National Center on Safe Supportive Learning Environments
Safe Supportive Learning
Engagement | Safety | Environment

Worksheet

Implementing School Mental Health Supports: Best Practices in Action

Introduction

Because interest and investment in school mental health has grown in the past two decades, the field recognizes the significant need for guidance about effective delivery models for integrating mental health or behavioral health services into schools.[1] Schools have reported struggling with several implementation challenges, including gaining teacher and administrator buy-in, limited school personnel time and resources, school accountability emphasizing academic rather than social-emotional outcomes, and limited parent involvement.[2,3]

School Mental Health and Behavioral Health

School mental health refers to specific emotional or behavioral needs that may be associated with a clinical condition and can be framed in terms of resilience to violence and trauma. **Behavioral health** is often used synonymously with mental health, although it can be defined more specifically as the conditions caused by problematic behaviors including substance use. In this brief, we use the term "school mental health" to encompass the full range of such conditions.

Social distancing imperatives responsive to the COVID-19 pandemic in 2020–21 complicated implementation challenges during the school year, as both K–12 learning activities and health surveillance and support from schools shifted from in-person physical environments to virtual platforms at the same time reported problems with anxiety, depression, and suicidal thoughts reached unprecedented prevalence levels among students. But despite the unprecedented insults from the pandemic within a complicated stew of social and political unrest and tension in the United States, it was reassuring to recognize that the substantial foundation of best practices in school mental health could be effectively adapted to even such uniquely challenging circumstances.

This resource draws from and describes critical best practices that can inform such adaptations to respond to the increasingly evident behavioral health issues students continue to experience.

Under two grant programs administered by the U.S. Department of Education (ED),[a] 25 state and local educational agencies (SEAs and LEAs) that had been awarded federal funding to strengthen and expand their school mental health services reported year-end data for the 2017–18 school year. More than three fourths of grantees reported reduced

[a] Two sets of grantees were awarded funding by the U.S. Department of Education (ED) to help improve school mental health supports. First, in 2014, 22 LEAs across 14 states were funded to develop and support implementation of comprehensive plans to improve school mental health, prevent violence, and increase student engagement (**Project Prevent or P2**). In 2016, three additional grantees (**Promoting Student Resilience or PSR**) were funded to develop their capacity to address students' comprehensive behavioral and mental health needs in communities that experienced significant civil unrest.

school discipline referrals, alongside of increases in the numbers of students in need who received mental health services related to their exposure to violence over 3 or 4 years. The grantees had used a variety of programs and approaches to achieve those results, so it is difficult to identify a specific profile for success. Instead, a suite of best practices is outlined in this brief, which reflects guidance provided by the Safe Schools/Healthy Students (SS/HS) Implementation Framework,[b] the National Center for Safe Supportive Learning Environments (NCSSLE) school climate improvement resource package (SCIRP),[c] and knowledge from the broader field about implementation of mental health programs in schools, training methods, and systems change.

This document offers guidance for other SEAs that are planning and seeking funding for comprehensive, effective, and sustainable approaches for preventing, identifying, and treating mental health in schools, including addressing violence and trauma.

Recommendation 1: Align Programs Across a Continuum of Services

Effective school-based mental health programs provide a continuum of services. Each service must be aligned with each other as well as have a clear theory of change—or logic model—that connects those services with desired outcomes. Most comprehensive school mental health programs are situated within a multi-tiered system of support that systematically identifies students' common and individual needs. At this universal level, also referred to as Tier 1, teachers are taught to increase their knowledge of student mental health needs and to use strategies to support psychological well-being and social and emotional development of students within their classrooms. At a more targeted level (Tier 2), school mental health staff (i.e., counselors, psychologists, social workers) may provide consultation to teachers on working with specific students, or they may provide direct services to those students such as a group program. At Tier 3, intensive, individualized management, and therapeutic strategies (e.g., counseling services) are provided to a relatively small number of students with significant treatment needs. Tier 3 services might be provided either within the school or through community mental health professionals and organizations.

Best Practices in Aligning Programs Across a Continuum	Grantee Example(s)
☐ Provide schoolwide supports for positive behavior, social-emotional learning, and school climate to reduce the need for mental health services.	▪ Baltimore Public Schools (Maryland; PSR grantee) provided a suite of trainings across staff in mindfulness and trauma (Tier 1), implemented restorative practices (Tier 2), and trauma-focused cognitive behavioral therapy (CBT) at Tier 3. ▪ San Francisco's Unified School District (California; P2 grantee) created Wellness Centers that provide a structured space for self-regulation and restorative conversations (Tier 1). Social workers manage these centers along with behavior coaches who provide individual and group interventions (Tier 2). Social workers also coordinate with community agencies to arrange mental health assessment and intervention.
☐ Provide a continuum of services across three tiers of intervention, which theoretically should be aligned within a comprehensive logic model.	
☐ Align mental health initiatives with academic programming—the primary mission of schools—to enhance administrator buy-in.	
☐ Create clear methods of communication about mental health programs and initiatives across staff and programs, such as through a management or an implementation team.	

[b] https://healthysafechildren.org/safe-schools-healthy-students-framework-implementation-toolkit
[c] https://safesupportivelearning.ed.gov/scirp/reference-manual

Recommendation 2: Incorporate Youth and Family Voices

Parent involvement in their child(ren)'s mental health treatment has a significant positive effect on outcomes,[4] yet there are many challenges to engaging parents as part of school-based efforts. Meaningful inclusion of parent and family voices in a participatory planning process will enhance the relevance and impact of any school mental health initiative. Parent participation is particularly important for populations who have been historically underserved and marginalized based on race, ethnicity, socioeconomic status, or sexual orientation, who may have different perspectives about needs and services, language barriers, or other preferences for how they might wish to participate.

Best Practices in Incorporating Youth and Family Voices	Grantee Example(s)
☐ Connect with community organizations in which parents are already engaged and consider piggy-backing activities and events.	▪ Chicago Public Schools (Illinois; PSR grantee) held Community Ambassador Trainings and created Youth Wellness Teams to combat stigma regarding mental health and increase the use of services.
☐ Conduct interviews or focus groups with students to obtain their perception of needs related to mental health and services and provide opportunities for their involvement in the planning process.	
☐ Seek parental advisory input on how to design appropriate activities and resources to meet their needs and preferences, including language diversity and use of technology.	
☐ Include families and members of the community from diverse backgrounds (including race/ethnicity, language status, faith community, family structure) in implementation planning.	

Recommendation 3: Engage Leadership in Implementation Planning and Support

As one grantee noted, "it all starts with leadership." Supportive school- and district-level administrators are critical for consistent implementation and sustainability of any school mental health initiative and should be involved early on in planning new mental health programming. Administrator buy-in ensures that staff will be supported in delivering the program and that resources will be reallocated as needed to do so. Administrators can also create policies for systems change to support effective implementation.

Best Practices in Engaging Leadership	Grantee Example(s)
☐ Involve leadership across school, district, and state levels in the planning of mental health programming early on.	▪ Baltimore Public Schools (Maryland; PSR grantee) developed a program matrix for administrators listing specific mental health supports being offered. ▪ St. Louis Public Schools (Missouri; PSR grantee) integrated trauma-responsive indicators into superintendent walk-through tools and distributed biweekly principal and superintendent newsletters with updates on initiatives. ▪ Chicago Public Schools (Illinois; PSR grantee) selected participating high schools in part based on principal commitment to prioritizing social-emotional learning.
☐ Share specific ways that school mental health programming supports the state's and district's strategic goals and plans.	
☐ Regularly share program successes and request leadership assistance in problem-solving challenges.	
☐ Plan proactively for engagement of new administrators when there is turnover.	
☐ Discuss with administrators how to align school disciplinary policy and practice with intervention approaches. In particular, discipline approaches that focus on teaching more appropriate behaviors and restorative practices are likely to support students' mental health while exclusionary practices may exacerbate mental health difficulties such as trauma.	

Recommendation 4: Build Staff Mental Health Capacity

The success of any school mental health program relies upon educator knowledge of mental health conditions, including how those conditions might manifest in school settings and how student (or staff) mental health concerns can be addressed. Unfortunately, teachers are often unaware of students' emotional needs,[5] and teachers' readiness to support students depends on their own well-being and support within the school.[6] Teachers may lack knowledge and skills for using evidence-based strategies to address students' emotional or behavioral difficulties.[7] Other school personnel (including administrators, counselors, social workers, nurses, and school resource officers) might need to expand their respective capacities to promote improved student mental health.[8,9] Research on professional development (PD) has identified several training and coaching characteristics that are associated with positive student outcomes.[10] [11] Those quintessential characteristics have been supported even as teaching and learning strategies have been adapted to distance learning (including asynchronous) and other technology-based platforms.

Best Practices in Building Staff Mental Health Capacity	Grantee Example(s)
☐ Provide whole-school and district-wide training (reinforced through professional learning communities) to promote knowledge of mental health concerns like trauma or depression. Explore opportunities for funding staff PD time and provide continuing education credits to encourage participation.	▪ Baltimore City Schools (Maryland; PSR grantee) provided all staff in every school with online training in trauma-informed practices, abuse, and neglect. They provided biweekly supervision sessions from a national trainer and implementation support to school mental health clinicians. ▪ Chicago Public Schools (Illinois; PSR grantee) provided PD on self-care and mindfulness to address secondary trauma and compassion fatigue in staff. They provided extended-day payments to staff participating in trainings. They also hired a full-time behavioral health coach for 10 targeted schools.
☐ Provide classroom coaching to help teachers' strengthen relationships with all students (including those with mental health challenges), increase their use of positive behavioral supports, and help them manage disruptive behavior.	
☐ Utilize school psychologists or counselors who are embedded within the education system to provide coaching and/or consultation. If mental health support staff are community-based, they should be knowledgeable of the school context and demands and constraints.	
☐ Provide ongoing, intensive PD from program experts with an opportunity to apply strategies in practice in order to enhance staff skills in delivering mental health programs.	
☐ Address staff's personal well-being so they can provide the level of emotional support needed by students who have mental health challenges.	

Recommendation 5: Utilize Data for Continuous Quality Improvement (CQI)

In addition to grant requirements for specific evaluation outcomes, systematically collected data can be used for CQI and sustainability planning. Data can be used to make decisions related to staffing and training, referral processes, program selection and delivery, and resource allocation. Information on program reach can be used to identify any disparities that may exist for historically underserved subpopulations of students and to make decisions regarding outreach efforts. Many types of data (e.g., survey, interviews, focus groups, observations, tracking systems) may be useful for different purposes and provide more information when used together.

Best Practices in Using Data for CQI	Grantee Example(s)
☐ Collect a variety of data, including information on: ✓ who is being referred, served, and trained (reach); ✓ program fidelity (i.e., to what extent is the program or intervention delivered as intended using measures such as session checklists); ✓ quality of training or services as experienced by different stakeholders, including teachers, parents, and students; ✓ outcomes related to the mental health needs of students (and staff, where relevant); and ✓ measures of educational outcomes like discipline referrals, grades, test scores, and advancement/graduation rates.	▪ Chicago Public Schools (Illinois; PSR grantee) utilized "exit interviews" with clinicians and site leaders, which led to a reduction in the number of group sessions that maintained fidelity. They examined service utilization data to strengthen training and target implementation supports. They also conducted universal trauma screening across the district as part of their needs analysis for their targeted focus area. ▪ Baltimore City Schools (Maryland; PSR grantee) assessed staff perceptions of trauma-informed care using a validated survey administered at baseline and follow up points. When response rates decreased, their team identified strategies to improve them. The team also conducted focus groups at the end of an implementation year at multiple schools with administrators, school mental health providers, support staff, and educators.
☐ Monitor survey completion rates and incentivize as needed to ensure that response rates are adequate for meaningful interpretation.	
☐ Examine data by subgroups (e.g., gender, grade, race/ethnicity, poverty status) to identify any disparities and inform efforts to promote equity.	
☐ Develop data management support systems with technical assistance when available, ideally with support from someone with dedicated time for these responsibilities (i.e., data specialist).	
☐ Provide training and technical assistance to clinicians on how to use data reporting systems accurately. This step may require data infrastructure to be developed across systems (e.g., community practices and schools).	
☐ Collect baseline data prior to initiation of new programs to adequately measure improvements.	

Recommendation 6: Build School–Community Partnerships

School–community partnerships provide ideas, expertise, and resources to strengthen school mental health programs and enhance outcomes, which can be particularly helpful for the most disadvantaged schools. Partnerships can also help address the highest level of students' mental health needs (Tier 3), which often exceed the expected capacity of schools for treatment and support. Partners may include community mental health and behavioral health providers, university and hospital faculty and programs, faith-based organizations, and other agencies with a shared vision and mission to improve children's mental health.

Partnerships may take many forms, including agencies that provide services directly to students, mental health clinicians who provide PD to school staff or who conjointly deliver programs to students with school staff, and strong referral processes that enhance students' access to community mental health services. Businesses, public health departments, and child welfare programs have played prominent roles as nontraditional partners, making collaborative contributions to support children, their families, and school systems during the COVID-19 pandemic. Ideally, community partners will be invested in long-term collaborations that prove to be mutually beneficial. Building, strengthening, and sustaining partnerships, even though it requires considerable time and energy, often yields demonstrable long-term returns on such investments.

Best Practices in Building Mental Health Partnerships	Grantee Example(s)
☐ Develop processes that ensure clear responsibilities and regular two-way communication using tools such as a Memorandum of Understanding or team charters, which should be informed by and shared with site leadership.	▪ St. Louis Public Schools (Missouri; PSR grantee) developed community-based mental health partner quality standards and operation manuals, as well as a manual to support external clinicians embedded in their schools. ▪ Chicago Public Schools (Illinois; PSR grantee) scheduled monthly 2-hour meetings with clinicians to provide time for PD and "team-think." They also began screening partner clinicians for "fit" and scheduled them to limit the number of individuals interacting with school staff at any given school.
☐ Ensure that community partners working in schools understand the school culture, existing support systems, and relevant educational laws and policies.	
☐ Ensure that community partners collaboratively develop and share treatment plans (while also ensuring student privacy), specify how treatment goals can be addressed within the school context, and coordinate their work with that of other school programs and interventions.	
☐ Evaluate the extent to which services offered by potential partners are evidence based for the specific population and concern to be addressed. For example, behavioral and cognitive-behavioral therapies have the strongest evidence base,[12] whereas nonspecific individual counseling may have limited impact, particularly for students with disruptive behaviors.	

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