school-based needs, can also be ordered across levels or tiers of need, but this can be a bit more difficult in execution.

For example, for a sense of safety, needs can potentially be recognized as affecting most students (e.g., lack of a sense of safety in the neighborhood), some students (e.g., direct exposure to violence in the community) and a few individuals (e.g., victims of violence at home or in the community). Similar differentiation can also be made for other potential areas of concern across the three tiers of support.

The table below organizes needs across settings for both student and adults, illustrating how schools can organize evidence-based interventions across the tiers.

Settings	Tier 1	Tier 2	Tier 3
	Needs of all students/adults	Needs of some students/adults beyond Tier 1	Needs of individual students/adults who need supports beyond Tiers 1 and 2
School			
Home			
Community			

Assessment and Screenings

A key method for determining the mental health and related needs of students and adults is to engage in evidence-based screenings or other baseline assessments in areas indicated as broad concerns (e.g., informal reports from teachers, surveys from parents). These screenings may already be collected as standard procedures in some schools or districts, or they may need to be added or supplemented.

There are two key reasons for collecting this information:

1. By identifying students (or adults) in need, as well as the level of need (e.g., at risk, clinical), a strategic, multi-tiered plan can be created to address all needs.

2. Establishing a baseline level of performance for the area of need will help determine whether supports and strategies had a meaningful impact.

Mental Health Screeners should not be used alone or as the only data point.

Once these areas of concern are identified, there are some key steps and considerations for screenings:

1. Clear and transparent processes and procedures are used for the screenings. For example, the schedule for screening, as well as the remaining considerations below, should be clearly communicated to all relevant stakeholders.

2. Active and passive consent are obtained, as necessary, from parents, youth and anyone else providing information.

3. Screening tools are selected based on good psychometrics, in terms of reliability and validity of the tool. In other words, we should be able to trust the results of the test over time, and we should know it's measuring what it says it's measuring. (See Resources, #5 for a list of tools and criteria for screeners with good psychometrics.)

4. Feasibility (cost, effort, ease of use) is an important factor to consider for any screening tool, since this may determine if schools will be able to effectively use the tool or sustain its use over time. If the tool costs too much, or takes too much effort, it may be abandoned after use.

5. "Fit" of the tool should also be considered, especially as it relates to the goals of the school. For example, a tool used for progress monitoring should measure aspects of the need that can be changed, to see if implemented strategies are successful. Additionally, the tool should be sensitive to small changes so it can effectively inform continuous data-based decision-making.

6. The plan of response to the data from screeners should be specified before screeners are administered. In other words, "What are we going to do with this information?" This would include:

a. Responding to any immediate risk or harm indicated on the screener (e.g., suicidal ideations).

b. General decision-making protocols that will determine how the needs will be addressed (fast track to advanced Tier 2 and 3 strategies for students who screen for severe needs).

7. Screeners should not be used alone, or as the only data point. Other existing or newly collected data should be used in conjunction with screening data to get a more complete picture. In addition, screeners only serve as initial assessments, and if students with more complex needs are identified, further assessments may be required to properly map out the needs of these students. This will inform the interventions and instruction utilized.

The table below provides a broad overview of some commonly used and well-supported screeners and assessment tools.

Instrument	Age/Grade Range	Type(s)	Time to Complete	Number of Items	Reporter	Areas Assessed
Social, Academic, and Emotional Behavior Risk Screener (SAEBRS)	K–12	Screener	3 minutes	19	Teacher	Social and emotional behaviors, academic competence
Strengths and Difficulties Questionnaire (SDQ)	3–16 years	Screening	10 minutes	25	Parent, teacher, or adolescent (11–16 years)	Social-emotional; predicts disorder
Scale for Assessing Emotional Disturbance (SAED)	5–18 years	Assessment	10 minutes	52	Parent, teacher, counselor, or other adults	Emotional disturbance
Social Skills Improvement System (SSIS)	3–18 years	Assessment	15–25 minutes	Varies	Parent, teacher, or adolescent (grades 3–12)	Social-emotional, academic, competence

Review of Overall Process for Needs Assessment

1. Create Representative Team from school, family and community members

↓

2. Collaborative Needs Determination
Determine if existing data is enough or additional data needs to be collected

↓

3. Collaborative Needs Determination
Select area(s) for assessment: 1) risk factors; 2) resilience/protective factors; and/or 3) general areas

↓

4. Collaborative Needs Determination
Determine scope of needs for school, community or both across the three-tiered continuum

↓

5. Selecting Assessments and Screening Tools
Select appropriate tools to assess each area determined to be relevant to the school, family and/or community

RESOURCE MAPPING

Once the needs assessment has been conducted, the second step is to match the identified needs to resources available in the school(s) and community. To do this, we need to create a resource map: a comprehensive list of resources (mental health professionals, curricula, etc.) along with what needs each resource is intended to address. Resource mapping can be done districtwide or schoolwide, depending on the scope of the project.

Resource maps are a critical part of creating a comprehensive school mental health model, as they allow for:

1. Getting a broad and systematic understanding of what current resources can be used to address mental health. Some resources may be missed or underutilized if they are not mapped out. For example, school nurses often play a critical role in school mental health, but may not be included in an informal, non-systematic consideration of this need.

2. Gaining a clear understanding of what resources are missing or required to appropriately meet the needs identified.

3. Analyzing resources that may be underutilized or not used efficiently. For example, there may be an overlap in resources for addressing one issue, and no resources for another. Similarly, additional resources may be available, but may not be directed towards addressing the needs or goals set by the team.

4. Creating better plans to use available resources. These plans could allow for alignment of programming, more efficient use of resources, and the abandonment/replacement of ineffective or unneeded resources.

5. Assessing the readiness of a school or district to implement a comprehensive school mental health initiative. This is where districts or schools may recognize that they do, or do not, currently have the resources to move forward with scaling up a schoolwide or districtwide initiative. If the resources are not present, this might inform and guide future activities for acquiring the necessary resources.

Getting Started: Goal Setting and Creating a Resource List

Resource mapping is, at its simplest, creating a list of all available resources. While this appears to be a straightforward exercise, there are two key steps to consider:

1. With the team, determine the goals and purpose of resource mapping. This is often directly tied back to the needs identified. However, the goals should further support the desired conditions (end point) the school wants to reach and under what time frame (by when).

2. Create a list of all relevant resources.

a. The list can include everything from the details related to staffing to the curricula and tools available in the school. Some considerations when discussing staffing might be:
   - Which professionals are available to support mental health?
   - What are their official roles and titles?
   - What needs do they address?
   - What tier of the MTSS model do they address?
   - When are they are available?
   - How are they contacted?

b. These resources could be narrow or broad in their scope, which is discussed in detail in the next section.

Scope and Details of Resource Maps

Like a needs assessment, resource maps can be narrow or broad in scope, depending on the goals of the school or district. This may depend on whether or not the resource map documents the services and supports available within the school environment alone, or if it extends into the home and community as well. If the needs assessment process extends beyond the school, then it is highly recommended that the resource map document these extended supports and services available. The section for tools and resources at the end of this chapter includes websites and handouts that can help with school- and community-based resource mapping. Whether mapping a single setting (schools) or across settings, resources can also be further organized within an MTSS framework to provide a clear analysis of the resources available across the continuum of tiered supports.

Looking at needs and resources across settings is a particularly important part of resource mapping, as it will identify gaps in services and supports that outside providers can fill. This type of collaboration, using a MTSS framework, is referred to as an Interconnected Systems Framework (ISF) and allows for supplementary resources for individuals with severe needs through collaborations between school and community mental health providers. Within ISF, community providers take an active role on the school team to facilitate the cross-system collaboration and sharing of resources.

Beyond professional providers, other resources to consider are evidence-based curricula, appropriate training for those carrying out the supports, and physical space and materials that may be needed to successfully deliver interventions.

Identifying Gaps and Creating a New Map

The last part of resource mapping, after a full list of needs and resources are collected and organized, is to identify any gaps between needs and resources, especially as they relate to the stated goals. This process is often referred to as a gap analysis. (For more details, see Gap Analysis Tool in the resources section.) Below is an updated chart where resources can be matched to identified needs across tiers and settings. This chart can also serve as a gap analysis if some of the needs appear to be lacking resources to address them.

Settings	Tier 1	Tier 2	Tier 3
	Needs of all students/adults	Needs of some students/ adults beyond Tier 1	Needs of individual students/ adults who need supports beyond Tiers 1 and 2
School	• Need • Resource to address need	• Need • Resource to address need	• Need • Resource to address need
Home	• Need • Resource to address need	• Need • Resource to address need	• Need • Resource to address need
Community	• Need • Resource to address need	• Need • Resource to address need	• Need • Resource to address need

Once gaps are identified, several steps can be taken to create a new map that will best meet these needs.

1. Move resources to be more efficient. Look for overlap where multiple resources may be addressing the same need when not necessary.

2. Add new resources to fill existing gaps. Consider resources within the school as well as supplemental resources from outside the school.

3. Consider removing resources that do not seem to align with goals or serve any particular need. This can potentially lead to a reallocation of resources or net savings, as well as the more efficient use of school professionals. (For more details, see the Strategic Abandonment Tool in the resources section.) Consider replacing resources with evidence-based practices or at least promising practices that address the identified need(s).

Review of Overall Process for Resource Mapping

1. With the team, determine the **goals and purpose** of resource mapping.

↓

2. Create a **list of all relevant resources.**

↓

3. Analyze the list in conjunction with needs to **identify gaps, overlaps, and possible inefficiencies** in resources.

↓

4. **Reorganize and create a new map** based on this analysis, including areas where resources can be aligned and integrated, what resources, if any, can be abandoned, and what resources need to be acquired to be successful.

CULTURAL CONSIDERATIONS

Culture and diversity have been mentioned indirectly previously in this chapter, but given the central nature of cultural responsiveness in comprehensive school mental health, it's worth taking time to consider this topic on its own. In particular, cultural responsiveness as it relates to needs assessment and resource mapping will be the focus here, including the following considerations:

1. As mentioned earlier, we want to include many diverse perspectives in our school team, as well as those to whom we reach out to determine needs and goals.

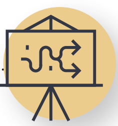
> Within the context of needs assessment and resource mapping, **cultural humility becomes important** in avoiding assumptions and, instead, engaging in actions to better learn from others.

2. To facilitate the inclusion of diverse team members, flexibility in the schedule and location of team meetings is key. Minimize barriers that may prevent people from attending.

3. Ensure that the modality of communication is itself diverse and responsive to the needs of team members as well as the broader school and community. This can include multiple ways of communicating (e.g., phone calls, surveys, text messages, video conferencing, in-person meetings) as well as communicating across different languages (as appropriate) and bi-directionally.

4. Understand that culturally responsive practice is a complex process, not a simple checklist or one-shot event. As such, the schools should not only follow the recommendations from steps 1 through 3, but also should continuously monitor (with data and documentation whenever possible) how the diverse needs of all stakeholders are being met, addressing any identified issues that may develop. A natural extension of the above recommendation is the recognition that cultural missteps and mistakes are inevitable, even with our best effort. This requires us to have cultural humility, which is the recognition that we may not know everything and, as a result, will maintain an attitude of openness and willingness to learn and improve. Within the context of needs assessment and resource mapping, cultural humility becomes important in avoiding assumptions and, instead, engaging in actions to better learn from others.

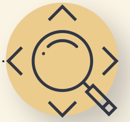
CHAPTER SUMMARY



As highlighted in the beginning, the first steps in the process of creating a comprehensive school mental health system using a MTSS framework is for the school or district team to work collaboratively to complete needs assessments and create a resource map to develop a clear plan for moving forward. This includes a careful analysis of the needs of the school, families, and community, from students and school personnel to parents and families. The resource map then provides an organized look at all the current resources available. Taken together, the needs assessment and resource mapping process can determine the gaps in services and supports, the readiness for moving forward with new initiatives, and how existing resources may be used more effectively to best address the present needs.

The process of determining needs should involve collaboration of the school team and other school professionals (educators, specialists, etc.), as well as students, families/caregivers, and other relevant community stakeholders.

SPOTLIGHT



NEWTON PUBLIC SCHOOLS

Mental Health Resource Map

The Newton Public Schools serve students in grades K–12. We developed and adopted a community schools' mindset as an essential expression of our district mission. Community schools are both a place and a set of partnerships between the school and other community resources that have an integrated focus on academics, health and social services, youth development, and community engagement. The development of the Mental Health Resource Map provides stakeholders with a list of services for students who need support on various social and emotional tiers.

Collaboration and Teaming

The consultant from the Mental Health Technology Transfer Center (MHTTC) met with our district team members (superintendent, administrators, social workers, guidance counselors, and nurses) to discuss the benefits of utilizing the teaming approach to develop a mental health resource map. Utilizing this method ensured we shared common language when discussing Multi-Tiered Systems of Support (MTSS), internal versus external supports, and student criteria. The collaborative piece was invaluable as the team identified overlapping services, obtained information from other team members regarding services in the area that they did not know were available, and discussed ways to expand services and how to communicate the resources to community members. The result is a comprehensive Newton Public Schools–Mental Health Resource Map accessible to all stakeholders..

Successes

- All district team members are aware of the services in our community. This alignment of resources throughout the district helps with the external and internal continuation of services when students move from one school to another within the district.
- All stakeholders have access to this resource and are able to:
  - Access the service overview
  - Review the criteria to receive the service(s)
  - Identity the forms of payments accepted (Medicaid, private insurance, fee for service or sliding scale options)
- Organizations are aware of our district's commitment to mental health and are more likely to team with us due to our documented partnerships with other community groups.
- The team was able to discuss ways to expand our services which resulted in the high school creating a "green room" which gives external providers an area where they have the ability to provide our students with services on site during the school day.

Lessons Learned

- Collaboration and teaming for districtwide resources must include the district team to eliminate fragmentation of services.
- Consistently communicating our district mission, which addresses the importance of allocating sufficient resources to the social, emotional, and physical well-being of our students resulted in:
  - Additional partnerships with organizations
  - Community awareness
  - Continued collaboration
  - Expansion of MTSS

Reflection Questions

What key mental health needs do you see in your community, district and/or school?

What are the needs of the students, families, and school professionals?

What available resources are you aware of to address these needs?

What resources may be missing but could be utilized to address identified mental health needs?

Can resources be moved, aligned, or integrated in ways that will allow for their more efficient use?

If the necessary resources are not available, what steps can you take to acquire them?

How are existing resources made available to students, parents, families, and staff?

What is the process for informing the school community about existing resources?

RESOURCES & LINKS

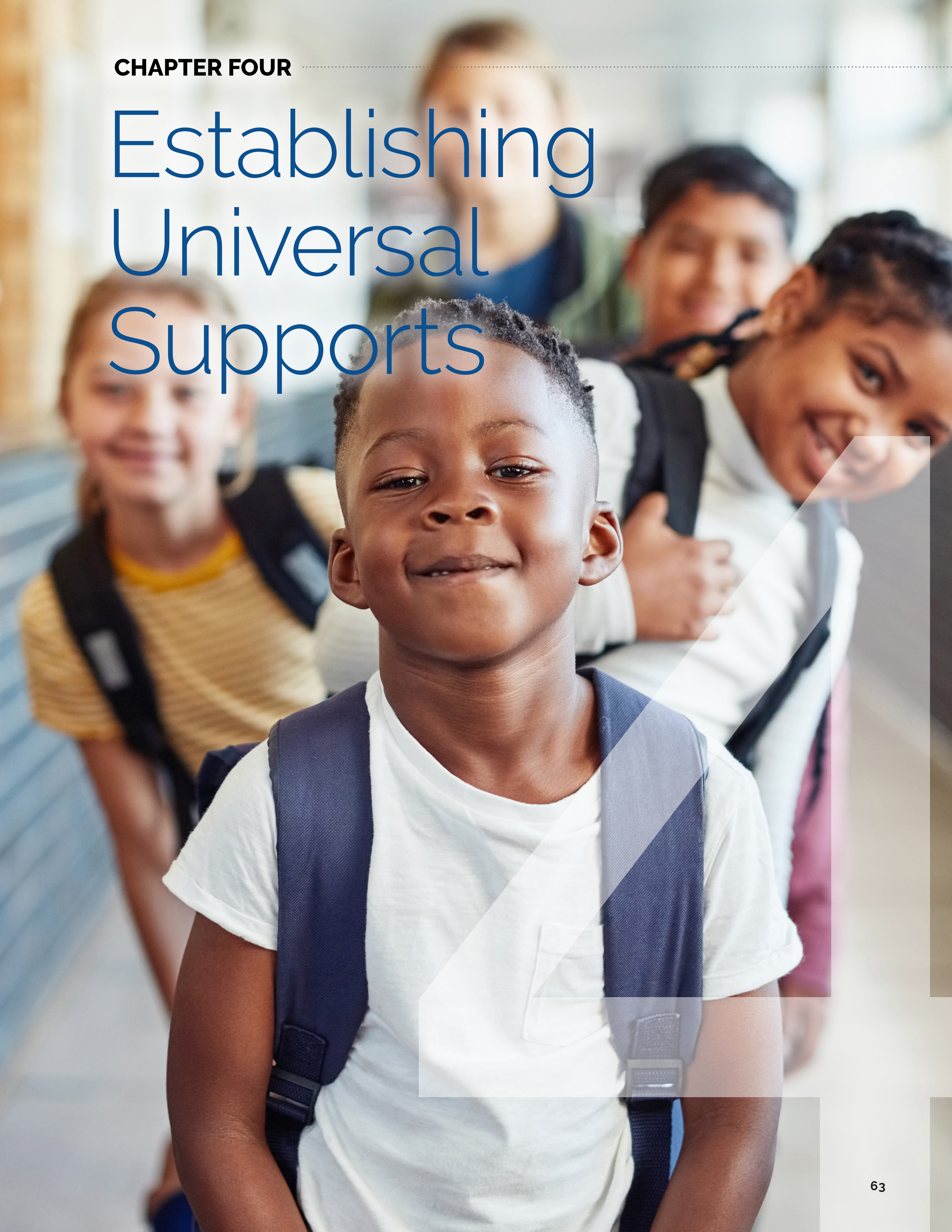
A full listing and review of needs assessments and screening tools is well beyond the scope of this document. However, below are some key resources and tools that can help schools that are starting to develop, or in the midst of revising, their own needs assessment processes.

Tools and Resources for Needs Assessments

1. Center for School Mental Health (CSMH) Resources
2. SHAPE Screening & Assessment Library
3. Wisconsin School Mental Health Needs Assessment
4. Screeners Guide
5. List of Evidence-based Screeners
6. Step by Step Guide for Selecting Data Tools for MTSS

Tools and Resources for Resource Mapping

1. Resource Map Manual (step-by-step workbook)
2. Multi-Disciplinary School Mental Health Team Roles and Functions
3. Community Service Locator
   • Behavioral Health Treatment Service Locator
   • Local Resources
4. Community Resource Map Filled Example
5. Gap Analysis Tool
6. Strategic Abandonment Tool
7. Alignment Tool
8. Goal Setting and Next Steps



CHAPTER FOUR

Establishing Universal Supports

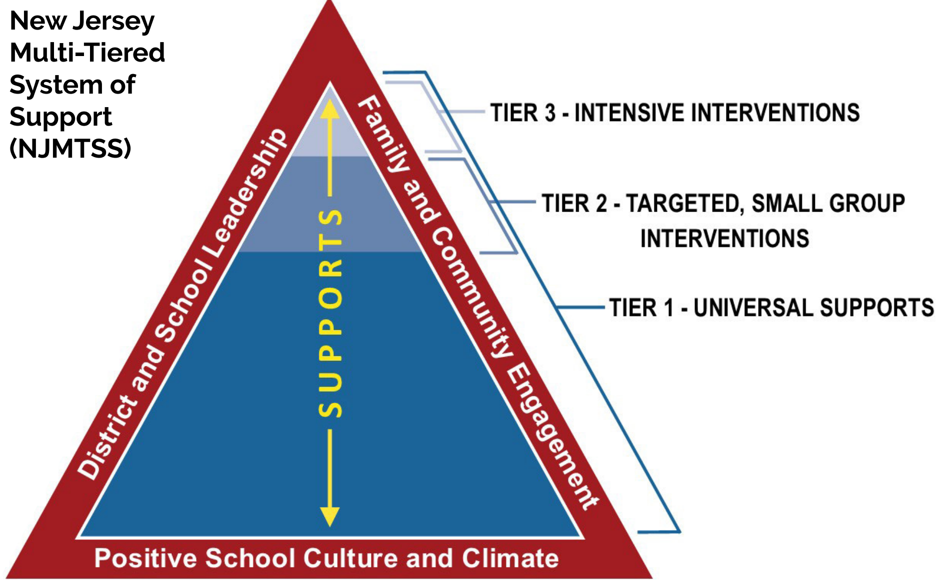
WHAT YOU NEED TO KNOW

n Chapter 2, you read about the foundational and theoretical framework of a multi-tiered system of support (MTSS). This chapter focuses on how to integrate and coordinate mental health, positive behavior and social-emotional learning (SEL) supports within the umbrella of universal Tier 1 academic and behavioral interventions.

> **"When we consider the list of problems** faced by our young people today, we should think about how to prevent some of these problems for their children and grandchildren."
>
> —Educator and philosopher Nel Noddings[1]

Evidence suggests that intentionally focusing on mental health, positive behavior supports, and social-emotional competencies in both staff and students helps create a positive school climate and promotes positive relationships between staff and students.[2] This chapter offers guidance on how to implement Tier 1 supports in a way that is prevention-focused; data-driven; responsive to local needs; includes staff, student, and parental voices; is continuously evaluated for improvement; and incorporates mental health, positive behavior and social-emotional supports in a systemic and coordinated way. Given the COVID-19 pandemic's pervasive negative impact on school communities, it is more important now than ever that educators adopt the "Maslow Before Bloom, All Day Long" approach for every school day.[3] This means, first and foremost, being sure we are supporting the following basic needs for all students, staff, and families in our school communities: social-emotional well-being, safety, feeling cared for and respected, and having a sense of belonging and connectedness. This is why incorporating mental health, positive behavior supports and SEL in Tier 1 universal supports is vitally important.

As the New Jersey Department of Education (NJDOE) recognizes, the success of these efforts requires a foundation of positive school culture and climate where all feel safe, included, heard, and respected. A positive school climate is an environment where all people—staff, students, and



families—feel respected and supported. The administration and staff show students, families, and one another positive regard and respect. Students are greeted and welcomed by name into the school and the classroom. Students and staff have a voice in how the school is run and are recognized for their positive contributions and importance. This voice and recognition contribute to their sense of connection and belonging to the school community. Research has shown that a positive school climate is associated with a myriad of positive student outcomes, including improved self-esteem and self-concept; reductions in absenteeism, substance use, violence, suspensions, and mental health problems; and improved academic outcomes.[2]

Tier 1 Universal Supports

Understanding the implementation of Tier 1 supports is integral to student success. Schools have to be places that provide the supports noted educator Linda Darling-Hammond challenges us to address.

> **"All young people—particularly those who live in stressful contexts—need to be able to recognize and address their feelings, so that fear, hurt, and anxiety do not overwhelm them; to recognize and respect the feelings of others; to learn problem-solving and conflict resolution skills; to have the opportunity to contribute directly to the welfare of others; to understand that problems and challenges are part of the process of learning and living, so that they can persist in the face of difficulties; and to become 'growth-oriented' in their approach to life."[4]**

We must meet that challenge in an organized, comprehensive, systemic way, with supports for all students. Tier 1 universal supports that are expanded to include mental health promotion, positive behavior supports, and SEL can meet that challenge.

The goal of MTSS when it was introduced was systems change—expanding student support systems already in place for students identified as needing additional academic, health, and/or behavioral support services, to include proactive prevention strategies for all students. This systemic change led to the implementation of universal screening of all students two to three times per year (Tier 1) to identify students who need more intensive support (Tier 2) or even more

individualized interventions addressing serious concerns (Tier 3), along with Tier 1 universal supports for all students.

Implementation of universal Tier 1 supports addressing student behavior, SEL, and mental health require preparation and buy-in from all school staff. Staff can:

Promote positive behavior through teaching all students what is appropriate and reinforcing positive behavior in the classroom and schoolwide.

Intentionally address students' social-emotional skills development in the classroom and schoolwide.

Intentionally incorporate mental health topics into classroom lessons and schoolwide programming.

Teach students positive coping strategies to promote mental health and resilience and provide opportunities to practice those strategies in the classroom. Examples of positive coping strategies that can be taught in the classroom include: relaxation techniques, such as breathing exercises or mindfulness; how to identify and reduce stress; how to communicate effectively to have needs addressed. Practicing these strategies helps students manage and reduce stress, self-regulate, build resilience and increase focus.

Promote Positive Behavior

Positive Behavior Intervention and Supports (PBIS) was initially developed as a classroom-based program to promote positive, pro-social student behavior. Teachers are provided strategies for: communicating expectations for student behavior, being proactive and discouraging disruptive classroom behavior, and monitoring students' responses to interventions. This approach has been expanded into a comprehensive, tiered systems framework, or schoolwide PBIS (SWPBIS).[5] SWPBIS is an evidence-based, three-tiered framework for managing student behavior and promoting prosocial behavior.[12] Research also points to the impact of SWPBIS on student outcomes, including reductions in problem behavior, improvement in academic performance, and increases in students' social-emotional competence. SWPBIS has also been found to correlate with positive school climate and improvements in teachers' perceived efficacy and school safety.[13]

Effective Tier 1 supports in the SWPBIS system require a Tier 1 leadership team and adherence to guiding principles and practices. The guiding principles of Tier 1 SWPBIS are:

- **Effectively teach appropriate behavior to all children**
- **Intervene early before unwanted behaviors escalate**
- **Use research-based, scientifically validated interventions whenever possible**
- **Monitor student progress**
- **Use data to make decisions**[6]

Social Emotional Learning (SEL)

The NJDOE has adopted the SEL framework of the Collaborative for Academic and Social Emotional Learning (CASEL). This framework is a systemic approach to embedding SEL in the classroom schoolwide, delivered in partnership with families and community. CASEL defines social-emotional competencies as a set of five core skills: self-awareness, social awareness, self-management, relationship skills, and responsible decision-making.[7]

It is clear from decades of research that intentionally addressing students' development of social-emotional skills leads to short- and long-term positive psychological, social-emotional, and academic impacts on students.[8,9] Further, research has shown that rather than using an SEL curriculum or program alone, a comprehensive, systemic inclusion of SEL in the classroom and schoolwide, as in the NJTSS framework, has a greater impact.[10]

CASEL recently revisited the SEL framework through the lenses of equity and social justice to create the transformative SEL framework: Transformative SEL is a process whereby young people and adults build strong, respectful, and lasting relationships that facilitate co-learning to critically examine root causes of inequity, and to develop

SEL Framework (CASEL 2020)

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SEL Core Competencies

Self-Awareness
- Labeling one's feelings
- Relating feelings and thoughts to behavior
- Accurate self-assessment of strengths and challenges
- Self-efficacy
- Optimism

Social Awareness
- Perspective taking
- Empathy
- Respecting diversity
- Understanding social and ethical norms of behavior
- Recognizing family, school, and community supports

Relationship Skills
- Building relationships with diverse individuals and groups
- Communicating clearly
- Working cooperatively
- Resolving conflicts
- Seeking help

Sources: CASEL Acknowledge Alliance

Self-Management
- Regulating one's emotions
- Managing stress
- Self-control
- Self-motivation
- Stress management
- Setting and achieving goals

Responsible Decision-Making
- Considering the well-being of self and others
- Recognizing one's responsibility to behave ethically
- Basing decisions on safety, social, and ethical considerations
- Evaluating realistic consequences of various actions
- Making constructive, safe choices for self, relationships, and school

collaborative solutions that lead to personal, community, and societal well-being. This form of SEL is aimed at redistributing power to promote social justice through increased engagement in school and civic life. It emphasizes the development of identity, agency, belonging, curiosity and collaborative problem-solving within the CASEL framework.[11]

School Mental Health Supports

There needs to be strong communication from district leadership that school mental health, positive beahvior supports and SEL are fundamental to creating conducive conditions for learning and have been demonstrated to prevent academic, behavioral, social and psychological difficulties in students.[16]

It needs to be understood that providing all students with opportunities to develop positive coping and resiliency skills; creating a school climate where all students feel safe, connected, and supported; and universal screening for more intense emotional and behavioral needs is fundamentally promoting social justice, equity, inclusion, and access for all students, if done in a culturally and developmentally appropriate way.

Many students and staff have been exposed to some form of trauma. According to the Centers for Disease Control and Prevention, a majority of people experience at least one adverse childhood experience (ACE) in their lifetime and 33% of children have experienced more than one ACE.[17] Those studying the long-term impact of ACEs have found that over time, unaddressed traumatic experiences can lead to disease and early death.[18] Further, educators can experience secondary or vicarious trauma from hearing about students' pain and suffering. When students share traumatic events with teachers, it takes an emotional toll on the teacher.[19] There is a clear connection between focusing on student and staff mental health and becoming a trauma-sensitive school.[20,21] Proactive, schoolwide Tier 1 interventions, combined

with an understanding of the negative impacts of trauma on well-being, can help build resilience in all students and staff.[22]

Universal Screening

Tier 1 services include regular screening of all students for behavioral support needs. While it is recommended that schools conduct these formal universal screenings two to three times per year, more frequent informal check-ins with students can help with early identification of behavioral needs. It would be great if teachers informally checked in with students individually on a daily basis, but this is not always practical. Universal screening tools can include self-report assessments, teacher/staff observation reports, and existing student data (e.g., discipline referrals, academic performance, attendance). Preferably, the screening is a sufficient, but not unduly burdensome, process. Universal screening tools should be age- and developmentally-appropriate and chosen with the cultural and ethnic diversity of the student body in mind. Universal screening is designed to be proactive and seeks to identify students early who might benefit from more individualized support. The team analyzes the universal screening data with the help of a school counselor, school psychologist, or a professional resource in the community and identifies students who could benefit from the more intensive Tier 2 or Tier 3 supports. Those recommendations are communicated to students and their families and to the Tier 2 and 3 leadership teams. See Chapter 3 for more information on universal screening tools.

Districtwide systemic support for including mental health, positive behavior supports and SEL into Tier 1 approaches is essential. It is important to purposefully work towards family and community engagement with the goal of getting buy-in from families and the community that mental health, positive behavior supports and SEL need to be delivered in schools. District supports need to be in place including, but not limited to, administrative leadership participation on MTSS teams, dedicated budgeted funds, and allocated time to "do the work." Leaders should ensure that the universal screening is done from a student's strength-based, asset-building approach rather than focusing on student deficits.

The National Center for School Mental Health provides technical support and guidance to schools/districts on how to create comprehensive, school-based mental health systems (CSMHS).[23] The best practice guidance for CSMHS is to have a multidisciplinary school mental health team, including key stakeholders from the community. The National Center and the Mental Health Technology Transfer Center developed a school mental health curriculum with implementation guidance and learning modules.[24] The National Center also offers the free School Health Assessment and Program Evaluation (SHAPE) system for schools/districts to assess and improve their mental health support system (see Chapter 2, Resources & Links).

INTEGRATION

Addressing the implementation of prosocial education in schools, educator Allen Cohen said: "There is no option not to do it; it must be done. The only real question is how to do it effectively, how to do it well."[25] The same can be said for creating an integrated system of universal supports in schools that promotes positive behavior, social-emotional learning and mental well-being.

Many strategies and programs are implemented in schools but are often not integrated or coordinated in their planning, delivery, or management. Different staff or offices may be responsible for different but interrelated services at different tiers of support. Staff may end up feeling isolated and unsupported, impacting their morale and work-life satisfaction.[26] Often a myriad of leadership teams and committees—school climate committee, SEL committee, health and wellness committee, SWPBIS leadership team, etc., are formed, each tasked with coordinating program implementation. As discussed in Chapter 2 (see **Integration**), it is more efficient to align initiatives, have fewer teams with overlapping functions, and coordinate all school mental health activities. A lack of coordination precludes getting the full potential schoolwide impact. Rather than having separate, competing initiatives, it makes more sense to deliver programs with related goals schoolwide through one system.

For example, many schools/districts have SWPBIS, SEL, and school climate interventions in place. However, they may not be implemented with great synergy. In fact, for some, SWPBIS and SEL may seem contrary, rather than complimentary, in their approaches. PBIS is a behavior management program that relies on the use of positive reinforcement, controlled and delivered by staff and teachers to encourage prosocial

behavior. Hence, the focus is managing behavior using external reinforcement. The goal of SEL is to achieve prosocial behavior as an outcome of students developing strong self-awareness, social awareness, and self-management skills. Hence, the focus of SEL is encouraging students' internal motivation for prosocial behavior.

Seeing PBIS and SEL as incompatible encourages them to be viewed as separate initiatives in already "jumbled schoolhouses" with overburdened teachers and staff suffering from initiative fatigue.[14] However, it has been suggested that the two approaches can be viewed as complimentary. In one study, researchers found that implementing SEL and PBIS together was more effective than either alone.[15]

Implementing Universal Supports

Suggested steps in implementing universal supports:[27]

Engage the school community in revisiting district/school mission, vision and core values and revise as needed to incorporate the NJTSS framework, including mental health, SEL, and positive school climate goals. This can be achieved by organizing several focus groups with representatives from key stakeholder groups to brainstorm ideas for a vision statement and core values that incorporate these whole child development goals. A school- or district-level team can review these ideas and draft a version for administrative review.

Seeing PBIS and SEL as completely incompatible encourages them to be viewed as separate initiatives in already "jumbled schoolhouses" with overburdened teachers and staff suffering from initiative fatigue.

Derive specific behavioral expectations that operationalize the core values. Make these visible and known so that students are able to say what the values and expectations are for student and staff behavior. For example, if students are expected to show other students respect in the classroom, what does that look like? It may be not talking when another student is talking. What would showing other students respect in the hallway look like? It may be always walking on the right side of the hallway.

Adopt a common language to describe the integrated Tier 1 supports—universal mental health promotion, positive behavior supports, SEL, positive school culture and climate—with specific goals and intended outcomes.

Review all district and school policies (e.g., code of conduct, discipline policy) for alignment with the core values and the philosophies underpinning Tier 1 supports.

Articulate the ways in which Tier 1 universal supports align with and can help achieve the district's strategic plan and meet other federal or state mandates.

Communicate with students, families, and the local community using the appropriate language(s), media, and stakeholder groups to ensure a common understanding and address questions and concerns.

Data Collection and Needs Assessment

Inventory all existing related programs and services. In Chapter 3 you read about district-wide resource mapping and school-based needs assessment done to identify existing resource supports as well as gaps. That resource mapping is critical for grounding this implementation work, avoiding duplication of services, and meeting the needs of staff, students, and families.

Identify all existing prevention efforts having to do with mental health of staff and students, positive behavior supports, SEL, and initiatives designed to improve school culture and climate and assess how they fit into the Tier I framework.

Examine the existing staff teams and committee structure with the goal of creating an umbrella Tier 1 Leadership Team.

Assess perceptions of school culture and climate using a school climate survey and disaggregate student and staff perceptions by key subgroups.

TEAMING

Tier 1 supports require the coordination of a leadership team. Below are considerations for developing your Tier 1 leadership team.

What is the team's purpose?

The team is the coordinating body for the universal Tier 1 supports. The team is responsible for developing and implementing schoolwide practices, procedures, and protocols supporting comprehensive integration of Tier 1 supports.

Who should be on the team?

The team ought to have broad representation from all stakeholder groups, including administration, classroom teachers, student support staff, teacher leaders/teacher coaches, parents/guardians, and students when implemented at the high school level. The team also needs an identified coordinator.

What are the key responsibilities of the team?

- Advocate for schoolwide universal supports that improve students' social-emotional well-being, promote positive behavior, and create a positive school climate.
- Regularly update and communicate with the school community.
- Coordinate universal screening of students for mental health, SEL, and/or behavior issues. The team should recommend the screening protocol and assessment tools to the administration.
- Collect data to determine the effectiveness of the universal supports.
- Ensure that students who are identified as needing more mental health, SEL, or behavioral support receive it, and that student outcomes are regularly assessed and inform next steps.

- Use effectiveness data for continuous improvement.
- Educate families and the wider community about universal supports and engaging family and community voices in improving schoolwide efforts.

What do teams need to be successful?

Ideally teams should meet monthly. Teams need to be empowered and supported with budget resources and release time to do the work. Teams should engage in periodic assessment of Tier 1 implementation. The Tiered Fidelity Inventory (TFI) from the Center for PBIS is a helpful tool for team self-assessment. In addition, teams should:

- Assess teacher readiness to implement Tier 1 supports designed for the classroom and provide training and supports needed.
- Create professional learning communities (PLCs) for staff to support one another and share their successes and challenges, including finding opportunities to be in PLCs with educators from other schools within and outside the district.
- Engage parents and families in the design, implementation, and assessment phases.
- To the degree possible, coordinate with before- and after-school programs so students have a seamless experience.
- Assess the degree to which implemented strategies are culturally responsive, inclusive, and equitable through dialogue with members of diverse groups in the school community.
- Seek out community collaboration opportunities for delivering Tier 1 supports.
- Adopt a data-driven, continuous assessment and improvement approach.
- Continually reinforce the interconnectedness of mental health, social-emotional competence, and behavior with staff, students, and parents.

Additional guidance on how to accomplish this integrated approach can be found in the new Interconnected Systems Framework (ISF).[28,29]

STAFF COMPETENCIES

First and foremost, staff need to be mentally, socially, and physically healthy to successfully build positive relationships with students and colleagues, function as supports for students, and model and teach social-emotional and positive coping skills. As you will read in Chapter 10, educators consistently report high levels of work-related stress as well as low morale.[30] Educators have reported experiencing poor mental health for 11 or more days per month, twice the rate of the general workforce in the U.S.[31] What has been found to mitigate stress in educators is supportive leadership and staff self-care and wellness programs, such as stress management or mindfulness training. So efforts to include mental health supports in schools must begin with assessing staff well-being and offering staff mental health resources. Having, and regularly updating, a collection of resources such as helplines, local agencies, mental health providers and employee assistance programs is helpful.

Further, before implementing teaching strategies for students' social-emotional learning, educators should have opportunities to reflect on their own competencies, work on improving skills in areas as needed, and draw on their strengths to create positive and supportive learning environments. Staff mental health and social-emotional competence are the necessary conditions for creating positive school and classroom climates where students can thrive.

To do all of what staff and teachers are being called to do in ISF requires extensive, ongoing professional development, instructional coaching, and resources/materials.

Professional development for staff has to build mental health literacy, provide training in recognizing symptoms of common mental health

needs, and offer strategies on responding to and referring people in crisis. Mental Health First Aid and Youth Mental Health First Aid training (YMHFAT) are examples of mental health literacy training programs.

Teachers can also incorporate mental health topics in classroom lessons and practice mental health promotion strategies with their students. Professional development and coaching can build teacher comfort and skill in bringing mental health promotion into the classroom in a safe, appropriate, and supportive way.[32]

Districts should provide professional development for staff in how to integrate social-emotional learning classroom-wide and schoolwide. Many districts have adopted SEL programs and provided teacher training on the delivery of those programs in the classroom. SEL programs should be evidenced-based (e.g., CASEL), include ongoing teacher training and support, utilize continuous assessment of fidelity, and ensure implementation within a positive classroom culture and climate where students feel safe, supported and valued.

Key knowledge, skills and dispositions of staff required for effective schoolwide implementation:

- **Staff's awareness** of their own social-emotional competencies and mental health and commitment to continuous growth in these areas.
- **Mental health literacy**—understanding the common symptoms of mental health needs and knowing how to respond to students who face mental health concerns or crises.
- **Learning strategies for promoting** positive behavior, SEL and mental health in the classroom and schoolwide.
- **Understanding why a trauma-sensitive approach** to teaching and in all interactions with students is important. Learning what a trauma-informed approach looks and feels like.
- **Learning strategies for creating** positive classroom and school climates.
- **Committing to reinforcing** and recognizing positive, pro-social behavior in the classroom through using a 4:1 ratio of positive feedback vs. corrective/negative feedback.
- **Understanding the MTSS framework,** and especially, universal Tier 1 supports, as that is the level all staff will be expected to engage in.
- **Learning and implementing** the school/district procedures for connecting a student to the appropriate staff member when the student demonstrates the need for additional assistance.

CULTURAL CONSIDERATIONS

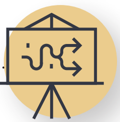
All in-school efforts to improve school culture and climate, and student and staff mental health, positive behavior and SEL, have to be designed and implemented in a culturally responsive way that ensures respect for diversity, and achieves equity and inclusion. School leaders should work toward building an inclusive and respectful school culture by engaging staff, students, and families in cultural humility training. The school's mission and values should include norms for school community members' behavior and language when interacting with people from diverse cultures, particularly those from traditionally underserved and oppressed groups. Build a shared anti-racism language and define key terms such as anti-racism, diversity, equity, inclusion, cultural responsiveness, implicit bias, microaggressions, etc. Examine universal screening tools and processes for potential cultural and/or English language learner bias. Critically review data on Tier 2 and 3 supports to identify trends. Are there sub-groups of students who are receiving more and/or less Tier 2 or 3 referrals than other groups? These trends may indicate cultural bias in the screening tools or in how student universal screening data are being interpreted. Ensure that instructional resources and materials for promoting SEL, mental health, and positive behavior represent diverse cultures. And most importantly, collaboration with diverse members of the school community in the planning process can help create culturally responsive interventions.[33]

COMMUNITY, STUDENT AND FAMILY ENGAGEMENT

Community, student and family engagement are critical for the successful implementation of MTSS, particularly the approach being advocated here to incorporate SEL, positive behavior and school-based mental health supports. Districts should conduct a community asset scan to identify potential community partnerships supporting the integration of Tier 1 positive behavior supports, SEL and mental health programming to supplement district resources, as needed. Local health systems and providers, nonprofit organizations, community agencies and mental health practitioners are all potential sources of community support. Schools/districts can collaborate with community partners to create CSMHSs.[34] There are funding sources, discussed in Chapter 11 of this guide, to support CSMHSs, and the collaboration can include school staff training.

A foundational component of the MTSS framework is including parent and student (if developmentally appropriate) voices on the MTSS leadership team. Further, by district policy, staff are required to notify a parent/guardian if a child is identified as needing Tier 2 or Tier 3 supports. Parents/guardians should have the opportunity to provide input on the support plan created for the student and should be regularly updated on the child's response. Ideally, school staff will create positive, trusting relationships with parents/guardians of students who are recommended for support services, and provide nonjudgmental and supportive feedback to parents/guardians.

CHAPTER SUMMARY



Recent trends in education suggest a paradigm shift towards considering the whole student rather than focusing exclusively on academic achievement. Students cannot learn if they are anxious, stressed, or experiencing trauma. Expanding Tier 1 universal supports to include mental health promotion, positive behavior supports and social-emotional learning in the general curriculum provides all students the opportunity to thrive both in and out of school.

Key Take-Aways

Expanding Tier 1 universal supports in an MTSS to include mental health, SEL, positive school climate efforts and SWPBIS offers a framework for truly educating the whole child.

For implementation to be a success, these multiple systems in Tier 1 must be integrated rather than delivered in silos and coordinated by separate staff teams. Schools/districts ought to consider re-organizing their committee structure to strengthen communication channels among the myriad of teams that exist (e.g., the school wellness committee, the safety and climate committee, I&RS,

SWPBIS, RtI teams, etc.). There is significant overlap with regard to implementing universal Tier 1 supports for behavioral issues, SEL, and mental health. There is overlap in a) the data used to drive decision-making, b) the foundational components that have to be in place, and c) day-to-day practices.

First and foremost, attention needs to be focused on staff and teachers. Staff morale, staff buy-in, and staff and teacher mental health and social-emotional competencies are necessary, but not sufficient, conditions for successful implementation. Staff will need long-term professional development, ongoing resources and support and opportunities to share their experiences with colleagues.

Schools/districts should employ a continuous improvement approach that is data-driven and includes the voices of students, staff, parents/guardians, and community partners.

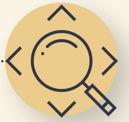
Funding is available to support a comprehensive, multi-tiered infusion of mental health supports (see Chapter 11) in schools. Districts can secure school-community partnerships with community-based mental health providers.

TIER 1 PREVENTION—EXAMPLE

Support	Data Used for Decision-Making	Foundational Components	Day-to-Day Operation
SWPBIS	• Attendance • Academic performance • Discipline referrals • DESSA* or DESSA-mini	• Buy-in • Staff training • Family partnership • Leadership team • Data-driven decision making • Continuous improvement model • Inclusion and cultural competence	• Shared expectations for behavior • Classroom-based practices • Adults model appropriate behavior
SEL	• Attendance • Academic performance • Discipline referrals • School nurse data • DESSA or DESSA-mini • DESSA SEL Inventory	• Buy-in • Staff training • Family partnership • Leadership team • Data driven decision-making • Continuous improvement model • Inclusion and cultural competence	• Shared definition of SE skills • Classroom-based practices • Adults model social-emotional skills
Mental Health	• Attendance • Academic performance • Discipline referrals • School nurse data • DESSA or DESSA-mini • Survey of Well-Being of Young Children • COPE Inventory	• Buy-in • Staff training • Family partnerships • Leadership team • Data-driven decision-making • Continuous improvement model • Inclusion and cultural competence	• Shared understanding of mental well-being • Classroom-based practices • Adults model positive coping and stress management techniques

**Devereux Student Strengths Assessment*

SPOTLIGHT



RAMSEY PUBLIC SCHOOLS

RULER Approach

At the core of our comprehensive mental health system is clear recognition that we are in the business of education, and we can't teach students who have a barrier to learning. One of our strongest assets is the research-driven RULER approach that integrates critical emotional skills into the K-5 academic curriculum. RULER stands for Recognizing emotions; Understanding their causes and consequences; Labeling them accurately; Expressing them appropriately; and Regulating them effectively. It connects emotional intelligence to effective teaching and learning, sound decision-making, physical and mental health, and success in school and beyond.

Our district has pledged to build a stigma-free environment in our schools and in our communities. As a leader in this movement, we look year-round at ways to eliminate the stigma that can prevent people from seeking help. Like the RULER approach, this philosophy is built into our school climates. In addition to those proactive steps, we have safety nets, including mental health counselors for kindergarten through Grade 12. All ninth graders undergo Mental Health First Aid training tailored to youth, and all administrators are trained similarly. This initiative teaches people how to identify, understand, and respond to signs of mental illnesses and substance use disorders. Further, our comprehensive system can help connect them to the appropriate care.

At our middle school and high school, counselors and child study team members collaborate on mental health prevention, intervention, and universal screening for students and a parent-authorized Depression Screening Intervention for students in grades 7, 8, and 10. We also have a strong relationship with the region's most widespread provider of mental health services. We partner with them to provide a "warmline" referral system that is a preventative step away from "hotline" crisis care.

Successes

- More students, parents and staff are asking for mental health help. We know that more people recognize the need for help, feel comfortable asking for it, and know how to access services.
- We have increased participation in our various stigma-free activities. What started as an in-person Walk-and-Talk-a-Thon shifted during the pandemic to virtual or individual-scale activities. These activities did not lose steam, and our no-judgement culture grew stronger.

Lessons Learned

- A district that has not yet made this kind of commitment should immediately start, and a district that hasn't yet expanded to all grades should immediately work toward that goal. The pandemic increased needs that were already present, and students can't learn well if they are mentally stressed.
- Districts should connect with the appropriate partners in their regions and leverage them for in-school support. These organizations want to help, this is their area of expertise, and they are already set up to provide a full range of services to a variety of age groups.

Reflection Questions

What Tier 1 universal supports does your school/district have in place now?

Who is involved in coordinating Tier 1 supports?

In what way(s) does a Tier 1 universal system of supports including mental health, positive behavior supports, SEL, and school climate align with your school/district's:

- —Strategic plan?
- —Mission and vision?
- —Core values?

What resources do you think your school needs to accomplish this expanded Tier I system of universal supports?

How does your school/district collaborate now with community organizations? What community resources can you identify to help achieve the expanded Tier 1 system of universal supports?

How are you embedding these values and practices into your onboarding procedures for new hires?

RESOURCES & LINKS

1. NJ Department of Education – Keeping our Kids Safe, Healthy & In School
2. George Lucas Educational Foundation – How to Maslow Before Bloom, All Day Long
3. NJ Department of Education – Restart & Recovery Plan: The Road Back
4. NJ Department of Education – NJ Tiered System of Supports
5. CASEL – CASEl's SEL Framework
6. CASEL – How Does SEL Support Educational Equity and Excellence
7. Centers for Disease Control and Prevention – Adverse Childhood Experiences (ACEs)
8. Edutopia – When Students Are Traumatized, Teachers Are Too
9. National Center for School Mental Health
10. Center on Positive Behavioral Interventions & Supports – What is Tier I Support?
11. Center on Positive Behavioral Interventions & Supports – Teaching Social-Emotional Competencies Within a PBIS Framework
12. Center on Positive Behavioral Interventions & Supports – Mental Health/Social-Emotional Well-Being
13. Center on Positive Behavioral Interventions & Supports – PBIS Tiered Fidelity Inventory (TFI)
14. Substance Abuse and Mental Health Administration (SAMHSA) – Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools
15. Mental Health Technology Transfer Center Network – The MHTTC National School Mental Health Curriculum
16. WestEd – Integrating Mental Health Services to Strengthen School Climate
17. RTI Action Network – Universal Screening Within a Response-to-Intervention Model
18. Mental Health Technology Transfer Center Network – Interconnected Systems Framework 201: When School Mental Health is Integrated Within A Multi-tiered System of Support: What's Different
19. Classroom Mental Health
20. Center for School Mental Health: School Mental Health Quality Guide – Screening
21. Classroom WISE: Well-being Information and Strategies for Educators

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Establishing Targeted Interventions

Tiers 2 and 3

WHAT YOU NEED TO KNOW

An estimated one in six youth ages 6 to 17 experienced a mental health disorder in 2016, yet only half received treatment.[1] Regardless of the status of treatment, these youth attend school and are expected to make academic gains. Meanwhile, public schools must make use of their existing resources to educate all students, yet many teachers are not trained to identify early signs of behavioral or mental health issues.[2] To attempt to meet the needs of all students, including those who are most vulnerable, schools have adopted multi-tiered systems of support (MTSS) that most effectively use internal resources and connect with external resources for consistent delivery of treatment.[3,4] Proponents of MTSS have embraced and integrated mental health services within a tiered framework to join together efforts of schools and providers to incorporate supports at each tier of intervention.[5] The resulting framework is a continuum of interventions that promotes social-emotional and behavioral wellness.

Tiered Mental Health Framework

In alignment with a public health approach, when students do not respond to the Tier 1, or primary, level of prevention and intervention, additional supports at Tiers 2 and 3 are to be considered. Tiers 2 and 3 supports are a system of interventions that are implemented to meet the often-changing needs of the student population.[6]

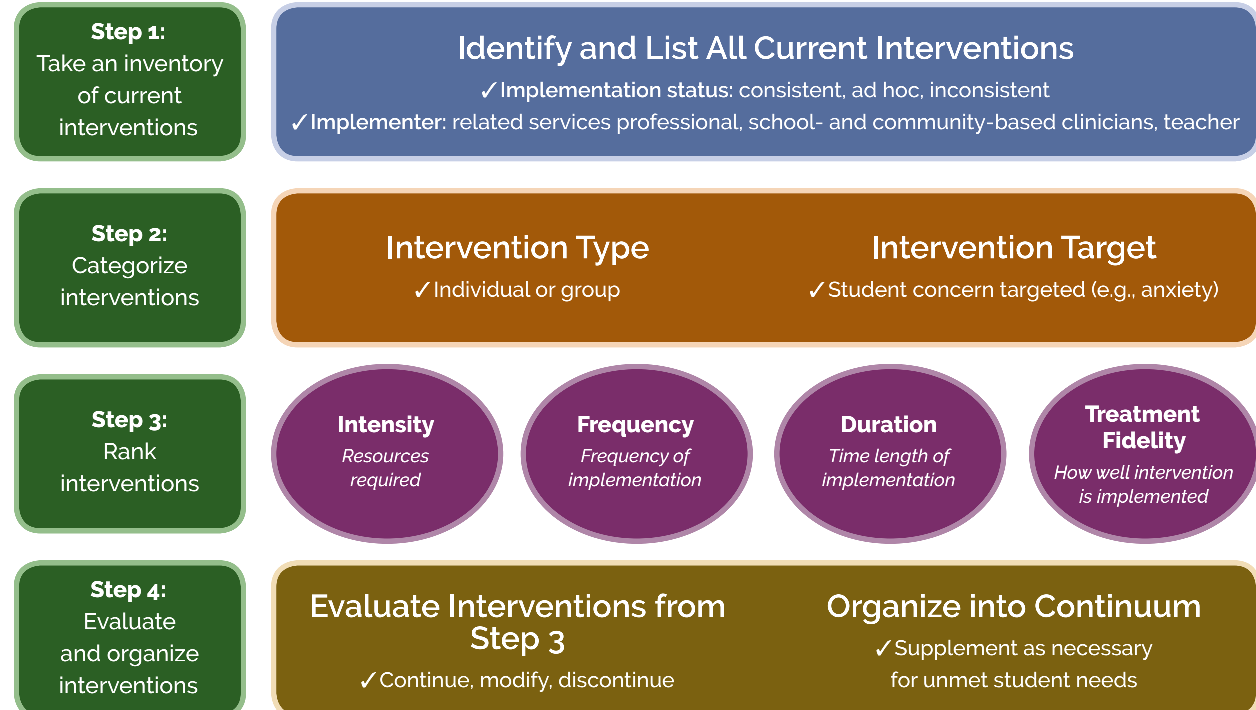
The defining feature of this system is the intensity of these supports. Tier 2 and Tier 3 supports are more intensive in nature to match the greater intensity of the student needs. Commonly in schools, when students do not respond favorably to schoolwide supports, an individualized approach is taken by tailoring an intervention plan to the needs of each and every student. While

admirable, it is important to remember that this type of approach is incredibly resource-intensive and overtaxes the whole system, most notably staff time. The lesson to be learned is that to effectively implement Tier 2 and Tier 3 supports, the school should have a robust set of Tier 1 supports. If Tier 1 support is nonexistent, then there is the potential for a large number of students to be identified as needing Tier 2 and 3 interventions. This often results in haphazard implementation of hastily developed intervention plans and students not making academic and/or behavioral gains.

In a tiered system, the intensity of supports is increased gradually in an effort to efficiently and effectively address various student needs. Thus, intervention supports at Tiers 2 and 3 range from low-intensity modifications of the Tier 1 system, to group-based interventions, to highly individualized plans for students with the greatest needs. Each set of interventions strategically leverages the existing resources of the school and is uniquely positioned to meet the needs of students.

Tiers 2 and 3 Interventions

Intervention inventory. To establish an efficient and effective system of Tiers 2 and 3 interventions, schools must take inventory of the existing interventions provided to students. The inventory should account for all means of intervention, including those that are implemented on an ad hoc basis (e.g., one to two problem-solving sessions with a peer group experiencing discord) and those delivered by school-based clinicians (e.g., school counselors who provide short-term counseling with individual students). Once the interventions have been identified, they should be categorized both by the type of intervention, and the student need targeted with each intervention. Interventions are then ranked by intensity, frequency and duration, as well as the degree to which the interventions are implemented as designed (i.e., treatment fidelity).



Implementation fidelity (sometimes called treatment fidelity) is an often overlooked data measure, yet it can have a significant impact on student behavioral outcomes.[7] Implementation fidelity can fall into two broad categories: fidelity to structure (i.e., adherence to intervention components; also referred to as procedural fidelity) and fidelity to processes (quality of delivery of intervention components).[8,9] Methods of implementation fidelity measurement include observations of implementation, self-assessment of implementation, and review of permanent products corresponding to the intervention.[8,9] Determination of implementation fidelity is a crucial task, as it emphasizes intervention implementation as a contributing variable to student outcomes.

In addition to implementation fidelity, any data metrics pertaining to outcomes of the interventions should be identified, described and analyzed. For interventions with low fidelity and/or little to no measurement of student outcomes, schools should critically evaluate if the interventions should continue with modification to improve fidelity and/or effectiveness or be discontinued. The decision for discontinuation can simply be due to lack of feasibility in light of current resources.

Continuum of interventions. Armed with the full picture of existing interventions, schools should then organize the interventions into a continuum of supports that span from group-based to individual student interventions. Many schools find that their continuum is heavier on individual student interventions, contributing to a strain on finite resources. This exercise may also illuminate the inconsistent implementation of group interventions that results in modification or discontinuation. Accordingly, it may be necessary for schools to supplement their intervention offerings.

To determine how best to add interventions to the continuum, a process of **resource mapping** may be undertaken during which the resources available within the school and community are pinpointed. Resources include staff, available time and materials, and funding. These resources must also be matched up with current student needs to design a system that is fully contextual to the local demands.

> The benefit of **a continuum of interventions** is to have multiple intervention options for student support.

Schools may then consider adopting group interventions to build out a continuum at Tier 2. There is a strong evidence base for group interventions embedded within a tiered framework for schools.[10] Group interventions comprise a standard set of interventions that offer the flexibility

of accommodating a larger group of students, provide supports that can be individualized, and operate throughout the school year to swiftly connect students to intervention. Group interventions are typically one of the following: Check-In/ Check-Out (CICO), social skills instructional groups, and group interventions that include individualized features.[2] Mentoring as an adaptable individual student intervention is also included as a Tier 2 intervention.[11] Group cognitive behavioral therapy can also be provided in school settings to address specific mental health concerns.

Interventions at Tier 3 are individualized for students with severe and intense needs. Supports may involve a function-based behavior plan conducted by an appropriately trained professional (e.g., school psychologist, board certified behavior analyst). In addition, students may participate in individual cognitive behavioral therapy sessions with a school-based clinician. A wraparound process may be utilized to engage the student, their family, and other relevant stakeholders (e.g., social service representative) in partnering for intervention development and implementation.[12] Referral to a community-based mental health agency may also be part of the Tier 3 intervention plan, when in-school supports are not sufficient to meet significant student needs. That said, a referral for outside support is not the entirety of a plan at Tier 3, as it can be expected that the student will require in-school support to be successful. (See **Intervention Tables** at the end of the chapter for a description of Tier 2 and Tier 3 interventions.)

Match to student need. The benefit of a continuum of interventions is to have multiple intervention options for student support. While CICO can enroll a large group of students, it will not be the best fit for all students. To improve the likelihood of success, teams should gather information about student needs upon identification for intervention. Armed with that information, teams review their available interventions in terms of the intervention purpose and students who are best served by each intervention. Teams then match the student with the most appropriate intervention, making adaptations as needed.

Fluidity of intervention supports. Tiers 2 and 3 are referred to as intervention supports and as such, may be applied in any combination to meet the needs of students. Note that students are not referred to as "Tier 2 students" and/or "Tier 3 students." This distinction is made to emphasize the delivery of interventions to support students, and not categorize or label students. Student needs will vary during a school year in response to home, school, and community factors, acute or chronic, and students may benefit from continued implementation of Tier 1 along with the supplement of a Tier 2 intervention, Tier 3 intervention, or a combination thereof. For example, a student may benefit from a short-term social instructional group intervention to augment coping skills, to

address an immediate need. The student may exit the short-term social instructional group but later exhibit more intensive needs which necessitate an individualized support plan with involvement from an outside mental health agency, which is consistent with a Tier 3 level of support. The student may also then re-enter the social instructional group, a Tier 2 intervention, while also receiving Tier 3 supports. The fluid nature of student needs requires a similarly fluid approach to intervention delivery, where students can access one or more tiers of intervention at any given time.

The fluid nature of student needs **requires a similarly fluid approach to intervention delivery,** where students can access one or more tiers of intervention at any given time.

The hallmark of a tiered framework is the provision of interventions that are organized and ready for implementation at any point in time, minimizing the delay of linking a student to intervention and serving a true preventive function.[13]

Data-Based Decision-Making

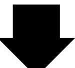
Like any intervention process, a tiered framework embeds the use of data in all aspects. Data collected in concert with Tier 1 involves data for team-based problem-solving at a macro-level (e.g., identifying school-wide behavioral trends). Tier 1 data (e.g., office discipline referrals, attendance) can also be utilized to identify students in need of additional support at Tiers 2 and 3. In addition, schools may employ universal screening as a method to proactively identify students as they exhibit early signs of difficulty. Once students receive Tiers 2 and 3 interventions, data collection continues and informs the ongoing delivery of interventions. In Tier 2 interventions as described earlier, data measures are pre-determined and part of the ongoing implementation of the intervention.[13] For example, in CICO, the daily percentage from each student's daily progress report (DPR) is an ongoing data measure to be utilized for decision-making regarding the success of the intervention. For other group interventions, it is recommended that the data measures are identified at the intervention planning stage so that when students are plugged into the groups, no additional data planning is necessary. Teams then analyze the data affixed to each intervention and make periodic decisions for continuation, modification, or discontinuation.

Decision Rules for Tiers 2 & 3

- Tier 1 data measures (e.g., ODR)
- Universal screening
- Teacher/parent request

Entry Criteria

Team establishes decision rules for each data source so that when a student exceeds the criterion, the student is matched to an intervention. The rules are applied to determine entry to Tiers 2 and 3 interventions.



Ongoing Monitoring

- Continuation
- Modification
- Discontinuation

Team-based Decisions

Utilizing data measures associated with the intervention, team monitors student data. Team decides if the intervention should continue, be modified to maximize success, or be discontinued due to student success or in favor of an alternate intervention.

Decision Rules for Tiers 2 & 3

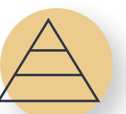
- Tier 1 data measures (e.g., ODR)
- Intervention data

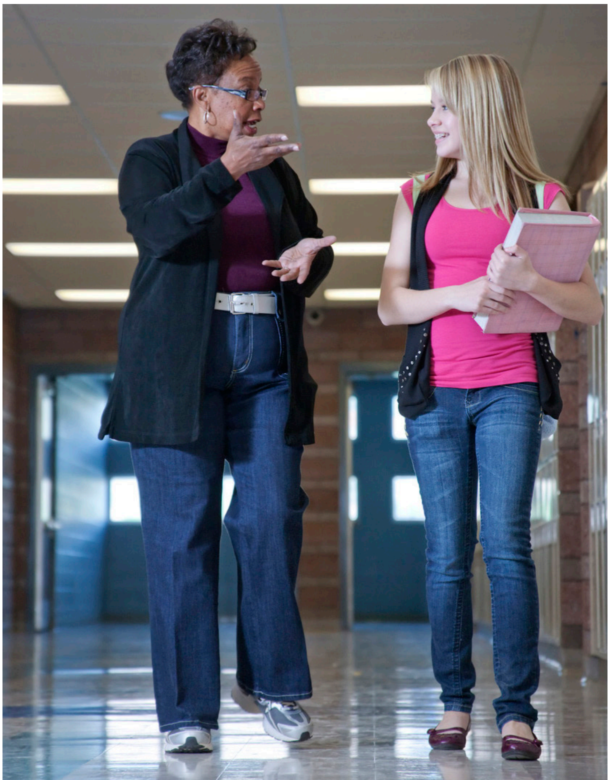
Exit Criteria

Team establishes decision rules for data sources which may include a combination of the Tier 1 data measures and data associated with the intervention. The rules are applied to determine exit from Tiers 2 and 3 interventions.

Aiding in the decision-making is the establishment of decision rules to analyze data. Decision rules should be developed for entry into, and exit from, Tiers 2 and 3, making for efficient data analysis. Creating a decision rule(s) for entry allows for teams to efficiently view data and make a swift identification of students who are in need of supplemental support. Entry criteria may be developed from multiple data sources, including Tier 1 data measures, screening measures, and teacher requests, with each data source having associated criteria for entry. Once a student exceeds the criteria, a school team should match the student with an ongoing intervention at Tiers 2 or 3. For example, a common Tier 1 data measure is office discipline referrals (ODR). To utilize ODRs as a data measure for Tiers 2 and 3, ODRs should be regularly analyzed to detect students who are accumulating multiple ODRs and consider them for entry into a Tiers 2 and 3 intervention. To expedite the decision-making process, a school should establish a criterion for the number of ODRs that triggers entry into a higher tier of intervention. A school may select an entry rule that if a student accrues three ODRs in a one-month period, the student will promptly be matched to an ongoing Tier 2 or 3 intervention. A similar process should be established for exit criteria, in which decision rules are set for exit from the intervention. As with the entry criteria, the rules for exit are predetermined and uniformly applied, to make for an efficient decision-making process. For example, the same student who entered an intervention with three ODRs in one month may exit the intervention after three months with no more than one ODR. Even if a school team decides to continue an intervention after reviewing the data, the attainment of the exit criteria should prompt a discussion by the school team.

INTEGRATION





Tiers 2 and 3 are aimed at providing intervention to students, but unlike the often-fragmented approach of student-focused supports in schools, Tiers 2 and 3 are coordinated efforts that are part of the mental health framework. To be maximally effective, Tiers 2 and 3 must be woven into the fabric of the school and viewed as a natural continuation of Tier 1 practices.

Tier 1 creates a set of preventive practices that all staff implement with all students. Tiers 2 and 3 extend those practices and carry out with greater intensity and specificity. For example, the behavioral expectations (e.g., be respectful, be responsible, be safe) taught schoolwide in Tier 1 may be instructed further in small-group sessions, and may be the basis for increased feedback as with CICO. Similarly, the Tier 1 acknowledgement system (e.g., tickets) can be integrated into a behavior support plan where a student can exchange their tickets for individual rewards.

Beyond the connection to Tier 1, schools are encouraged to evaluate their current intervention efforts and existing resources as described in the aforementioned inventory of interventions. This task should be completed with a broad brush that considers all available programs and activities in place at the school. While difficult, decisions about continuation as is or with modification must be made, along with discontinuation for all endeavors in operation. The intention of a tiered system is to form a coordinated framework of supports that is contextual to the school community. That can only be accomplished when the capacity of a school and its staff are considered in concert with student needs.

The New Jersey Tiered System of Supports (NJTSS) is a multi-tiered framework comprised of academic and behavioral supports. NJTSS emphasizes building the foundation of strong district and school leadership, a positive school culture and climate, and family and community engagement. Building a system of Tiers 2 and 3 mental health interventions aligns with the NJTSS foundation and the goal to "prepare every student for postsecondary education, career and life in the community" (NJDOE, 2019).

Other approaches and initiatives that share similar goals may be integrated within a tiered framework. Intervention and referral services (I&RS) is one such approach that seeks to plan and deliver interventions and referral services to students with learning and/or behavioral issues. The purpose of I&RS is to intervene early and link students to necessary interventions. The emphasis on school-based teaming, assessment, and evidence-based intervention fits nicely under the umbrella of a tiered framework. Rather than the typical practice of overlaying a new initiative, a key feature of tiered frameworks is the integration of existing practices and resources into the framework.

TEAMING

The backbone of any school initiative is a school team that takes on the charge for the initiative. Yet, a common practice in schools is to convene a new team for every new initiative, resulting in a multitude of teams that overlap in membership, purpose, goals, and intended outcomes. Adding to the numerous co-existing teams, teams often have poor operating procedures, leading to inefficient and ineffective processes. Therefore, the planning process must include not only an inventory of currently implemented interventions, but also a close look at how to effectively utilize existing teams, or if there is the need to create a new team to lead the formation (or improvement) of Tiers 2 and 3.

When preparing for the formation of a system of Tiers 2 and 3, a school's first task should be to assess the current landscape of teams. As discussed with the Tiers 2 and 3 interventions, schools must take inventory of their existing teams, looking for redundancy, with the intention to prioritize integrating teams rather than adding another team for student interventions. Once the school takes stock of teams and does any necessary reorganization, Tier 2 and Tier 3 teams should be specifically designated.[14] The Tier 2 team is tasked with coordinating and monitoring the systems features of Tier 2 interventions and the progress of individual students. Systems features include fidelity of implementation of all Tier 2 interventions, broad-level review of data for Tier 2 supports (e.g., number of students in each Tier 2 intervention), and use of data decision rules to identify students for Tier 2 interventions. The team will also engage in problem-solving regarding students who may require additional supports. Tier 3 teams have similar functions with coordinating the system's features and monitoring individual student progress. Coordination involves both fidelity of implementation of Tier 3 interventions, and oversight of

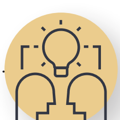
student-specific teams convened for the purposes of planning for individual students. The Tier 3 team will also review tier-wide data to monitor the functioning of Tier 3 interventions. Note that a school may decide to have one building-level team that addresses all functions, rather than separate teams. If doing so, schools must be mindful to allocate sufficient time for each function so that all tiers receive adequate attention.

Team membership should broadly represent the relevant stakeholders, including administration, education, and mental health support staff.[14] The role of administration on tiered teams is to support decisions involving finances, policy, and resources. Administrative representatives may include the principal, assistant principal and/or other designee with administrative responsibilities. Education professionals, including general and special education teachers, represent the voice of educators who will carry out the day-to-day instructional tasks with students. Mental health professionals include school-based clinicians (e.g., school counselor, school psychologist, school social worker) and community-based clinicians (e.g., clinical social worker with a community agency) that bring expertise in mental health intervention. Schools may also invite other members of the school community (e.g., building administrative assistant, school nurse, cafeteria worker).

Additional members are family members. A student's family and important people in the student's life are critical members in Tier 3 teams convened for individual student planning. Other relevant members may be probation officers, school resources officers, and social service agency representatives who have direct involvement with the student. Last but certainly not least is the student as a member of their team. A student's goals, interests, and desires cannot be adequately considered without hearing directly from the student.

Team membership should broadly represent the relevant stakeholders, including administration, education, and mental health support staff.[14]

COMMUNITY, STUDENT, AND FAMILY ENGAGEMENT



Robust mental health frameworks embrace the community resources as a part of the supports provided to students. Community-based clinicians are an important component of a tiered school mental health framework, as they can provide much needed intervention to students and their families outside of school, in particular when student needs necessitate a supplement to school supports. Schools will need to identify and seek to establish partnerships with mental health providers in the community. An initial step for identification is to utilize the resources of the county mental health association. These organizations have integral knowledge of the providers in the county, services provided, and funding streams that could lead to partnerships with providers and clinicians. Certain contractual agreements may be necessary to link the community mental health providers with school-based mental health initiatives.[5] The Department of Children and Families also has a Children's Interagency Coordinating Council (CIACC) in each county that meets regularly, is an excellent resource, and encourages school district participation.

As schools endeavor to provide Tiers 2 and 3 interventions, it is important to recognize that students and families are the vulnerable stakeholders as the recipients of mental health supports. Concerted efforts must be made to engage students and families to garner buy-in and ongoing support of the process. These efforts begin with Tier 1 and extend to Tiers 2 and 3.[15] Keeping lines of communication open with families through each tier is vitally important, particularly as intervention planning becomes more targeted to individual students. At Tier 2, providing families with written notice about intervention availability and involvement, and giving periodic updates on progress, along with data, will include families in the intervention process.

In Tier 3, families are to be integral members of individual student teams. Team meetings should be held to accommodate family attendance (e.g., offer various meeting times and alternate meeting formats), and time should be allocated for families to share their perspective, concerns and goals. As with Tier 2, periodic progress updates with data are to be shared with families. Assisting with engaging students and families at Tier 3, person-centered planning approaches that actively engage youth and their families have been found to be successful[16] (e.g., Rehabilitation for Empowerment, Natural Supports, Education & Work; RENEW). For additional ideas and suggestions for building out these Tier 2 and Tier 3 interventions, the School Mental Health Quality Guide on Early Intervention and Treatment Services and Supports (Tiers 2 and 3) is a helpful resource.

CULTURAL CONSIDERATIONS

A comprehensive mental health framework is designed to be contextual in nature so that it meets the needs of students. The context refers not just to the systemic characteristics of the school, but to the cultural identity of the students. The students' cultural identity must be at the center of the development of a school's tiered framework, so that the adopted practices align with, and value, students' identities.

Professional development and discussions with staff around culture, including defining culture, promoting staff's own awareness of culture, and acknowledging and validating the culture of their students, can lay the groundwork for more culturally responsive practices to students.[17] When considering interventions for Tiers 2 and 3, a critical eye should be placed on the cultural relevance of the interventions and/or modifications made to key aspects of the intervention to ensure relevance (e.g., modifying a social skill to include relevant language reflective of a student's culture). Similarly, the data utilized at each tier should be evaluated for its ability to identify valid indicators of behavioral concerns, and not by-products of staff subjectivity (e.g., validity of behaviors reflected in ODRs). In schools' efforts to respond to student needs, schools should consider emphasizing their ability to effectively respond to students from differing backgrounds, rather than their ability to produce the same outcomes for all students.[17]

As schools develop and engage in ongoing progress-monitoring of their tiered framework, questions like the following can be helpful to prompt reflection:

Are data indicators showing that particular groups of students are differentially identified for Tiers 2 and 3 interventions? If so, have Tier 1 practices been reevaluated?

Is there intentional pairing of students with adults who are relatable in mentoring and CICO?

Do the selected social skills and/or mental health curricula reflect the cultural identity of students?

Do the selected social skills and/or mental health curricula reflect the surrounding community?

When partnering with a community-based provider, does the school have expectations for the provider to be involved in the school community?

When partnering with a community-based provider, does the provider have clinicians that reflect the student body?

If a student is not responding to an intervention, are cultural barriers considered and explored as a possible reason for non-response?

STAFF COMPETENCIES

Staff are integral to the success of a tiered framework for mental health prevention and promotion. At a minimum, staff will be responsible for carrying out and/or supporting Tier 1 programming as designed as Tier 1 involves all staff and all students. At Tiers 2 and 3, select staff will be involved through a variety of methods, including team membership, either permanent or on an ad hoc basis; implementation of interventions; and/or supporting implementation of interventions for students.[13] For example, a general education teacher may have a student taking part in a CICO intervention. The teacher will be responsible for completing the DPR at the end of each defined period, and also providing time for the student to check out with their designated school personnel. Another consideration is the role and responsibilities of school-based clinicians. Clinicians are a rich resource for schools as they typically have the skill set required to implement Tier 3 interventions. However, these staff may be mired down with other non-clinical responsibilities (e.g., course scheduling), impacting their bandwidth to provide clinical/mental health services. Administrators must be willing to offset non-clinical responsibilities to others, thus freeing up the time and resources of their clinical staff.

For staff to be effective contributors to the mental health framework, they must possess several competencies. Understanding the uses of data across multiple purposes is key: including knowing how data are utilized to proactively identify students for interventions (i.e., entry criteria); monitoring the effectiveness of interventions within and across tiers as well as for individual students; and discontinuing interventions (i.e., exit criteria) underscores the important role of data in mental health prevention frameworks.

Similar to the role of data in evaluating outcomes, instilling the link between outcomes and fidelity of implementation is an important competency. Staff must understand that interventions

are designed for maximum effect and when implemented with low fidelity (i.e., limited frequency, or for too short a duration), the intended outcomes may be compromised. If fidelity is low, attention must be given to the barriers for implementation before evaluating for intervention effectiveness.

To fully understand the implications of mental health and the role of the school in mental health promotion, staff would benefit from psychoeducational training. Training on Adverse Childhood Experiences (ACEs) will assist staff in realizing and recognizing the impact of trauma and its manifestations in the classroom. Similarly, training staff how to respond to students in an empathetic manner can greatly enhance supportive responses to students. Youth Mental Health First Aid is one such training that instructs participants how to respond to youth in crisis and non-crisis situations.

Tiers 2 and 3 interventions are not merely a collection of siloed interventions but rather, **are threaded together as part of an overarching system** that meets the context of the school, staff and students.

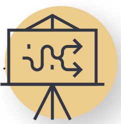
School-based clinicians bring a wealth of expertise to schools, yet they still benefit from ongoing professional development to build their toolkit in response to student needs. Clinicians will primarily be responsible for delivery of the social skills or psychoeducational groups, and as student needs change, so will the content of these instructional groups. Clinicians must be trained on new

methods and curricula in response to the evolving context of the student population. Keeping abreast of current and emerging evidence-based practices is critical for clinicians to be providing the most up-to-date treatment to students.

A final competency is an understanding of the system as a framework. Tiers 2 and 3 interventions are not merely a collection of siloed interventions but rather, are threaded together as part of an overarching system that meets the context of the school, staff and students. While the intervention practices may change based on student needs, the overall system will remain. Moreover, the system is not just another initiative that demands attention for a short period of time and then slowly, or abruptly, fades away. The system is dynamic in response to the changing school context (e.g., staff turnover, student mobility, declining resources) and will continue to evolve.

These competences will not be taught in one professional development session or even a series of professional development sessions. While the competencies should be the target of professional development, ongoing coaching and technical assistance will provide the much-needed practice to promote acquisition and generalization.

CHAPTER SUMMARY



This chapter provided an overview of Tiers 2 and 3 of a comprehensive mental health framework for schools. To establish Tiers 2 and 3, schools must harness their existing resources and interventions to create a continuum of supports for students within a system, as the system will be key for long-term implementation. System features include teaming structures; engagement of the community, student, and family; essential staff skills and competencies; and a commitment to culturally responsive practices.

Key Takeaways

Building and implementing a successful Tier 2 and 3 system of supports requires:

- Effective teaming structures;
- Engagement of the community, students, family and staff;
- Building essential staff skills and competencies;
- The use of evidence-based interventions to address the identified needs of students; and
- A commitment to culturally responsive practices.

Schools are encouraged to leverage their existing student-focused resources to create a continuum of interventions;

Existing school-based teams, whenever possible, should be leveraged to manage the work of building out and managing Tiers 2 and 3;

Implementation responsibilities for Tier 2 and Tier 3 interventions extend beyond school-based clinicians to include all school staff in varying capacities; and

Data are a central and driving factor at all tiers of MTSS.

KEY FEATURES OF TIER 2 AND TIER 3 INTERVENTIONS

Intervention: Check-In/Check-Out (CICO)

Description

Group intervention that provides students with feedback throughout the day. Designed to accommodate large groups of students.

Key Components

Each morning a student checks in with a designated school staff member (e.g., teacher, specialist, administrative assistant). The staff member greets the student, does a quick check (i.e., does the student appear prepared for the day?), gives the student a daily progress report (DPR), and sends them on their way with a positive statement ("Have a great day!"). The student takes the DPR to each class, where teachers will rate the student's behavior on the DPR along a 3-point scale. At the end of the day, the student checks out with a designated school staff member, who adds up the points received. If the student reaches a certain number of points, they receive a small prize. An additional check-out may occur at home, where the student shares the DPR with parent/caregiver, who also signs off.

Students Best Served

Students who would benefit from increased attention from adults at school.

Resources Required

Training

- One 30-minute training for all school staff; refresher trainings may be necessary during the year.
- 10 minutes daily for morning check-in person.
- 1-2 minutes at end of each academic period for classroom teacher or assistant.
- 15 minutes daily for afternoon check-out person.

Materials

- One-page summary of CICO intervention. Distribute to school staff when a student in their class is enrolled in CICO.
- Development and reproduction of DPR, a standardized form that lists the school expectations corresponding to Tier 1.

Implementation Recommendations

- While CICO is a standardized intervention, modifications may be made on a limited basis (e.g., check-in/check-out staff, individualized expectations on the DPR) to meet the needs of each student. However, it is recommended that individualization is done only on a limited basis.
- The check-in and check-out staff may change; having back-up staff is recommended.
- As the number of students enrolled in CICO increases, consider increasing the number of check-in staff and check-out staff.
- Have a standard location for check-in and check-out.

Resource

Published guide by Hawken et al. (2020) to CICO implementation

KEY FEATURES OF TIER 2 AND TIER 3 INTERVENTIONS

Intervention: Social skills instructional groups

Description
Provides students with social skills modeling and opportunities to practice these skills, facilitated by a clinician.

Key Components
The instructional content should extend the Tier 1 schoolwide expectations, while also following a scripted, evidence-based curriculum, articulating the targeted skills, curriculum objectives, lesson plans, and time required for delivery. Curricula should be versatile; include classwide or large group lessons that can also be delivered to small groups of students for additional skills practice.

Students Best Served
Students who would benefit from increased social skills instruction and practice in a session facilitated by a clinician.

Resources Required
- One 30-minute training for all school staff; refresher trainings may be necessary during the year.
- Training for clinicians as required by curricula.
- Multiple 30-45-minute sessions per week.
- Purchase of evidence-based curricula.

Implementation Recommendations
Build in methods for classroom staff to prompt the use of skills taught in the groups. Frequent use of the skills will help facilitate their use outside the group session.

Resources
Repository of social skills curricula:
- Office of Juvenile Justice and Delinquency Prevention Model Programs Guide (Filter by: *Mental Health* and *School-Based*)
- SAMSHA Evidence-Based Practices Resource Center

Examples of social skills curricula:
- PATHS Programs
- PREPARE Curriculum
- Skillstreaming

KEY FEATURES OF TIER 2 AND TIER 3 INTERVENTIONS

Intervention: Mentoring

Description

Pairs a student with an adult, typically a school staff member, to develop a caring, supportive relationship. While mentoring is often an informal support for students, formalizing the mentoring relationship provides many benefits for both mentor and mentee.

Key Components

To formalize mentoring as an intervention, expectations must be established, including the mechanics of mentoring, the role of the mentor, the commitment from the mentor, and the importance of frequent mentor-mentee contacts. These contacts should be viewed as brief check-ins, offering an opportunity to engage in problem-solving as needed. Initial training should cover tips for developing a relationship, solution-focused problem-solving, and data collection efforts.

Students Best Served

Students who would benefit from increased attention and support from an adult at school.

Resources Required

- One 2-hour initial training for new mentors; refresher trainings may be necessary during the year.
- One 30-minute training for all school staff; refresher trainings may be necessary during the year.
- Brief weekly meetings with student/mentee.

Implementation Recommendations

- Conduct initial training with new mentors prior to matching them with mentees.
- Hold a training with mentees upon enrollment in the intervention.
- Allocate time for weekly mentor-mentee meetings.

Resources

- Checklist for implementation of mentoring
- Garringer et al. (2015). Elements of effective practice for mentoring (4th ed.). Mentoring practice topics including recruitment and training.

KEY FEATURES OF TIER 2 AND TIER 3 INTERVENTIONS

Intervention: Cognitive behavioral group therapy

Description
Provides students with treatment for a target concern led by a clinician in a group setting.

Key Components
Evidence-based programs that follow a cognitive-behavioral approach are available that target specific student concerns (e.g., anxiety). The programs articulate the targeted skills, programmatic objectives, specific activities, and time required for delivery. Programs with an evidence-based approach are highly recommended, as they provide a set of skills that have been tested for effectiveness.

Students Best Served
Students with mental health concerns who would benefit from group treatment led by a clinician.

Resources Required
- Training for clinicians as required by programs.
- Multiple 30-45-minute sessions per week.
- Purchase of evidence-based programs.

Implementation Recommendations
Build in methods for classroom staff to prompt the use of skills taught in the groups. Frequent practice will encourage students to use the skills outside of the group session.

Resources
Repository of programs:
- Office of Juvenile Justice and Delinquency Prevention Model Programs Guide (Filter by: *Mental Health* and *School-Based*)
- SAMSHA Evidence-Based Practices Resource Center

Evidence-based programs by target:
- *Aggression*—Anger Coping Program *and* Coping Power Program
- *Anxiety*—FRIENDS Programs *and* Coping Cat
- *Externalizing behavior problems*—Incredible Years Small Group Dinosaur Curriculum

KEY FEATURES OF TIER 2 AND TIER 3 INTERVENTIONS

Intervention: Individual cognitive behavioral therapy

Description
Provides students with treatment led by a clinician in an individual setting.

Key Components
Evidence-based programs that follow a cognitive-behavioral approach are available that target specific student concerns (e.g., anxiety). The programs articulate the targeted skills, program objectives, specific activities, and time required for delivery. Programs with an evidence-based approach are highly recommended as they provide a set of skills that have been tested for effectiveness.

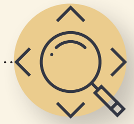
Students Best Served
Students who demonstrate mental health concerns and would benefit from treatment led by a clinician.

Resources Required
- Training for clinicians as required by program.
- Multiple 30-45-minute sessions per week.
- Purchase of evidence-based programs.

Implementation Recommendations
Family involvement is an important part of many programs for youths; some include specific components for families.

Resources
Depression: Primary and Secondary Control Enhancement Training (PASCET)
Anxiety: Cool Kids

SPOTLIGHT



FRANKLIN SCHOOL (NEWARK PUBLIC SCHOOLS)

Targeted Tier II Groups

Over the past five years, Franklin Elementary School has emphasized developing schoolwide, sustainable SEL/PBIS practices. We developed a sustainable Tier 1 program where the entire school developed and reinforced core values and developed classroom systems that were reinforced schoolwide. Shortly thereafter, we developed our Tier II system to address students in need of additional support.

During the first phase of implementation, we piloted a student universal screener to identify the strengths and needs of our middle school students. Students completed the Strength and Difficulties Questionnaire (SDQ). Those who scored high on more than one behavioral scale were referred for the first round of Tier II groups. This data was also used to prioritize areas of focus, strategies for program implementation, and action steps. For example, one group was focused on self-regulation, emotion management, and social awareness. This group was comprised of a lead teacher, a behaviorist and additional staff members who signed up to be mentors. Additionally, we developed a Girl Group, led by our behaviorist and social worker. This group emphasizes self-esteem and social skills. These pilot groups helped the school team identify the most pressing needs impacting students, gaps in existing services, and patterns of needs.

Successes

- As a result of these groups, our teachers reported less time off-task in their classrooms, and less time dealing with discipline issues.
- The overall mindset of our staff has transitioned to focus on preventive strategies and rewarding positive behaviors, which has decreased referrals and supported students to self-regulate. These skills will benefit students throughout their lives.
- Universal screeners help identify student needs and gaps in existing services.

Lessons Learned

- We have adapted and developed a schoolwide Success Hour. Groups throughout our middle school become part of a small-group setting to work on areas encompassing their SEL needs and academics.
- Developing teacher leaders helped with buy-in and supported a sustainable coaching model for our school. Last but most important, we have made SEL practices a priority at our school, hosting a monthly SEL grade level meeting for all staff and monthly SEL leadership team meetings. We discuss all our TIER II group meetings at our bimonthly student support team meeting. We find that having all these meetings helps triangulate and support our staff in supporting our students' SEL needs.

Reflection Questions

What data sources does my school have to efficiently identify students in need of additional intervention?

How can my school leverage our existing student-focused interventions to create a system of supports?

What teaming structures does my school need to establish a system of Tiers 2 and 3 intervention?

What competencies do my staff/colleagues possess to support a comprehensive mental health framework?

What professional development do my staff and colleagues need to support a comprehensive mental health framework?

How can we engage our families to support this system? What workshops or information sessions would be useful?

Should we create district-level or school-based positions to address Tier 2 and Tier 3 needs or contract with a community provider?

If we create district-level positions to support a comprehensive mental health framework, what are the essential skills needed and what does the job description look like?

RESOURCES & LINKS

Access to current information that will aid in all aspects of the Tiers 2 and 3 system, including assessment and intervention, is also vital. The School Health Assessment and Performance Evaluation System (SHAPE) is a wonderful resource for schools to locate screening and assessment measures designed specifically for school mental health programming. The National Center on Safe Supportive Learning Environments (NCSSLE) focuses their efforts on improving school climate and the conditions for learning for all students. To meet this goal, NCSSLE has offered information on various mental health topics pertinent for schools. The Substance Abuse and Mental Health Services Administration (SAMSHA) has assembled a collection of programmatic resources relevant to school mental health. In addition, please see the resources contained within the **Intervention Tables** on the previous pages.

1. The School Health Assessment and Performance Evaluation System
2. The National Center on Safe Supportive Learning Environments
3. Substance Abuse and Mental Health Services Administration

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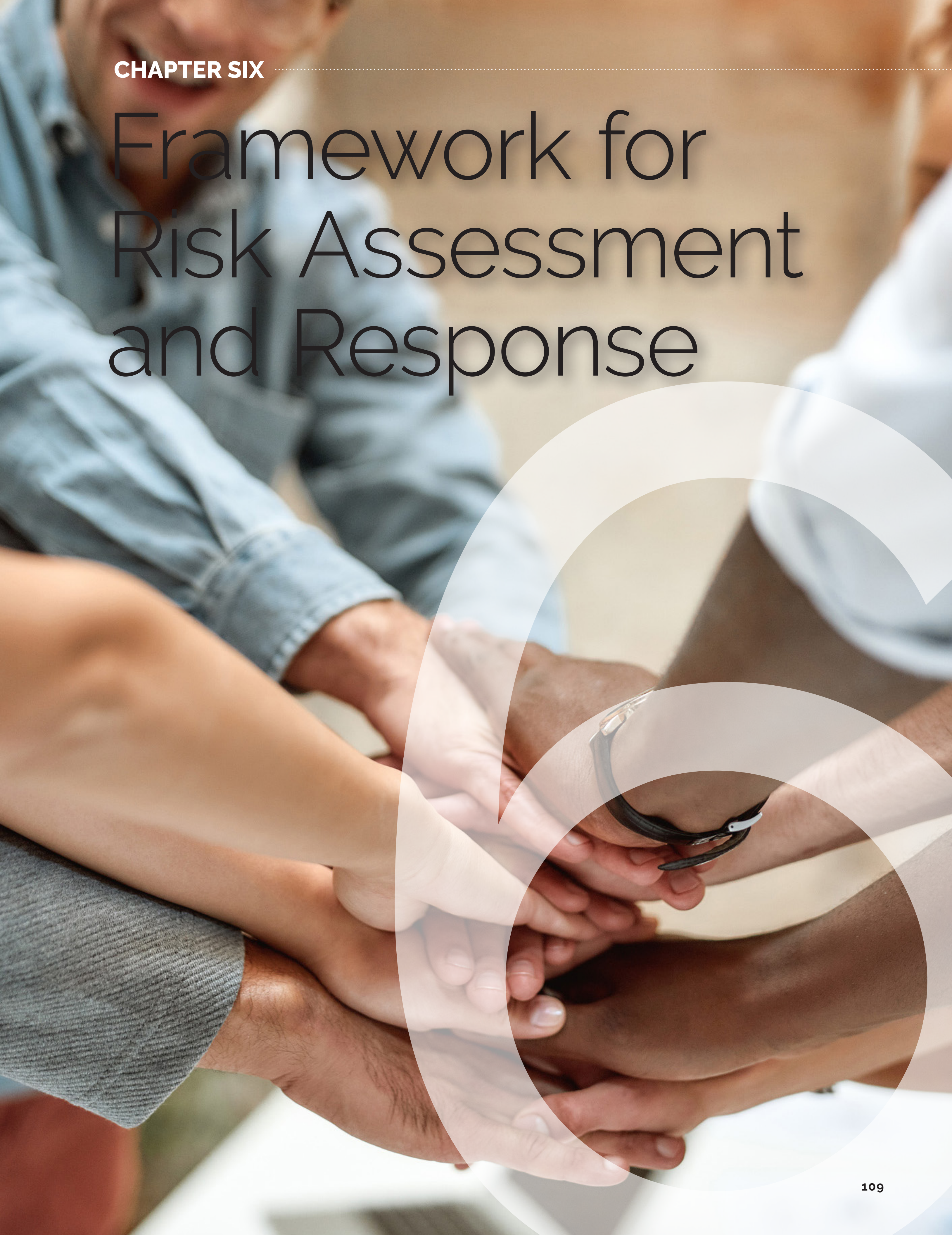


CHAPTER SIX

Framework for Risk Assessment and Response

WHAT YOU NEED TO KNOW

The primary aim of this chapter is to provide a general overview of recommended protocols, procedural tasks, and best practice insights in school-based mental health triage, student assistance and risk assessment. As such, this chapter is not exhaustive in scope. It is intended to augment information outlined in Chapter 7 on suicide risk assessment and serve as a functional reference source for school staff when encountering and managing students placed at risk and/or demonstrating any form of psychological distress. Managing risk to students' well-being, however, has grown more and more complex and urgent over the years, requiring schools and the mental health sector to partner at the intersection of education and mental health to improve school-based mental health strategies, support services, and programming to ensure children and adolescents have greater access to the education to which they are entitled.

Like physical health and education, mental health and education are bidirectionally linked. That is, access to a quality education is an investment and protective factor in the mental health and well-being of children and adolescents, and positive mental health and well-being is essential for learning, academic performance and achievement.[1] The ability to fulfill key life functions is at the center of living mentally healthy. And although the terms mental health and mental illness tend to be used interchangeably these days, the Centers for Disease Control and Prevention (CDC) remind us that it is remarkable to note that poor mental health and mental illness are not the same things. Thus, it is important to realize that being mentally healthy and emotionally stable is more than the absence of mental illness, but rather the presence of positive characteristics and protective factors that buffer against risk and promote building better mental health to support our psychological needs.

School-based mental health programs and services are essential in addressing the diverse psychological needs of youth and helping them build better mental health. Moreover, there is a strong correlation between mental health and academic outcomes.[2] Therefore, unmet mental health needs impact those outcomes, and not only do they interfere with learning, but they also create barriers to it—placing many already vulnerable children and adolescents at increased levels of risk. For that reason, the principal tasks of effective school-based mental health services are aimed at reducing and managing risk-related barriers to learning and bolstering resilience through establishing a safe, equitable, and healthy school culture and climate vis-à-vis an interconnected continuum of care.

However, it should be noted that there is considerable variability in programs and services at both local and state levels. Consequently, the ways in which schools and larger districts understand, organize, prioritize and implement school-based mental health services varies greatly, and is largely determined by the resources available. Keeping this in mind, it is essential for schools to base student assistance protocols and procedural tasks on the premise that all behavior has meaning and is a form of communication.[3] Our behaviors often express our preoccupations, fears, interpersonal experiences, worldview and relational history. Therefore, to increase the likelihood of successful interventions as well as academic outcomes, it is our professional obligation to broaden our repertoire of responses, particularly in matters concerning mental health and well-being, to enhance our understanding and assessment of complex developmental issues.[3]

Types of Risk/Assessing Level of Risk

"At-risk" is a broad term commonly used in educational settings to note a wide variety of issues and/or behavioral concerns that interfere with learning and compromise students' academic functioning. According to the Glossary of Education Reform, a comprehensive online resource that describes widely used school improvement terms, concepts, and strategies for journalists, parents, and community members, this term is used to refer to general populations or categories of students who have a higher probability of failure or drop out. However, the term may also apply to individual students who have raised concerns based on specific behaviors observed over time. Commonly identified indicators of at-risk behavior include, but are not exclusive to: poor attendance, truancy, excessive tardiness, poor or failing grades, limited school participation, physical learning disabilities, prolonged or persistent health issues, family welfare or marital status, parental educational attainment, income levels, employment status, immigration status, incarceration history, or households in which the primary language spoken is not English.

Still, it is remarkable to note that there is no universally understood definition of this term. And although well-intentioned, debate within the field suggests there are limitations and implications to the use of this catch-all phrase that may give rise to overgeneralizations that can be stigmatizing, especially to minority groups and those from lower socioeconomic backgrounds. Therefore, to use the term effectively and appropriately, it is important to be more mindful of our intent and impact when we consider its usage and utility.

For the purposes of this chapter, the term "at-risk" will be substituted with "***placed*** at-risk," and operationalized as responding to a student or group of students in distress, during an emergency (personal or schoolwide), because of an immediate crisis or personal safety situation, or when the student is demonstrating and/or being observed exhibiting concerning behavior. Thus, when assessing risk, the intention is to describe a situation, condition, or cluster of circumstances that may contribute to the presenting problem being assessed, not just an individual characterization of a particular student and interpretation of subjective surface behavior to ascertain what steps are needed to: ensure safety, reduce undue harm, and connect said student to available resources at school, within the community and at home. Approaching risk assessment in this way, from what can be considered a bio-psycho-social perspective, better positions school-based mental health providers to purposefully account for contextual variables associated with implicit and explicit student risk behaviors at the onset of their interview and initial assessment. Moreover, it endorses an ecological, non-pathologizing, student-in-environment perspective in all phases of intervention on the continuum of student mental health supports.[4]

It is important to remember that the ways in which schools respond to risk matters. Again, it is vital to note that all behavior has meaning and is a form of expression and communication—specifically in the context of interpreting, understanding and evaluating child and adolescent risk behaviors. This cannot be overstated or undervalued. Thus, surface behaviors alone, that can be easily misunderstood and often misinterpreted, should not be the sole determinant in shaping screening and assessment policies, informing intervention practices, or influencing a student's educational program. Certainly, behavior serves a function and can be viewed as a set of data points to be appraised. However, there are many other factors that need to be considered to get a more comprehensive view of the issue that goes beyond pathology.

Hoover and Bostic[4] outline several best practices and considerations for student mental health screening in schools:

Screening should be a part of a comprehensive, multi-tiered system of student mental health supports.

Families and students should be involved in planning and implementing screening.

School mental health screening practices should prioritize accuracy, privacy, safety, and follow-through.

The School Mental Health Screening Playbook is one of a series created by the National Center for School Mental Health (CSMH) as a part of the National Quality Initiative, funded by the Health Resources and Services Administration. According to the School Mental Health Screening Playbook, action steps toward establishing a screening process include:

1. **Building a foundation**
   - Assemble a team
   - Generate buy-in and support
2. **Clarify goals**
   - Identify purpose and outcomes
3. **Identify resources and logistics**
   - Identify student mental health support resources

- Create a timeline
- Identify staffing and budget resources
- Develop administration policies

4. **Select an appropriate screening tool**
5. **Determine consent and assent processes**
   - Deliver a consistent message
   - Share information in multiple formats
6. **Develop data collection, administration, and follow-up processes**
   - Develop screening data collection and progress monitoring systems
   - Pilot screening procedures
   - Consider using advisory or homeroom time to administer screenings
   - Provide screening scripts for staff
   - Provide follow-up

It is equally imperative to understand that the terms risk assessment and crisis intervention are not synonymous with emergency room (ER) screening or hospitalization. Not all risk assessments and/or students identified in acute crisis require a referral to the local emergency room or psychiatric facility. In fact, on the contrary, *referrals to the ER should be considered the most restrictive intervention within the student's environment and considered only in cases of high risk and imminent danger.* Accordingly, it is essential that school staff and student mental health teams can distinguish the difference between risk assessment and school clearance, as they are similar in nature but not the same in breadth and scope. Clarifying this difference should be a part of any protocol put in place by an established school mental health or crisis team to limit further exposure to trauma and to respond to various levels of student risk systematically and strategically. To the extent possible, it is best to first seek to partner with collateral contacts and resources vetted within the community, to connect students and their families to available services offered by the NJ Children's System of Care (CSOC).

Nevertheless, it is common for a school clearance to be deemed necessary, depending on the presenting circumstances at the time of the request, to formally rule out risk of harm to self or others, in order for a student to return to school. A school evaluation and clearance letter should be completed by a licensed mental health clinician, such as a licensed clinical social worker (LCSW), licensed psychologist (PhD/PsyD), licensed professional counselor (LPC), psychiatric advanced practice nurse (APN), or psychiatrist (MD/DO). The purpose of the clearance letter is to acknowledge that the student of concern can return to school with written documentation by a trained evaluator that confirms said student does not present as a danger to his/her/themselves. It is not expected, nor is it appropriate, to include diagnostic information or clinical disposition. The letter should be addressed to the designee, administrator, or other named personnel and be directly provided to the authorized designee upon student arrival. The letter should include the following:

- **The evaluator's name and license number**
- **The student's name and date of birth**
- **Confirmation that the evaluator assessed the student following, and in connection with, the precipitating school-based incident**
- **The date and location of the assessment**
- **An explicit statement that notes "at this point in time" the student does not present a danger to his/her/themselves**

Also, as illustrated in the figure on the following page, the Children's Interagency Coordinating Council of Bergen County (CIACC) maintains a resource, "School Mental Health Assessments and Clearances: Listed Partners." This resource is always available on the CIACC page on BergenResourceNet.org for sustainable reference. It is reviewed and updated as needed each year.

BERGEN COUNTY SCHOOL MENTAL HEALTH ASSESSMENT PROVIDER LIST (UPDATED MARCH 2021)

Please make sure you indicate the assessment is for a school mental health assessment and letter of clearance (as appropriate)

QUESTION	CARE PLUS NJ, INC	COMPREHENSIVE BEHAVIORAL HEALTH CARE	WEST BERGEN MENTAL HEALTH CARE	CHILDREN S AID AND FAMILY SERVICES
Does the agency issue school clearance letters?	Yes, with understanding family many need to follow through with treatment recommendations	Yes	Yes	Yes, with understanding family many need to follow through with treatment recommendations
If yes, who can assess students and sign clearance letters?	Licensed clinical professional	Child psychiatrist or LCSW	Licensed clinical professional	Licensed clinical professional
For a clearance, what is the typical waiting period to see a licensed clinical professional?	Same day or next day	As available, usually same day or next	Almost always accessed the same day, but virtually during Covid	Seen the same day or next day
What is the typical duration of time for the clearance letter to be sent out?	Family leaves appointment with letter	Within 48 hours of the assessment	During COVID, with parent consent, letter is emailed to school after assessment. Normally, parent leaves assessment with letter.	Family leaves appointment with letter and recommendations
Are the follow-up recommendations only on the discharge summary or in any other report?	Recommendations will be made for additional evaluations if needed	Left to discretion of psychiatrist, LCSW, and school request	Not in letter, but in follow-up communication provided with signed release	Recommendations will be made for additional evaluations if needed with a signed release
Does your agency obtain written parental consent for release of assessment and recommendations to the school staff?	Yes	Yes—required before information is released	Yes	Yes
Does your agency see students from outside your catchment area for assessments and letters?	Yes	Yes	Yes	Yes
Access number and/or title of staff member to be contacted for this type of service	For scheduling, call 201-797-2660 x5602 If needed, ask for Director of Children's Services. **Request a school clearance assessment**	For scheduling, call 201-646-0195 If needed, ask for Resource Utilization Manager. **Request a school clearance assessment**	For scheduling, call 201-688-7098 Ask for Access Center; if needed, ask for Outpatient Director. **Request a school clearance assessment**	For scheduling, call 201-740-7082 Ask for Director of Clinical Services. **Request a school clearance assessment**
How is the cost for the assessment and clearance letter covered?	***Varies***—discuss costs and payment options with specific providers *Please note: New Bridge Medical Center (formerly Bergen Regional) will no longer provide clearances.*			

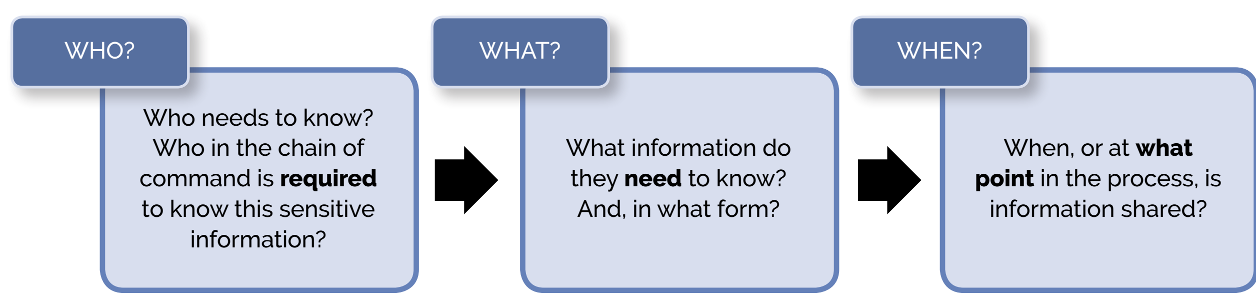
Additional resource: Children's Mobile Response (Care Plus)—24-hours/7 days a week crisis intervention and stabilization for children and youth in Bergen County. To make a referral or for help, call 877-652-7624; Jaime Arlia, LPC, ACS, Director of Children's Mobile at 201-796-9479 or email JaimeD@CarePlusNJ.org. ***Program goal***—maintain children in safe and stable living arrangements in the community, thereby reducing the need for out-of-home placement or psychiatric hospitalization.

To this end, and to the extent possible, it is recommended that school-based mental health teams designed to address student risk operate on a crisis intervention continuum and offer a range of social-emotional, behavioral and intensive psychological supports aimed at reducing harm while limiting interruption to a student's educational program and developmental needs.

Establishing a Communication Protocol

School-based mental health is an umbrella term that refers to an emerging field comprised of several separate but related mental health disciplines. These include social work, psychology, school counseling, nursing, psychiatry and allied health professions.[2] Hence, school social workers, school psychologists, school counselors, school nurses and medical staff, as well as special education and related service providers, either employed by the district and/or contracted through a memoranda of understanding (MOU) with a local mental health agency, are considered to be school-based mental health staff and identified as the "qualified designee" to assess student risk, depending on the specific needs and resource allocations of each school site.

To facilitate the transfer and flow of important and sensitive student information, as well as to determine designee status, a detailed chain of command in the form of a communication protocol must be put in place. This communication protocol is intended to guide direct interactions and outline points of contact in a sequence of orderly steps to resolve matters as efficiently as possible. As illustrated in the figure below, these steps should be determined based on:



In most schools, once a problem or student concern is identified, a designated member of the school-based mental health team is immediately consulted. Subsequently, an informal or formal screening takes place to understand the context of the situation, assess the symptoms presented, and engage in triage processing to determine whether a more in-depth interview is warranted. The outcome of triage processing and the support needed will largely depend on the level of risk associated with the student presentation, as outlined in the risk continuum or severity index categories below:

Low Risk Non-Urgent = Responsive, Light Support (T1)	→	Moderate Risk Urgent = Targeted Support (T2)	→	High Risk Imminent Danger = Crisis Intervention (T3)
Student is demonstrating or reporting low levels of mood or behavior difficulty or distress.		**Student is demonstrating or reporting moderate to high levels of mood or behavior difficulties or distress.**		**Student is demonstrating or reporting significant levels of mood or behavior difficulties or distress, and is at high to extreme risk for imminent harm or suicide.**

Developing and impressionable minds look to the adults at school to model and mirror physical and psychological safety, felt security, predictability, and reliability.[5] These elements are the foundational features of a corrective emotional experience and nurturing holding environment. In other words, if we modify our understanding and adjust our attitudes toward student risk from traditional reaction to transformative responding, we have the power and influence to help children and adolescents turn crisis into opportunities for learning, connection and corrective emotional regulation. Adapting the principles and strategies of the life space crisis intervention model (LSCI) can be helpful in achieving this. LSCI is an evidenced-based crisis intervention model that is grounded in knowledge of what is going on in a child's brain during stressful moments. This model provides developmentally appropriate and brain-based focus to effectively regulate, respond and build relationships with children and adolescents from a trauma-sensitive and culturally responsive lens.

General Triage and Student Assistance Protocols

Responding to student psychosocial concerns in any form requires schools to have an established set of best practice guidelines, preferably in the form of a flowchart or decision-making visual aid, to follow, that connects said student/s to the right help based on the circumstances of the situation. It is recommended that at the beginning of each school year, a full review of these guidelines should be provided in a training for all staff in each building. While each district and respective school building within each district will likely determine its own procedures to adhere to as per district administrative policies, some general best practices should be adapted and applied when establishing student assistance and risk assessment guidelines. These include:

1. Immediately interview student of concern and conduct an informal initial assessment to identify crisis type and gauge severity index. Not every student of concern will require a formal screening or assessment.
2. Depending on the outcome of this interview, the designee will indicate whether a formal assessment needs to be conducted. If so, the designee will select a formal measurement tool approved by building/district administration to administer. (Please refer to Chapter 7, **suicide risk assessment,** for a comprehensive listing of endorsed screening options.)
3. If necessary, as determined by the initial interview and outcome of severity index, notify the parent/guardian about the situation. If parent contact is a concern to the student's well-being, you must determine whether a call to the Division of Child Protection and Permanency (DCP&P) is warranted, and follow district procedures accordingly.
4. Assist student and family in determining the appropriate form of intervention. In addition to offering ongoing school counseling support and monitoring, make appropriate referrals for ongoing psychological services within the community as needed or as requested by a parent/guardian. Offer linkage assistance based on the needs of the family to ensure follow-through. If a preexisting outpatient relationship is present, seek an authorization for the release of information to consult and partner with said provider on how to best support the student in the school setting.
5. Document the situation and inform the administration as determined by district policy standards, in accordance with mandated HIPPA/FERPA confidentiality requirements.

Many schools partner with the medical staff in the school health office when keeping student mental health information. All student mental health information is privileged, and as such, should be considered a part of the student's medical file, not their general student record, for an added layer of privacy.

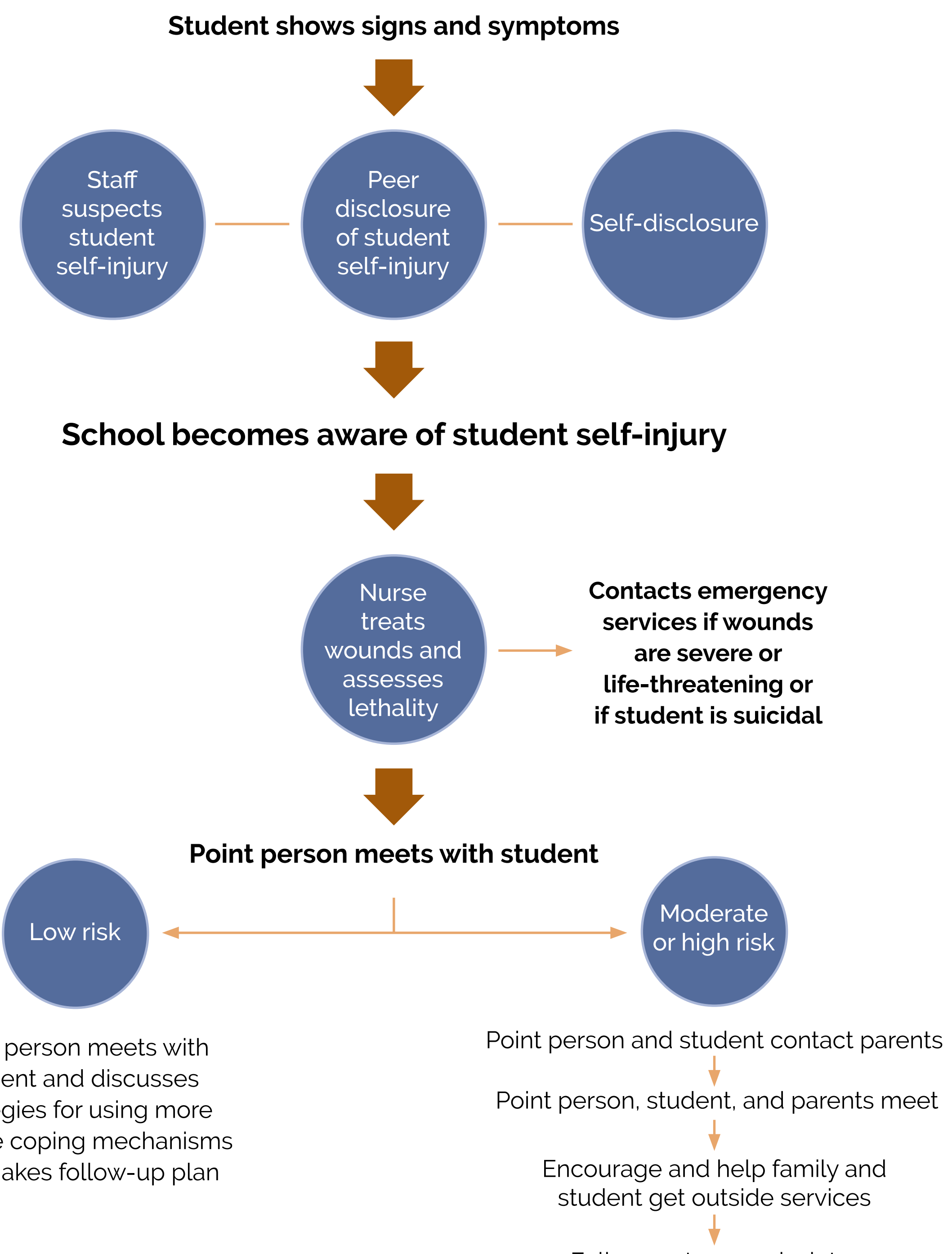
6. Follow up with said student when they return to school or within 48 hours after assessment interview and intervention. Maintain contact with family for future needs.

Additional trauma-responsive considerations specific to identifying students placed at high risk of suicide and/or non-suicidal self-injury (NSSI) include the following:

- The risk of suicide or potential harm to self is raised when any peer, teacher, or other school personnel identifies someone who is potentially suicidal because they have directly or indirectly expressed suicidal thoughts (ideation) or demonstrated warning signs.
- When the risk is raised, the student should be brought by school personnel to the designated school-based mental health team member to be assessed for level of risk. The student should remain supervised and asked if they have any weapons or anything that could be used to carry out self-harm.
- The designated school-based mental health team member should gather essential background information that will help with assessing the student's risk for self-harm or suicide (e.g., what the student said or did, information that prompted concern, or copies of any concerning writings or drawings).
- Phone calls for consultation should be made in a confidential setting and not in the presence of the student.
- The designated member of the school-based mental health team, trained in suicide assessment, should meet with the student to complete a suicide risk assessment. (See Chapter 7 for more information specific to **suicide screening and intervention.**)
- Parents should be notified as soon as possible when there appears to be any possibility of high-risk/imminent danger, unless it is apparent that such notification will exacerbate the situation and further traumatize the student. In a case where there is suspected abuse, consult school administration immediately and follow mandated reporting policies as per DCP&P.
- The designated member of the school-based mental health team will determine the next steps, depending on the level of risk the student presented. This can also be an opportunity to consult with team members and/or team lead to support your disposition.
- For matters specific to NSSI, or for more comprehensive guidance in developing or implementing school protocol for NSSI as illustrated in the figure on the following page, please refer directly to the **Cornell University Research Program on Non-Suicidal Self-Injury in Schools.**

School Protocol Process

The flowchart below can help school staff decide what action(s) to take after discovering that a student may be engaging in self-injury.



Assessment Measures, Screening Tools and Recommended Documentation

Mental health assessment and screening measures offer structure to the content of the risk assessment interview and provide an opportunity for identified school-based mental health personnel to determine the severity of risk more accurately and objectively. The information collected can offer valuable insight into a student's well-being and provides a starting point to inform the most appropriate student-centered intervention.

It should be noted that many of the assessment tools provided in the screening section of Chapter 7 on suicide risk assessment can be adapted and utilized for a continuum of psychosocial concerns demonstrated in the school setting at all three tiers. Please refer to that chapter for a listing of endorsed screening options. However, another formal Tier 2 instrument worthy of mention is the **Brief Intervention for School Clinicians** (BRISC), which provides a structured triage approach to assess and inform intervention planning. BRISC was developed collaboratively between researchers and practitioners to translate educational adaptations of the public health model into practical, research-based strategies.[6] This evidenced-based tool helps the school-based mental health provider engage-assess-teach. For training information and technical assistance, please refer to the **University of Washington (UW) School of Mental Health Assessment, Research, and Training (SMART) Center** website.

Re-Entry and Transition Recommendations

It is best practice to hold a re-entry meeting for students returning to school from an absence related to their mental health. These meetings are an opportunity to transition a student back to school as seamlessly as possible. During re-entry planning, a needs-based school safety plan can be established, on-site supports can be put in place, and any necessary educational recommendations or accommodations can be made. Re-entry typically includes a meeting with designated mental health staff, administration (if necessary or if school protocol requires it), the student, and the student's parent(s) or guardian(s) on the morning of the student's planned return. Sharing between partner agencies and collateral contacts is vital to effectively planning and coordinating student re-entry and transition as well. It is important to keep in mind that the signed consent of a parent or legal guardian to obtain and release information is essential to comply with privacy laws in educational settings. Creating a consent to release information checklist is a good place to start to ensure compliance when communicating with partners to monitor care and track student progress.

Additional practice considerations are explicitly outlined in Chapter 2 of the "School Mental Health Referral Pathways (SMHRP) Toolkit" and introduced below to guide re-entry planning (Clemens et al., 2002; Cook-Cottone, 2004; Kaffenberger, 2006; Vermeire, 2008):

Meet with the young person and family to find out what information will be shared and how they want information shared.

Ensure that appropriate release of information documents are signed to share information among providers for intervention planning.

Designate a "go to" person who will meet and greet the student upon return.

Provide support and understanding to the student, including assessing the student's perceptions of their functioning as well as their preferences regarding the type of support wanted (e.g., check in with staff at end of the day, role play how to respond to questions from classmates).

Make up a list of missed work for each class, review it with the parents and the student, and assist in contacting teachers to compile this information.

Implement appropriate modifications and temporary accommodations (reduced workload, half-day attendance for a period of time, alternative assignments, extended time on tests, peer tutoring or mentoring if desired).

Inform student of supportive resources available (consider special support systems such as personal phone contact, an assigned counselor, school-based support group).

Adhere to recommendations from outpatient providers.

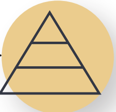
Provide specific plans and guidance about issues that contribute to the student's problems (e.g., people, places, and things that may trigger a response).

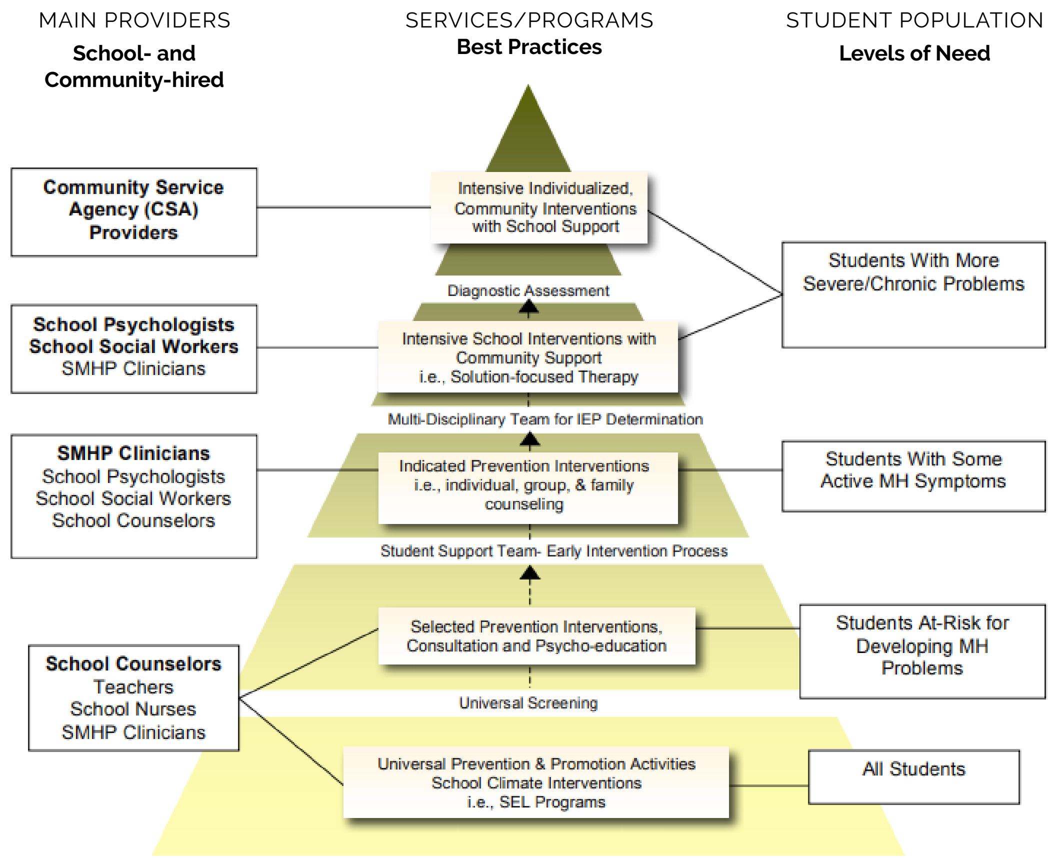
Ensure staff are trained in signs of relapse and appropriate interventions and strategies.

Keeping privacy considerations and constraints in mind, provide information and direction to staff who will interact with the student.

Monitor systematically and adjust educational plan as needed.

INTEGRATION





Source: Adapted from "Communication Planning and Message Development: Promoting School-Based Mental Health Services" in *Communiqué,* Vol. 25, No. 1. National Association of School Psychologists, 2006.

An MTSS continuum of services and supports is designed to meet the developmental needs of the whole child by systemically integrating learning, social and emotional functioning, mental and physical health, and the overall well-being of students. As illustrated in the figure above from the Center for Health and Healthcare in Schools at George Washington University's "School Mental Health Services for the 21st Century: Lessons from the District of Columbia School Mental Health Program" (2008), mental health services and programs fall into different levels of intensity. Those services and programs can be provided by school-employed or community-contracted professionals.

To echo what we have already learned from the information provided in the chapter on teaming, the success of any effective MTSS framework for mental health services is contingent on the establishment and maintenance of collaborative, coordinated, and communicative interdisciplinary school-based teams. Depending on the school setting and specific context, different types of teams are created and assembled to address a range of student, school, and community needs, and aim to provide less fragmentation of services and more shared responsibility for student learning and social-emotional outcomes.

TEAMING

Teaming, as it relates to explicitly handling triage, student assistance and risk assessment, is integral to identifying intervention priorities with accuracy and precision. The three most fundamental aspects of successful teaming include:

Collaboration—Increases resources for the student and family

Coordination—Decreases overlap and duplication of service

Communication—Open communication allows for various viewpoints and perspectives

School-level collaboration, coordination and communication is needed when addressing risk: primarily because combined, they are an intentional process that helps clarify roles and responsibilities, which in turn helps avoid confusion, reduce service overlap, and facilitate the management and flow of information in an organized manner. The collaborative functions of a school-based mental health team impact all domains of student assistance. These domains include:

1. **Assessment**
   - initial screening, diagnosis, and intervention planning
2. **Referral, triage, or monitoring/ management of care**
3. **Direct services**
   - primary prevention programs/ activities; early intervention; individual, family, and group counseling; or crisis intervention and planning
4. **Indirect services**
   - consultation, supervision, in-service training

Each school site and/or district's school-based mental health team will be comprised differently, based on available resources. For example, many schools have case-oriented teams in the form of child study teams, intervention and referral services (I&RS) and 504 committees, that focus on specific individuals or discrete services. Other schools may have both case-oriented and resource-oriented teams that focus on all students and the resources, programs, and systems to address barriers to learning.[7]

For many districts, building/site-based teams will be developed based on need, and comprised of a combination of administrative staff, school-based mental health staff, school health professionals, and other ancillary support staff. The School Mental Health Teaming Playbook defines a school mental health team as a group of school and community stakeholders that meet regularly to review student mental health, school climate, student and staff well-being, and addressing individual student strengths and needs. As mentioned in previous chapters, consideration should be given to repurposing or building upon existing school teams (e.g., creating a subcommittee of the school climate team) or creating a new team, depending on the resources and expertise available.

COMMUNITY, STUDENT, AND FAMILY ENGAGEMENT

Central to a shared model of care are ongoing partnerships with local community-based agencies and engagement with the Department of Children and Families (DCF) NJ Children's System of Care (CSOC) as a single point of contact to increase access to, and utilization of, behavioral health services to youth and their families across the state. For psychiatric services, crisis intervention, mental health information and referrals, PerformCare NJ is a full-service behavioral health managed care organization that partners with CSOC and CSOC's providers across the state and is accessible 24 hours a day, seven days a week. PerformCare NJ provides mobile response and stabilization for urgent situations at home, school, doctor's offices, police stations, or in a student's community, and can offer up to eight weeks of stabilization services. For county-specific information, please refer to the Designated Screening Services in New Jersey Directory created by the Department of Human Services Division of Mental Health and Addiction Services.

> **Engaging families is essential to the risk assessment process,** as they are key, if not critical, stakeholders in the fidelity of any intervention intended to improve student learning outcomes.

Another community-based resource hub available to schools and the families they serve can be accessed through the Office of School-Linked Services (OSLS). As a division of DCF, OSLS offers school districts across the state prevention and intervention supports for youth at the elementary, middle, and high school levels. OSLS contracts with private organizations and school districts to facilitate access to resources. The Traumatic Loss Coalitions for Youth (TLC) program is one of the many programs available and a resourceful partner to consult regarding risk assessment and training opportunities. TLC's school curricula includes suicide prevention, intervention, postvention and trauma response.

Engaging families is essential to this process, as they are key, if not critical, stakeholders in the fidelity of any intervention intended to improve student learning outcomes. Regarding developmental risk and resilience, families are essential partners in ensuring student safety. Engaging students and families as change agents is largely based on secure relationships with school staff. Utilizing a trauma-sensitive school checklist like the one from Lesley University and the Trauma and Learning Policy Initiative (TPLI) is a helpful tool to inform schoolwide practices and policies and classroom strategies and techniques, as well as ensure complementary collaborations and linkages with mental health, family partnerships, and community.

CULTURAL CONSIDERATIONS

Factors such as race, ethnicity, culture, adverse childhood experiences (ACEs) and school safety impact students' education and mental and behavioral health. For any intervention to be effective, district and school leadership must understand these factors, their causes and their impact on student success—especially following the COVID-19 pandemic. As stated by the National Conference of State Legislatures (NCSL), the COVID-19 pandemic that began in March 2020 has put even more stress on students and institutions tasked with providing both academic and mental health supports. It should be noted that emergencies that close schools *exacerbate inequities in access to mental health services among school-aged children and adolescents.* We have yet to fully understand the impact and long-term effects COVID-19 has had, and will continue to have, on future generations. Therefore, it is more important than ever to apply trauma-informed and culturally responsive practices to all domains of school-based mental health, especially in the context of understanding, assessing, and interpreting student risk.

Bearing this in mind, student support staff are expected to demonstrate multicultural intentionality to best meet students' diverse mental health needs in school settings that target a range of cultural factors, and outline best practice strategies to support the development of culturally responsive school-based mental health practitioners. Best practices include the following:

1. Engage in self-evaluation to build cultural self-awareness.

Culturally responsive practitioners continually examine their own views, identities and biases, and explore how these cultural factors may affect

school mental health practice. Please refer to NASP's Self-Assessment Checklist for Personnel Providing Services and Supports to Children and their Families for examples of values and practices to foster a culturally aware environment.

2. **Improve cultural and racial literacy.**

Practitioners who are sensitive to cultural diversity seek current knowledge of other cultures but are careful to avoid stereotyping. These practitioners consult with other professionals about multicultural issues.

3. **Apply culturally responsive micro-skills.**

Culturally sensitive school mental health professionals adjust basic counseling skills to take the cultural norms of the student and family into account. For example, nonverbal attending norms (e.g., eye contact, body language and physical space during conversation) may vary across cultures.

4. **Engage the student and family to establish and access a circle of support that is culturally relevant and meaningful.**

Remember that stronger positive connections to language and culture are an important part of intervention.[7]

> The **collective value of any team, crisis or otherwise, is informed by the various cultural identities,** personal and professional life experiences, and established worldview of individual members.

Furthermore, it is remarkable to note that the collective value of any team, crisis or otherwise, is informed by the various cultural identities, personal and professional life experiences, and established worldview of individual members.[7] As a result, we would be remiss if we did not acknowledge that these values and worldviews have the potential to impact and shape team members' perceptions, assumptions, and expectations of student performance, as well as their behavior. Therefore, the following should be taken into consideration when:

- **examining the existence of any problem**
- **identifying the type and source of the problem**
- **interpreting a student's behavior**
- **deciding action steps—especially regarding disciplinary action**

Incorporating a self-assessment checklist like the one developed at Georgetown University's National Center for Cultural Competence is a helpful resource to increase cultural self-awareness of individual team members. The Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Needs and their Families is an easily accessible tool on the center's website. Due to the range of implications for mental health practice and student outcomes,

recognizing the cultural context within which a student and/or family may have experienced a potentially traumatic event is necessary to effectively encourage help-seeking behaviors, improve acceptance and collaboration with families, and adapt interventions to be most comfortable and acceptable for the student, especially in the context of risk and risk assessment.[7] Populations more vulnerable to trauma face significant burdens and may require services adapted to their needs. The National Child Traumatic Stress Network (NCTSN) identifies these populations as LGBTQ+ youth, homeless youth, youth living with intellectual or developmental disabilities, military and veteran families, families experiencing economic stress or poverty, immigrant and refugee families, and families struggling with substance and alcohol misuse and abuse.

The National Association of School Psychologists (NASP) also offers guidance specific to developing culturally competent crisis response and suggests ways school counseling and support staff can incorporate cultural competence into their overall crisis planning and preparation. As adapted directly from the organization's website, NASP recommends that when addressing the diverse needs within the school community, crisis plans should specifically include the following:

Identifying specific culture-related needs of the community, such as access to interpreters, religious figures, and healers.

Maintaining a current profile of the cultural composition of the school/district community. Include race/ethnicity, languages/dialects spoken, age, gender, religion, refugee/immigrant status, income and poverty levels, percentage of students living in rural vs. urban areas, history of trauma, torture, or war experience, and history of racial/ethnic relations within the greater community.

Identifying formal and informal community resources that can help meet diverse mental health needs.

Developing a list of community resources able to lend assistance as interpreters and translators in the event of a crisis.

Identifying the meaning of suffering, pain, and death relevant to the norms of the community's cultural groups (Young, 1997).

Anticipating and identifying possible solutions to cultural problems that may arise in the event of a crisis.

Identifying the full names of the parents and guardians of all children in the school, since last names can differ within families.

STAFF COMPETENCIES

The continuous expansion of school-based mental health support necessitates unique oversight and guidance to enhance clinical skills and bolster knowledge of emerging best practices and practice trends in the field. Thus, it is noteworthy to remind school-based mental health and student support staff to be active in their respective professional organizations, so as to remain up-to-date on field-specific information, practice and research developments, emerging national models and best practices, legislative action alerts, conferences/events, and local, regional, and national networks. Regarding increasing proficiency in the areas of triage processing, student assistance, and risk assessment, school-based mental health staff should demonstrate the ability to establish a working relationship or therapeutic alliance that conveys the following to a student at all phases of interaction, especially in the context of risk:[7]

1. **Positive value**
2. **Personal credibility**
3. **Permission and protection to engage in exploration and change**

In addition to the specific training resources on crisis intervention, psychological first aid (PFA), trauma, and cultural and linguistically sensitive services as outlined in the Resources section at the end of this chapter, it is important to recognize and introduce the concept of school-based clinical supervision. Supervision, or peer supervision, is a widely understood and accepted component of effective clinical practice in the mental health field. However, this term is often misunderstood in school settings, just as supervision in education is often associated with the traditional supervisory tasks of overseeing and evaluating staff and connotes a leadership capacity. As it pertains to clinical practice in school settings, incorporating supervision into regular professional development can be operationalized as a deliberate opportunity (during work hours) to review and reflect upon our clinical work with students and families among experienced and supportive colleagues in school settings. The aim of school-based clinical supervision is to seek and share insight from these colleagues to sharpen clinical skills; engage in practitioner self-care; safeguard for compassion fatigue, vicarious traumatization, and burnout; build stronger teams; and provide better care to students and families.

Making and holding the space for this type of review and reflection in school settings is vital to strengthening staff practice competencies and further developing psychologically sound mental health supports at all three tiers of the MTSS framework. With this purpose in mind, it is important for school administrators to expand their understanding of supervision in schools and prioritize its place as a vital professional development and training need for the school-based mental health teams within their buildings. Plus, integrating this type of regularly infused professional development into the teaming process will encourage insight-oriented professional self-reflection in the workplace, naturally contributing to staff wellness. Furthermore, it should be noted that most professionals who come to schools directly from preservice programs still need considerably more training once they arrive at the school site.[2,7] This is a natural approach to meet the various training needs of entry-level staff members.

CHAPTER SUMMARY

Key Take-Aways

In the context of risk, it is essential for schools to base all mental health intervention, student assistance protocols and procedural tasks on the premise that all behavior has meaning and is a form of communication.

- Always reflect on *what is best for the student.* As stewards in a human services profession, that is our essential task, and the key to navigating the competing demands and domains of this difficult and complex work.
- When encountering students in psychological distress or crisis, psychological safety must be balanced with physical safety for vulnerable youth to embrace assistance.

When assessing risk, the intention is to describe a situation, condition, or cluster of circumstances that may contribute to the presenting problem being assessed, not just an individual characterization of a particular student and interpretation of subjective surface behavior, to ascertain what steps are needed to take.

An effective school-based risk assessment aims to accomplish three main tasks to reduce barriers to learning: ensuring safety, reducing exposure to harm, and connecting said student to the right help.

While school staff, including school-based mental health staff, are not responsible for treating high-risk or suicidal students, we are accountable for taking reasonable and prudent actions to assist and support vulnerable youth and their families.

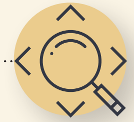
- This includes, but is not exclusive to, prioritizing student need, notifying parents and other community agencies as needed, making appropriate referrals, and securing outside assistance when necessary.

All school personnel can benefit from a structured set of understood and well-defined protocols made visible to guide how they address and refer students placed at risk to the proper support staff for further evaluation.

- Site-based referral pathways must be an administrative priority determined by various stakeholders within the school community and reviewed regularly for developmental, cultural, and linguistic specificity.

Our reactions to crisis are influenced, and can be modified by, knowing the role of theory in understanding, interpreting, and responding to risk and behavioral concerns and shifting our inquiry from "What's wrong with you?" to a trauma-responsive "What happened to you?"

SPOTLIGHT



BOUND BROOK SCHOOL DISTRICT

Student Screening & Mental Health Personnel

Bound Brook School District understands that mental health and wellness are crucial to address and support students' emotional, social, and overall well-being by offering resources, restorative practices, counseling, and other internal/external assistance. Bound Brook takes a proactive approach in providing these services through conducting restorative circles which create interconnectedness and rapport amongst students and staff. This is in addition to providing mental health counseling on campus, supportive meetings to address needs and behaviors, SRO, community involvement offered after school, and assistance through technology that monitors student activity on digital devices and an anonymous reporting platform. On average, the counseling program provides 8 hours of individual/family counseling per day. In addition to these counseling sessions, crisis response, IEP meetings, and program development are part of the daily work. Consultation with a mental health clinician is not limited to students and continues to be available to all staff members if they have any questions or concerns.

Our Mental Health Personnel consists of the following positions. Full job descriptions can be found here.

- Three Clinicians—Licensed Clinical Social Workers
- 8 School Counselors
- Intervention Specialist
- Student Assistance Counselor
- Guidance Secretary

Successes

- Every student in the district was given a mental health survey in the Fall. While it was a large undertaking for staff, many students were identified as needing counseling services, follow-ups, or even risk assessments. The response team was crucial in providing a safe space for these students to share about challenges and any mental health concerns that they may be having.
- Between the 5 schools in our district, 688 students were identified as needing additional follow-up or support after completing the survey.
- Every student was met with or contacted individually to complete check-in and to assess further needs.

Lessons Learned

- The counseling program is culturally sensitive to the demographics of our district; 2 out of our 3 clinicians are Spanish speakers. Having family sessions and communications in their native language allows for a stronger relationship between home and school.
- Having 3 clinicians allows for peer supervision and case consultation, leading to better outcomes.
- As district employees, the clinicians are given the flexibility to meet with students on an as-needed basis, and they are not limited to specific regulations or insurance coverage. This becomes the quality care they are seeking that is often hard to come by.

Reflection Questions

What services and risk-specific assessment intervention measures do you already have in place, at the district and/or building level, that align with the information provided in this chapter?

How often are infrastructure and service capacity evaluated to assess gaps in supporting students placed at-risk at all three tiers of service? What can be done to reduce any identified gaps and improve service capacity?

What are whole-school culture and climate factors in your buildings that most affect student learning and impact students placed at risk?

How do you understand and address the diverse social, cultural, and language needs of students being referred for student assistance and risk assessment?

What can school administrative staff do, particularly for members of designated school-based mental health teams, to sponsor professional learning opportunities specific to culturally and linguistically appropriate services (CLAS) to ensure that student assistance protocols, triage processing, and risk assessments are culturally and linguistically responsive?

What is the role of school-based mental health providers in supporting traumatized youths and providing trauma-responsive staff consultation, risk assessments, and student assistance?

Considering your experience processing triage and conducting risk assessments in your day-to-day work, what qualities or skills do you feel help you meet the needs of students placed at risk? Conversely, which qualities or skills do you feel you need to develop further to broaden your repertoire of responses?

RESOURCES & LINKS

1. School Mental Health Referral Pathways (SMHRP) Toolkit
2. Life Space Crisis Intervention (LSCI) – LSCI Certification and Training
3. Zero Suicide (Education Development Center-EDC)
   - Toolkit
   - Screening Options
4. National Center on Safe and Supportive Learning Environments
   - Addressing the Risk of Violent Behavior in Youth
   - Cultural and Linguistic Competence
5. National Center for School Mental Health (NCSMH) – Cultural Responsiveness & Equity
6. The Search Institute
   - Relationship-Focused Schools
   - Developmental Assets Survey
7. Centers for Disease Control and Prevention (CDC):
   - School Connectedness
   - Youth Risk Behavior Surveillance System (YRBSS)
   - LGBTQ + Youth Resources
8. The National Child Traumatic Stress Network
   - Trauma-Informed Mental Health Assessment
   - Psychological First Aid (PFA)
9. Trauma and Learning Policy Initiative – Helping Traumatized Children Learn
10. Traumatic Loss Coalition (TLC) – Training & Technical Assistance for the NJ Children's System of Care
11. The Thrive Initiative –Training and Technical Assistance

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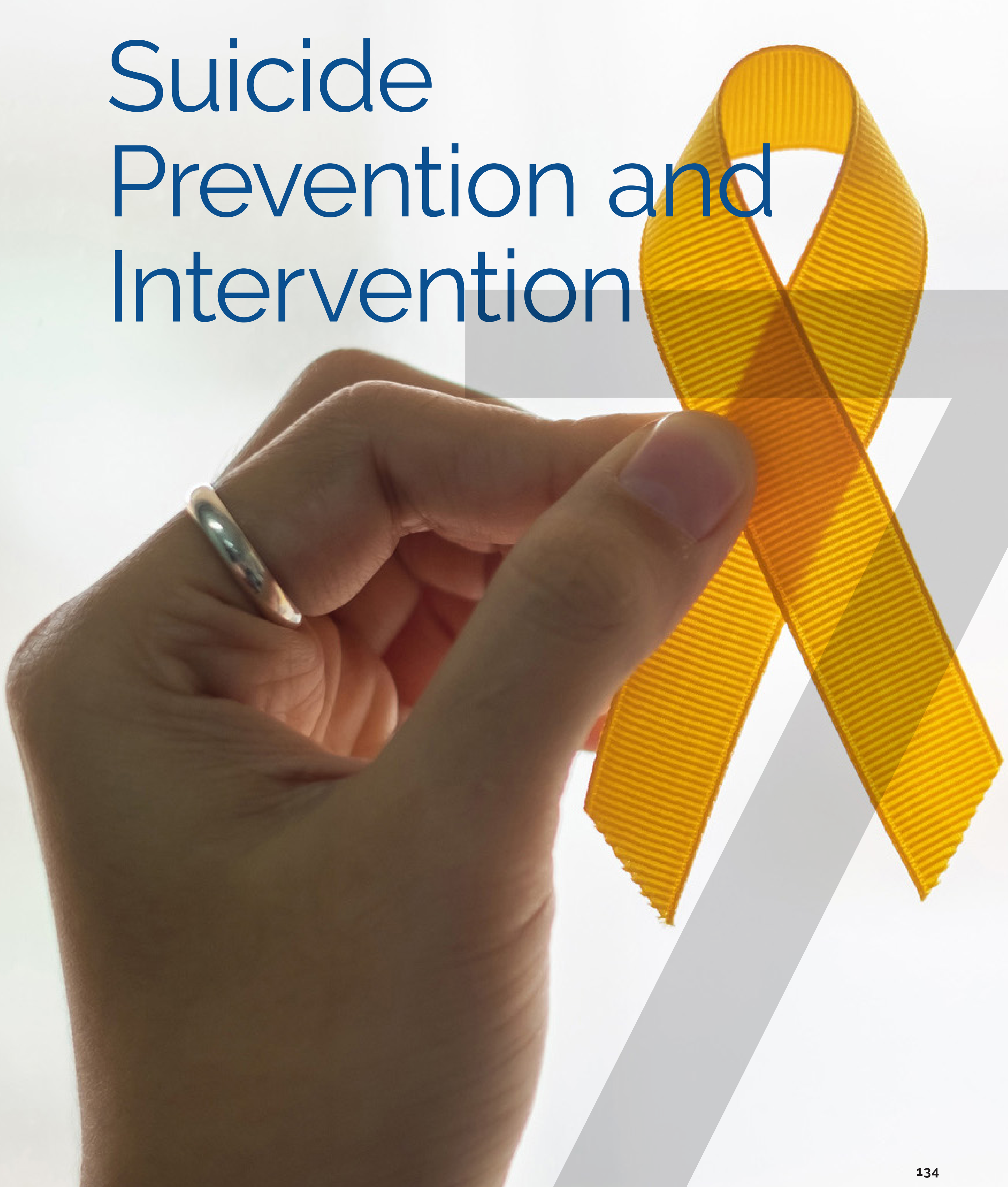
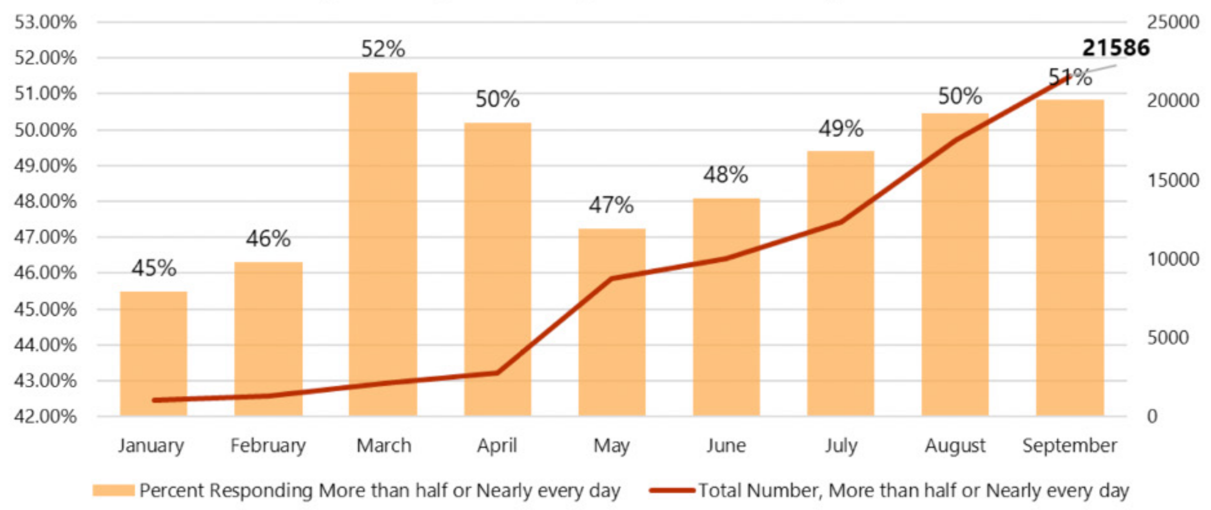
Suicide Prevention and Intervention



WHAT YOU NEED TO KNOW

Suicide is a significant concern among school age children. It is the second leading cause of death nationally among youth ages 10–24.[1] Despite a general increase in mental health awareness, the rate of suicide attempts has continued to increase, rising 39% in New Jersey between 2009 and 2018 for those 10 to 24 years old.[2] Suicidal thoughts are quite common, with one out of every five young people experiencing them, and 9% actually making a suicide attempt. The rate of suicide attempts jumps to 23% among youths who identify as lesbian, gay or bisexual.[3] Suicide attempts among children ages 5 to 11 are less common, but they do occur and unfortunately are also on the rise.[4] Most recently, the COVID-19 pandemic also appears to be contributing to increases in suicidal thoughts.[5]



(MHA, 2020)

Suicide is a public health concern, and schools are in a unique position to identify and intervene with students at risk. Schools can take action to help deter suicide by engaging in activities to prevent, intervene and respond when students are in need.

Support: Schools can create supportive school environments where students feel connected to peers and adults.

Education: Schools can educate their staff, parents, and students on the early warning signs of suicide, questions to ask and how to get help.

Identification: Schools can implement universal screenings and protocols to identify at-risk students.

Referral: Schools can connect students in need of more support than the school can provide to mental health professionals who can offer appropriate screening or treatment.

Re-entry: Schools can support students who were referred outside the school for assessment and/or treatment by developing and implementing re-entry protocols.

Response: Schools can develop response protocols that are implemented in the event a student or staff member dies by suicide.

These steps create a comprehensive suicide prevention approach that aligns with the multi-tiered system of support (MTSS). When working to develop this approach, it is important to prioritize the most serious circumstances first: helping students at possible risk of suicide and responding to suicide deaths. These critical responses should form the foundation of your suicide prevention program.[6]

Understanding Risk Factors and Protective Factors

Suicide does not discriminate among race, ethnicity, culture or sexual orientation. Certain personal or environmental factors are associated with suicide. Awareness of these risk factors allows educators and parents to be more mindful of what students' behaviors might mean in terms of potentially contributing to the probability of suicidal behavior. Protective factors, on the other hand, are characteristics that reduce the likelihood of suicide. When assessing students, it is important to identify risk factors, as well as protective factors that serve to promote resilience.

In addition to risk and protective factors, there are also warning signs: indications that someone is in danger of suicide, either immediately or in the near future. Action steps should be taken in response to these warning signs. The chart on the following pages contains a list of risk and protective factors and warning signs. These lists are not meant to be exhaustive; in fact, there is no agreed-upon list of factors and signs, and they can differ across ages and cultures.[6] Rather, this list is intended to give you an idea of the types of indicators to be considering. Notice how many risk and protective factors are related to the school environment.

RISK FACTORS, PROTECTIVE FACTORS, AND WARNING SIGNS OF SUICIDE[6]

Risk Factors	Protective Factors
Prior suicide attempt	Psychological/emotional well-being
Preexisting mental illness	Emotional intelligence
Undiagnosed mental illness	Internal locus of control
Conduct/disruptive behavior disorders	Adaptable temperament
Substance use disorder	Strong problem-solving skills
Self-injury	Good coping skills
Hopelessness	Self-esteem
Low self-esteem	Physical activity
Loneliness	Positive body image and care
Social isolation	Spirituality/faith
Impulsivity	Cultural and religious beliefs that discourage suicide
Low stress tolerance	Resilience
Risk taking	Sense of hope
Poor coping skills	Emotional regulation
Poor body image	Frustration tolerance
Perception of being a burden	Family support and connectedness
Childhood trauma	Close relationship with at least one adult
Interpersonal difficulties	Close friendship
Disciplinary problems	Parental pro-social expectations
Bullying/humiliation	Family support for school
Problems at school/work	Positive school environment
Physical/sexual/psychological abuse	Close school community
Chronic illness/disability	Safe school environment
Suicide of a peer	Adequate academic achievement
Family history of suicide	Feeling connected to school
Parental mental illness	Involvement in activities
Parental divorce	Access to physical and mental health care
Death of friend/family	Limited access to lethal means
Access to means	
Negative social and emotional environment at school	

RISK FACTORS, PROTECTIVE FACTORS, AND WARNING SIGNS OF SUICIDE[6]

Warning Signs	Action Steps
Saying they want to hurt or kill themselves	Seek immediate help from a mental health provider. Can call 911 or local emergency provider/screening.
Saying they want to die	
Looking for ways to kill themselves	
Talking/writing about death, dying, or suicide (when out of the norm)	
Talking about feeling hopeless or having no reason to live	Seek help from a mental health professional.
Expressing feeling trapped, like there's no way out	
Expressing wanting the pain/extreme distress to stop	
Rage, anger, seeking revenge	
Risky behavior without thinking	
Marked increase in alcohol/drug use	
Withdrawal from friends/family	
Anxiety, agitation, inability to sleep, or sleeping all the time	
Dramatic mood swings	

INTEGRATION

Specific actions can be taken in schools at each level of intervention to address suicide. It is important that all teachers and staff members learn to recognize students at risk, identify warning signs of suicide, take preventive measures, and report suicide threats to parents and the appropriate authorities. Administration is charged with ensuring that all staff members have a copy of the district's suicide prevention policies and procedures and know how to carry them out. Effective suicide prevention requires a multi-faceted, comprehensive approach. Strategic planning is required to match the needs of your school community with suicide prevention, intervention, and response activities.

Tier 1

Tier 1 strategies for suicide prevention include student, parent/caregiver, and staff education; universal screening of students for social-emotional concerns; and a supportive and protective school environment.

Education as Prevention • Enhancing the ability of everyone in the school and home environment to recognize the risk factors and warning signs of suicide can help increase the likelihood of help-seeking and timely intervention. For educators, understanding the protective factors can help reinforce the importance of a positive school environment and promoting social-emotional learning.

Education for teachers and school staff is described in detail later in this chapter in the Staff Competencies section. Here, suicide awareness education for students and caregivers will be discussed.

There are several curricula available for student suicide prevention education (see table below for some examples). Educating students about suicide can help them recognize concerning signs in themselves and their peers and encourage help-seeking behaviors. While education related specifically to suicide may only be appropriate for middle and high school students, programming on problem-solving, decision-making, and coping skills can begin in elementary school and form the foundation for later suicide education.[7] Education for students is particularly important, as research indicates that most youth who have thoughts of suicide share their concerns with their peers rather than an adult.[7] Teaching students to know what to do with this information is critical.

Program	Grades	Curricula
Lifelines Intervention: Helping Students at Risk for Suicide	Middle and high school	Education on how to respond to signs of suicide Four 45-minute sessions
Helping Every Living Person (HELP): Depression and Suicide Prevention Curriculum	9–11	Addresses stress and depression, risk factors and warning signs, intervention skills and problem-solving skills Four 45-minute sessions
SOS (Signs of Suicide)	Middle and high school	Teaches students to identify signs of depression and suicide; assesses depression with a screening tool 20-minute videos with supplemental lesson plans
Linking Education and Awareness for Depression and Suicide (LEADS) for Youth	High school	Increases knowledge of depression and suicide, recognition of risk and protective factors, and ability to identify resources and seek help Three-hour curriculum
Sources of Strength	Middle and high school (elementary curriculum available)	Focuses on suicide prevention by training peer leaders Adult advisor training: 3-6 hours Peer leader training: 5-6 hours
teen Mental Health First Aid (tMHFA)	10–12 (Ages 15–18)	Covers signs and symptoms of mental health and substance use challenges, crisis and suicide, how to talk with peers about these topics, and seeking help from an adult Three 90-minute sessions or six 45-minute sessions

Parents and caregivers must be educated about the signs of suicide. Caregivers may see behaviors in their children that are not present in school. Partnering with parents to identify these risk behaviors will help provide a more complete picture of what the student is experiencing. Schools can help parents by providing education on the risk and protective factors of suicide and on resources available for support, both within and outside the school. Resources for caregivers are provided at the end of this chapter.

Supportive and Protective School Environments

School communities themselves can help prevent suicide. A study looking at the impact of social networks on suicide attempts found that both student-to-student and student-to-adult relationships served as protective factors against suicide. Notably, schoolwide peer and student-adult relationships were more influential than individual student connections.[8] One way to develop a supportive and protective school environment is by instituting a social-emotional learning (SEL) program. These programs help students of all ages develop self-awareness, self-management, social awareness, and relationship skills, and promote responsible decision-making.[9] SEL programs can support the development of protective factors against suicide as described above.

The New Jersey Department of Education has developed SEL competencies and offers online resources and learning modules around SEL. School climate also impacts risk and protective factors for suicide. Administrators can assess the level of safety and support offered in their school environment by utilizing school climate surveys. The NJ State School Climate Survey is available for free on the NJDOE website. Other tools are available as well to assist districts in developing school climate plans.

Screening • Universal screening of all students can be used to help identify students in need of additional supports and, potentially, mental health services. Screenings can be used to identify students who are experiencing mental health challenges that may be related to suicide. Screenings are not intended to be diagnostic. They can be conducted at varying points throughout the school year. There are benefits to screening at the beginning of the school year, again at the midway point, and then prior to summer break; however, some schools may not elect to screen that frequently.

It is important to determine your school's specific goals for the screening. These goals will inform your selection of a screening tool and the frequency of screening. Prior to screening, you will also want to outline a process for following up with students who are identified by the screening as needing additional supports. On the following page is a list of universal screening tools that can be obtained at no cost. See Chapter 3 for additional information on screening.

Assessment Tool (Age Range)	Areas Assessed	Implementation Method	Administration Time Frame
Strengths and Difficulties Questionnaire (SDQ) **Ages 2–17**	Emotional symptoms Problems with conduct Hyperactivity/impulsivity Peer relationship problems Prosocial behavior	Print and electronic versions 40 languages Self-report by parent, teacher, student	5–10 minutes
Student Risk Screening Scale (SRSS) **Ages K–12**	Academics Anxiety Depression/mood Social skills	Print version Educator report English	15–20 minutes
Pediatric Symptom Checklist (PSC) **Ages 3–18**	Anxiety Depression/mood Disruptive behavior Global functioning Hyperactivity/inattention	Self-report by student or caregiver Multiple languages	Self-report 5–10 minutes

Prior to administering a screening tool, you will need to decide on the type of consent and assent you will seek from parents and legal guardians. There are active versus passive consent procedures to consider. In terms of assent, students should be given the opportunity to voluntarily agree to participate in the screening. Students should be assured that choosing not to participate will not result in any negative consequences. All students and families should be provided with resources such as confidential hotlines and community providers since some students who may need additional supports may not participate in the screening process, and therefore may not be identified. It is strongly recommended that schools seek specific guidance from their legal counsel regarding consent requirements.

Student confidentiality must be maintained within the confines of relevant regulations. When considering disclosure of any student-related information, it is important to understand the confidentiality rules to which you may be subject. There are two primary considerations: the Federal Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA). Schools must abide by confidentiality rules laid out in FERPA. Under FERPA, parents are generally required to provide consent before disclosure of any personally identifiable information from their child's education records. There are limited exceptions to FERPA's general consent rule, including disclosures in connection with health and safety emergencies.

HIPAA, on the other hand, protects the release and disclosure of individually identifiable health information. Generally speaking, HIPAA does not apply to schools because they are not considered covered entities. However, in some situations, the school can be considered a covered entity (e.g., if a school provides health or mental health services).[10] Even if the school is considered a covered entity, if student health information is maintained in "educational records," HIPAA may not apply.[11] For additional guidance, please consult the Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to Student Health Records and your legal representative.

Tier 2

For students with a higher level of need, targeted Tier 2 interventions are recommended. Within Tier 2 services you will want to assess for suicide risk, help set up a support system for the student, consider school-based interventions, connect caregivers with community-based resources, and implement suicide-related protocols.

Suicide Risk Assessment • Further screening of all students who are identified as at risk of suicide is a critical step towards providing assistance for more intensive needs and making appropriate referrals. Suicide risk assessment tools can be administered when there is suspicion that a student may be at risk. If you are concerned about a student's potential suicide risk, do not hesitate to ask direct questions about their thoughts and behaviors. It is not true that asking about suicide will make someone suicidal; in fact, it can help reduce distress. Below are suicide risk assessments that can be utilized in school settings.

Support System • It is important for schools to provide ways for at-risk students to connect with peers and adults in the school building. As discussed previously, connection can help protect against suicide. When students feel at least one adult in the school cares about them, it can serve as a protective factor.[12] Additionally, schools can support students at risk for suicide by connecting their caregivers with community-based resources. Schools can serve as a repository for information on available mental health support services.

School-Based Interventions • Tier 2 group-based interventions can help at-risk students build targeted skills. Two programs to consider are Coping and Support Training (CAST) and Reconnecting Youth: A Peer Group Approach to Building Life Skills.

Coping and Support Training (CAST) is a program designed for at-risk youth in middle or high school that builds coping skills, encourages healthy activities, and facilitates social support. Twelve 55-minute group sessions given over a six-week period focus on increased social performance, self-esteem, and personal and social protective factors. Goals are to decrease anxiety, depression, hopelessness, anger, suicide risk and drug use, and increase supportive connections and school achievement. Groups should be limited to six to eight students. Training can be delivered by counselors, teachers, mental health professionals or anyone else who is trained as a facilitator. There is a cost for this program.

Assessment Tool (Age Range)	Implementation Method	Administration Time Frame	Training Required
Columbia-Suicide Severity Rating Scale (C-SSRS) **All ages**	Print version Interview style; multiple languages	Five to 60 minutes, depending on responses	Training not required but helpful
Ask Suicide-Screening Questions (ASQ) **8 years and older**	Print version Interview style; multiple languages	20 seconds to several minutes, depending on responses	Online video accompanied by written directions

Reconnecting Youth is a program designed for middle and high school students at risk of dropping out of school or facing other emotional challenges. It promotes school performance and aims to decrease drug use, anger, depression and suicidal behavior. A group of 10 to 12 referred students meets with trained facilitators every day, receiving academic credit for their participation. There is a cost for the training and materials.

> When students feel at least one adult in the school cares about them, **it can serve as a protective factor.**

Suicide Protocols • There are two sets of suicide-related protocols schools need to have developed and implemented. All school personnel need to be familiar and comfortable with these protocols. The first protocol will address supports for students deemed at risk for suicide, and the second will outline how the school will respond in the event a student dies by suicide.[6]

Protocols for students at risk for suicide should include:

1. Chart of staff responsibilities
2. Identification of a suicide response or crisis coordinator
3. Identification of mental health service providers available for referrals
4. Procedure to assist students at risk, to include risk assessment and parent notification
5. Documentation guidelines
    a. Demographic/identifying information about student
    b. Who identified the risk?
    c. Reason for concern
    d. Assessment conducted (date, time, type, results)
    e. Notification of guardian (by who, to who, date and time of notification)
    f. Referral (type of referral, date, who was responsible)
    g. Follow-up procedures
    h. Plan for student return to school
    i. Procedure to conduct periodic staff refreshers around these protocols

Protocols for assisting after a student death by suicide should include:

1. A meeting of the school crisis team to determine roles of all members for the next five days.
    a. Identify at-risk students (e.g., friends, students who may have engaged in bullying behavior, past friends who may harbor guilt for dissolving the friendship)
    b. Who will follow the student's schedule?
    c. Who will meet with the deceased student's social circle?
    d. Who will be the point of contact with the student's parents/caregivers?

2. Identify one person who will contact community partners to assist in the crisis response, including local mental health partners, neighboring school personnel, and the Traumatic Loss Coalition (TLC), a New Jersey state-funded network that can provide support following traumatic loss.
3. Bring together teachers, coaches, advisors, and other school staff who were close to the student to hold a debriefing session and offer specialized support.
4. Convene a meeting with all staff to discuss the schoolwide response and distribute a written statement staff can use to communicate about the situation. Identify the locations where mental health assistance will be available for staff. Provide in writing the locations where counseling is available to students. Prepare staff for possible student reactions they may encounter; offer resources for self-help and support.
5. Designate one person to monitor social media to determine what information and misinformation students are sharing. If possible, have this person dispel rumors, reinforce important information, and offer resources.
6. Reconvene the crisis team prior to any funeral/memorial services to determine if additional supports are needed following these events.
7. Reconvene the core teacher group about a month after the death to determine how each person is coping and whether additional debriefings are necessary.
8. Reconvene the crisis team to determine how members are coping personally and professionally.

The Substance Abuse and Mental Health Services Administration (SAMHSA) offers additional information about suicide-related protocols. Additionally, exemplar samples of New Jersey school policies and regulations related to suicide are available.

SAMHSA Suicide Prevention Toolkit for High Schools

Livingston Board of Education

- 5350 Suicide Prevention Policy
- 5350 Suicide Prevention Regulations

Ridgewood Board of Education

- 5350 Suicide Prevention Policy
- 5350 Suicide Prevention Regulations

Tier 3

As mentioned in earlier chapters, Tier 3 supports focus on individualized therapeutic and behavioral help for students needing intensive intervention. As this relates to suicide, Tier 3 services include responding to immediate suicide risks, coordinating with mental health services, and supporting a student's return after a suicide attempt or mental health crisis.

Immediate Risk • If a student attempts suicide or you see warning signs of suicide (review warning signs), such as a student saying they want to hurt or kill themselves or are taking actions to prepare to kill themselves, you should act immediately according to your district policies and regulations. You should not leave the student alone after an immediate risk is determined and you should remove access to all lethal means.

Coordination With Mental Health Services • Ideally, if a student is receiving mental health services in response to suicide risk or suicide attempt, a member of the school team will coordinate with the mental health professionals. A release of information agreement can facilitate this communication. Parents may not recognize the benefit of this coordination or may be concerned about confidentiality, so education for the parents may be needed.

Return to School • When a student has been out of school because of a suicide attempt or mental health crisis, a plan must be in place for their return. This is a critical time for the student and they will need a positive, supportive reintegration process. At a minimum, the protocol for reentry after a mental health crisis should include: 1) identification of a staff member to facilitate the student's return and serve as a point of contact; 2) a meeting with the family; and 3) the development of an individualized re-entry plan.[6]

If the student was hospitalized, it is also helpful to collaborate with the hospital treatment team (with the family's agreement).[14]

Strategies can include the following:

1. Identify a point person to support the student; have this person serve as the point of contact.
2. Familiarize yourself with basic information about the student's circumstances, including what precipitated the suicide behavior, how the student's risk was identified, and any medications the student is taking.
3. Meet with student, family, and relevant school staff to determine needed services and supports upon the student's return. Be sure to leverage the student's strengths and resources to address possible needs.
4. Work with teachers and school staff to:
   a. Modify the student's schedule and course load to relieve stress, if necessary.
   b. Arrange for tutoring from peers or teachers, if necessary.
   c. Allow for makeup work without penalty.
4. Implement a daily check-in with the student.
5. Complete a safety plan with the student[13] (safety plan template).
6. Provide regular feedback to caregivers regarding student's adjustment back to school following their return.
7. Connect family with relevant supports and services, if needed.

TEAMING

Multiple important collaborators are needed for an effective school-based suicide prevention program. They include administrators, teachers, counseling department staff, parents and students. Support from administrators, school leaders, and other stakeholders/community partners is essential to the program's success. Schools should have a representative from the district attend local Traumatic Loss Coalition meetings to learn more about suicide prevention and programs to inform prevention strategies. A list of team members and their roles related to suicide prevention and intervention are described below.

Team Member	Role in Suicide Prevention, Intervention, and Response
Superintendent	Approval and adoption of a suicide education curriculum Policies and procedures to support suicide education and suicide prevention, intervention, and response
Principal Assistant principal	Implementation of policies and procedures Oversee fidelity of Tier 1–3 interventions Supervise education/training of staff in suicide prevention Participate in student re-entry process
Curriculum director	Research and acquisition of suicide education curriculum Supervise individuals implementing suicide education curriculum
Health educator	Delivery of suicide education programs within classrooms Member of crisis team, when trained appropriately
School nurse	Member of crisis team Possible screener of students at risk for suicide Support student re-entry process
Counselors Social workers School psychologists School-based mental health workers* Child study team (CST) members	Member of crisis team Possible screener of students at risk for suicide Support student re-entry process Collaborate with parents and family members to follow up on clinical recommendations Provide school-based intervention and follow-up services
Teachers Additional staff	Participate in suicide prevention training Refer students at risk
Families	Participate in suicide educational programs Provide valuable input into needs of students and families Collaborate with school and mental health provider Possible family representation on the crisis team
Community stakeholders	Participate in suicide educational programs Assist with connecting families to community resources

**School-based mental health workers could include mental health providers contracted by the schools or independent providers who occupy space in the school but operate much like an outpatient clinician.*

COMMUNITY, STUDENT AND FAMILY ENGAGEMENT

Community members, students and families can all play a role in suicide prevention for our youth. They can help bolster protective factors, like connection to caring adults and peers and development of coping skills, and watch for risk factors that might indicate the need for additional supports. Schools can engage with the community, students, and families by providing suicide prevention education and increasing awareness of suicide risk and protective factors. To facilitate this engagement, schools can:

- **Convene a group of stakeholders to plan and implement suicide prevention activities (e.g., community partners, parent groups, students, representatives of local faith communities and cultural organizations, first responders).**
- **Provide suicide prevention education.**
- **Distribute fact sheets and information on local mental health resources.**
- **Identify strategies to increase participation of families and community members.**
- **Conduct local suicide awareness campaigns.**
- **Utilize resources from local Traumatic Loss Coalition for community and parent workshops.**

CULTURAL CONSIDERATIONS

Culture profoundly influences how people think about suicide and death. Suicide prevention efforts are more effective when based on the values, needs and strengths of the students and their families. Suicide prevention programs and assessments need to respect the beliefs, practices, and cultural and linguistic needs and preferences of students, families, and community. Creating an effective suicide prevention program requires that you take these cultural factors into consideration. Components to consider include race, ethnicity, age, education, physical and mental health, gender identity, sexual orientation, refugee or immigration status, and religion.[15] Cultural differences can also impact students' attitudes towards suicide, how they display warning signs, and how they feel about sharing personal information, speaking with adults, or seeking help.[6]

To ensure that protocols regarding suicide prevention, risk assessment and interventions are culturally responsive, they should:

- **Demonstrate understanding and respect for student and family culture(s).**
- **Create services that build on cultural strengths and protective factors.**
- **Engage families in all aspects of suicide prevention, intervention and response.**
- **Respect the student's religious and spiritual beliefs, allowing for the involvement of spiritual leaders when appropriate.**
- **Incorporate how cultures display or conceal distress into suicide prevention education.**
- **Be sensitive to cultural stigma related to mental health, suicide, help-seeking and mental health services.[6]**

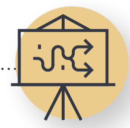
STAFF COMPETENCIES

Every teacher and staff person plays a role in suicide prevention. Each person needs to understand their role, as well as the policies and regulations of their district. Education and training, implementation of policies, and subsequent supervision need to be embedded in the fabric of the school system to ensure sustainability. All staff should learn to recognize the risk factors and warning signs of suicide and know what steps to take in response to a student in need. Select professionals within the school should be trained to formally assess suicide risk and should know how to follow up, as necessary, for screening and referral.

Schools implementing suicide prevention training programs that teach these skills may experience an increase in the number of students who seek help for behavioral health problems, including those related to suicide.[6] The list below identifies staff education and training programs.

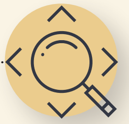
Program	Length	Teaches
Question, Persuade, Refer (QPR) Gatekeeper training	1–2 hours	Warning signs of suicide How to offer hope, get help and connect to services
Applied Suicide Intervention Skills Training (ASIST)	2 days	Recognition of signs of suicide Skilled intervention Development of safety plan
Youth Mental Health First Aid (YMHFA)	8 hours	Common mental health challenges for youth Signs and symptoms Five-step action plan

CHAPTER SUMMARY



It is imperative that schools integrate suicide prevention and education as a primary component of their school-based mental health programming. Schools must broaden the scope of suicide prevention to include all stakeholders, students, staff, parents and community partners. Schools can support the development of protective factors against suicide, as well as recognize the risk factors and warning signs of students in need. Then, utilizing protocols to identify at-risk students, they can connect the students with mental health services and supports, either within or outside of school. Students who are referred out for suicide risk evaluation or treatment should be supported upon return by creating re-entry protocols that ensure effective communication and collaborative support. Establishing and utilizing community partners and taking cultural considerations into account are also critical elements of an effective approach to reducing suicide.

SPOTLIGHT



MAPLE SHADE SCHOOL DISTRICT

Youth Mental Health First Aid

Maple Shade's journey with teen mental health began with our partnerships with New Jersey Health Initiatives and the Mental Health Association in New Jersey. They helped provide a forum for our district to promote teen mental health awareness and reduce stigma. Through their direction and support, we trained five community members and school staff in the Youth Mental Health First Aid (YMHFA) curriculum. The course teaches the important step of involving a responsible and trusted adult. The YMHFA experience was expanded when we received a grant through the Born This Way Foundation for teen Mental Health First Aid (tMHFA). We successfully trained our 10th grade students.

tMHFA is in-person training designed to teach high school students about mental illnesses and addictions, to help them identify and respond to friends who may have a mental health or substance use problem. This training empowers our high school students to assist their friends when a mental health problem or crisis, such as suicidal thoughts, is apparent.

Successes

Testimonial: "The teen Mental Health First Aid training has helped me identify warning signs of mental health illnesses in my family, friends, and peers. With the step-by-step guidance, I feel confident providing appropriate assistance to someone developing a mental health illness or experiencing a mental health crisis. This training has encouraged me to take action and handle difficult situations with compassion." *Shreeya Kamal, student, Maple Shade High School*

Lessons Learned

- tMHFA and YMHFA provided our students with powerful and essential tools for recognizing mental health challenges and helping friends who are struggling with mental health or substance abuse.
- The class sessions were well received, based on feedback from school staff and interaction with students during the lessons.
- The quality of the materials and the inclusiveness of examples and vignettes allowed students to connect with the concepts and relate to experiences. This should be a required curriculum for all adolescents navigating their way through an ever more complex and connected world.

Reflection Questions

How does our school address suicide throughout the year and not just when there is a crisis?

What training can our school provide teachers and staff to enhance their understanding of suicide and prevention strategies?

How can we create a school environment that allows students to feel safe sharing their concerns regarding their own or peers' feelings related to suicide?

What policies and regulations are in place to support students transitioning back to school after a suicide attempt, mental health crisis, or hospitalization?

How do our policies and regulations related to suicide prevention, intervention, and response take into account cultural responsiveness?

What steps can we take to ensure that all school staff understand the role they play in suicide prevention, intervention, and response?

RESOURCES & LINKS

Suicide Prevention Training Programs

- Youth Mental Health First Aid
- Question, Persuade, Refer (QPR)
- ASIST: Suicide Intervention Training

Suicide Prevention Education Programs for Youth

- Lifelines Intervention: Helping Students at Risk for Suicide
- Helping Every Living Person (HELP) Depression and Suicide Prevention Curriculum
- SOS Signs of Suicide
- Linking Education and Awareness for Depression and Suicide (LEADS) for Youth
- Sources of Strength
- teen Mental Health First Aid (tMHFA)
- A Promise for Tomorrow Student Curriculum
- Ask 4 Help! Youth Suicide Prevention

Suicide Prevention Resources

- Suicide Prevention Resource Center
- Preventing Suicide: A Toolkit for High Schools
- After a Suicide: A Toolkit for Schools, Second Edition
- American Foundation for Suicide Prevention
- National Institute of Mental Health: Suicide Prevention
- Traumatic Loss Coalition (TLC)

Suicide Risk Assessments

- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Ask Suicide-Screening Questions (ASQ)

RESOURCES & LINKS

School Crisis Prevention and Response

- PREPaRE Training Curriculum

Parent/Caregiver Education

- Not My Kid
- Parent Awareness Series: Having a Conversation About Suicide With Your Child
- Preventing Youth Suicide: Tips for Parents and Educators

Tools for Community Involvement in Suicide Prevention

- Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention

HIPAA/FERPA Guidance

- Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to Student Health Records

New Jersey Crisis Resources

- PerformCare • 877-652-7624
- NJ Psychiatric Emergency Screening Centers by County
- National Suicide Prevention Lifeline • 800-273-8255
- NJ Suicide Prevention Hopeline • 855-654-6735
- 2NDFLOOR Youth Helpline (call or text) • 888-222-2228
- Crisis Text Line • Text HOME to 741741
- Boys Town National Hotline (for all youth) • 800-448-3000 or text VOICE to 20121

LGBTQ+ Resources

- The Trevor Project • 866-488-7386 or text START to 678-678
- Garden State Equality

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Substance Use Prevention and Intervention

WHAT YOU NEED TO KNOW

Substance misuse and substance use disorders have far-reaching impacts on the health and well-being of individuals, families, and our larger communities. According to the Centers for Disease Control and Prevention (CDC), nearly 841,000 people in the U.S. have died from a drug overdose since 1999, with the majority of those being tied to opioids.[1] In addition to the risk of overdose, the misuse of alcohol and other drugs contributes to substance-related accidents, engagement in risk-taking behaviors, increases in crime and violence, family disruption and stress, and long-term health consequences, including chronic disease.[2]

An estimated 14.6% of the population will develop a substance use disorder (SUD) in their lifetime, causing significant impairment to health, well-being and daily functioning.[3] Research has demonstrated that early substance use, especially before the age of 14, is associated with a significantly higher risk of developing a SUD in later life.[4] Adolescents are at particular risk for early substance use and SUDs, given their stage of brain development that favors immediate rewards and emotional reactivity over careful consideration of outcomes.[5] Youth substance use has also been associated with a host of other negative outcomes, including poor school performance and disengagement, interpersonal problems, earlier unsafe sexual activity and evidence of lower cognitive functioning and neurodevelopmental disruptions.[5,6] Furthermore, evidence suggests that having a SUD in adolescence is predictive of more severe and persistent disorders in adulthood and is often co-occurring with other psychiatric problems (REF; Johnson et al., 2000).[7,8,9]

Alcohol, marijuana, and tobacco are the most commonly used substances among adolescents. According to a national survey of middle and high school youths, roughly 60% of students report having tried alcohol by their senior year and close to half of high-schoolers report having used marijuana.[10] State-specific data from the National Survey on Drug Use and Health revealed that roughly 9% percent of adolescents in New Jersey ages 12 to 17 (64,000 youths) used alcohol in the

past month, 11.5% (78,000 youths) used marijuana in the past year, and 3.3% (22,000 youths) met criteria for a past-year SUD.[11] Additional New Jersey state data from the Department of Education documents more than 6,000 substance-related incidents, 67% of them related to marijuana.[12] The report also highlights that more than 2,500 incidents were referred to law enforcement for substance use/possession/distribution.

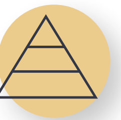
Research has identified several risk factors that influence adolescent substance use and related disorder. Risk factors among youth include

Adolescents are at particular risk for early substance use and SUDs, given their stage of brain development that favors immediate rewards.

poor self-regulation, high impulsivity, antisocial behavior, aggressiveness and other externalizing problems.[5,6,13] Cognitive difficulties, such as poor working memory, inattention, and low executive functioning overall, have also been linked to adolescent substance use.[6] In addition, school failure and peer influences, such as peer rejection and isolation among children and peer drug use among adolescents, play a significant role.[5,14] Parenting and family factors are also important considerations. Studies have found that poor family functioning and conflict, as well as parenting marked by inconsistent discipline and low involvement, are associated with increased risk.[5,14] Children experiencing trauma in the home, such as neglect, maltreatment and abuse, are at particularly high risk of developing adolescent onset SUDs.[14] Moreover, parent mental illness, especially a parent SUD, are additional powerful risk factors for youth substance use and SUDs.[15]

Preventing and intervening to reduce youth substance use and SUDs represents a clear public health priority, at both the national and state level. In 1987, New Jersey legislature set the stage for schools to address student substance use with the enactment of P.L. 1987, c.387 (codified as NJSA 18A: 40A-1, et. seq.). This act established the requirement for "a comprehensive substance abuse intervention, prevention and treatment referral program in the public elementary and secondary schools of the district." Given the significant overlap and relationship between student mental health, adverse childhood experiences (ACEs) and substance use, all school officials need to understand the legal framework, best practices and emerging trends for student substance use prevention, identification and response. This chapter will outline key legal regulations that schools must follow to support youths in need, describe how they fit within an MTSS framework, and highlight best practices.

INTEGRATION



A MTSS Framework for Substance Use Prevention

The National Institute on Drug Abuse (NIDA) has identified several evidence-based guidelines for the development and delivery of effective substance use prevention programs.[5] As NIDA highlights, successful prevention efforts have focused on decreasing risk factors, such as those noted above, and increasing protective factors associated with positive outcomes. In children, examples of protective factors against adolescent substance use include good self-regulation, effective interpersonal skills, positive peer relationships, academic competence and strong executive functioning.[5] At the family and community levels, protective factors include consistent and supportive parenting, positive family functioning and strong school and community connection.[5,16]

Interactive multicomponent programs (addressing individual, family, school and community-level factors) have been shown to be most effective in preventing substance use.[5] Early intervention, attention to major school transitions (e.g., shift to middle school) and differentiated programming are also critical to maximizing prevention benefits.[5,16,17] At the elementary school level, research indicates that programs aimed at enhancing academic success (particularly in the area of reading), self-control, social problem-solving, emotional awareness and communication are associated with the greatest benefits.[5,16] In middle and high schools, interventions should also focus on developing and reinforcing assertiveness, anti-drug

attitudes and refusal skills, and healthy relationships with peers.[5,16]

Prevention programs that attempt to mitigate risk and enhance protective factors associated with youth substance use contribute to a wide array of positive outcomes supporting students' academic functioning and overall well-being. As such, these strategies integrate well with many existing classroom and schoolwide approaches to optimizing learning and school success. NIDA offers an excellent overview of evidence-based substance use prevention programs at all levels of intervention, including multi-tiered programs and a growing body of evidence-based research, to guide schools.[5,18] The MTSS framework is central to comprehensive substance use prevention efforts and integrates multiple levels of intervention.

Tier 1 interventions, geared towards primary prevention and health promotion, involve all students and again focus on risk and protective factors, such as improving social and coping skills, increasing awareness of substance use risks and refusal strategies, supporting parental involvement, and enhancing school engagement. Examples of evidence-based Tier 1 interventions for substance use prevention include: the Life Skills Training Program (LST), which offers separate curricula for elementary, middle, and high school students and works to strengthen general social skills, drug and alcohol resistance skills, and personal self-management skills; and Project STAR (Students Taught Awareness and Resistance), a comprehensive program engaging middle school students, parents, schools, and communities through education and skill-building in drug and alcohol resistance, positive parenting, social-emotional competence and community organizing.[5]

Tier 2 interventions target those students at risk for early substance use, such as students with significant behavioral or emotional challenges, youths with an immediate family history of substance use disorder, or children experiencing significant

family stress and instability. One example of an evidence-based Tier 2 intervention for substance use prevention is the Strengthening Families Program (SFP), a multicomponent family skills training program targeting 6- to 11-year-olds. It is designed to enhance positive parenting, healthy communication, emotional awareness and regulation, and overall family functioning.[5]

Tier 3 interventions address the needs of students who have already initiated substance use and may show signs of early onset SUD. These targeted supports are designed to mitigate ongoing risks and prevent progression to SUD or worsening substance use. Bolstering protective factors is a continued goal with more intensive interventions, such as individual and group counseling, as well as referral to community mental health services for assessment and treatment as needed. An example of an evidence-based Tier 3 (or Tier 2) substance use intervention for high school students is Project Towards No Drug Abuse (TND), integrating substance use education and motivation building with social-emotional, coping and decision-making skills.[5]

School and parent referrals, along with the results of universal screeners and psychological assessments (e.g., Strengths and Difficulties Questionnaire [SDQ], Behavior Assessment System for Children [BASC]) can be used to inform referrals to Tier 2- and Tier 3-level substance use interventions. As described in Chapter 2, universal screening is an integral part of the MTSS framework and helps identify at-risk and high-need students, especially those who may not present with obvious risk factors or symptoms. Given the substantial overlap of risk and protective factors for youth substance use and other mental health outcomes, as well as school functioning, key universal screeners and existing prevention efforts, such as social-emotional learning (SEL), can serve multiple prevention goals. Schools might also consider utilizing substance use screening tools (e.g., Screening to Brief Intervention [S2BI], Brief Screener for Alcohol, Tobacco, and other Drugs [BSTAD]) to help identify students at high risk for early substance use and SUDs.

Requirements by the State of New Jersey for the establishment of comprehensive alcohol, tobacco and other drug use programs ensure that children in every school district have access to standard, evidence-based substance use prevention and intervention supports and services. Consistent with the MTSS framework, these regulations emphasize prevention, intervention, community referral and continuity of care and are outlined by the New Jersey Administrative Code (N.J.S.A. 18A:40A-10; N.J.A.C. 6A:16-3, 6A:16-4, 6A:16-6). The following sections will describe key considerations for establishing comprehensive substance use programs, and offer guidance for the provision of tiered supports and services in accordance with student needs and New Jersey state regulations.

Checklist of Key Legal Requirements for Schools

- ✓ **N.J.S.A. 18A:40A–1 through 20:** Governing how public schools respond to issues of substance abuse by students
- ✓ **N.J.A.C. 6A:16, Subchapter 3:** Comprehensive Alcohol, Tobacco and Other Substance Abuse Programs
- ✓ **N.J.A.C. 6A:16, Subchapter 4:** Procedures for Alcohol and Other Drug Abuse Intervention
- ✓ **N.J.A.C. 6A:16, Subchapter 6:** Involvement of Law Enforcement
- ✓ **N.J.A.C. 6A:16, Subchapter 8:** Intervention and Referral Services
- ✓ **N.J.A.C. 6A:14:** Special Education
- ✓ **N.J.S.A. 2C:33-15:** Underage Possession, Consumption of Alcohol & Cannabis
- ✓ **FERPA, CFR Part 2 and 20 U.S.C. 1232g and N.J.S.A. 18A:40A–7:** Confidentiality of student records
- ✓ **Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act:** Protections for those with drug or alcohol addiction as impairment

SETTING THE STAGE:

Establishing a Comprehensive Substance Abuse Program

All New Jersey school districts are required to have in place a comprehensive program addressing the prevention, identification, immediate response (including referral for immediate medical examination pursuant to N.J.S.A. 18A:40A-12) and ongoing response (intervention, referral for evaluation, referral for treatment, and continuity of care) for students involved in alcohol, tobacco, or other substance use (See N.J.S.A. 18A:40A-10 and N.J.A.C. 6A:16-3.3). The New Jersey Administrative Code guides districts in establishing these comprehensive substance abuse programs in compliance with state requirements. On the following pages are some of key components and considerations:

Student Assistance Coordinator (SAC) Program

The unique expertise of a SAC allows schools to have a key person in place to ensure that a comprehensive substance use prevention, intervention, and referral services program is truly integrated into the school system to best serve students. A thorough knowledge of community resources and referral sources will ensure compliance and maximize community partnerships. While the SAC position is not legally required, it is a key component of providing a comprehensive program. SACs or the district's designee should be educated about addiction and best practices in prevention, intervention and treatment referrals, and have the support to properly respond to students in need.

Prevention programs that attempt to mitigate risk and enhance protective factors contribute to a wide array of positive outcomes supporting students' academic functioning and overall well-being.

Annual Policy Review

Each year, districts are required to assess the effectiveness of their student alcohol and substance use policies and procedures (see N.J.A.C. 6A:16-4.2; 18A:40A-20). Licensed agencies providing substance use prevention, intervention, and treatment may be consulted in this process, in addition to parents, students and community stakeholders. Annual reviews include elements of process evaluation (assessing the extent to which programs have been implemented as planned or prescribed) and outcome evaluation (measuring the effect of the program on rates and risk factors for student substance use). Reports should include incidence data; a thorough description of the prevention, intervention, and treatment referral program; impact reports; and any recommendations for program modifications based on the evaluation. These assessments are critical to ensuring that the needs of students are being addressed, particularly given the changing trends in student substance use.

As noted previously, routine screening and assessment are fundamental components of comprehensive school-based mental health systems, as well as necessary tools in the development and implementation of multi-tiered systems of support. Data from these assessments can be used to

inform, integrate and evaluate various components of comprehensive programs, including those that address substance use and SUDs. Systematic universal screening and assessment of student behavior, mental health and well-being may capture relevant information about substance use risk and protective factors, as well as data on actual substance use and SUDs. In addition, information from referrals (within school and community), incident reports, utilization of tiered services, trainings and outreach, and other relevant program-related data may also be pertinent to these program evaluations and the annual review.

SUPPORTIVE SCHOOLS

Evaluation, Intervention, Referral, and Continuity of Care

Regarding ongoing response (intervention, referral for evaluation, referral for treatment and continuity of care), school districts are required to provide assistance to students and families experiencing substance misuse; preliminary determinations of a student's need for programs, services or treatment beyond the general school program; and referrals to outside agencies for assessments, ongoing treatment and care. In addition, schools must ensure that students continue to receive educational programs and services while in treatment. Schools must also provide necessary services to support a successful return to school following treatment (see N.J.A.C. 6A:16-3.2.). Students who may be experimenting with substances but are not at immediate medical risk should be referred to a SAC or designee. Ideally, schools will have a SAC on board who can play a central role in coordinating the district's substance use counseling program. In schools without a SAC, these functions are performed by other personnel.

If students require a leave of absence from school, re-entry into school should involve the student, parents, and key staff and district teams. In the case of short-term absences for health and/or disciplinary reasons, re-entry may be as straightforward as providing a reasonable but short period of time to make up missed work, while agreeing on a plan to address the underlying issues that caused the absence or removal. For longer-term absences or removals, school leaders must ensure a well-planned, coordinated approach that considers the student's social and emotional needs, coordinates academic make-up assignments and provides for planned check-ins. Having a designated point person for the re-entry process helps ensure that it will go smoothly.

Throughout this process, state and federal laws place a strong emphasis on maintaining confidentiality to the greatest extent possible. This includes maintaining the confidentiality of the student and family members; however, some exceptions require disclosure, including:

- When a student is suspected of being involved in drug distribution, the chief school administrator or designee is required to disclose this information to law enforcement.
- When a student may be the victim of child abuse or neglect, this information must be disclosed to the Division of Child Protection and Permanency, with notice to local law enforcement.
- When a student is suspected of being under the influence, the principal and other school officials must be notified and a medical examination arranged. This situation does not require notification of law enforcement. This is optional depending on local district policy.
- If a student indicates an intent to harm him/her/themself or others and that indication is deemed a valid safety threat, it needs to be disclosed. If there is a credible threat that a student intends to cause death, serious or significant injury to another person, law enforcement must be notified.

IMMEDIATE INTERVENTION

Reporting, Notification, and Examination

All school staff and parents should receive annual training on the signs and symptoms of substance use. In addition, school districts should follow a protocol ensuring that students who are suspected of being under the influence are sent for an immediate medical examination (see N.J.S.A. 18A:40A-12). Here is the step-by-step protocol, in its simplest form:

Step 1: An initial report must be made to the school nurse, medical inspector or SAC, as well as the principal. No staff member can override the initial report. In such an emergency situation, the school nurse plays a pivotal role in assessing medical needs and providing care. Those responsible staff members must complete Steps 2 through 5 once the initial report is issued.

Step 2: Arrangements must be made for immediate medical examination: either by a parent taking the student to a doctor, or the district calling an ambulance to transport the student to the nearest hospital.

Step 3: Before the child is transported for the medical examination, the school nurse must conduct an assessment to address any emergent medical needs. Note that the nurse is not empowered to overrule any staff member who suspects a student may be under the influence. The student must be sent for the medical examination, even if the nurse disagrees with the referring staff member.

Step 4: School personnel must review the report from the medical examination (which should be issued within 24 hours) and allow the student re-entry to school when he/she/they are medically cleared to do so.

Step 5: Necessary supports and referrals for the student must be provided.

Step 6: If appropriate, impose other consequences as per the code of student conduct. A supportive, non-punitive response is recommended.

TEAMING

Integration of School and Community Resources

It is important to understand how school requirements and systems intersect to assist students in need. School teams/personnel need to coordinate their efforts to ensure students are receiving proper support. Creating a comprehensive, multi-tiered approach includes knowledge of universal prevention practices, the signs and symptoms of substance use, the impact of addiction on the family, and supportive services and resources in the community. Several key staff teams, designated to act as safety nets for students, need to be made aware that students do not always present obvious indications of substance use.

Within a school, established teams can ensure students receive prevention, intervention and/or referral services as needed. Team members should be familiar with available services and comfortable with referral processes. Teams that can be involved with these efforts include:

Intervention and referral services (I&RS) team. The I&RS team is the multidisciplinary team that is tasked with identifying and addressing the academic, behavioral and health needs of students and subsequently developing effective action and/or intervention plans, monitoring progress, and making decisions regarding the referral of students to additional services based on the progress observed.

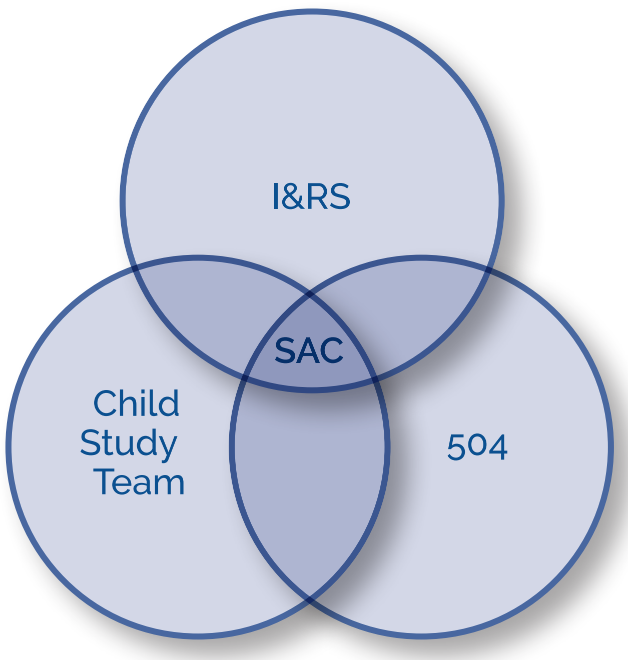
Section 504 committee. When mental or physical impairments limit any of a student's major life activities, reasonable accommodations to their program are required. Two conditions that create potential for 504 plan eligibility are behavioral difficulties and the presence of SUDs.

Child study team. The child study team (CST), as required by New Jersey state regulations, is a multidisciplinary team responsible for identifying, evaluating, and developing appropriate educational support plans for students with special needs or disabilities. Students who are classified as eligible for special education and related services may have or experience conditions that put them at higher risk for substance use and SUDs, and referrals could be made by the CST for Tier 2 and 3 interventions as deemed appropriate.

Resiliency teams: school resource teams (SRTs). SRTs can support and promote trauma-responsive school environments, ensuring that ACEs are being addressed appropriately. Teams should include school administrators, teachers, counselors, student assistance counselors, CST members, school resource officers, nurses, I&RS team members, and any other appropriate staff.

Best practices include considerations of engagement strategies and practices for successful partners that will expand the school's substance use prevention efforts. With limited resources, the needs of students to address their substance use and the risks associated with it will require outreach beyond the school, engaging parents, local and state service providers, and community members. Youth leadership can also play an instrumental role in a school's efforts to encourage student involvement in drug prevention efforts.

Resource mapping is key in identifying community resources that can support schools, students, and families in the prevention and



treatment of substance use and SUDs. Contracting with community mental health providers specializing in substance use can help with conducting assessments for the school district, offering treatment recommendations, and possibly providing Tier 3 supports to the student and family. One recommendation to facilitate community linkages is for each school district within a county to participate in, or have a liaison for, the Children's Interagency Coordinating Council (CIACC). This can help the district connect with regional and local providers as well as stay up-to-date with the resources and needs of the surrounding communities. One model of bringing the school and the community together is New Jersey's School-Based Youth Services Programs (SBYSP). Provided in selected districts, SBYSP coordinates with existing community resources. All students within the district are eligible. Services are provided before, during and after school and include mental health counseling, employment counseling, substance use education/prevention and preventive health awareness.

CULTURAL CONSIDERATIONS

Tailoring programs to the cultural and developmental needs of a target population is a critical component of any intervention. District communities can vary widely in terms of socio-demographics, profiles of risk and protective factors, and rates of substance use/SUDs. Findings from national surveys consistently show that rates of adolescent substance use and SUDs differ significantly by variables such as race, ethnicity, religiosity, socioeconomic status, and sexual orientation.[19-22] These variables may also predict differences in the type and prevalence of risk and protective factors for substance use.[23,24] The role of culture is primary in explaining these variations.

Culture also plays a role in varying perceptions of stigma with regard to mental illness, substance use, and treatment seeking.[25] For example, while African Americans tend to report lower rates of substance use relative to other racial/ethnic groups, research indicates that they are also less likely to seek and complete substance use treatment,[26] resulting in higher levels of unmet needs. Historical and ongoing discrimination towards marginalized groups can also contribute to a sense of cultural mistrust, which may discourage students and families from engagement in school or community-based substance use prevention and treatment programs.[27]

Youth from racial/ethnic minority groups also face fundamental barriers to substance use treatment, with lower rates of health insurance, few referrals to specialty care when facing SUDs, and at the community level, higher shortages of health care providers, including multilingual services.[28,29] Individuals belonging to sexual and gender minority populations similarly experience substantial

obstacles to mental health care and as a result undergo high levels of unmet needs.[30]

Schools are instrumental in early detection of substance use problems and referrals to appropriate specialized treatment services.[28] Development of culturally sensitive systems, curriculum, and practices, including diverse representation among school leadership and staff, is key to addressing potential cultural barriers to prevention and intervention services.

Culturally sensitive approaches reflect core values of diversity and inclusion, better serve participant needs, and optimize program outcomes. In this context, cultural sensitivity is defined as: "the extent to which ethnic or cultural characteristics, experiences, norms, values, behavior patterns and beliefs [of target populations], as well as relevant historical, environmental and social forces are incorporated in the design, delivery and evaluation [of a CSMHS]."[23] Culturally sensitive school-based prevention programs can serve to increase engagement of students, staff and administrators.[31] Engagement is paramount to positive program outcomes and evidence shows that culturally sensitive services, including substance use prevention programs, enhance program success.[31,32]

Cultural sensitivity involves two main features: 1) attention to social and behavioral characteristics of a population; and 2) an understanding and appreciation of deeper socio-historical factors and cultural beliefs that may influence substance use, SUDs, mental health more generally and utilization of formal mental health services, including school-based services.[23] New Jersey state regulations for comprehensive substance use programming, together with the MTSS framework, create an infrastructure for developing culturally sensitive programming through prioritizing equitable and just access to services and reduction of health disparities.

Engagement is paramount to positive program outcomes and evidence shows that culturally sensitive services, including substance use prevention programs, enhance program success.

Key tools in creating culturally sensitive substance use programs are: universal screening and assessment, continual monitoring of fidelity and intervention outcomes, and ongoing professional development that attends to cultural factors and potential disparities in access, delivery, and outcomes. Equally important is the active and ongoing engagement of diverse community members in the development, modification, delivery and evaluation of school-based substance prevention programs.[33]

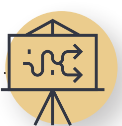
STAFF COMPETENCIES

Staff members should receive annual in-service trainings on substance use prevention and intervention, in addition to district drug use policies and procedures. These in-services should be updated each year to ensure that school staff receives the most current information. School districts should also provide parents with easily accessible educational programs on substance use (including pharmacology, physiology and the psychosocial and legal aspects of substance use). Aspiring teachers must receive training as part of their pre-service education. (See N.J.S.A. 18A:40A-3, 4, 15 through 17; see Resources section below for training resources.)

Annual training for staff on substance use issues should include:

- Training on identifying the symptoms and behaviors that may indicate substance use and strategies for intervention.
- Information about state, local and community resources for students at high risk or showing signs of substance use.
- Instructions on how to recognize and respond to students who appear to be under the influence, and information about procedures for reporting such a student to a school nurse or student assistance coordinator (SAC) and the school principal.
- Information about liability protections for making good faith reports, and established protocols to support and protect reporting staff.

CHAPTER SUMMARY



Students are at risk for multiple negative consequences associated with substance use, including the possibility of persistent SUDs. Schools have played and will continue to play a central role in substance use prevention and intervention efforts, using best practices within the MTSS framework to coordinate tiered services within and beyond the school setting.

New Jersey laws guide schools in creating comprehensive programs to prepare and educate students and staff, as well as provide supportive environments and responses when students are involved with substance use. This chapter has offered an overview of the legal protocols for districts to institute, and includes compliance checklists, helpful resources, and key considerations for success.

District policies and procedures should reflect this legal guidance and share it with staff and the larger school community. While districts are required to have comprehensive policies in place, it is also important to foster connections with local community and statewide resources to support students and families. Attending to the role of culture is also crucial to successful outcomes, and cultural considerations are relevant at all stages of program development, delivery and evaluation.

Reflection Questions

What barriers impede the coordination of your substance use programs and services?

What community agencies and resources have you identified to support students with substance use concerns?

To what extent are parents engaged in training programs related to substance use and their role in working with the school district to support their child?

What screening assessment protocols are in place to support the development and evaluation of a comprehensive substance use prevention program?

What meaningful substance use determinants and outcomes are being captured by current screening and assessment tools? What additional tools need to be introduced to capture all important information?

What trends are you seeing in student substance use? Do your trends mirror or deviate from regional or national trends?

What process do you have in place for regularly updating your health curriculum to address emerging trends in substance use?

For students being supported by multiple teams/programs (e.g., I&RS, IEP, 504, substance use), what systems do you have in place for information sharing, communication and coordination?

What cultural influences, specific to your school community, have you identified that may impact substance use prevention efforts?

How have you included diverse community members representative of your local school community in the development, modification, delivery and continued evaluation of school-based substance prevention programs?

RESOURCES & LINKS

1. **Screening, brief intervention and referral to treatment (SBIRT).** Learn more about SBIRT: "Youth at Risk Substance Misuse and Mental Health… The Most Important Questions New Jersey Schools Can Ask."
2. **Association of Student Assistant Professionals of New Jersey (ASAP)** defines student assistance programs as a framework for the delivery of K-12 universal, targeted prevention and intervention strategies and programs.
3. **LEGAL ONE** is a leading provider of education law workshops, online courses and webinars for school leaders and teachers on critical legal issues.
4. **New Jersey Prevention Network** works with local agencies in every county. These agencies in turn work with communities and schools to provide support in implementing comprehensive substance use programs and provide training for school personnel.
5. **Tobacco-Free for a Healthy New Jersey** provides resources for schools, including a Tobacco/Vaping Policy Toolkit: "Don't Get Vaped In," ASPIRE educational programs, Incorruptible.us County Youth Tobacco Action Groups, and youth cessation services.
6. **RWJBarnabas Health Institute for Prevention and Recovery** offers 504 and I&RS team training to school districts.
7. **Cape Assist** offers resiliency team training.
8. **Garden State Equality** provides innovative community programs, educates and trains service providers, and advocates for pro-equality policies to protect and meet the needs of LGBTQ New Jerseyans.
9. **PerformCare** connects young people and their families statewide to behavioral health care services.
10. **Recovery High Schools** are schools for students with a substance use disorders.
    - Raymond Lesniak ESH Recovery High School, Union County
    - Coastal Preparatory Recovery High School, Cape May County
    - KEYS Academy Recovery High School, Monmouth County

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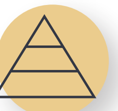
CHAPTER NINE

Collaboration With System Partners

WHAT YOU NEED TO KNOW

Accessing mental health supports can be an overwhelming process for many students and families, particularly during periods of distress. There are times when families want to reach out to the school for support, or would like some guidance on how to access support services for their children because they do not know what supports are available. Parents are often relieved to hear that school-based mental health services can be offered to them at no cost, are offered in their school or community, and are confidential.

INTEGRATION



An overarching goal of school-based mental health programming is providing an extra level of support to existing services. Rather than supplanting existing services, the goal is to enhance the services provided for the most at-risk students. This can be accomplished in a variety of ways, depending on the needs of the district and the primary goals of the program.

While some community mental health agencies have therapists providing clinical services on-site in schools, billing the student's insurance, schools have realized that some students need more comprehensive services. The expanded school mental health (ESMH) framework offers programs that build on the core services typically provided by a school, thereby offering an extra layer of support, also known as Tier 3 services. This framework aims to give students a full continuum of services, including mental health assessments, education, promotion, preventions, early intervention and treatment. Such programs augment services in schools through community partnerships that emphasize shared responsibility to fill in the gaps. A strong connection between schools and community agencies helps a school move toward a collaborative, school-based mental health services model and ensures that wrap-around services are provided to support the whole child and family.

An introductory meeting with school administrators may help districts identify their primary needs, which can then guide the type of collaborative, school-based mental health services that should be implemented in the school district. Different districts will opt for different services, depending on their primary program goals and their budget. Therefore, school-based mental health services can look very different across the state.

Staff members may take on varying roles as part of collaborative, school-based services, depending on what the focus is, whether it is prevention, intervention, crisis management, parent support, staff support and/or training. The program can be comprised of mental health clinicians, mental health specialists, family resource coordinators, youth development coordinators, psychiatrists, and/or advanced practice nurses (APN). Below are examples of possible supports and community provider options to meet your district needs.

A strong connection between schools and community agencies helps a school move toward a comprehensive, school-based mental health model and ensures that wrap-around services are provided to support the whole child and family.

Tier 1 Support
Professional Development

When a school district prefers to focus on staff training and support, they can partner with community providers who offer trainings to enhance existing services, as well as build confidence, increase skill sets, and support the school staff. Training topics can vary based on the needs of the district. These may include, but are not limited to, strategies for creating a trauma-informed school environment, suicide prevention and awareness, understanding depression and anxiety in youth, strategies for self-care and emotional regulation, and strategies for incorporating SEL (social-emotional learning) within the school. Other topics may include how to incorporate mindfulness strategies in the classroom, utilization of the Nurtured Heart Approach (a philosophy for creating healthy relationships), and strategies for managing challenging classroom behaviors. Districts can contract with community providers for professional development programming in several ways. Providers could either be a stand-alone support, or can be integrated into a more comprehensive, school-based mental health program.

Tier 1 Support
Family Engagement Model

If your district's identified need is predominantly family engagement and programming, then incorporating a family support specialist into the collaborative school-based model is a valuable resource. Family resource coordinators can provide case management support for families. They can be valuable in identifying community resources and will work closely with school staff and families to connect families to these supports. They can provide linkages to physical and mental health services, as well as support families with housing,

food, and child care needs. Family resource coordinators can also support family outreach and engagement by hosting both social and educational family nights focused on increasing families' connections with the school, utilizing these events as an opportunity to communicate what resources are available through the school and community. Districts with a large ESL/ELL population may opt for a family resource coordinator who is bilingual, and whose focus is on supporting immigrant youth and families. The family resource coordinator can be a stand-alone position or part of a larger, comprehensive, school-based mental health program.

Tier 2 Support

Prevention Programming and Support for At-Risk Youth

If your district's primary focus is to provide preventative programming and Tier 2 support for identified at-risk youth, then programming which combines a youth development coordinator and a licensed mental health clinician is a recommended approach. Youth development coordinators can support the school community in a variety of ways. Coordinators can develop schoolwide initiatives, such as wellness fairs or team building activities. The goal of this programming is to spread awareness and provide information on important topics, such as mental health, emotional regulation, kindness, and inclusivity. Additional examples of prevention programming can include classroom-wide lessons on coping skills or after-school programming for students who might benefit from additional support. These groups can be open to students who are identified as being at risk, in an effort to provide them with an added protective layer of support.

The role of the mental health clinician can include a variety of supports. The primary role of a mental health clinician includes providing individual, group, and family therapy. Additional supports can include completing crisis assessments and screenings, consulting with school staff, and providing case management and referral services for the school community. The clinician can serve as the linkage between school and community supports. The intensity of the supports may vary based on the primary needs of the district, which may vary from daily to monthly check-ins. Programs with a small group of Tier 3 students (see below, Tier 3 Support) can create an intensive model, with daily services provided to those students, in addition to weekly individual therapy. This model could be developed by hiring a staff member with clinical expertise to focus specifically on supporting these students.

Tier 2 groups can vary based on the needs of the school. Some examples of Tier 2 group topics include managing stress and anxiety, social skills development, managing anger and frustration, developing emotional regulation skills, self-esteem, and mindfulness. Student needs can be identified through the utilization of needs assessments. Consultation and collaboration with school staff, including school counselors, child study team members, administrators, nurses, and teachers,

is a crucial part of the clinician's role. This collaboration ensures that all the key players are on the same page and working together to support the students' needs. Clinicians can also be very valuable in building school capacity by providing staff training. Trainings can vary based on staff needs, and can include strategies for creating a trauma-informed school environment, incorporating SEL (social-emotional learning) strategies into the classroom, increasing student motivation, and providing self-care strategies for staff.

Tier 3 Support

Outpatient Model

As mentioned above, a licensed mental health clinician can support a district by providing both Tier 2 and Tier 3 supports. One approach to providing Tier 3 supports is to contract with a mental health agency that utilizes an outpatient treatment model. The agency's mental health clinicians would deliver clinical services on-site at the school. The agency would receive payment, either from the school district or through utilizing the student's health insurance (as long as the contracted agency is an approved insurance provider and the school is listed as an approved provider site).

During the initial weeks of program startup, the clinicians or other program staff should meet with the child study team members, school counselors, and building administrators to identify Tier 3 students who would benefit from school-based services. Program staff can work closely with building administrators to develop the referral process and identify a program point person who will streamline referrals. Typically, a referral form is completed by the referral source, who could be a school counselor, child study team case manager, school nurse or administrator. Students referred to the program should meet the identified criteria as in need of additional support services that warrant an outside referral.

> If the primary needs of districts are to provide intensive, in-school services to their most at-risk students, then the focus of the CSBMHP is to keep students in school rather than seeking an out-of-district school placement.

Once a student is deemed eligible for Tier 3 school-based mental health services, the clinician will work with the student and family to develop treatment goals. The duration of treatment often depends on the individualized needs of the student and is based on the amount of time needed to meet treatment goals.

After eligible youths are identified, meetings with the above-mentioned identified staff should occur monthly to discuss student progress. The integration of a successful, comprehensive,

school-based mental health program relies on constant communication with school staff, including teachers, child study team members, school counselors, school nurses, administrators, the youths and their parents/caregivers. Building relationships with the school community through engagement and communication are key components in ensuring the success of a comprehensive, school-based mental health program. School staff are encouraged to participate in various events throughout the school and community so they can establish and sustain these crucial relationships.

If the district has a significant need for psychiatric evaluation and medication monitoring services, the district should consider hiring a part-time psychiatrist or APN who can be a valuable resource, especially considering the challenges in securing a timely appointment or finding a resource locally that accepts the youth/family's health insurance. Having a psychiatrist or APN readily available at the school can aid in ensuring a child receives consistent and affordable medication management. This has been a valuable resource to families in need who would not otherwise have access. School-based psychiatrists work closely and collaboratively with the clinician as well as school staff to provide a team-oriented approach. This collaborative model is an ideal way to obtain and share information with the clinician as well as with a child's teacher and school counselor and/or case manager. At times, schools have used APNs as a more affordable and available alternative to psychiatrists.

Tier 3
In-School Wrap-Around or Self-Contained Programming

If the primary needs of the district are to provide intensive, in-school therapeutic services to their most at-risk students, then the focus of the collaborative, school-based mental health services would be developed with the goal of keeping students in school rather than seeking a higher level of care or an out-of-district school placement, since the services can be provided on-site. In this model, the district would partner with a community provider to work intensively with a small group of students with significant emotional or behavioral challenges that impact their ability to be successful in a traditional school model. Students may receive daily group therapy, weekly individual therapy, and weekly or biweekly family therapy with a licensed clinician. Students and families work closely with the clinician and treatment team to collaboratively develop treatment goals. These goals are evaluated every three months to assess progress. The clinician also works with each student on developing their individualized self-care plan, so school staff can identify known triggers, warning signs, and effective coping strategies for each student.

TEAMING

The integration of successful, collaborative, school-based mental health services relies on constant communication and ongoing collaboration with school staff, including teachers, child study team members, school counselors, school nurses, administrators, students, and parents. Building relationships with the school community through engagement and communication are key components to ensuring successful integration. These services are designed to fully integrate into the school community and are an added resource, not only for students and families but also as a support for teachers, staff and administrators. Furthermore, community providers are encouraged to participate in various events throughout the school and community so they can establish and sustain these crucial relationships. Other ways in which community providers can connect with a schoolwide team is by co-facilitating groups, consulting on high-risk youth, assisting during crisis situations, providing professional development trainings for teachers, providing open forums for parents and students that offer education on mental health topics, and assisting in the coordination of schoolwide events.

It is important for the school mental health team to ensure that school staff and the larger community are aware of available supports/services. Information about the programs and services offered can be discussed with school staff during staff meetings. Other opportunities to discuss program services and the referral process can include participation at Back-to-School Night, presentations at PTO/PTA meetings and other school events, and placing information on the school district's website and in brochures or flyers distributed throughout the school. Students and families should be able to self-refer by reaching out to school-based staff directly. Services are to be provided at no cost to the student or family and offered in a location that is most comfortable for them. Providing school staff, students, and families with a comprehensive and collaborative approach to supporting at-risk youth that is easily accessible at school is an efficient way to ensure that students and families receive services to support the whole child.

Various supports and services are available in New Jersey to enhance existing school-based mental health programs. Every county in the state has a Children's Interagency Coordinating Council (CIACC), which brings together critical groups of agencies and stakeholders to address students' mental health needs. Participation by local school districts is highly encouraged, since it can facilitate relationships with local agencies and service providers and allow districts to collaboratively problem-solve with system partners. The following programs are often free resources that provide extra layers of support to students, families and school staff:

- Traumatic Loss Coalitions
- 2NDFLOOR Youth Helpline
- Children's System of Care (CSOC)/ PerformCare
- Family Support Organizations (FSOs)
- County Mental Health Services/ Community Mental Health Centers
- Catholic Charities
- Jewish Family Services
- Family Health Consortia

The **Traumatic Loss Coalitions for Youth Program** (TLC) at Rutgers University Behavioral Health Care is New Jersey's primary youth suicide prevention program. Funded by the Department of Children and Families, Children's System of Care, the TLC is a statewide network that effectively works to prevent suicide and promote healing and resiliency in the aftermath of traumatic loss. TLC has operated as a county-based collaborative since 2000, providing support to communities affected by traumatic events such as homicide and illness, the most difficult being suicide, now the second leading cause of death in New Jersey for youths ages 10 to 24. As an interactive statewide network, TLC offers collaboration and support to professionals working with school-age youth. The dual

mission of TLC is excellence in suicide prevention and trauma response assistance to schools following unfortunate losses due to suicide, homicide, accident, and illness. This is accomplished through county, regional, and statewide conferences; training; consultation; onsite traumatic loss response; and technical assistance. Each county has a TLC coordinator who arranges meetings and trainings throughout the year, bringing together school personnel, mental health clinicians, juvenile justice personnel, law enforcement officials, social service agencies, child welfare workers, and many others who work closely with youth. The meetings are effective forums for reviewing traumatic loss events, identifying service needs, and providing professional development through the inclusion of an educational component. The speakers are experts in topics related to the needs of youths, providing up-to-date knowledge about mental health issues, suicide prevention, traumatic grief, and resiliency enhancement.

Traumatic Loss Coalition
151 Centennial Avenue
Piscataway, NJ 08854
Phone: **732-235-2810**
E-mail: **tlc@ubhc.rutgers.edu.**
Contacts: **Maureen Brogan, LPC, ACS, DRCC, statewide program manager, and Kisha Harrison, resource coordinator**

The **2NDFLOOR Youth Helpline** is a safe place to call when an individual needs help with any problem. 2NDFLOOR is free, confidential and anonymous (except if a caller says they are going to hurt themselves or others). 2NDFLOOR is available 24 hours a day, seven days a week. 2NDFLOOR's phone counselors are caring and supportive and anyone can anonymously write a message on their online message board.

For problems, questions or non-life-threatening situations, call or text the **Youth Helpline at 888-222-2228.** *Email:* **info@2NDFLOOR.org**

The **Children's System of Care** (CSOC), formerly the Division of Child Behavioral Health Services, serves youth and their families with emotional and behavioral health care challenges, developmental and intellectual disabilities, substance use challenges, and co-occurring needs.

CSOC is committed to providing services based on the needs of the child and family in a family-centered, community-based environment. It offers a wide range of services for children up to age 21 for substance use, behavioral health or developmental disability needs. It also offers a wide array of substance use treatment services, including withdrawal management, outpatient, intensive outpatient, partial care, and out-of-home services.

To access services, call the 24-hour, toll-free access line of CSOC's contracted system administrator, **PerformCare, at 877-652-7624.** Additional information is available on the PerformCare website.

One of the services offered through CSOC is Care Management Organization (CMO). CMOs are community-based agencies that provide a full range of treatment and support services to children with the most complex needs. The CMOs work within the context of the child family team approach to develop individualized service plans for children and families while keeping the children in their homes, schools, and communities. **To access services call: 877-652-7624.**

Family Support Organizations (FSOs) are family-run, county-based organizations that provide direct family-to-family peer support, education, advocacy and other services to family members of youths with emotional and behavioral challenges. To access services, you may call these organizations directly or call **877-652-7624.**

Each county offers a wide range of community mental health services, often at a **community mental health center** where different levels of care are provided, including outpatient, intensive outpatient, and partial care programs. These centers also offer a number of different therapeutic groups for all ages. The community mental health centers will often accept all insurance plans and can provide services to individuals who do not

have health insurance. For information, check this **Mental Health Services Directory** (DMHAS contracted providers).

The New Jersey Pediatric Psychiatry Collaborative (NJPPC) is a state-funded grant program where health care system partners (i.e., Hackensack Meridian Health, Cooper University Health Care, the Atlantic Health System and Rutgers University Behavioral Healthcare) provide support, evaluations, and referrals for children with emotional and behavioral health issues. The program is available for children up to age 18 or older if the patient is still seeing their pediatrician who is registered with the NJPPC. Services are provided statewide through regional hubs. **For more information, primary care physicians (PCPs) may call 609-842-0014 or email MHC@njaap.org.**

The Human Services Advisory Council is a network of state and local human service leaders who meet to share information about human service issues across New Jersey and create a unified forum to address those issues. Click **here** for information regarding your county's advisory council.

Catholic Charities offers a variety of affordable community-based resources. The specific services provided vary by county, but include immigration services, shelter and housing, counseling, youth and childcare services, child care and maternity care. The resources are available to all individuals. For more information, visit the **Catholic Charities** website.

Jewish Family Services (JFS) is a nonprofit organization that provides vital human services to children, adults and families. Some of the resources provided include supports for homelessness, women's health, behavioral health, and food resources. Each county has its own JFS chapter. For information specific to your county, contact your local office.

The **Family Health Consortium** offers a variety of resources for families. Some initiatives include supports for childbearing, pregnant and non-pregnant people and their families, perinatal mood and addiction prevention programming, early intervention resources, safe kids and teen health initiatives. **For more information call 732-937-5437.**

COMMUNITY, STUDENT, AND FAMILY ENGAGEMENT

The success of comprehensive school-based mental health programs requires not only close collaboration between the school and mental health agency, but also an understanding and buy-in from students and families. Identification and collaboration with community agencies creates a network of resources to ensure families are connected with needed services.

Community Engagement

There is considerable value to identifying resources available within the community. Forming relationships with community providers and understanding what supports are available helps provide continuity of care. Families may need more than just school-based mental health support, such as access to food and resources for housing. Students may also at times require a higher level of care. Identifying the levels of care available within the community allows for a smooth transition to the right level of care when needed.

Student Engagement

Engaging students involves a variety of strategies. Creating preventative programming, such as classroom presentations on topics such as mindfulness, social skills, and coping strategies, is a valuable way to normalize the supports available and begin getting students comfortable with the mental health staff and where they are located within the

school building. When students are referred, it can be helpful for a trusted adult to make the initial introduction. For example, the mental health clinician could be asked to meet the student in the school counselor's office at the time of initial referral. Small counseling groups are also a great way reach more students and continue to break down the stigma of mental health services within the school community.

One of the major benefits of school-based mental health services is that services can be tailored to meet students' individual needs.

Engaging families involves outreach and development of programming focused on increasing the families' connections with the school.

Given that services are often provided without going through a child or family's insurance, a school-based clinician can see a student every day for 20 minutes if needed, or twice a week for 45 minutes, etc. Services can be customized for each individual student or family, based on their identified needs. Clinicians often complete thorough assessments with referred students to ensure a complete picture of each student's needs. Many times, they find that students with poor attendance, poor academic performance, and multiple disciplinary issues are struggling with mental health concerns or have basic needs that are unmet. Clinicians work collaboratively with the student, school, and family to ensure that the whole team works together.

Family Engagement

Engaging families involves outreach and development of programming focused on increasing the families' connections with the school. A parent survey may help identify the needs of the community. Parent outreach events can be educational, such as "parent university" training nights where parents are offered education on a needed topic. Another option is a meet-and-greet with school-based staff, giving parents the opportunity to meet the staff and ask questions about the programming. Some schools have community resource fairs, where local organizations come to share information about the services offered. These types of meetings and events inform families and also help to reduce the stigma and fear surrounding mental health supports.

Another useful approach is creating a parent advisory committee. This provides a platform for family and community voices to be heard. The advisory committee objectively shows families that their voices are important and matter to the school, and their recommendations are taken into consideration.

CULTURAL CONSIDERATIONS

Approaching programming with a culturally sensitive lens ensures that families' struggles and needs are recognized and met with understanding and respect. When developing programming with a contracted mental health agency, be mindful of school cultural demographics. Culture strongly impacts a family's decision-making process and their openness to obtaining support. Particularly when working with immigrant and undocumented families, there may be an initial level of distrust and wariness over the services recommended. Clinicians should approach these families with empathy and understanding, slowly building trust. It is critical for clinicians to ask how a student and family's cultural beliefs, values, and traditions impact their lives, and find a way to incorporate these beliefs, values, and traditions into their treatment recommendations. Inquiring about religion and spiritual beliefs should also be a part of treatment.

Allowing for other accommodations, such as traveling to the family's home or meeting them in a safe place, flexing work hours to accommodate a family before or after school hours, and speaking to the family in their native tongue, all serve to break down the stigma and get families to engage and be open to seeking supports.

It is highly recommended that therapists receive both ongoing and extensive training in working therapeutically with diverse populations. It is also recommended that staff have access to a language line to provide interpretation when necessary. This would be preferred over having children translate for their parents.

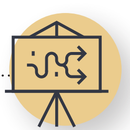
For refugee/forced immigration families and students, the New Jersey Department of Education maintains resources for educators and families. Also, the International Rescue Committee is a nonprofit organization with an office in Elizabeth, New Jersey that supports refugees and displaced people. A series of free learning modules can be accessed to assist school personnel with understanding the complex needs of refugee families and students.

STAFF COMPETENCIES

It is important to provide school staff with ongoing education about the purpose of the programming and their role in supporting the school. When integrating collaborative, school-based mental health services into a school, starting with an introductory meeting with administrators, counselors, child study team members and nurses gets everyone on the same page in terms of goals and expectations. It helps school staff and community providers clarify the differences in their roles and figure out how to best work with and support their efforts in managing student needs. When it comes to providing Tier 1 and Tier 2 interventions in particular, it can be valuable to partner with school staff and work collaboratively. This can be done through classroom presentations, groups, or parent programming. Community providers are most effective when they have support and can work closely with school staff.

Teachers also play an integral role in effectively working with community providers. Present the collaborative, school-based mental health services at staff meetings, send out written information about the resources offered, and host informational meet-and-greets. All are valuable ways to ensure that teachers gain an understanding of the community providers' role within the school.

CHAPTER SUMMARY



Schools are recognized as places where students can receive mental health services, given that challenges are usually identified there, and that is where children and adolescents spend the majority of their day.

Given the important interplay between emotional health and school success, schools must be partners in the mental health care of children.

The goal of collaborative, school-based mental health services is to create healthy environments for learning by partnering with schools in developing prevention and intervention strategies that promote academic and life success for all of the students.

Parents are often relieved to hear that school-based mental health services are available at no cost to them, are offered in their community, and are confidential.

The addition of collaborative, school-based mental health services can provide supports at Tier 1, Tier 2, and Tier 3 levels, depending on the needs of the school district.

Tier 3 level of supports can help students struggling the most by providing more intensive services, with the goal of keeping young people in school and not referring them to a higher level of care or an out-of-district placement.

The integration of successful, collaborative, school-based mental health services relies on constant communication and ongoing collaboration with school staff, including teachers, child study team members, school counselors, school nurses, administrators and parents.

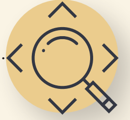
Many supports are available in New Jersey to enhance existing school-based mental health programs. These programs are often free resources that provide extra layers of support to students, families and school staff.

> Given the **important interplay between emotional health and school success,** schools must be partners in the mental health care of children.

Identification and collaboration with community agencies creates a network of resources to ensure families are connected with needed services.

Different roles can encompass collaborative, school-based mental health services, depending on what the focus is: prevention, intervention, crisis management, parent support or staff support and training.

SPOTLIGHT



DUMONT PUBLIC SCHOOLS

Linkages to Community Resources

Dumont Public Schools has developed mental health programs to include linkages with numerous community resources and system partners. This includes full-time educational specialists such as school psychologists, social workers, and counselors within our pre-K through 12th grade public school system. Our district is proud to have partnered with higher education institutions that provide internship field placements for disciplines who serve on child study teams in public schools (e.g., School Social Work, School Psychology, Learning Disability Teacher Consultant, and Speech Therapy). These collaborations facilitate internship opportunities within our schools. Through this partnership pre-service students are able to provide additional Tier 1 and Tier 2 supports for our students and families within our schools on a daily and/or weekly basis. Internship responsibilities are correlated to the respective training programs' learning objectives and professional organizations' standards. Trainees from the various higher education institutions serve as consultants to teachers within each of our buildings via the Intervention & Referral Services structure, providing direct counseling/ related service support to students, as well as other supports to parents, administrators, and school personnel.

Dumont Public Schools has developed a collaboration with a mental health agency that provides a full-time clinician to work closely with students and families. One of the many benefits of working with a mental health agency is the direct access to additional and supplemental services the agency can provide, outside the typical school day. Our clinician provides robust professional development to district personnel and families on a multitude of topics that are reflective of our needs, ranging from dealing with anxiety and depression to school refusal.

Further, Dumont Public Schools has maintained a linkage with our county management organization (CMO) with quarterly meetings and training opportunities for parents, administrators, and school personnel. Parents and all school personnel have received specialized training in positive reinforcement strategies. Dumont Public Schools and our CMO collaborate to provide targeted opportunities for our students and families to access appropriate tools that will effectively address their personal and social-emotional needs.

Successes

- Developed an annual Tier 1 mental health awareness program at Dumont High School
- Implemented Tier 2 after-school program for 3rd and 4th graders
- Developed a mental health agency affiliation that provides Tier 2 counseling support for students, as well as Tier 1 and Tier 2 parent support services
- Implementation of our restorative practice model to establish positive discipline policies and procedures

Lessons Learned

- Build supportive services through affiliations with higher education programs that focus on educational specialist roles, such as school psychology, speech therapy, learning disability teacher consultant (LDTC), and school social work. These services increase the number of interventionists available to students, parents, and school personnel.
- Collaboration with community resources provides additional support for students, teachers, and parents outside the school day.
- Our affiliations with higher education institutions and a mental health agency provide direct access to current evidence-based practices related to procedures, interventions, and training opportunities.

Reflection Questions

What are the greatest needs in my school district? What components of a school-based mental health program would meet these needs?

What are our current resources? What services are needed to enhance existing resources?

How many at-risk students have we identified as needing Tier 3 level services? How many additional staff are needed to provide these additional services?

How do we create and implement a program that focuses on prevention, early identification and intervention?

What types of training do school staff need to enhance existing services so they can provide additional support to identified students?

Who can represent our local school district by participating in the county Children's Interagency Coordinating Council?

What providers serve our area/region?

How can I learn more about the Children's System of Care (CSOC) and the services they offer?

What relationships currently exist with the local providers in our area? Which staff may already have connections to these providers?

RESOURCES & LINKS

1. SAMHSA—Guidance to States and School Systems on Addressing Mental Health and Substance Issues in Schools
2. Now is the Time Technical Assistance Center—School Mental Health Referral Pathways Tookit
3. Mental health promotion in schools: A comprehensive theoretical framework
4. Children's Division, Bureau for Behavioral Health—Creating a Framework for School Based Mental Health Services in West Virginia
5. A Framework for Safe and Successful Schools
6. Education Law Center—Unlocking the Door to Learning: Trauma-Informed Classrooms & Transformational Schools
7. L. O'Neil, S. George, & J. Wagg—Trauma-Informed Classroom Strategies
8. Helping Traumatized Children Learn
9. CASEL—Program Guide

Staff Training Resources

1. Question Persuade Refer Institute
2. National Center on Safe Supportive Learning Environments—Trauma-Sensitive Schools Training Package
3. National Center on Safe Supportive Learning Environments—Leading Trauma-Sensitive Schools Action Guide

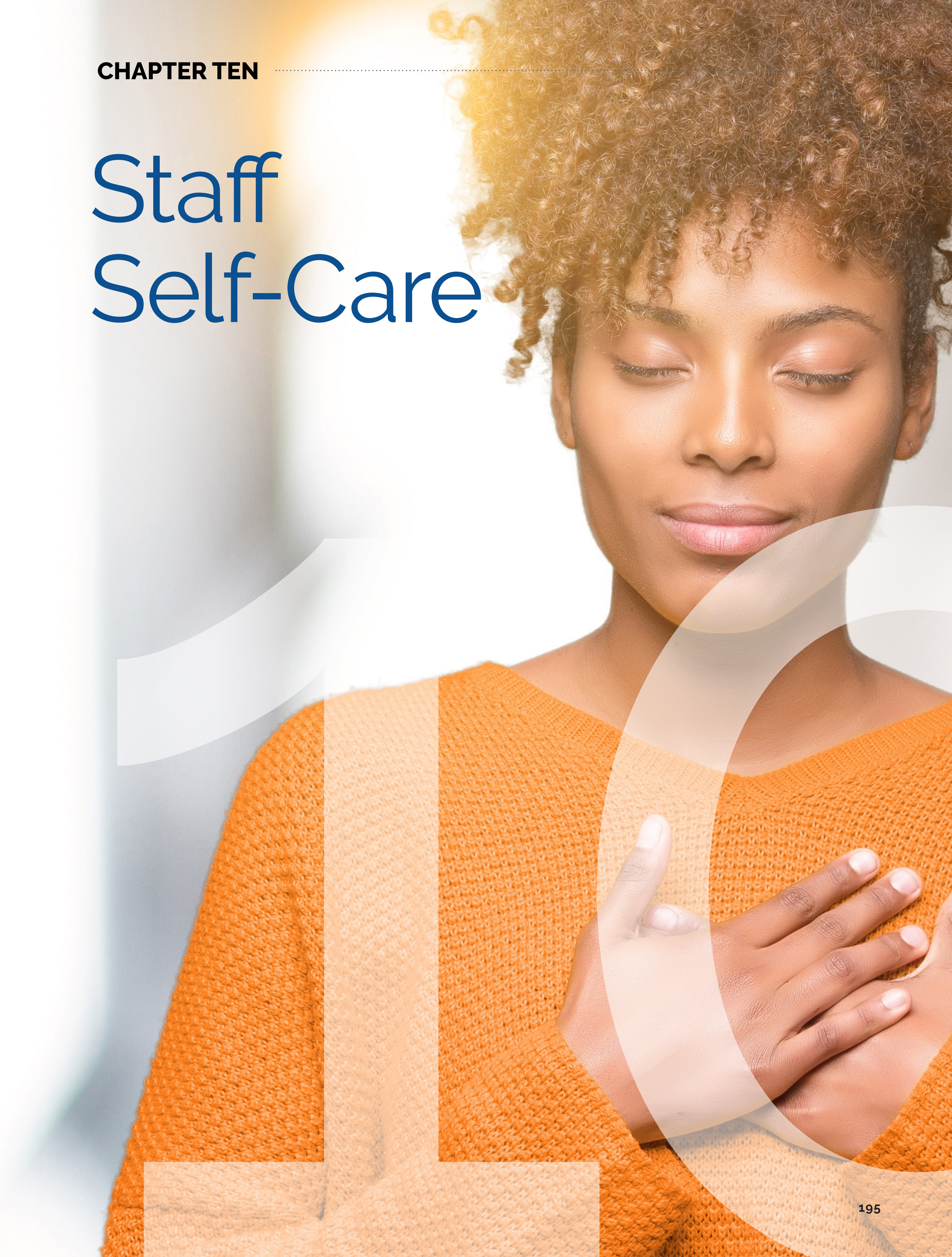
Behavioral Health Resources

1. NJ Department of Human Services—Directory of Mental Health Services
2. NJ MentalHealthCares
3. Mental Health Association in New Jersey
4. Open Counseling—New Jersey Mental Health Services Guide
5. NJ 211—Mental Health Resources
6. National Alliance on Mental Illness New Jersey—Important Hotlines and Helplines

Reference

1. Skalski, A. K. & Smith, M.J. (2006). Responding to Mental Health Needs of Students. Students Services.

Staff Self-Care



WHAT YOU NEED TO KNOW

This chapter focuses on one of the most critical and often overlooked aspects of school mental health: the well-being of the adults who work hard to meet the needs of students. The need of adult well-being is often best highlighted by the advice shared at the beginning of every commercial airline flight: "Always put your own oxygen mask on first." This adage holds true for teachers and staff in schools. If the adults are not healthy, how can they look after the students? This is underscored by the myriad ways a teacher and/or staff member influences a student's daily life.

To address school staff well-being, this chapter will cover several topics, including:

- Defining and highlighting the importance of well-being and self-care
- Using an MTSS framework to create systems-level self-care by establishing a school wellness team, conducting needs assessments, and linking self-care supports and strategies across the tiered continuum of supports

Well-Being and Self-Care

Well-being is an umbrella term that includes 'having good mental health, high life satisfaction, a sense of meaning or purpose, and the ability to manage stress. More generally, well-being is just feeling well.'

This definition of well-being can be extended to include the five broad types listed below.

Emotional well-being. The ability to practice stress management and relaxation techniques, be resilient, boost self-love, and generate emotions that lead to good feelings.

Physical well-being. The ability to improve body function through healthy eating and good exercise habits.

Social well-being. The ability to communicate, develop meaningful relationships with others,

and maintain a support network that helps you avoid loneliness.

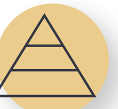
Workplace well-being. The ability to pursue your interests, values, and life purpose to gain meaning, happiness, and enrichment professionally.

Societal well-being. The ability to actively participate in a thriving community, culture, and environment.

Self-care for staff can be defined as any activity we deliberately do to take care of our mental, emotional, and physical well-being. Given the many broad domains of well-being, self-care is varied and can include a range of strategies. Moreover, while the term "self-care" implies an individual focus, self-care should not be used as a shifting of responsibility completely to the individuals in need of it. Other care, in the form of support from the broader community, schoolwide system, and policy, should be considered equally with efforts to help school staff develop personalized self-care strategies.

This can be seen as the inside out (self-care) and outside in (other care) approach, similar to how mental health supports are set up for children—where we want to build strong skill sets for students to use (coping strategies) as well as create nurturing and supportive environments that cultivate strong mental health and overall well-being.

INTEGRATION



To address self-care for all adults in schools, the Multi-Tiered System of Support (MTSS) framework can be as useful as it is in helping to support student mental health. As a reminder, the MTSS framework starts with looking at universal supports to see how we can promote positive health and prevent challenges for everyone (Tier 1); followed by adding more targeted group supports for those that need them (Tier 2); and the addition of individualized supports for those with the most intensive needs (Tier 3). When considering school staff wellness and self-care strategies, the same framework can be used to organize strategies from both the individual's perspective (self-care) and the school's perspective (other care).

Below is an example of strategies that can be used across the continuum.

As the table below demonstrates, many strategies can be employed across the tiers and context of care. However, for each school, these strategies should be specifically selected and implemented to meet the needs of the adults (as indicated by the needs assessment). Importantly, while the focus of this chapter is on school staff, these needs and corresponding strategies can include adult family members and others in the community, either as recipients of training/workshops or as aids in creating supports for others (e.g., family members acknowledging and demonstrating appreciation for the hard work of school professionals).

Context of Care	Tier 1	Tier 2	Tier 3
	Needs of all adults in the school/district	Needs of some adults beyond Tier 1	Needs of individual adults who need supports beyond Tiers 1 and 2
Self-Care	• Develop general coping strategies (e.g., daily mindfulness practice) • Encourage healthy eating • Encourage regular exercise	• Attending group yoga class • Guided mindfulness meditation group	• Seeking supports for specific strategies based on needs assessments and problem identification
Other Care	• Creating a strong sense of community and belonging for all staff • Schoolwide acknowledgement system for staff • Creating time and physical space for staff to engage in regular self-care practices • Create professional learning communities (PLC) for staff to share/exchange strategies that have worked • Training and support for addressing school-based stressors (e.g., if student behavior is source of stress, providing supports to address behaviors)	• Hiring yoga and mindfulness instructors to come to school to offer courses • Providing targeted strategies for professional development based on staff input • Staff support groups	• Providing opportunities for one-to-one staff mentoring • Making available local mental health resources

TEAMING

To create a system of support for staff self-care that is tailored to local needs, we can borrow what we have outlined in previous chapters around building comprehensive MTSS school-based mental health for students. A good place to begin addressing staff wellness is by creating a schoolwide staff wellness team (or repurposing an existing team) to lead the initiative. To fully embrace a culture of self-care and well-being in a school community, coordination and leadership are essential. Staff wellness teams are an excellent way to lead and coordinate a schoolwide focus on the well-being and self-care of the adults in the school. Specifically, the team can 1) assess the needs of the staff, 2) link appropriate strategies to areas of identified needs, and 3) provide implementation supports to ensure that the self-care initiatives will be put into place.

It is important to note that the staff wellness team is a representative group that is separate from potential intervention teams such as a "staff wellness support group" or an "after school yoga club," which may serve as Tier 2 supports. The staff wellness team leads, coordinates, communicates, and helps implement a schoolwide system that focuses on staff well-being. However, depending on the school and community, the staff wellness team can be the same team that is leading the student-focused schoolwide MTSS process, or it can be a sub-committee of that leadership team. Even if they are not the same team, strong collaboration and communication between teams is highly recommended to ensure activities are aligned.

Creating a Staff Wellness Team

- Obtain support and endorsement from building leadership.
- Obtain support and endorsement from school staff. (Any efforts to provide self-care for staff without their knowledge or consent are likely to backfire.)

- Create a representative team—ideally, one comprised of diverse individuals from different roles within the school community: classroom teachers, school counselors, social workers, school nurse, support staff, aides, coaches, parents, and in many cases, students.
- Establish a time to meet regularly.
- Agree on the team's structure and create specific roles (e.g., note taker, discussion leader, organizer).

To fully embrace a culture of self-care and well-being in a school community, **coordination and leadership are essential.**

General Activities and Roles of the School Wellness Team

- Gathering information regarding the wellness and mental health of staff
- Collecting information about local services and resources available
- Organizing and coordinating these services and resources
- Ensuring that staff wellness is a visible priority within the school
- Serving as a conduit for staff voice and participation
- Creating action plan templates to address staff well-being and self-care
- Ensure policies are in place that support staff
- Monitoring and evaluating the impact of school wellness efforts

First Steps for the School Wellness Team

Conduct a needs assessment to identify areas of need for the school community (coping skills, areas of stress, etc.) and also what available resources are in place to support adult well-being (physical and emotional). Identify any resource gaps. This is similar to the process outlined in Chapter 3, Resource Mapping. Be sure to include all stakeholder groups—teachers, staff, and parent teacher organization (PTO).

Create a plan and recommendations based on the above assessment. Be sure to include input from as many voices as possible. Communicate the plan with building and district leadership. Be sure to build in ways to receive ongoing feedback and assess the impact of what is being implemented.

Ensure that school leadership demonstrates visible support of implementation efforts and provides support as necessary, and as appropriate, to help ensure success.

Needs Assessment

As covered in Chapter 3, needs assessment is a key part of providing programs, services and supports in an MTSS because it is the process by which areas of need are identified to be linked to appropriate supports. This can include areas such as levels of stress, current competencies related to social-emotional skills/coping strategies, and specific school-related challenges that staff might be facing (e.g., addressing behavioral challenges in the classroom). Below is a list of resources that staff can use for self-assessments that can also be administered schoolwide to determine overall needs for school staff.

Self-Care Assessment Resources

- Understand one's own SEL strengths and opportunities for growth by completing an SEL self-assessment (more about SEL in the following section).
- Complete a self-care assessment.
- Create a self-care plan, including an additional plan for when things get tough.

Additionally, resource mapping, along with needs assessment, offers a good picture of available resources and services in place to support school staff, as well as identifying areas where resources are needed or need to be realigned. Similar to student-focused mental health supports, the supports provided for staff can include a range of activities beyond specific self-care strategies (e.g., relaxation, yoga). These include building social-emotional skills, cultivating positive school climate and mental health literacy, implementing positive behavioral interventions and supports (PBIS) to prevent challenging behaviors that lead to stress, and trauma-informed care (TIC) to address staff and student concerns related to trauma.

(Note: A mechanism should be in place for referrals to appropriate mental health services to treat more serious concerns that cannot be addressed in schools.)

Continuum of Self-Care Strategies

Once the needs assessment and resource mapping processes are completed, the staff wellness team can look to create a tiered continuum of strategies as shown in the example table earlier in this chapter. In addition to the examples in the table, here are some additional strategies that can be applied at Tier 1 (universal) and Tier 2 (secondary) levels.

1. A supportive, caring environment

Creating a supportive school environment is the first step in promoting staff self-care. Building and district leadership should ensure that:

There are ample opportunities for staff to build positive relationships.

- **PLCs.** Provide staff with opportunities to connect and collaborate. Examples: grade level teams, regular team meetings, collaborative work on curriculum.
- **Staff wellness support groups.** Can be more formal PLCs or informal groups.
- **Hobby/interest groups.** Book clubs, gardening groups, foreign language groups, cooking, musical groups, healthy eating groups.
- **Physical activities.** Yoga classes, exercise classes, walking challenges, faculty intramurals after school.

Creating and sustaining a positive school climate is a priority.

- The school should be intentionally focusing on creating and sustaining a positive school climate using a data-driven approach.
- A positive school climate should be explicitly listed as a goal in the strategic plan, on the website, and in any relevant school communication.

2. Visibility, prioritization and policies

The importance of staff well-being and self-care should be visible and recognizable to all in the school community and should be reflected in relevant school policies.

- Have staff well-being be an explicitly stated value in the school strategic plan, on the website, and in communications.
- Share specific examples regularly with the school community of how the school is prioritizing staff well-being and supporting opportunities for staff self-care.
- During staff meetings, include regular time for wellness updates.

- Regularly communicate and celebrate achievements of individuals, teams, and the school as a whole.
- The school wellness team should review the school wellness policy to ensure it addresses staff wellness in addition to student wellness. Along with nutrition and physical exercise, the policy should also include social and emotional wellness. If a school wellness policy does not exist, creating one could be a first step for the school wellness team.

3. Scheduling and the physical environment

School administration needs to ensure that time is built into the schedule for staff teams to meet, discuss and connect. Creating time may involve revisiting the school schedule.

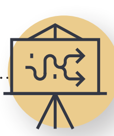
- These identified times for self-care and connection should not be infringed upon if other events threaten to interrupt the regular meeting time or any regularly scheduled activity times. When events seem to become more urgent and pressing, that is when staff needs their wellness time the most.

Create time for classroom and schoolwide mindfulness minutes and additional reflection time if recommended by the staff wellness team.

In addition to ensuring time is available, it is important to create well-being spaces for school staff to connect, reflect and recharge. Spaces should be considered both indoors and outdoors and be available before, during, and after school.

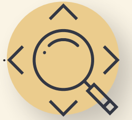
In addition to universal or secondary strategy suggestions, the strategies can also include teaching approaches that staff can use on their own as part of their personal self-care efforts. The resource list at the end of the chapter provides guidelines for coping strategies as part of self-care practice.

CHAPTER SUMMARY



The emotional and physical well-being of staff is critical to the success of a school and its students. The school/district's role is to ensure that a positive, supportive environment exists throughout the school community and staff members have the tools to build self-care skills. It is within this environment that staff can thrive. A coordinated, team-based approach within the MTSS framework ensures sustainability and efficient use of resources, and creates a consistent, positive school climate where all feel welcomed, valued, heard and supported.

SPOTLIGHT



LUMBERTON TOWNSHIP SCHOOL DISTRICT

Supporting Staff Mental Health and Self-Care

The Lumberton Township School District was in the process of developing initiatives to improve the overall school climate for staff and students when the COVID-19 pandemic took hold. With students and teachers facing unprecedented challenges, the district sought to enhance its mental health supports and access not only for students, but for staff as well.

A grant from the Elementary and Secondary School Emergency Relief Fund (ESSER) allowed the district to hire an additional school social worker dedicated to creating a culture of staff wellness, while also providing direct counseling services to staff and students. As part of this initiative, staff mental health has been promoted as a central theme of professional development. Presentations emphasize the importance of self-care, help-seeking, and open communication among colleagues. Discussions with staff strive to dispel misconceptions of self-care as "selfish" and challenge expectations that "we have to have it together all the time." A protocol is in place for accessing counseling services privately and confidentially, with hours that extend before and after school.

The district has also paid special attention to building trust and addressing mental health stigma. While the initiative is still under development, staff input plays a central role in determining the next steps. A guiding belief is that staff well-being is part of an overall positive school climate, and supporting teachers' mental health leads to better outcomes for everyone, including students.

Successes

- School staff members have been highly engaged and positive about the staff wellness initiative, including the introduction of an additional social worker to support their needs.
- The initiative has provided a strong foundation for staff (and students), building resilience to navigate more significant challenges that may arise over the school year.
- The initiative has aligned well with the Culturally Responsive Positive Behavioral Interventions and Supports (CRPBIS) framework adopted by the district in collaboration with Rowan University's Center for Access, Success, and Equity as part of the "School Climate Transformation Grant" from the U.S. Department of Education.
- Efforts are already in place towards capacity-building to sustain the staff wellness initiative.

Lessons Learned

- Input and buy-in from local teacher associations and coordinated support across all district levels are essential in developing staff wellness efforts in schools.
- Building trust and addressing stigma among school staff are fundamental to creating and sustaining successful staff mental health initiatives.
- Changing cultural norms around mental health in the workplace is challenging, but it is important to remain open-minded and optimistic about possibilities and paths to success that are not immediately evident.
- The district has adopted a theme for the school year: Give Grace, Get Grace.

Reflection Questions

What components of a coordinated plan to address staff well-being does your school or district already have in place? Is there a way to combine teams under one umbrella with sub-groups to encourage coordination and efficiency?

How are you currently using PBIS, SEL and a trauma-informed approach to support staff well-being?

What are some self-assessments that can help you understand your own strengths and opportunities?

Does your school and district prioritize staff well-being on its website, in its strategic plan, and in relevant policies?

To what extent are parents, families and the community involved in staff wellness activities (e.g., teacher appreciation events, teacher acknowledgement activities)?

RESOURCES & LINKS

1. CDC school wellness plans
2. CDC: How right now: How are you feeling?
3. Harvard Business Review Ideas for Self-Care
4. Harvard Medical School—Harvard Health Gratitude Research
5. Coping with stress
6. Well-being
7. Self-Care Program Manual: Self-Care in the Workplace
8. Tools for Educators in a Public Health Crisis

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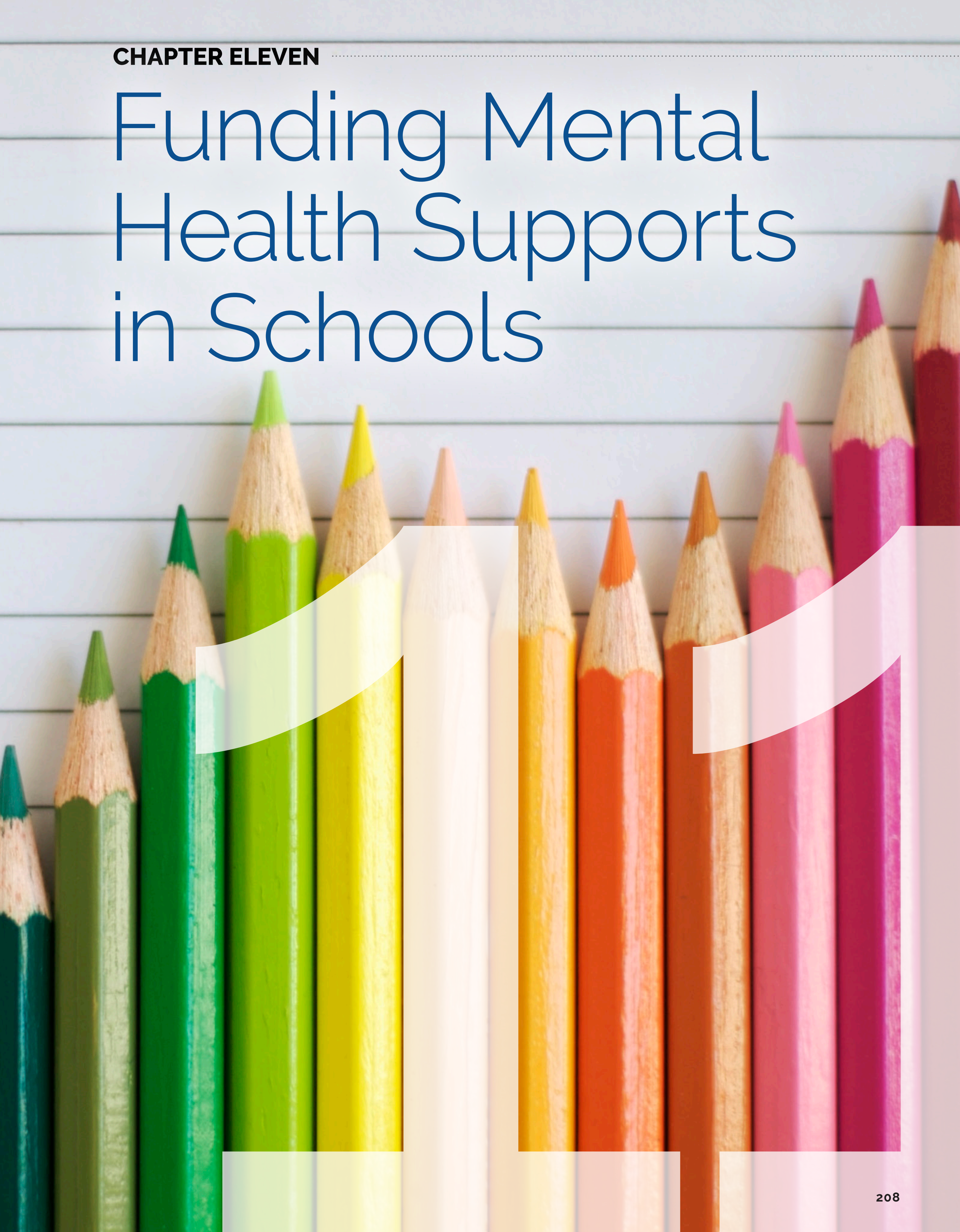


Funding Mental Health Supports in Schools

WHAT YOU NEED TO KNOW

Multiple and diverse funding and resources must be utilized to maintain a long-term, comprehensive multi-tiered system of support (MTSS) to meet mental health needs for all students and staff. Maximizing opportunities within federal and state funding can build a sustainable school mental health system that covers: Tier 1 (universal services for all), Tier 2 (early and targeted intervention for some), and Tier 3 (intensive interventions for few). Additionally, schools and school districts should avoid relying on a single source of funding, but instead strategically use multiple funding streams to support their MTSS needs. This can include braiding funding sources from different levels (e.g., school, local, district, state, federal), types of funding (e.g., grants, third-party reimbursement, private foundation funding, block grants), and different systems (e.g., education; physical, mental, and public health; substance use).

Overview of Funding Streams

FEDERAL FUNDING STREAMS

Federal funding is an often underutilized stream of funding to support comprehensive school mental health. While state and local aid are the primary funding sources for K–12 schools in New Jersey, school districts receive federal funding through a variety of mechanisms, including block grants and direct payments. Understanding the flexibilities allowed within these funding streams, and how to maximize them, can lead to increased, sustainable funding for school mental health.

Every Student Succeeds Act (ESSA) • New Jersey's state ESSA plan underscores the importance of promoting a positive school climate and ensuring students have access to mental health supports

in schools. School districts have tremendous flexibility in utilizing ESSA funding, including Titles I, II, III and IV, to support comprehensive school mental health.

- **TITLE I** provides financial assistance to districts and schools with high percentages of children from low-income families. Title I funding can support the full continuum of school mental health services and supports, including implementing schoolwide programs, such as positive school climate programs and social emotional learning curricula, hiring school mental health providers, and providing wraparound services and intervention processes.
- **TITLE II** provides funding to school districts to prepare, train and recruit high-quality teachers, principals and other school leaders. Title II funding can be used to support comprehensive school mental health professional development on trauma and mental illness, recruitment of school mental health providers, and implementation of staff mental health programming.
- **TITLE III** provides funding to support English-language learners (ELL) and their families. Title III funding may be used to meet the mental health needs of ELL, including developing social emotional skills.
- **TITLE IV** is meant to support the comprehensive needs of students in a variety of settings, strengthen family engagement, and support after-school programs. This includes the Student Support and Academic Enrichment Grants (Title IV-A) which provide designated funding to school districts that can be used to implement comprehensive school mental health, including schoolwide programming and targeted services and supports. Funding is also available through Title IV-F to support community schools, which include wraparound supports for students and their families.

Medicaid • Through New Jersey's Special Education Medicaid Initiative (SEMI), participating public school districts are reimbursed a portion of the costs associated with providing certain health-related services to eligible students. SEMI is administered by the Department of Human Services through the Division of Medical Assistance and Health Services (DMAHS). To be eligible for Medicaid reimbursement, a service must be:

- Included in a Medicaid-enrolled student's Individualized Education Program (IEP)
- Primarily medical in nature, not educational
- Delivered by a qualified Medicaid provider
- A coverable service as defined by New Jersey's state Medicaid plan

Medicaid offers a key funding stream for Tier 2 and Tier 3 school-based mental health services included in students' IEPs. In New Jersey, Medicaid-eligible mental health care includes assessments and therapy services (individual, group, family) delivered by one of the following Medicaid-eligible providers: licensed RN, licensed practical nurse

(LPN) under direction of an RN, licensed psychologists, licensed social workers, school-certified psychologists and school-certified social workers.

Medicaid is jointly funded by the federal and state governments. This means that 50% of New Jersey's state Medicaid funding is matched by the federal government. For the SEMI program, New Jersey's state match is met by school districts through certified public expenditures (CPE): each school district certifies that public funds are used to support the full cost of providing the Medicaid-covered service. Based on this certification, New Jersey can then claim the federal share of these costs. In addition, DMAHS keeps 65% of the federal payment to cover the cost of administering SEMI, and the school district receives 35% of the net revenue.

Given that SEMI is a federal-state partnership and that school districts must meet the state's match through CPE, school districts cannot bill Medicaid for services delivered by health providers employed by 100% federal funds, such as IDEA or COVID relief funds. Therefore, it is in the school district's best interest to utilize state and local dollars whenever possible to pay the salaries of the school district's Medicaid-eligible school health providers (e.g., licensed RN, licensed psychologists, licensed social workers) so the school district can bill Medicaid for covered services.

Medicaid's funding stream is guaranteed and sustainable. For every covered service delivered that meets state requirements, school districts can submit a claim and be reimbursed. The revenue generated for a school district by SEMI goes to the school district's general fund.

For guidance related to Medicaid reimbursement in New Jersey, see State of New Jersey: School Based Medicaid Reimbursement for Programs Providers Handbook.

COMMUNITY PARTNERSHIPS

Medicaid also reimburses for covered mental health services delivered to Medicaid-enrolled students through community partnerships. In these cases, the Medicaid reimbursement goes to the mental health care providers (e.g., school-based health centers operated by federally qualified health centers, community mental health centers, community mental health practitioners) and not the school district, but it represents an

important mechanism for expanding access to school-linked mental health services beyond services included in students' IEPs. When establishing partnerships to deliver mental health services, it is critical to ensure the community provider understands they can bill Medicaid for eligible services delivered to students.

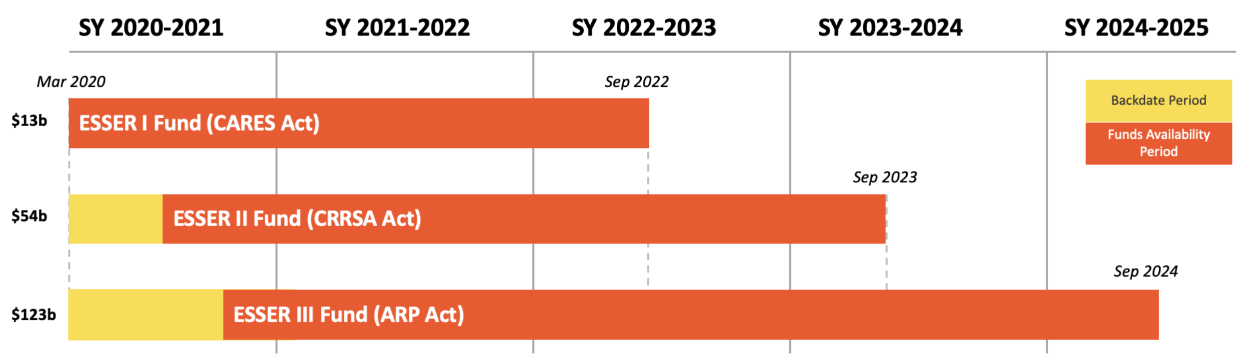
IDEA • The Individuals with Disabilities Education Act (IDEA) provides federal funding for the education of children with disabilities, and requires, as a condition for the receipt of such funds, the provision of a free, appropriate public education (FAPE) for children with disabilities. In fiscal year 2021, New Jersey received $398 million in IDEA funding. Under IDEA, school districts are required to identify students who may have a disability, evaluate them, and (if eligible) develop an IEP, including special education and related services, such as mental health services, needed for the student. IDEA funds can be used to support the delivery of mental health services included in a student's IEP (e.g., individual counseling, parent counseling, social work services, psychological services, and residential treatment). Any service agreed upon by the student's IEP team as necessary for the student to access FAPE may be considered a related service and covered by IDEA funds. In order to meet these needs, school districts can use IDEA funds to provide mental health services and supports included in students' IEPs.

COVID Relief Funding • COVID relief funding presents a historic opportunity to advance comprehensive school mental health. The New Jersey Department of Education received $4,305,930,673 in Elementary and Secondary Emergency Education Relief (ESSER) funds through the three federal COVID relief bills. The New Jersey Department of Education will distribute at least 90% of these funds to school districts based on their proportional share of ESSA Title I funds.

School districts have a tremendous amount of flexibility in how they use ESSER funds. For example, allowable uses of ESSER funds include any allowable use of ESSA Title I-IV funding. COVID relief funding also presents an important opportunity to make investments that will build district capacity to support comprehensive school mental health (e.g., data systems and training) and to leverage access to additional funding streams to ensure sustainable programming. This could include hiring a district Medicaid coordinator to ensure Medicaid reimbursement for school mental health services is maximized, or hiring community school coordinators who can establish local partnerships and leverage additional funding streams.

Chiefs for Change published this workbook to support districts' efforts to create a thorough plan for receiving and strategically using ESSER funds.

This chart provides a comparison and timeline of the ESSER funds.



Source: Chiefs for Change, Chiefs for Change ESSER Planning Workbook v1.1

STATE AND LOCAL AID

State and local aid are the primary funding sources for New Jersey state public schools. The majority of New Jersey state public schools receive their funding from their annual school budgets through local property tax levied on a per pupil basis. Some public school districts also receive a substantial amount of state aid. State aid is made up of equalization aid, categorical aid, and specific grants. This state and local funding can be used to support comprehensive school mental health, and it is at the discretion of school district leadership to determine how these funds are invested. In addition to the state and local aid school districts receive, state aid that presents a targeted opportunity to support student mental health includes the following:

State Budget • Funding for school mental health is included in the New Jersey state budget, primarily through funding appropriated to the Office of School Linked Services within the Department of Children and Families. Programs funded through the office include mental health counseling, employment counseling, substance abuse prevention, suicide prevention, pregnancy prevention and sexual assault prevention.

Extraordinary Aid • Extraordinary Aid (EX-AID) for special education is a provision in New Jersey's funding law that provides supplemental state aid to school districts for each student who needs intensive services and who has special education costs that exceed a certain threshold. For in-district public or private placement, where the student is educated alongside their non-disabled peers, New Jersey covers 90% of total costs for providing direct instructional and support services that are in excess of $45,000. For specialized public school programs, the state will pay 75% of costs that are in excess of $45,000. Finally, the state will pay 75% of excess costs above $55,000 for students placed in private schools for students with disabilities. The district of residence is responsible for providing the excess funding for students with high-cost disabilities.

Establishing relationships with community partners to advance comprehensive school mental health is a critical strategy for accessing additional funding streams and in-kind supports.

EXAID can be used to support the delivery of intensive school mental health services and supports that are required by the student's IEP. When possible, keeping the student in district schools and educating the student alongside non-disabled peers will maximize the EXAID for the school district.

LOCAL COMMUNITY PARTNERSHIPS

Multiple opportunities exist at the local level for funding comprehensive school mental health. These include the following:

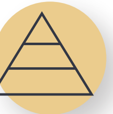
Private foundations • This funding tends to be more flexible and may provide funds for pilot projects or mental health prevention and/or promotion activities.

Community-based organizations • Partnerships with community organizations can be leveraged to advance comprehensive school mental health in a number of ways. Community organizations can provide direct services and programs in schools, support the development of communications and marketing materials, or partner with school districts to seek philanthropic support.

Nonprofit hospitals • Nonprofit hospital organizations are required by federal tax law to spend some of their surplus on community benefits: goods and services that address a community need. This could include providing training to school staff on mental health, providing school staff to deliver services in schools, or implementing staff mental health programming.

Community health care providers • School districts can partner with community health care providers to deliver mental health services in schools. Often, the community providers will be able to bill Medicaid or private insurance for the services delivered.

Establishing relationships with community partners to advance comprehensive school mental health is a critical strategy for accessing additional funding streams and in-kind supports.



INTEGRATION

The following are examples of allowable uses of federal, state and local funds for schools and school districts to support student and staff mental health within all MTSS tiers. These examples focus on investments that support capacity building and infrastructure while furthering evidence-based practices and services and employing sustainable funding strategies. While this list is not exhaustive, it provides examples of opportunities to invest funds today to strengthen student and staff mental health now and into the future.

TIER 1: UNIVERSAL SUPPORTS FOR ALL

Universal services offered to all students to increase awareness, screen for needs, promote wellness, and address prevention, trauma-informed and culturally responsive approaches.

Implementation Strategies	Funding Source
WELLNESS STAFF AND TEAMS	
Identify or hire staff such as: a district wellness coordinator, social-emotional learning specialist, registered nurse*, school counselor, student assistance counselor (SAC), licensed mental health professional*, child study team (school social worker or school psychologist^), etc. to: • Provide technical assistance and direct support to/in schools. • Act as liaison and lead cross-sector collaboration and committees that guide school mental health efforts. • Conduct asset mapping to develop and update guidance documents and resources. • Provide direct support/services to students.	• ESSER • ESSA Title I • ESSA Title II • ESSA Title IV, Part A • SEMI* • IDEA^ • State and local aid • Grants • Bonds
DATA SYSTEMS AND COLLECTION	
Enhance data systems by building data pipelines and modifying student information systems (SIS) to capture mental health data; improve reporting mechanisms to receive timely reports (e.g., Milwaukee Public Schools SIS Guidance). Implement data collection efforts for all students to ensure strong systems to monitor early student warning signs, such as: • School climate surveys • Youth Risk Behavior Surveillance System (YRBSS) • Universal screenings – Social-emotional screenings (i.e., BIMAS-2, DESSA-mini, etc.) – Suicide prevention screening (Suicide Prevention Resource Center)	• ESSER • ESSA Title I • ESSA Title IV, Part A • State and local aid • Grants • Bonds

* See page 214 for table notation

TIER 1: UNIVERSAL SUPPORTS FOR ALL

Universal services offered to all students to increase awareness, screen for needs, promote wellness, and address prevention, trauma-informed and culturally responsive approaches.

Implementation Strategies	Funding Source
PROFESSIONAL DEVELOPMENT (PD)	
Identify or create in-house professional development and training opportunities on: • Classroom management to create strong norms and routines (e.g., Classroom Wise) • Non-cognitive factors • Trauma-informed practices and resiliency • Brain development (The Neurosequential Model in Education) • Self-care • Being a trusted adult • Inclusive environments • Referrals to providers • ASIST (Applied Suicide Intervention Skills Training) • Suicide risk assessment and preventions (e.g., QPR)	• ESSER • ESSA Title I • ESSA Title II • ESSA Title IV, Part A • State and local aid • Grants • Bonds
EVIDENCE-BASED PROGRAMING	
Use a data-driven process to identify evidence-based programming needs. Common evidence-based programming and supports include: • Signs of Suicide • Sources of Strength • Second Step • Capturing Kids Hearts Develop or purchase classroom-based comprehensive health education that includes SEL, mental health, substance use prevention, suicide prevention, violence prevention and healthy relationships, stress management, etc. • SEL programming/curricula: – Use the NJ SEL competencies to drive program development. – Utilize Collaborative for Academic, Social, and Emotional Learning (CASEL) framework to promote intrapersonal, interpersonal and cognitive needs. – Create resources for schools to integrate SEL into health education classes and/or other content areas. – Use a systemic framework and criteria to select/purchase curricula.	• ESSER • ESSA Title I • ESSA Title IV, Part A • State and local aid • Grants • Bonds
POLICY CONSIDERATIONS	
Convene a team and conduct a facilitated process to analyze current policies at the district and school level to promote mental health and school climate. Conduct a scan of district policies to ensure they are inclusive of mental health, equity, trauma-informed practices, and positive school climate and culture. • School policies that promote school climate and student connectedness. • Proactive behavior management and alternatives to punitive school discipline procedures. Conduct an analysis of your comprehensive school mental health system quality by completing the School Mental Health Quality Assessment.	• ESSER • ESSA Title I • ESSA Title IV, Part A • State and local aid • Grants • Bonds

* *See page 214 for table notation*

TIER 2: TARGETED INTERVENTIONS FOR SOME

Schools offer evidence-based group and/or individual interventions to identified student groups, with progress monitoring integrated into the school day.

Implementation Strategies	Funding Source
EVIDENCE-BASED PROGRAMING	
Use a data-driven and collaborative process to identify needs, review and implement supports for student mental health, such as: • Mentoring programs for students (e.g., Check and Connect). • Motivational interviewing, an evidence-based approach that addresses ambivalence to change. • Classroom supports to help teachers differentiate instruction and behavior management such as brief interventions to address mild-to-moderate or transient mental health behaviors (e.g., Brief Intervention for School Clinicians). • Small group interventions to teach students emotional regulation, coping, stress management, and problem-solving strategies. • Parent/caregiver education.	• ESSER • ESSA Title I • ESSA Title III • ESSA Title IV, Part A • State and local aid • Grants • Bonds
MENTAL HEALTH SERVICES	
Utilize existing school mental health professionals (i.e., school counselors, social workers, psychologists) or contract with local mental health providers to provide direct mental health services: • Small group counseling and therapy.* • Progress monitoring integrated into the school day. Conduct individual, targeted, culturally-relevant assessments/evaluations by licensed professionals (e.g., BASC-3, SDQ, etc.) to identify needs for Tiers 2 and 3 supports.*	• ESSER • ESSA Title I • ESSA Title III • ESSA Title IV, Part A • SEMI* • IDEA* • EXAID* • State and local aid • Grants • Bonds

* See page 214 for table notation

TIER 3: INTENSIVE INTERVENTIONS FOR FEW

Schools and partners offer evidence-based approaches for immediate and ongoing individual and group interventions during the school day, have re-entry programs for students transitioning from hospitalization, and have a crisis response plan.

Implementation Strategies	Funding Source
EVIDENCE-BASED PROGRAMING	
Use a data-driven and collaborative process to identify needs, review, create processes, and implement supports for student mental health such as: • Individualized interventions to teach students emotional regulation, coping, stress management, and problem-solving strategies.* • Teacher/environmental interventions that identify students' triggers and develop strategies to reduce and address these issues. • Wrap-around services and intervention processes that involve multidisciplinary teams (i.e., school and mental health staff, family members) and other systems (e.g., child welfare, juvenile justice), as needed.* • Parent/caregiver training and support. Build a referral system to coordinate with community-based treatment and providers. Create a re-entry program for students transitioning from hospitalization or treatment. Develop and execute a crisis response plan, which should include training^ staff and even students (e.g., Psychological First Aid) on strategies to prevent, prepare for, respond to, and recover to help and heal in a time of crisis at the individual, school, and/or community level. • Improve and strengthen schoolwide approaches to safety and crisis management plans and emergency response (e.g., NASP PREPaRE Training Curriculum).	• ESSER • ESSA Title I • ESSA Title II^ • ESSA Title III • ESSA Title IV, Part A • SEMI* • IDEA* • EXAID* • State and local aid • Grants • Bonds
MENTAL HEALTH SERVICES	
Utilize existing certified school mental health professionals (i.e., school counselors, social workers, psychologists) or contract with local mental health providers to provide direct mental health services: • Individualized evidence-based counseling/therapy interventions such as cognitive behavior intervention and dialectical behavior intervention that may be included in general education service plans (action plans), students' IEPs (for eligible students) and 504 plans.* • Behavioral interventions (e.g., functional behavior assessments, behavior intervention plans, function-based problem solving).* • Psychological and social work services, including case management, to monitor student progress and response to interventions, and coordinate multidisciplinary teams.* • Family and/or group therapy.*	• ESSER • ESSA Title I • ESSA Title II • ESSA Title IV, Part A • SEMI* • IDEA* • EXAID* • State and local aid • Grants • Bonds

Note: Tier 2 and 3 approaches are most effective when individualized based on student need.

*Services included in students' IEPs can be covered by SEMI, IDEA and/or EXAID. IEP services delivered by SEMI-approved providers will generate Medicaid revenue for the school district. This revenue will go into the district's general fund and can be reinvested as needed, including to support ***all*** the activities described above.

Building and maintaining a comprehensive MTSS effort may require hiring staff. If labor is needed, first consider contract labor or stipends for current staff. If new FTEs are needed, be sure to consider what funding will sustain that position. Please note that in the 2021–2022 school year, it is likely that there will be a significantly higher number of students in need of mental health supports, as well as more students with intensive mental health needs. Contracting with a local mental health provider or community-based mental health center should be considered to meet the vast number of shorter-term needs.

Additionally, working with outside agencies or contractors should be considered to provide long-term additional mental health services, as needed. Develop agreements or MOUs to outline the services to be provided by outside partners.

- Example MOU (Source: School Mental Health Quality Guide Funding & Sustainability)

TEAMING

In general, schools and school districts can convene a team of experts and stakeholders to capture and utilize data to drive decision making, identify student mental health needs and gaps in their community, and allocate resources accordingly, while ensuring equity. For budgetary planning and decision-making, the following stakeholders should be involved:

- **Superintendent, district administration, or school administration**
- **Budget planning lead**
- **Finance lead**
- **Communications lead**
- **Subject matter experts and mental health/ wellness staff**
- **Community partners**
- **Community members**

COMMUNITY, STUDENT, AND FAMILY ENGAGEMENT

Determining how funding should be allocated for mental health supports should include collaborative and inclusive processes. These efforts may include:

Engaging community, families and students through existing stakeholder groups (e.g., parent-teacher organizations or school accountability committees) or forming ad hoc groups to provide guidance on funding.

Building the capacity of community members, families and students to understand district/school budgets and effective mental health supports.

Implementing collaborative decision-making processes.

Community partners, including health providers, community-based organizations, local businesses and others, can play a key role in providing support to schools. It is important to engage the surrounding community in this work and leverage their assets and resources (e.g., funding, exchange of services, training, or resources).

> The district or school budget should be considered a "values" document and **reflect what the district or school considers important.**

Budgeting processes and funding allocation can be overwhelming and intimidating, so building the capacity of those outside of the district or school is important. This capacity building may include addressing:

Level of funding available or needed for mental health supports.

Effective mental health resources or services that are currently being offered.

Data to show gaps or needs in mental health resources or services.

ESSA includes several family engagement requirements. Districts must reserve at least 1% of their ESSA Title I funding for family engagement activities, such as outreach and capacity-building at the school level. Activities can include increasing understanding and engaging families and the community in the budgeting processes. Active Family and Community Engagement is essential to fostering relationships of trust and respect. Including multiple stakeholders in decision-making will help sustain and support mental health efforts over time.

CULTURAL CONSIDERATIONS

The district or school budget should be considered a "values" document and reflect what the district or school considers important. Ensuring equity, diversity and inclusion are addressed in funded mental health efforts is key. District and school staff conducting budget planning should:

Ensure funding is utilized to support evidence-based programs or resources that meet the needs of the student population served in the school or district.

- Utilize educational or mental health expertise to adapt programs or resources to meet the cultural needs of students, ensure cultural and linguistic competence, and reduce disproportionality in services.

Allocate resources by ensuring a budget line item for interpretation and translation of mental health curricula, resources and materials for families and students.

Support collecting data on mental health needs and stratifying the data to understand the needs of priority populations (e.g., gaps and needs by race/ethnicity, sexual orientation, gender identity, etc.). Data sources to consider: reasons for absences, CDC School Health Profiles, CDC Youth Risk Behavior Survey, climate surveys, health education assessments, staffing ratios, IEPs/504s, behavioral referrals, suspension data, student health records (district SIS), public health department records, hospital community needs assessments, etc.

Support communication strategies to address stigma or concerns related to providing services or collecting data on mental health.

STAFF COMPETENCIES

The funding allocation and budgeting process can also be overwhelming for staff in districts and schools. Increasing capacity for staff to identify, utilize and track funding for mental health is another important factor. The following actions can build staff competencies with budgeting and financing for mental health supports:

Understand school budgets and funding sources (i.e., where the funding comes from and how it can be utilized).

Identify who in the district is responsible for different aspects of the budget (e.g., learn who in the district oversees federal funding/Title funding, grants, donations, etc.).

Consider where different funding decisions are made.

- Some are made at the district level (e.g., use of federal funding). These funds may be used for district-wide efforts or allocated to some or all schools through funding formulas, grants or identified gaps and needs.
- Other funding decisions are made at the school level, and schools can use local data and information to fill gaps in mental health supports.

Determine if any new or different funding opportunities or grants are available.

Utilize data to identify gaps (e.g., funding for staff, resources, curricula, school-based or contracted services, etc.).

Make the case to decision-makers for allocating funding to mental health initiatives.

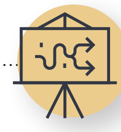
Create a budgeting plan.

Collect additional data to determine any formative or summative changes due to your efforts (e.g., number of students reached, improvements in short-term outcomes, etc.).

Track expenditures and continue to consider which funding sources are a fit for different mental health supports over time.

Present regularly to decision-makers about the impact of the funding on students.

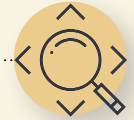
CHAPTER SUMMARY



Key Takeaways

Multiple and diverse funding and resources must be utilized to build and sustain a long-term and comprehensive MTSS effort to meet mental health needs for all students and staff. There are many funding sources at the federal, state and local levels that can and should be maximized to fund mental health supports at the MTSS Tier 1, 2 and 3 levels.

SPOTLIGHT



WOODBURY CITY PUBLIC SCHOOLS

School Mental Health Funding

Over the past 15 years Woodbury City Public Schools has worked to create a district culture of compassion and social-emotional support, with this theme: "Keep Love Present." The theme has developed into an underlying thought process of how the administration treats students and their parents, how faculty and staff treat each other, and how the students interact with their peers. This culture has been the key to the trust that has emerged between district personnel and our students and their families, and is essential to the development and use of our school mental health programs.

Tier I: Our mental health support staff includes counselors, social workers and school psychologists working collaboratively with school staff to provide the best possible care for students. **Our school has cultivated grant funding to provide after-school programs for our students at no additional cost to the district.** This includes our 21st Century Program for grades 6 through 8, which offers students homework support, social-emotional development activities, and recreation, led by passionate faculty. Our Blues Brothers and Gals Program, in collaboration with student resource officers, offers similar activities for grades 3 through 5.

Tier II: Our district has partnered with the Youth Advocacy Program (YAP) to dedicate in-school office space where YAP provides outpatient services to students during the school day. **These services are paid for through Medicaid to those students who qualify (60% to 70% of our student population). Those who do not qualify are offered fees on a sliding scale, offset by funds secured through Elementary and Secondary School Emergency Relief** (ESSER). Additionally, ESSER funding has been utilized to bring on a social worker who serves as a liaison between YAP, the district, and families.

While some students will benefit from psychiatric medication, their families face multiple barriers in receiving psychiatric services. To provide this support, the school has employed a psychiatrist who sees students two days a month. **These services are funded by ESSER and the district's local budget through the understanding that these services, coup[led with counseling, will allow students to maintain their current school placement.** Often without appropriate psychiatric services, students are required to attend specialized out-of-district programs to meet their diverse mental health and academic needs. By providing these services, the district actually saves money on out of district costs. More importantly, greater numbers of students can stay in their own school community.

Successes

- Development of a climate and culture that offers love and compassion to students and families when they need it most.
- Creation of a collaborative work environment across various mental health roles in the district.
- Extending the school day provides additional nurturing services in a safe space for students, reducing burdens on families.
- Implementation of psychiatric care in the school building at no cost to families—a service many families face barriers in receiving.

Lessons Learned

- Simply placing mental health providers in the building is only half the story. Cultivating a culture that increases student and family trust will increase the use of these services.
- Start slow and start small.
- Network and cultivate relationships with individuals and institutions in the field of school mental health. Many of the services we have implemented in our school buildings have been made possible through the relationships developed in the community.

Reflection Questions

What gaps in mental health supports exist?

What funding do you have available?

Who makes the funding decisions at the school and district level?

What funding streams can cover those services and resources, and which funding stream is more strategic to use?

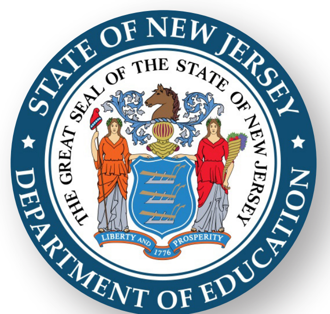
How can we identify funding supports to address immediate needs and build a plan for sustainability?

Does it make more sense financially to create an internal mental health position(s) to deliver more intensive Tier 2 and Tier 3 supports or to contract with a community mental health provider?

RESOURCES & LINKS

To leverage funding opportunities, identify what sources could be utilized to support mental health and wellness initiatives and map current funding and existing resources. Clarify what you need and by when, and outline how funds could be most effectively leveraged or shifted to support these needs to select financing strategies and applicable funding sources.

1. Strategic Budget Considerations for MTSS Flowchart
2. Sample Budget Planning Worksheet
3. Example of Local Engagement in Budgeting
   The State of New Jersey requires school districts to post the district's budget information in a state-designed, user-friendly format. The budget format includes information on federal funding sources (e.g., Title funding) and general fund expenses for support services (e.g., social work and health services).



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