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School Mental Health Referral Pathways (SMHRP) Toolkit

September 2015





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The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

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INTRODUCTION





INTRODUCTION

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

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

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

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

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

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

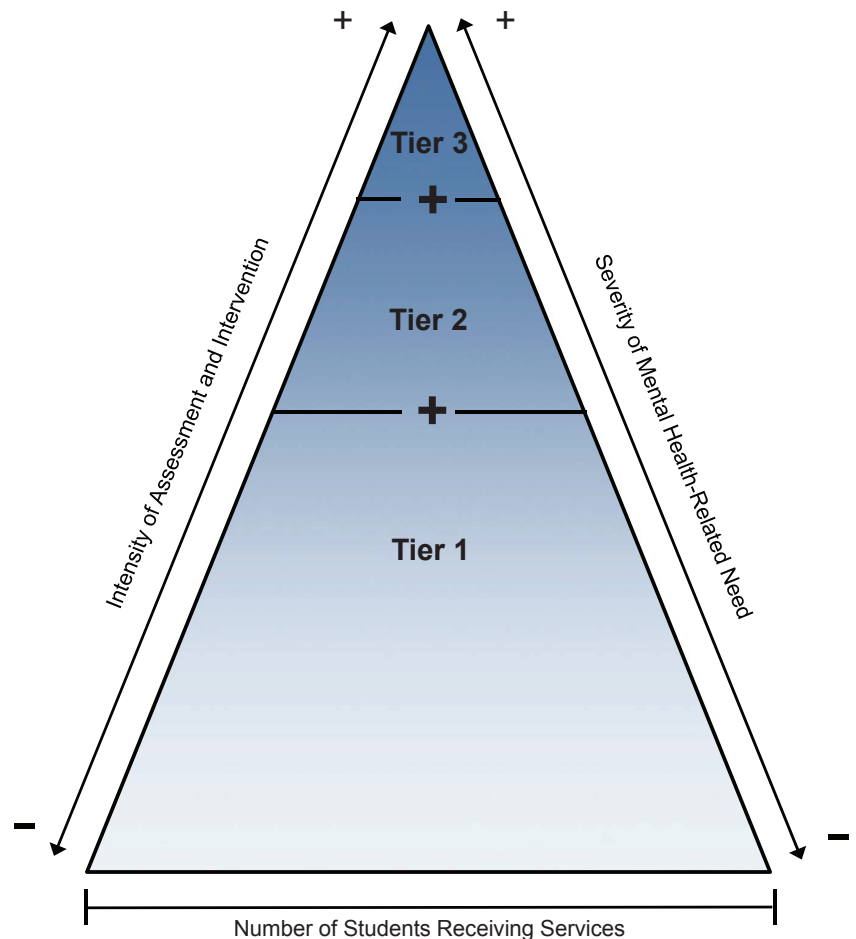
Multitiered System of Supports: A Conceptual Framework

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

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

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

Figure I.1. The Multitiered System of Support Model for Mental Health Supports in Schools¹



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

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

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

Organization of the School Mental Health Referral Pathways Toolkit

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

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

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

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

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

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

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

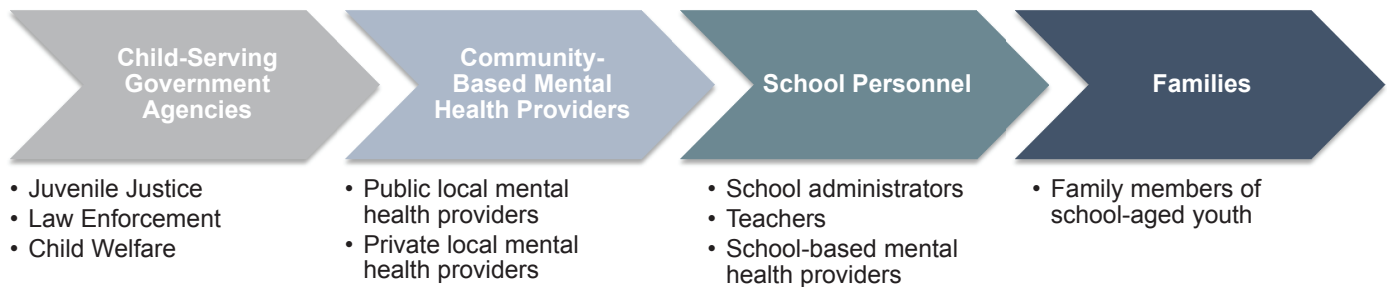
Chapter 4, *Cultural and Linguistic Considerations*, provides an overview of cultural and linguistic considerations for building effective referral pathways. Topics detailed in Chapter 4 include:

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

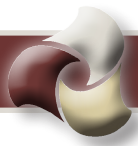
Using the School Mental Health Referral Pathways Toolkit

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

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



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



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

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

The Status of Mental Health Among School-Aged Young People

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

- Approximately one in six school-aged children experiences impairments in his or her life functioning due to a diagnosable mental health disorder¹ and an estimated 70% of children have experienced some type of physical or emotional trauma.²
- The majority of mental illnesses emerge in childhood³, yet fewer than half of children who suffer from mental illness receive treatment.⁴
- Young people with mental illness are frequently absent from school and many experience reductions in academic achievement.⁵
- Among students with disabling conditions, young people with mental illness are the most likely to drop out of school.⁶
- Only one third of young people with mental illness advance to postsecondary education.⁷
- More than 60% of children in juvenile detention have a diagnosable mental illness.⁸

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

Supports for Mental Health in Schools: The Current Landscape

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

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

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

- The overall average ratio of students to qualified mental health services staff in schools across the U.S. is 500 to 1.¹³
- The activities assigned to school staff with mental health expertise compete for time that might otherwise be spent working on prevention and early intervention efforts. For instance, over 50% of school psychologists' time is spent conducting psychoeducational assessments to identify students for special education.¹⁴ The assessment process is reserved for students who appear to require intensive, individualized, and resource-intensive intervention.
- Administrators may struggle with requirements to provide mental health services for students with mental, emotional and behavioral disorders because the services themselves are perceived as time consuming, costly, and hard to integrate into the existing school schedule.¹⁵

Advances in School-Based Mental Health: Partnerships That Work

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

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

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

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

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CHAPTER 1

Laying the Foundation:
Assessing Your Current Referral
Management Approach





CHAPTER 1

LAYING THE FOUNDATION: ASSESSING YOUR CURRENT REFERRAL MANAGEMENT APPROACH

Key Questions

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

The Challenge: Building Referral Systems that Work

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

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

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

Four Stages of Referral Pathway Self-Assessment

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

**Stage 1:
Establish a Referral System**

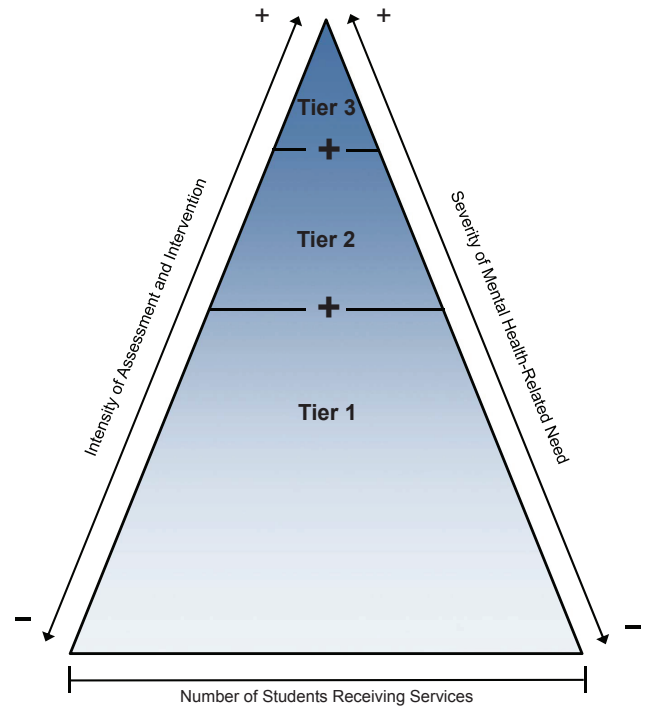
Stage 1: Establish a Referral System

The initial stage of a referral pathway self-assessment process examines how the

school identifies student need. Schools must consider several things when examining their referral processes:

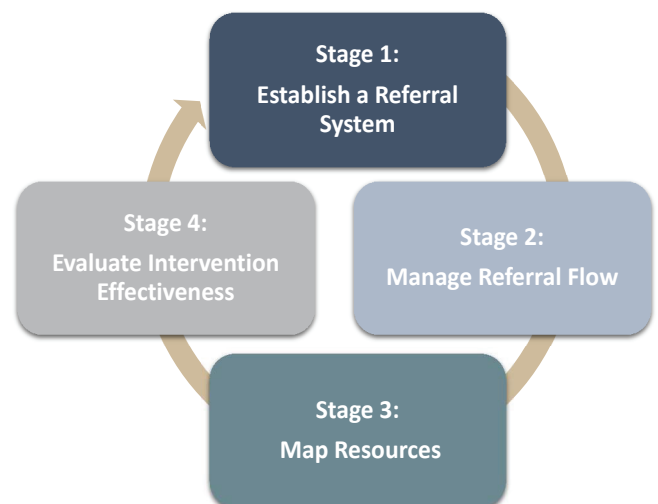
- **Are systems in place to manage all types of referral concerns?** Referral concerns may include a constellation of problems within one or more of the following domains: academic, emotional, behavioral, social, or physical. High-quality referral systems can effectively manage all types of referral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

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



Adapted from: Renshaw & O'Malley (2015)

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



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

Steps for Establishing a Problem-Solving Team

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

1. **Assess Existing Teams.** Avoid redundancy by assessing existing campus teams that focus on student support. Consider which current groups might be natural fits for the task of managing referrals. Examples of existing teams include (Lachini, Anderson-Butcher, & Mellin, 2013):
 - school climate teams,
 - wellness teams,
 - transition teams,
 - grade-level teams,
 - crisis intervention teams,
 - wraparound teams,
 - multidisciplinary individualized educational plan (IEP) teams, and
 - Positive Behavior Interventions and Supports (PBIS) teams.
2. **Identify Team Members.** Multidisciplinary teams should include physical health, general education, special education, law enforcement, and mental and behavioral health personnel. Although some schools may have fewer personnel to participate on a problem-solving team than others, it should never be the case that a single individual is responsible for managing all tasks. If an effective referral system is a priority, then schools should bring together several people to do this work collaboratively. Consider inviting the following individuals to become members of your problem-solving team:
 - administrators
 - school resource officers
 - school psychologists
 - school counselors
 - school social workers
 - teachers
 - school nurses
 - family representatives
 - PTA representatives
 - member of community organizations
 - mental health providers
 - health care professionals
 - police
 - child protective services
 - social services
3. **Articulate Team Purpose and Clarify Roles.** All members of the team should be able to articulate the common purpose for the group as well as the roles and responsibilities of individual team members for meeting that common purpose. Problem-solving teams work best when:

Include Family Members and Caregivers.

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

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

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

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

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

Stage 2:
Manage Referral Flow

Stage 2: Manage Referral Flow

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

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

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

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

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

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

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

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

Communication, Collaboration, and Leadership

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

Relationships with School Staff, Families, and Community Partners

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

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

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

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

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

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

- **Conduct Observations.** Observation of the student can provide valuable insight into the context of the referral concern(s).
 - Does the problem-solving team follow a formal observation protocol?
 - Is parental consent considered when conducting observations?
 - Are there specific team members who are most qualified to conduct observations?
 - How are observation records used in combination with other sources of data related to the referral?
- **Interview Teacher(s) and Other School Adults.** Problem-solving teams may also choose to interview school staff who frequently interact with the student in order to address specific questions about the presenting problem and understand how the student functions in a variety of school settings.
 - Does the problem-solving team follow a formal interview protocol?
 - Are there specific team members who are most qualified to conduct interviews?
 - How are interview records used in combination with other sources of data related to the referral?
- **Interview Community Partners.** In addition to interviewing school personnel, the problem-solving team may learn that the student frequently interacts with partners in the community, such as afterschool youth-development staff, law enforcement, or a mental health provider. If these individuals do not sit on the problem-solving team themselves, they may need to be interviewed to obtain their insights into the student's presenting concern. The team should be considerate about sharing student information with school personnel outside of the team; furthermore, the problem-solving team will need to consider whether the child's parent or guardian has given signed consent for information about the child to be shared across partner agencies. All sensitive information should be carefully managed and student and family rights to confidentiality honored.

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

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

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

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

Stage 3:
Map Resources

Stage 3: Map Resources

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

- 1. Has the team identified all school and community resources available to them?** The problem-solving team will need to create a database of all existing and potential resources, interventions, and partnerships. To obtain information for the database, the team may wish to ask community partners to submit information about their organization ([Toolbox 1.2](#)) that will then be used to populate a resource database (for example, see [Tool 1.2](#)). To optimize utility of the resource database, the team may wish to describe the MTSS tiers each resource fits into. [Toolbox 1.3](#) displays a sample database of resources and partners (e.g., providers, services, programs) both within and outside of school, categorized by tier.
- 2. Has the team examined the breadth and quality of interventions provided at school?** After thoroughly mapping resources available within the school, the problem-solving team will need to judge the quality and breadth of resources in order to answer the following questions:
 - Are any interventions not supported by research and therefore appropriate for disqualification?
 - Are there sufficient types of Tier 2 and Tier 3 interventions to match diverse student needs?
 - Are there enough spaces in Tier 2 and Tier 3 interventions to adequately serve all students who may need them?
- 3. Has the team examined issues related to access to community-based resources?** Below are several questions that could be used to guide the problem-solving team's relationship with community partners. Additional strategies for building effective partnerships are covered at length in [Chapter 2](#) of the SMHRP Toolkit.
 - Whose responsibility is it to facilitate contact between the student's family and the community partner?
 - Is there a structured relationship between the school and the community partner?
 - Is there a written agreement between the community partner and the school?
 - Are data shared between the partner agency and the school? Is there a memorandum of understanding (MOU) in place to codify data sharing?
 - Whose role is it to track a referral after it has gone from the school to the community partner?
 - Is the student's family experiencing any barriers to accessing services offered by the community partner? (e.g., transportation, concerns about confidentiality, cultural or linguistic barriers)
 - Are there any barriers to accessing services by community partners that the school may be able to address, such as school policies that prevent collaboration?

Toolbox 1.2. Community Resource Recruitment Form

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

| | |
|--|---|
| How Is Progress Monitored at the Community Site? | <input type="checkbox"/> Checklists <input type="checkbox"/> Clinical Judgment <input type="checkbox"/> Progress Monitoring Forms <input type="checkbox"/> Other _____ |
| Languages | <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____ |
| Age Population | <input type="checkbox"/> Early childhood <input type="checkbox"/> Elementary <input type="checkbox"/> Adolescents <input type="checkbox"/> Adults |
| Other Notes | |

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

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

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

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

Stage 4:
Evaluate Intervention
Effectiveness

Stage 4: Evaluate Intervention Effectiveness

The final set of procedures that the problem-solving team must self-assess are the ones they use to monitor the effectiveness of the interventions they've prescribed. This stage is critical for ensuring that the problem-solving team can speak with confidence when they say they are improving the social, emotional, and behavioral well-being of young people. In addition

to the detailed steps articulated in [Chapter 3](#) of the SMHRP Toolkit, the problem-solving team will need to answer the following questions:

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

Toolbox 1.4. Software Systems for Tracking Intervention Data¹

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

8. Does the problem-solving team report intervention effectiveness information to stakeholders?

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

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

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

Tool 1.1. *Example Referral Forms*

Example Referral Form: School Staff

Name of student: _____

Your name: _____

Relationship to student: _____

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

Phone: _____ Best time to contact: _____

Area of concern (please describe):

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

Behavioral concerns (please mark all boxes that apply):

- | | |
|--|--|
| <input type="checkbox"/> Exposed to community violence, other trauma | <input type="checkbox"/> Sad, depressed or irritable mood |
| <input type="checkbox"/> Nightmares, intrusive thoughts | <input type="checkbox"/> Hopelessness, negative view of future |
| <input type="checkbox"/> Anxious, fearful or irritable mood | <input type="checkbox"/> Low self-esteem, negative self-statements |
| <input type="checkbox"/> Jumpy or easily startled | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Avoids reminders of trauma | <input type="checkbox"/> Diminished interest in activities |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Low or decreased motivation |
| <input type="checkbox"/> Sexualized play or behaviors | <input type="checkbox"/> Anxious and fearful |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Worries excessively |
| <input type="checkbox"/> Talks excessively | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Gets out of seat and moves constantly | <input type="checkbox"/> Restless and on edge |
| <input type="checkbox"/> Interrupts and blurts out responses | <input type="checkbox"/> Specific fears or phobias |
| <input type="checkbox"/> Inattentive, distractible, forgetful | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Disorganized, makes careless mistakes | <input type="checkbox"/> Clingy behavior |
| <input type="checkbox"/> Angry towards others, blames others | <input type="checkbox"/> Appears distracted |
| <input type="checkbox"/> Fights and is aggressive | |
| <input type="checkbox"/> Argumentative and defiant | |

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

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

To your knowledge, what interventions have previously been tried?

- In school supports:

- Outside of school supports:

To your knowledge, what interventions are currently in place?

- In school supports:

- Outside of school supports:

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

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

Example Referral Form: Parent or Guardian

Date: _____

Name of child: _____

Your name: _____

Relationship to child: _____

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

Phone: _____ Best time to contact: _____

Who does your child live with?

- | | |
|---|--|
| <input type="checkbox"/> Biological parents | <input type="checkbox"/> Relative care |
| <input type="checkbox"/> Adoptive parents | <input type="checkbox"/> Group home |
| <input type="checkbox"/> Foster parents | <input type="checkbox"/> Other: _____ |

Desired language of service?

- English
 Spanish
 Other: _____

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

- Yes
 No
 I don't know

Area of concern (please describe):

- | | |
|---|--|
| <input type="checkbox"/> Academic Concerns: | <input type="checkbox"/> Physical Health Concerns: |
| <input type="checkbox"/> Behavioral Concerns: | <input type="checkbox"/> Family Concerns: |
| <input type="checkbox"/> Social Concerns: | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Emotional Concerns: | |

Behavioral concerns (please mark all boxes that apply):

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

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

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

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

How long have you had this concern about your child?

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

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

What do you think will help your child experience success?

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

Example Referral Form: Self or Peer

Date: _____

Your name: _____

Who are you looking for support for?

- Myself
- Another student at my school

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

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

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

Please mark all boxes that apply:

- | | |
|--|--|
| <input type="checkbox"/> Exposed to community violence, other trauma | <input type="checkbox"/> Sad, depressed or irritable mood |
| <input type="checkbox"/> Nightmares, intrusive thoughts | <input type="checkbox"/> Hopelessness, negative view of future |
| <input type="checkbox"/> Anxious, fearful or irritable mood | <input type="checkbox"/> Low self-esteem, negative self-statements |
| <input type="checkbox"/> Jumpy or easily startled | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Avoids reminders of trauma | <input type="checkbox"/> Diminished interest in activities |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Low or decreased motivation |
| <input type="checkbox"/> Sexualized play or behaviors | |
| <input type="checkbox"/> Difficulty concentrating | |
| | |
| <input type="checkbox"/> Talks excessively | <input type="checkbox"/> Anxious and fearful |
| <input type="checkbox"/> Gets out of seat and moves constantly | <input type="checkbox"/> Worries excessively |
| <input type="checkbox"/> Interrupts and blurts out responses | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Inattentive, distractible, forgetful | <input type="checkbox"/> Restless and on edge |
| <input type="checkbox"/> Disorganized, makes careless mistakes | <input type="checkbox"/> Specific fears or phobias |
| <input type="checkbox"/> Angry towards others, blames others | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Fights and is aggressive | <input type="checkbox"/> Clingy behavior |
| <input type="checkbox"/> Argumentative and defiant | <input type="checkbox"/> Appears distracted |

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

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

Tool 1.2. Sample Completed Database

Approved Service Providers for Local Education Agency Schools

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

Tool 1.3. Additional Resources for Assessing Your Referral Management Approach

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

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CHAPTER 2

Building Effective Partnerships





CHAPTER 2

BUILDING EFFECTIVE PARTNERSHIPS

Key Questions

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

Understanding the Need to Partner

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

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

Why Partner?

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

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

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

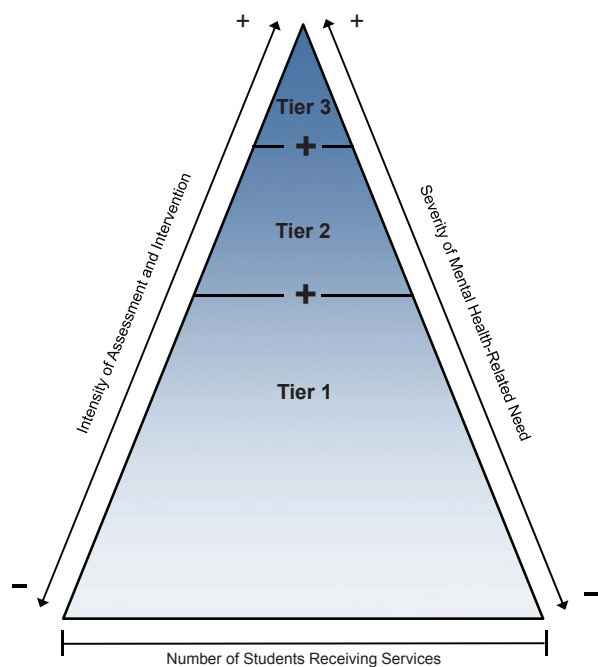
- It improves access to services by reducing barriers such as transportation, child care, cost, and stigma (Freeman, Grabill, Rider, & Wells, 2014; Hoover Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). Providing services in schools within a multitiered framework also allows for more prevention efforts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

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

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

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

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



Adapted from: Renshaw & O'Malley (2015)

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

Mental Health Partnerships: Leveraging Community Resources for Maximum Impact

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

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

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

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

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

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

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

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

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

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

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

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

How Can Schools Partner Effectively?

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

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

Defining features of the system of care philosophy and approach:

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

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

The Partnership Process

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



Phase 1: Defining Roles and Responsibilities

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

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

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

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

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

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

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

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

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

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

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

Memoranda of Understanding (MOU)

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

Toolbox 2.2. MOU Checklist

1. Parties to the Collaboration

- Education partner name
- Community partner name (police department, mental health service, counseling service, etc.)

2. Purpose for the Collaboration

- Include goals and objectives

3. Collaborative Functions

- Assessment (initial screening, diagnosis, and intervention planning)
- Referral, triage, or monitoring/management of care
- Direct service and instruction (e.g., primary prevention programs/activities; early intervention; individual, family, and group counseling; or crisis intervention and planning)
- Indirect services (consultation, supervision, in-service instruction)

4. Roles and Responsibilities of Mental Health Clinician

- Prevention, early intervention, treatment, and assessment services to young people in the school
- Individual/group therapy
- Social skill training or coaching
- Family therapy
- Substance abuse counseling
- Psychosocial evaluations
- Consultation, training, and support to teachers, administrators, and other school staff
- Collect data/notes on students to monitor progress
- Complies with a request to share any other information related to a student's treatment (requires an appropriate release of information signed by the student's parents)
- Visits students' homes or community agencies (permission not needed from the school)

5. Supervision Responsibility of the Community Agency Partner

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

6. Roles and Responsibilities of the School

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

7. Miscellaneous Procedures

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

8. Legal Considerations

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

Phase 2: Sharing Information and Monitoring Progress Across Sectors

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

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

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

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

Toolbox 2.3. *Consent to Release Information Checklist*

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

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

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

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

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

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

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

Figure 2.2. Electronic Data Tracking System, User Interface

Source: ABC Unified School District

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

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

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

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

Toolbox 2.4. Resources for Identifying Treatment Monitoring Instruments

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

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

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

- **YouthServices.net**
Customizable software for registering participants, tracking attendance and measuring outcomes. Service providers use the software for data collection, service management and program evaluation needs of the youth services sector.
URL: youthservices.net
- **Wisconsin Department of Public Instruction Student Intervention Monitoring System**
Created by the Madison Metropolitan School District with support from the Department of Public Instruction, the Student Intervention Monitoring System (SIMS) is a software program designed to monitor interventions and help educators provide additional support for children who are not learning. SIMS is a systematic way to share information between teachers and to monitor student progress over time.
URL: rti.dpi.wi.gov/rti_sims2

Planning for
transitions
between levels of
care

Phase 3: Planning for Transitions between Levels of Care

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

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

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

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

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

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

Conclusion

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

Tool 2.1. Overview of Privacy Laws

The Family Educational Rights and Privacy Act (FERPA)

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

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

Personally Identifiable Information (PII):

| Includes | Does NOT Include |
|---|---|
| <ol style="list-style-type: none">1. Student's name2. Names of student's family members3. Address of student or student's family4. Personal identifier (e.g., student's social security number)5. Indirect identifiers that are not unique to the student or family but can be used in combination with other information to identify the student | <ol style="list-style-type: none">1. Records kept in the sole possession of the maker (e.g., personal notes)2. Records of the law enforcement unit of an educational agency or institution3. Records relating to an individual who is employed by an educational agency or institution, except when the records are of a student employee4. Records created or received by an educational agency or institution after an individual is no longer a student in attendance and that are not directly related to the individual's attendance5. Classwork not graded by a teacher |

Circumstances Under Which or Individuals to Whom An Educational Agency Can Disclose PII

Privacy Technical Assistance Center, US Department of Education

ptac.ed.gov

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

FERPA or HIPPA?

| | FERPA | HIPPA |
|--|--|---|
| Records covered | <p>Education records, including information directly related to a student maintained by an educational agency or a party acting on behalf of the educational agency:</p> <ul style="list-style-type: none"> • Grades. • Behavior referrals. • Information relating to young people with disabilities who receive evaluations, services or other benefits under the Individuals with Disabilities Education Act. | <p>Records relating to:</p> <ul style="list-style-type: none"> • past, present, or future physical or mental health or condition • providing health care to the individual • past, present, or future payment for the use of health care. <p>Students' immunization and other health records that are maintained by a school district or individual school, including a school-operated health clinic.</p> |
| Levels of protection | <ul style="list-style-type: none"> • Personally identifiable information and education records cannot be disclosed without written consent, even for case management, whereas aggregated data, system level data sharing is sharable. • Need written consent from guardian in order to share records. | <p>It may only be shared with:</p> <ul style="list-style-type: none"> • with the individual (or his/her personal representatives) when they request access to or share their protected health information • with the Department of Health and Human Services when an investigation is underway. • If there is written consent from the guardian |
| Exceptions to confidentiality/ procedural safeguards | <p>Confidentiality may not be broken except in certain circumstances.</p> | <p>The Security Rule specifies a series of administrative, physical, and technical safeguards for service providers and their associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.</p> |

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

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

Name of Parent/Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

I [Name of Parent/Guardian]: _____ hereby authorize information from [Name of LEA] _____ to be released to [Name of Agency] _____ for the purpose of coordination of services.

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

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

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

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

Signature of Parent/Guardian

Date

Tool 2.3 Additional Resources for Building Effective Partnerships

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

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CHAPTER 3

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





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

Key Questions

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

A Problem-Solving Approach for Promoting Mental Health

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

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

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

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

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

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

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

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

- **Values based.** As mentioned above, a problem is a discrepancy between valued behavior and actual behavior. From this perspective, values can be defined as desired qualities of behavior that are intentionally chosen and used to guide goal setting. Goals can then be defined as behavioral expectations that can be quantified and achieved, while values are the things people care about that motivate them to set and achieve goals in the first place. Probably the most common value for school personnel is that youth be academically successful. This value guides the setting of various academic goals, including benchmark and test scores that indicate mastery of skills and subject areas. Working toward goals is a way to realize values—to support students in behaving in desirable ways—but achieving goals doesn't finalize values, as there is always more to do to be a "successful student." When school personnel choose to value youths' mental health in a similar way that they value academic success, then they empower themselves to set and achieve goals for student well-being.
- **Outcome focused.** The ultimate aim of a problem-solving approach is to improve student outcomes that reflect alignment between student behavior and school personnel's related values. The practical implication of this is quite simple: if student outcomes are improving and goals are being met, then school personnel's problem-solving efforts are working. And if student outcomes are not improving and goals are not being met, then problem-solving efforts are ineffective and need revising. To that end, the important principle underlying an outcome-focus is to set realistic goals that are tightly linked with values, and which can be feasibly evaluated to determine success.
- **Data driven.** A problem-solving approach relies on data-based decision-making as the primary means for identifying problems, generating hypotheses for how to best solve problems, selecting specific strategies to intervene with problems, and evaluating the effectiveness of problem-solving efforts. Such data are collected and interpreted systematically and repeatedly, using pre-established decision rules. From a problem-solving perspective, the only way to judge if mental health outcomes are improving, if goals are being met, and if values are being realized is by collecting and using student behavior data.
- **School led.** When a problem-solving approach is used by school personnel, they take responsibility for leading all aspects of the process, including establishing values, determining outcomes, collecting data, and testing solutions. This means that the responsibility for achieving desired student outcomes rests squarely on school personnel's shoulders. If problem-solving efforts are ineffective for promoting students' mental health, the onus is on the school personnel, not the student or the student's family. If school personnel do not have the time, resources, or expertise to lead a particular aspect of the problem-solving process or to provide students with needed mental health services, it is their responsibility to contact and collaborate with community partners to ensure that such services are made available.

- **Collaborative.** Although school personnel begin and lead the problem-solving process, they must also actively collaborate with students, families, and community partners to efficiently and effectively accomplish their purposes. Depending on the scope of the problem, it can be helpful to invite students and families into the problem-solving process to clarify and establish shared values, develop culturally sensitive outcome goals, and design socially feasible intervention procedures. And when mental health problems become severe or require time and resources beyond those available in the local school setting, community partners with advanced expertise should be engaged in the problem-solving process to provide necessary or specialized support services.
- **Process oriented.** Instead of being a quick fix, a problem-solving approach is a process-oriented method that involves following specified steps of a logic model (described below), which requires a significant time and resource investment from school personnel. The payoff of this investment is that staff members' efforts are likely to effectively achieve valued student outcomes. Also, when efforts to promote mental health in schools are ineffective, the logic model underlying the problem-solving process provides a self-correcting mechanism to act more effectively in the future.

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

Establishing a Problem-Solving Team

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

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

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

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

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

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

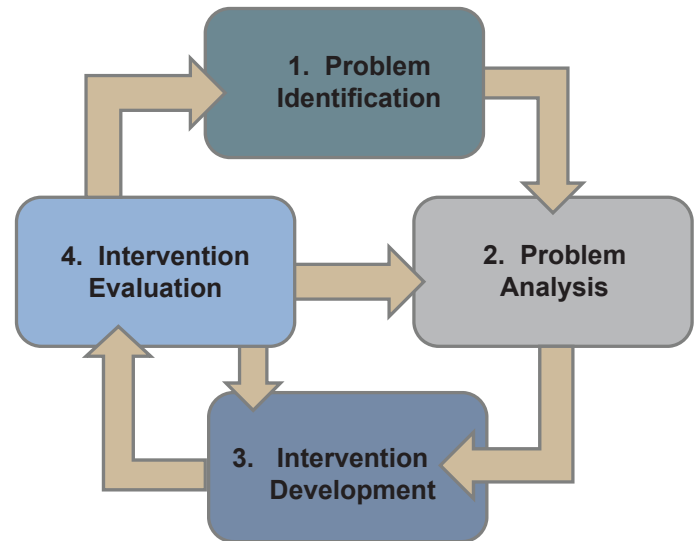
After a core group of school personnel and community partners have been established as a problem-solving team, the next major step is to select a problem-solving model that will guide all future steps the team will take in promoting youths' mental health.

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

The Four-Step Problem-Solving Model

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

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



Step 1: Problem Identification

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

Step 2: Problem Analysis

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

Step 3: Intervention Development

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

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

Step 4: Intervention Evaluation

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

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

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

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

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

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

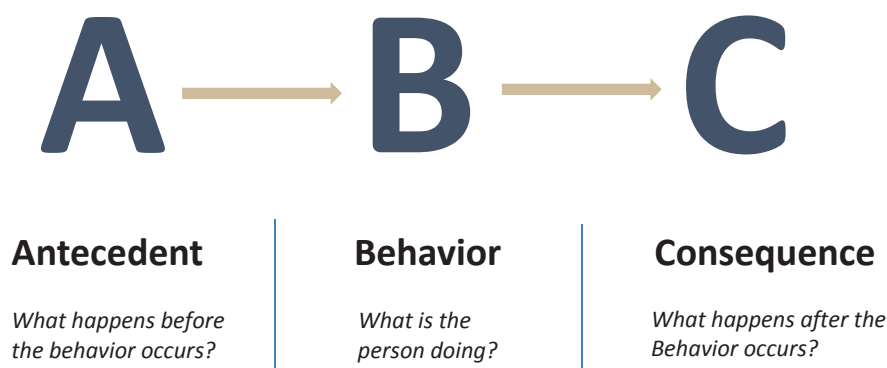
Using the ABC Theory to Promote Youths' Mental Health

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

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

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

Figure 3.2. Key Features of the ABC Theory of Behavior



- **Antecedents** are the environmental events that happen right before a behavior occurs. For example, a common antecedent for a student's aggressive behavior is being teased by his peers, while a common antecedent for a student's test anxiety is being told by the teacher that there will be a test tomorrow. Antecedents can be seen as the environmental triggers or sparks for mental health problems, as they set the stage for them to occur. The important thing to remember is that antecedents are not important in and of themselves but rather because they signal the availability of a consequence that is somehow beneficial to a student. Because of this tight relationship, mental health problems can sometimes be improved by simply altering the antecedents that are reliably associated with problem behaviors and their consequences.
- **Behaviors** are the actual actions of the student: the things the student is doing or, in some situations, is not doing. Mental health problems usually consist of combinations of *public behaviors* (observable by other people around the student) and *private behaviors* (only observable by students themselves). For externalizing problems, common examples of public behaviors include hitting or yelling at other students and disrupting the teacher during instruction. Private behaviors associated with these kinds of externalizing problems are angry thoughts and impulsive feelings. For internalizing problems, common examples of private behaviors include fear about things happening in the future or negative thoughts about one's self-worth, while public behaviors associated with these private behaviors include avoiding school tasks or escaping social interactions with peers. Although private problem behaviors are often aversive and unwanted, the public problem behaviors associated with them produce the consequences that are most perceptible to others and are therefore most commonly reported as problematic.
- **Consequences** are the external or internal changes that take place following a behavior. For instance, a common environmental consequence for a student's aggressive behavior is that his peers will stop teasing him, while a common internal consequence of a student's test-avoidance is that her negative thoughts and feelings about how poorly she will perform will cease. When something happens following the problem behavior that is likely to make that behavior more likely to occur in the future, this is called a *reinforcing consequence*. From the perspective of the ABC theory, mental health problems are maintained because of the reinforcing consequences that the problem behavior brings about. So although the behavior is a problem to caregivers, it continues to occur because it is actually functional in some way for students. How behaviors that are viewed as problems can actually be useful to students is better understood by considering the two types of reinforcing consequences: *positive reinforcement* and *negative reinforcement*.
 - **Positive reinforcement** occurs when a behavior helps a student increase or obtain a desirable consequence. This kind of reinforcement is positive because it adds something to the situation that benefits the student in some way, making the behavior more likely to occur in the future. Both externalizing and internalizing behaviors can be positively reinforced.
 - *Externalizing problem example #1.* Disrupting a teacher's classroom instruction might help a student get attention from peers.
 - *Externalizing problem example #2.* Bullying other youth can be a means for a student to get money, food, clothing, or other desired things.
 - *Internalizing example #1.* Withdrawing from one's peers can lead to increased attention from concerned adults at school.
 - *Internalizing example #2.* Telling caregivers that they feel depressed or anxious might result in a student receiving privileges or gifts that he or she wouldn't have had otherwise.
 - **Negative reinforcement** happens when a behavior helps a student reduce or avoid an unwanted consequence. This kind of reinforcement is negative because it subtracts something from the situation that benefits the student in some way, making the behavior more likely to occur in the future.
 - *Externalizing problem example #1.* Verbally threatening a peer might stop the current teasing or harassment from that peer.
 - *Externalizing problem example #2.* Talking to other students during classroom instruction can allow a student to escape from the demands of academic tasks.
 - *Internalizing problem example #1.* Not attending school on the day of a major test may substantially reduce a student's feelings of anxiety associated with that test.
 - *Internalizing problem example #2.* Avoiding social interaction with peers can lead to reduced negative thoughts about one's self-worth in comparison to those peers.

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

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

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

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

Assessment Strategies for Gauging Youths' Mental Health

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

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

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

- **Baseline measures** are the starting points of a problem behavior prior to intervention. Intervention effectiveness is judged by comparing measures of the problem behavior obtained after intervention to baseline measures.
- **Progress-monitoring measures** are the follow-up points of a problem behavior at different times during the intervention process. If progress-monitoring measures show improvement in relation to baseline measures as well as earlier progress-monitoring points, then the intervention is working and is judged to be effective.
- **Determining behavioral function** refers to strategies for mapping the logical connections between problem behaviors, the antecedents that trigger them, and the consequences that maintain them. This aspect of behavioral assessment helps the problem-solving team identify the factors that are maintaining the problem behavior so that an appropriate intervention strategy can be selected. Prior to determining the function of any problem behavior, school personnel must first describe it. But it makes little difference if the dimensions of the problem behavior are measured prior to, in combination with, or following this process.

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

Table 3.1. Relation of Behavioral Assessment Methods to Assessment Purposes

| Behavioral Assessment Method | Behavioral Assessment Purpose | | |
|------------------------------|-------------------------------|--|--|
| | <i>Describing behavior</i> | <i>Measuring behavioral dimensions</i> | <i>Determining behavioral function</i> |
| Direct behavior observations | X | X | X |
| Direct behavior ratings | | X | |
| Behavior rating scales | | X | |
| Interviews | X | X | X |
| Surveys | X | X | X |

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

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

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

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

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

Intervention Strategies for Promoting Youths' Mental Health

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

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

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

- **Differentially reinforcing valued behavior** refers to providing youth with desirable consequences when they exhibit valued behaviors that either replace or are incompatible with the problem behavior. This approach is effective by itself, but is also useful when used in combination with the other two approaches. When using this strategy, it's important to explicitly tell students why they are receiving a desirable consequence so that they do not mistakenly attribute the reinforcement to an unrelated or non-valued behavior.
 - *Externalizing problem example.* If while standing with friends in the hallway during passing periods (antecedent) a student makes rude comments to those walking by (problem behavior) to make her friends laugh and get their attention (consequence), then specifically praising the student when she talks kindly or is helpful to other students in class who are not her friends (differentially reinforcing valued behavior) may increase her likelihood of being respectful towards similar students in other situations in the future.
 - *Internalizing problem example.* If during unstructured times in class (antecedent) a student puts his head down on his desk (problem behavior) to avoid interacting with peers that he says don't like him (consequence), then specifically praising the student when he interacts positively with others during structured class activities (differentially reinforcing valued behavior) may increase the likelihood of more prosocial behavior occurring in the future.
- **Withholding reinforcement from problem behavior** refers to not providing youth with the desirable consequences that usually follow their problem behavior. This strategy is best used in combination with one of the previous two strategies, not as a standalone strategy.
 - *Externalizing problem example.* If during recess on the playground (antecedent) a student yells at and hits her peers (problem behavior) to get immediate access to the play equipment she wants (consequence), then having a supervising adult prevent her from accessing the equipment when she is aggressive (withholding reinforcement from the problem behavior) until she waits her turn (differentially reinforcing valued behavior) may reduce the likelihood of the aggressive behavior continuing in the future.
 - *Internalizing problem example.* If during in-class testing (antecedent) a student often complains of feeling depressed (problem behavior) and as a result is allowed to stop taking the test (consequence), then having the teacher encourage the student to persist in the test following the complaint (withholding reinforcement from the problem behavior) and providing him with verbal praise for finishing the exam (differentially reinforcing valued behavior) is likely to reduce the likelihood of this problem behavior in the future.
- **Teaching skills** refers to explicitly instructing students in new behaviors that help them act in valued, prosocial, and healthy ways when they encounter antecedents that have historically triggered problem behaviors. The important thing for problem-solving teams to remember is that new skills must help students experience similar or more preferred consequences than the problem behavior did, otherwise these skills will not be maintained. Although an infinite number of skills can be taught to students, a useful way of talking about them is to divide them into two general categories: *teaching replacement behaviors* and *teaching self-regulation behaviors*.
 - **Teaching replacement behaviors** refers to explicitly teaching students skills that serve the same function as problem behaviors, but that are considered to be appropriate and valued by the problem-solving team. Although school personnel often assume that students don't know the right thing to do and need to be taught replacement behaviors, students often already possess the necessary skills and they will engage in valued behaviors when antecedents and consequences are altered. However, this is not always the case, and young children and students with developmental disabilities are especially likely to benefit from teaching replacement behaviors.

- *Externalizing problem example.* If during small-group activities (antecedent) a young child takes toys and materials from other children in his group without asking (problem behavior) so that he can use them himself (consequence), then instructing the student in strategies for appropriately getting what he wants—such as asking politely trading and waiting his turn (teaching replacement behaviors)—may allow him to experience desirable consequences without frustrating peers and teachers.
 - *Internalizing problem example.* If when working with a one-on-one aid on a new academic task (antecedent) a student with a development disability covers her face and cries (problem behavior) to escape from the demands of the aid (consequence), then instructing the student in strategies to appropriately request short breaks when she feels overwhelmed (teaching replacement behaviors) may allow her to briefly escape the academic demands while facilitating greater overall work completion.
- **Teaching self-regulation behaviors** refers to teaching students skills that help them manage their problem behavior more effectively by disrupting the tight connection that has been formed between the antecedents, problem behaviors, and consequences. Specifically, this approach consists of three core strategies: making students aware of the antecedents that trigger their problem behavior, teaching them skills that calm their aversive thoughts and feelings (private behaviors) that automatically follow those triggers, and training them to use problem-solving skills to guide their actions in difficult situations (public behaviors).
 - *Externalizing problem example.* If during most cooperative social interactions with peers (antecedent) a student becomes frustrated or angry with them (problem behavior) and this results in him getting his way (consequence), then being instructed to use deep breathing techniques accompanied by positive self-talk in response to feeling angry (teaching self-regulation behaviors) may enable him to interact more prosocially with his peers in the future.
 - *Internalizing problem example.* If when engaged in a challenging academic task (antecedent) a student experiences negative self-talk (e.g., “I’m a complete failure—I’ll never be good at anything and nobody likes me”) that is followed by giving up on the task (problem behavior), which temporarily stops the negative self-talk (consequence), then being instructed to be mindful and accepting of her negative self-talk while persisting in challenging tasks (teaching self-regulation behaviors) may allow her to be more academically successful in the long run.

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

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

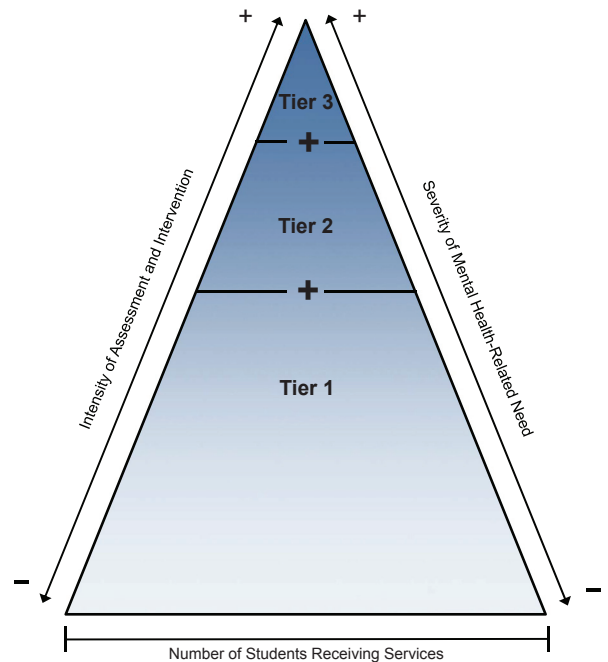
When teaching replacement behaviors and self-regulation behaviors, interventionists should remember that it is almost always easier for students to successfully demonstrate skills in teaching situations than to actually use the skill when they need it in real-life situations. Therefore interventionists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

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

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

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

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



Adapted from: Renshaw & O'Malley (2015)

Core Problem-Solving Procedures that are Flexibly Applied Across Tiers

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

- **Conduct a discrepancy analysis to identify differences between desired and observed levels of behavior.** This procedure involves comparing baseline data obtained on the problem behavior to determine exactly how it is different from the values and expectations of the problem-solving team. The intent is to clarify exactly how much change is desired for the problem-solving process to be considered successful. An example exercise for accomplishing this procedure is provided in [Tool 3.7](#).
- **Step 2: Problem Analysis**
 - **Determine the factors maintaining the problem behavior and link them with an intervention strategy to positively influence problem behavior.** This procedure involves stating the factors that appear to be maintaining the problem behavior and then linking intervention strategies to these factors. The intent of this exercise is not to fully develop an intervention but rather to clearly lay out the logic underlying why a particular approach to intervention is selected over other approaches. An example exercise for accomplishing this procedure is provided in [Tool 3.8](#).
- **Step 3: Intervention Development**
 - **Plan the procedures and schedule of the intervention.** This procedure explicitly plans out all aspects of the evidence-based intervention to ensure it is capable of being effectively implemented to resolve the problem behavior. An example exercise for accomplishing this procedure is provided in [Tool 3.9](#).
 - **Develop an implementation fidelity measure and establish a schedule and procedures for evaluating and enhancing intervention integrity.** This procedure requires the problem-solving team to create a measure that can be used to track implementation of the core procedures of the intervention plan to gauge if it is being implemented appropriately. Although some intervention plans have various procedures and are quite complex, the point here is not to track all possible intervention components but rather to track those that appear to be the most important.
 - **Develop an outcome goal, select a progress-monitoring method, and establish a schedule and procedures for evaluating intervention effectiveness.** This procedure is accomplished by establishing a goal that is derived from the discrepancy analysis from Step 1 and then determining how often progress-monitoring will occur and what decision rules will be used to determine how well the intervention is working. Although evaluating intervention effectiveness should occur on a schedule that is feasible for school personnel, the following schedules are recommended:
 - *Tier 1.* Three or four times per school year
 - *Tier 2.* One or two time per month
 - *Tier 3.* One or two times per week
- **Step 4: Intervention Evaluation**
 - **Determine the level of implementation fidelity.** This procedure involves determining how effectively the intervention is being applied. All that is required is that the measure, schedule, and procedures that were established for this purpose in Step 3 be followed according to plan.
 - **Determine the effect of the intervention on the problem behavior.** This procedure involves following the plan that was developed for this purpose in Step 3.
 - **If needed, identify potential improvements to the problem-solving process.** If the intervention evaluation process indicates that the intervention is not effective and it has already been determined that it is being implemented with fidelity, then the first option in this procedure is to systematically revisit Step 3 (intervention development) and look for potential improvements that can be made to the intervention plan to increase its effectiveness. If no improvements can be made to the plan, then the second option is to systematically revisit Step 2 (problem analysis) to

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

Core Problem-Solving Procedures that are Variably Applied Across Tiers

• Step 1: Problem Identification

- **Obtain a baseline measure of problem behavior.** The types of measures used to obtain baseline observations of problem behavior typically differ across tiers. A key point for problem-solving teams to remember is that measures used with greater numbers of students typically have less specificity and therefore require that the problem behavior be understood and intervened with in more general terms. On the other hand, measures used with individual students and small groups of students may have greater specificity and therefore result in more targeted intervention plans.
 - *Tier 1.* Brief behavior rating scales called *universal screeners* are most useful because they provide an efficient way to measure the mental health of every student in a school (see [Table 3.2](#) for a listing of common behavior rating scales and their key characteristics). Brief behavior rating scales are available that measure overall mental health problems as well as general internalizing and externalizing problems. Teacher-report screeners are most efficient for primary students, while youth self-report screeners are most efficient for secondary students.
 - *Tier 2.* Brief rating scales can be useful, but lengthier behavior rating scales called *narrowband* (targeting a single problem) or *broadband* (targeting multiple problems) measures are recommended because they provide a more in-depth assessment of mental health problems. Teachers or students can complete these lengthier rating scales. Additionally, direct behavior ratings and direct behavior observations of groups' or individual students' data can be used to obtain measures of problem behavior that are easily seen by school personnel, such as aggression or social withdrawal.
 - *Tier 3.* Although narrowband and broadband measures may be useful, direct behavior ratings and direct behavior observations should be used as the primary methods. Although using a single measurement method is most efficient in the previous tiers, using multiple methods to measure the problem behavior is helpful in this tier.

• Step 2: Problem Analysis

- **Identify the factors maintaining the problem behavior.** The assessment techniques useful for understanding the factors that maintain the problem behavior are likely to vary across tiers, as targeted methods are more useful for understanding more specific problems, while general methods are useful for understanding less specified problems.
 - *Tier 1.* Brief surveys asking teachers or students to report on the context of problem behaviors are the most useful. Survey items should directly state the mental health concerns and should ask specific questions about the relation of problem behaviors to antecedents and consequences so that the most appropriate approach to intervention can be determined. Both multiple-choice and free-response questions may be helpful.
 - *Tier 2.* Brief interviews with caregivers and students can provide information on the relation of mental health problems to antecedents and consequences. Similar to surveys, interviews should be directly linked to the identified problem behavior and focus on intervention planning. The primary benefit of interviews over surveys is that they allow respondents to provide detailed information or offer important information that was overlooked on surveys.

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

- **Step 3: Intervention Development**

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

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

| Name | Type | MTSS Tiers | URL |
|---|------------|------------|---|
| Youth Internalizing Problems Screener | Screeners | 1, 2 | https://www.researchgate.net/publication/279295613_Youth_Internalizing_Problems_Screener |
| Youth Externalizing Problems Screener | Screeners | 1, 2 | https://www.researchgate.net/publication/279295611_Youth_Externalizing_Problems_Screener |
| Strengths and Difficulties Questionnaire | Screeners | 1, 2 | http://www.sdqinfo.com/ |
| Behavioral and Emotional Screening System | Screeners | 1, 2 | https://www.pearsonclinical.com.au/products/view/250 |
| Pediatric Symptoms Checklist | Screeners | 1, 2 | http://www.massgeneral.org/psychiatry/services/psc_home.aspx |
| Student Risk Screening Scale | Screeners | 1, 2 | http://www.sai-iowa.org/10_%20Behavior%20Screeners.pdf |
| Achenbach System of Empirically Based Assessment | Broadband | 2, 3 | http://store.aseba.org/ |
| Conners Comprehensive Behavior Rating Scales | Broadband | 2, 3 | http://www.mhs.com/product.aspx?gr=edu&id=overview&prod=cbrs |
| Burks Behavior Rating Scales (2 nd ed.) | Broadband | 2, 3 | http://www.mhs.com/product.aspx?gr=cli&prod=bbbs2&id=overview |
| Behavior Assessment System for Children (2 nd ed.) | Broadband | 2, 3 | http://www.pearsonclinical.com/education/products/100000658/behavior-assessment-system-for-children-second-edition-basc-2.html |
| Beck Youth Inventories (2 nd ed.) | Narrowband | 2, 3 | http://www.pearsonclinical.com/psychology/products/100000153/beck-youth-inventories-second-edition-byi-ii.html |
| Revised Children’s Manifest Anxiety Scale | Narrowband | 2, 3 | http://www.mhs.com/product.aspx?gr=edu&prod=rcmas2&id=overview |

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

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

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Tool 3.1. Example Event Recording Form

Example of Event Sampling Data Collection Sheet

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

Tool 3.2. Example Time Sampling Form

**Sampling Record Sheet
10-Minute Intervals**

Student: _____ Date: _____

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

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

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

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

Record + or –

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

Tool 3.3. Example ABC Recording Form

ABC Observation Form

| Student Name: _____ | | Observation Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> |
|---------------------|----------|---|
| Observer: _____ | | Time: _____ |
| Activity: _____ | | Class Period: _____ |
| ANTECEDENT | BEHAVIOR | CONSEQUENCE |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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

Youth Internalizing Problems Screener (YIPS)

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

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

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

THANK YOU for completing the survey!

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

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

Youth Externalizing Problems Screener (YEPS)

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

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

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

THANK YOU for completing the survey!

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

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

Date:

Young person receiving services:

Problem-solving team members:

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

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

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

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

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

Tool 3.7. Discrepancy Analysis Exercise

Date:

Young person receiving services:

Problem-solving team members:

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

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

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

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

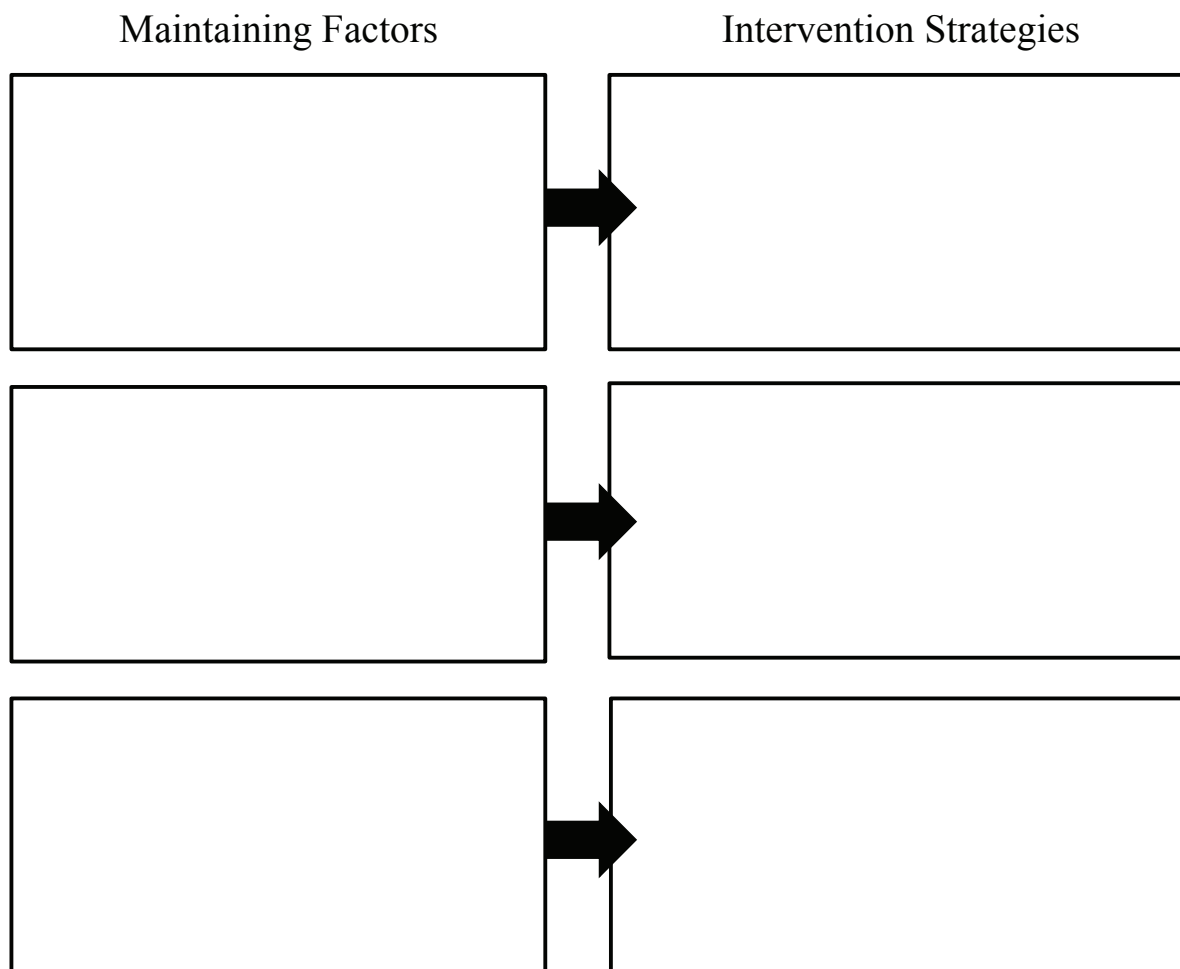
Date:

Young person receiving services:

Problem-solving team members:

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

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



Tool 3.9. *Intervention Planning Exercise*

Date:

Young person receiving services:

Problem-solving team members:

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

- *How* will it be implemented?

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

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

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

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

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

Topic: Behavior Assessment and Consultation

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

Sheridan, S. M., & Kratochwill, T. R. (2007). *Conjoint behavioral consultation: Promoting family–school connections and interventions*. New York, NY: Springer.

Simonsen, B., & Myers, D. (2015). *Classwide positive behavior interventions and supports: A guide to proactive classroom management*. New York, NY: Guilford.

Steege, M. W., & Watson, T. S. (2009). *Conducting school-based functional behavioral assessments: A practitioner’s guide* (2nd ed.). New York, NY: Guilford.

Stormont, M., Reinke, W. M., Herman, K. C., & Lembke, E. S. (2012). *Academic and behavior supports for at-risk students: Tier 2 interventions*. New York, NY: Guilford.

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

Topic: Interventions for Specific Mental Health Needs

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

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

McCabe, P. C., & Shaw, S. R. (Eds.) (2014). *Psychiatric disorders: Current topics and interventions for educators*. Bethesda, MD: National Association of School Psychologists.

Merrell, K. W. (2008). *Helping students overcome depression and anxiety: A practical guide* (2nd ed.). New York, NY: Guilford.

Merrell, K. W., & Gueldner, B. A. (2010). *Social and emotional learning in the classroom: Promoting mental health and academic success*. New York, NY: Guilford.

Miller, D. N. (2010). *Child and adolescent suicidal behavior: School-based prevention, assessment, and intervention*. New York, NY: Guilford.



CHAPTER 4

Cultural and Linguistic Considerations





CHAPTER 4

CULTURAL AND LINGUISTIC CONSIDERATIONS

Key Questions

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

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

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

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

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

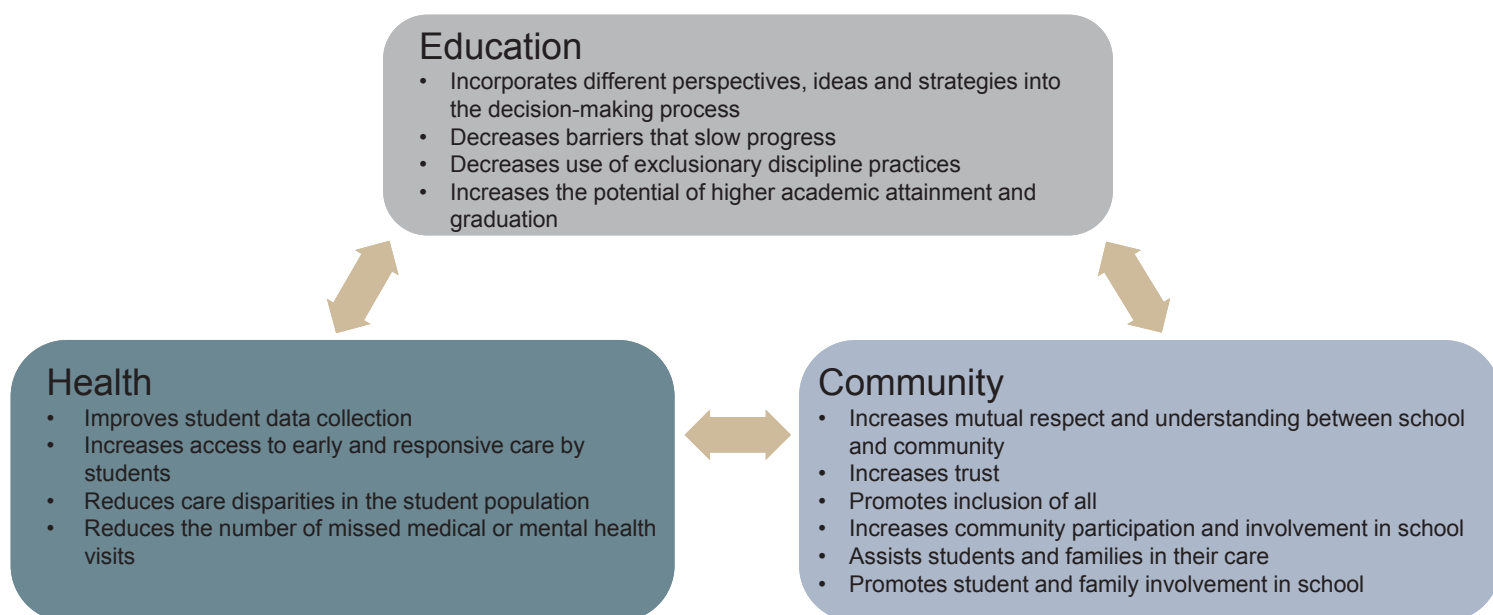
A large amount of research evidence has shown that punitive, reactionary discipline approaches are often unfairly applied to students who are English-learners, Black, Hispanic, and American Indian (Gregory, Skiba, & Noguera, 2010; Sullivan, Van Norman & Klingbeil, 2014). This pattern of bias has continued,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

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

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

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

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



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

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

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

Elements of Culture

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

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

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

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

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

Table 4.1. Elements of the Cultural and Linguistic Competence Framework

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

Mental Health Disparities in Culturally Diverse Students

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

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

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

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

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

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

Disproportionalities in Child Welfare

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

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

Addressing the Challenges of Diverse Cultural and Language Needs

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

Culturally and Linguistically Appropriate Services

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

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

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

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

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

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

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

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

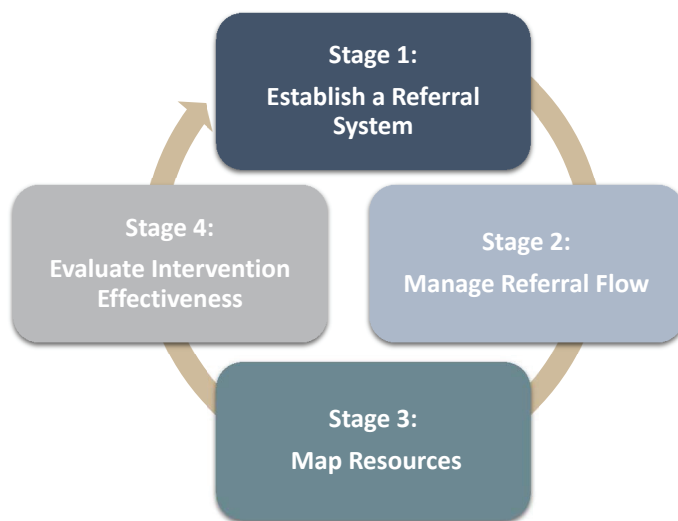
- educating all stakeholders about the disproportionalities that exist, including local government, school personnel, families and communities, and stakeholders representative of the entire community;
- working to change the school experience for families and communities from diverse cultures to one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

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

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

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

Figure 4.2. Four Stages of Referral Pathways Development



1. What cultural and linguistic competencies should problem-solving team members demonstrate?

A key first step is to help the school's problem-solving team establish both self-knowledge and knowledge of the school community. First and foremost, the school problem-solving team members will need to develop knowledge and awareness about:

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

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

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

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

Teachers/School Personnel

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

Toolbox 4.1. Continued

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

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

- a. Identify the right members to participate on the problem-solving team. Look for team members who:
 - have a true understanding of their own cultural identity,
 - are aware of the fact that others have diverse identities,
 - understand that culture is a part of all behavioral contexts,
 - represent various lived experiences and can bring diverse perspectives to this work, and
 - are committed to ongoing personal assessment.
- b. As a practice, recruit diverse team members who can serve as natural networks of support.
- c. Identify cultural brokers to participate on the school-based problem-solving team. Cultural brokers are individuals from the community who can serve as a bridge between an organization and people of different cultural backgrounds. Cultural brokers should be familiar with educational institutions and mental health services within the community in which they live or from where they originated. They can become a valuable source of cultural information and serve as mediators in conflicts and as agents for change.

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

Toolbox 4.2. Characteristics of Effective Cultural Brokers

Cultural brokers are aware of:

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

Cultural brokers are knowledgeable of:

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

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

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

Toolbox 4.3. Guiding Questions for Identifying Effective Cultural Brokers

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

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

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

Toolbox 4.4. Using Translators and Interpreters Effectively

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

Pre-Work:

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

During Problem-Solving Team Meetings:

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

During Debriefing Conversations:

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

Do:

- repeat and summarize the major points
- be specific (e.g., "daily" rather than "frequent")
- use diagrams, pictures, and translated written materials to increase understanding
- clarify that you understand or that you have understood the person

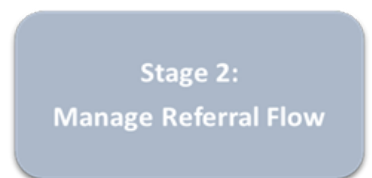
Don't:

- use metaphors, colloquialisms (e.g., pull yourself up by your bootstraps), and idioms (e.g., kick the bucket) because such phrases are unlikely to have a direct translation
- use medical terminology unless the interpreter and person are familiar with the equivalent term

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

- e. Create a friendly and inviting space for team meetings.
 - When it is in the best interest of culturally and linguistically diverse families, consider hosting problem-solving meetings in a neutral environment, such as a community library or community center.
 - Providing food and drink (even water and simple snacks) is an indication of good intentions.
 - Consider whether the length of the meeting is sufficient to appropriately address all the issues, particularly if a cultural broker or interpreter is part of the team.
 - Consider whether your team has arranged a meeting time that's accessible for the student's family.
- f. Create routines that incorporate regular self-assessment of the team's cultural and linguistic competence.
- g. Communicate to family members and stakeholders within the community how the referral system works and make modifications as feedback is collected.
- h. Use referral tools that have built-in cultural and linguistic considerations. (Refer to [Tool 4.2](#) at the end of this chapter for guidance in building a culturally competent referral system.)
- i. Add cultural and linguistic identifiers to referral forms and team protocols. These identifiers will assist the team in constructing a deeper understanding of the young person's environment and will be useful later when examining data for persistent disparities in referral and intervention. Consider adding the following identifiers:
 1. Country of origin
 2. Generation
 3. Acculturation (may need to collect data from student and families)
 4. Linguistic characteristics, including languages spoken, written or signed; dialects or regional variants; and literacy levels
 5. Family household and composition
 6. Socioeconomic status
 7. Educational attainment
 8. Employment
 9. Health and mental health practices
 10. Religious and spiritual practices
 11. Military affiliation
 12. Racial and ethnic groups
 13. Sex
 14. Sexual orientation
 15. Gender identity
 16. Disability

Stage 2: Cultural and Linguistic Considerations when Managing Referral Flow



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

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

Toolbox 4.5. Key Characteristics of Cultural Competence Training

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stage 3: Cultural and Linguistic Considerations When Mapping Resources

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

Stage 3:
Map Resources

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

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

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

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

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

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

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

Structure of the intervention

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

Delivery of the intervention

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

Program content

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

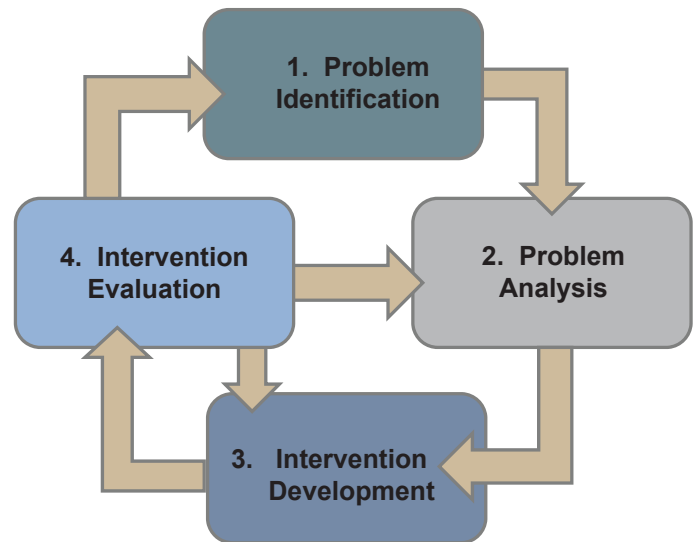
Stage 4: Cultural and Linguistic Considerations When Evaluating Intervention Effectiveness

Stage 4:
Evaluate Intervention
Effectiveness

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

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

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



Step 1: Problem Identification

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

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

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

Step 2: Problem Analysis

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

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

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

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

Step 3: Intervention Development

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

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

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

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

Step 4: Intervention Evaluation

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

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

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

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

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

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

Tool 4.1. Applying National CLAS Standards in Schools

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

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

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

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

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

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

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

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

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

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

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

Considerations When Making Child and Family Referrals to Mental Health Providers

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

Preparing for the Referral

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

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

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

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

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

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

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

Facilitating the Process Once the Referral Has Been Made

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

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

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

Checklist Items for Facilitating the Referral Process for Children and Families

I have...

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

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

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

References

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