

Colorado Framework

for School Behavioral Health Services



A Guide to K-12 Student Behavioral Health Supports with a Focus on Prevention, Early Intervention, and Intervention for Students' Social, Emotional, and Behavioral Health Needs



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Executive Summary

A Guide to K-12 Student Behavioral Health Supports with a Focus on Prevention, Early Intervention, and Intervention for Students’ Social, Emotional, and Behavioral Health Needs

Comprehensive School Behavioral Health Systems Defined

K-12 comprehensive school behavioral health systems include district- and school-level educational and local behavioral health professionals working in concert with families to improve prevention, early intervention, and intervention strategies within the school and community to meet students’ social, emotional, and behavioral health needs.

Why School Behavioral Health Systems

Research increasingly points to the link between students’ academic success and social, emotional, and behavioral health. However, schools are generally not measured and evaluated on social, emotional, and behavioral health outcomes for students. As a result, they are often unable to justify and provide the attention, data infrastructure, and funding necessary to embed social, emotional, and behavioral health initiatives into school culture. Additionally, many schools do not have the necessary resources and support to address the misconceptions and lack of understanding about behavioral health, which contributes to its stigma.

The Colorado Opportunity

While multiple barriers persist in regard to implementing comprehensive school behavioral health systems, recent state and federal legislation and various state-wide behavioral health initiatives are now affording Colorado schools more opportunities to improve student behavioral health. With this improvement, the state will be positioned to realize greater academic achievement, enhanced student and staff wellbeing, and improved school climate and culture.



Framework Snapshot

Includes:

- ▶ Best Practices Guide
- ▶ Tools and Resources
- ▶ Implementation Spotlights From Districts and Schools



“Given schools’ unique ability to access large numbers of children, they are most commonly identified as the best place to provide supports to promote the universal mental health of children” (CASEL 2008, p. 1).¹



The Framework

To reduce barriers to learning, schools need comprehensive systems that integrate behavioral health supports into the daily academic life of the school. With this understanding and with support from Rose Community Foundation, the Colorado Legacy Foundation (CLF) created a statewide *Framework* for school behavioral health services. Additionally, CLF identified challenges to and opportunities for improving school behavioral health systems in Colorado. Along with a state-wide gaps and barriers analysis, CLF has investigated the scalability of the Colorado Department of Education’s Building Bridges for Children’s Mental Health. Building Bridges was piloted in Mesa County and integrated two complementary approaches: 1). Positive Behavioral Interventions and Supports (PBIS), “an implementation *Framework* that is designed to enhance academic and social behavior outcomes for all students” (Sugai and Simonsen, 2012, p. 1)² and 2). System of Care (SOC) from the behavioral health system (see definition below). Other research that informed the development of this *Framework* includes: a review of appropriate literature and state policy documents, interviews and focus groups throughout Colorado with district and school personnel and behavioral health and education experts, a scan of national models, and interviews with school district leaders throughout the nation engaging in this work. The development of the *Framework* was guided by a leadership advisory committee comprised of education and behavioral health professionals.

Based on the aforementioned methods, the *Colorado Framework for School Behavioral Health Services* blends a Multi-Tiered System of Supports (MTSS) from the education realm with a System of Care (SOC) more commonly used in the public health arena. Along with state and federal movements toward MTSS, CDE is using a MTSS system, which combines Positive Behavioral Interventions and Supports (PBIS) with Response to Intervention (RTI) so that all students receive a layered continuum of supports.

Definitions

MTSS combines Positive Behavioral Interventions and Supports (PBIS) with Response to Intervention (Rti). MTSS is a whole school, data-driven, prevention-based framework for improving learning outcomes for every student through a layered continuum of evidence-based practices and systems. MTSS includes: shared leadership; a layered continuum of supports; universal screening and progress monitoring; evidence-based instruction, intervention, and assessment practices; data-based problem solving and decision-making; and family, school, and community partnering (Colorado Department of Education 2013).

A System of Care is a “spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated school network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life” (Stroul, et.al, 2010, p. 3).³



Introduction

According to the American Psychological Association, less than half of children with mental health problems get treatment, services, or support.⁴ Yet, research increasingly reveals the connection between social, emotional, and behavioral health and academic achievement.⁵ Because students are much more likely to seek behavioral health support when school-based services are available (Slade, 2002),⁶ schools need comprehensive behavioral health systems to create positive learning environments where all students can flourish.

Historically, school policies and procedures have separated behavior and academics; as a consequence, classroom management has been largely addressed in a superficial manner. Students who have *externalizing* behavioral health problems have traditionally received behavioral health services because they have been referred through a disciplinary approach—for example, an office referral, suspension, or expulsion. Conversely, students with behavioral health issues that are often *internalized* – for example, anxiety and depression – have largely been under-identified. In addition, educators have long noted that the unmet social, emotional, and behavioral health needs of children challenge their capacity to effectively teach their students (Atkins, et al., 2010, p. 2).⁷ However, research reveals that when schools focus on district- and school-wide systemic improvements to prevention and early intervention for student’s social, emotional, and behavioral health needs, both externalizing and internalizing students not only improve their social outcomes, but they also have increased academic outcomes.

What is *externalizing* behavior?

Externalizing behavior is the undercontrol of emotions, which could include difficulties with attention, aggression, and conduct.⁸

What is *internalizing* behavior?

Internalizing behavior is the overcontrol of emotions, which could include withdrawal, anxiety, fearfulness, and depression.⁹ Internalizing behaviors may not be apparent to others and may manifest themselves as frequent worrying, self-denigrating comments, and low self-confidence.¹⁰



“A study estimating the relative influence of 30 different categories of educational, psychological, and social variables on learning revealed that social and emotional variables exerted the most powerful influence on academic performance”

(CASEL, 2003, p. 7).¹¹



Comprehensive School Behavioral Health Systems Overview

The *Colorado Framework for School Behavioral Health Services* melds a System of Care within a Multi-Tiered System of Supports. *The Framework* includes three models of service delivery for students with high behavioral health needs: 1). Co-located services, where a district or school has a school-based health center that includes behavioral health and primary care; 2). A school-based therapist, where a therapist from the community comes to the district or school to deliver group and individual based therapy; and 3). A referral to a community based therapist, where a district or school has a strong relationship with a Community Mental Health Center (CMHC) and has a streamlined referral process with the center to create a seamless service delivery model for children, adolescents, and their families. Given the Colorado context, the service delivery model should be determined based on each community's location, needs, and resources. While the specific model may vary between communities, there are critical foundational elements both within and outside of the school that must be in place to foster and sustain comprehensive school behavioral health systems. In addition, it is the shared responsibilities of a given district, school, and the people they serve to gauge their local needs and ensure they are building the best system for all stakeholders.

The following *Framework* and best practices guide provide the key elements required to implement comprehensive school behavioral health systems in districts and schools across Colorado. As part of a tiered system of supports, school staff must realize that individual students' needs are not fixed at one of the tiered levels; instead, students may move fluidly between tiers—up or down—at any time, depending on circumstances. While the pyramid is fixed, students' needs are not.

It is the shared responsibilities of a given district, school, and the people they serve to gauge their local needs and ensure they are building the best system for all stakeholders.

Definitions

Who are local behavioral health professionals?

Local behavioral health professionals are therapists from the Community Mental Health Center (CMHC), School-Based Health Center (SBHC), or other children- and adolescent-serving behavioral health practice.

Who are school behavioral health professionals?

School behavioral health professionals include school psychologists, school social workers, and school counselors.

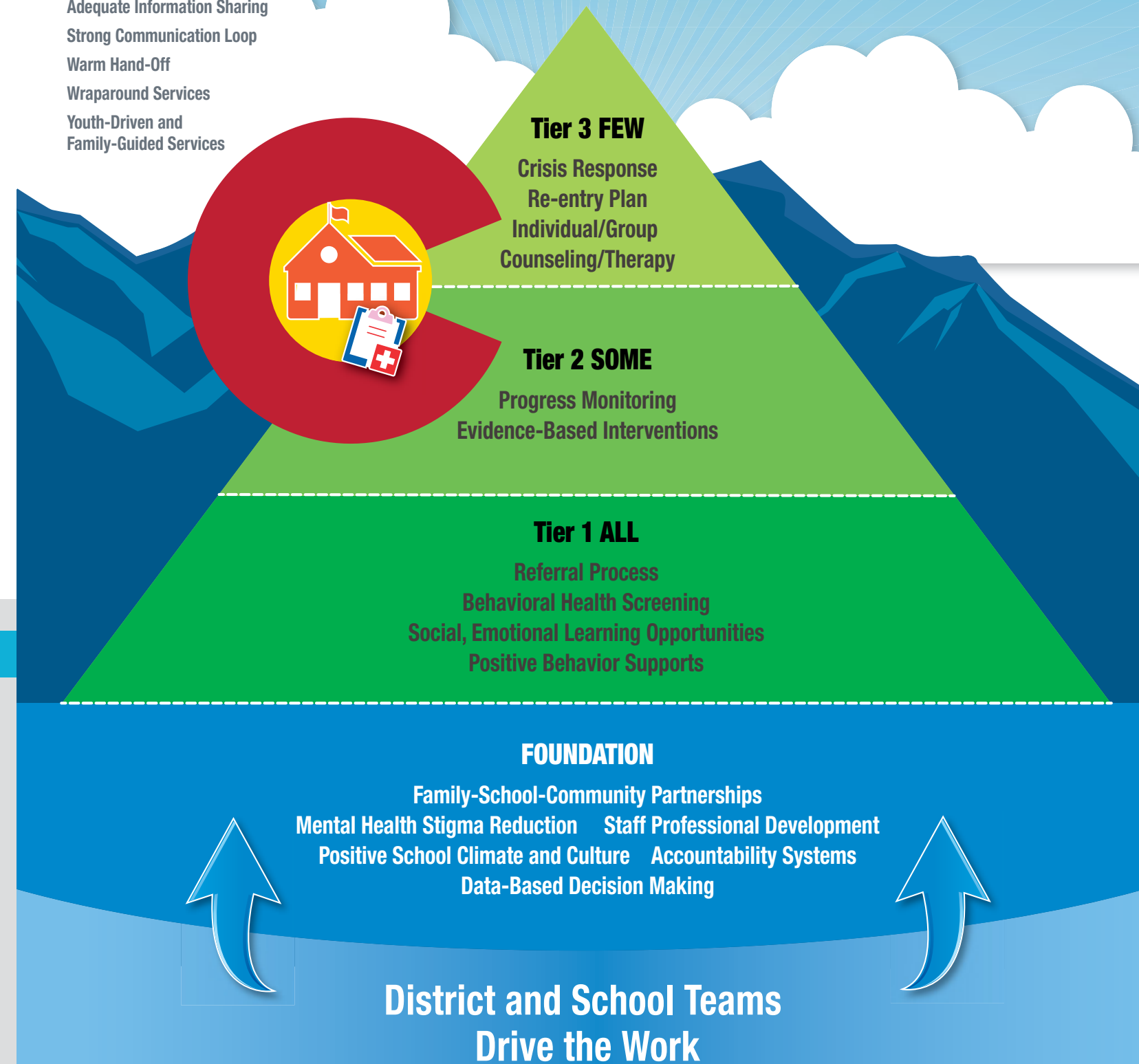
What is student behavioral health?

Student behavioral health includes the social, emotional, and mental health needs as well as the substance abuse behaviors of students. All students require social and emotional skill-building opportunities while some students may have more complex needs as suggested by the three-tiered pyramid in this guide (see p. 9).

School Behavioral Health Services Framework

Linking with Systems of Care

- Adequate Information Sharing
- Strong Communication Loop
- Warm Hand-Off
- Wraparound Services
- Youth-Driven and Family-Guided Services






“The Surgeon General identified the stigma surrounding mental illness as one of the primary reasons that individuals and families don’t seek help.”¹³



Best Practices Guide

for Implementing Comprehensive School Behavioral Health Systems


District and school teams guide the behavioral health work.

District- and school-based teams must be the drivers of the work, and these teams must garner buy-in from administration and school staff. For many districts and schools, the teams could be the pre-existing RtI/PBIS/MTSS, health and wellness, school climate and culture, or leadership team. It is important the teams are comprehensive with representation from various stakeholders, including family representation, to create buy-in. The teams should gauge their local needs to inform next steps and to create sustainable school behavioral health policies. Teams can use the readiness assessment in the  tools and resources section of this *Framework* to do so.


The foundational elements that support the tiered levels of support students receive are critical to the success of prevention, early intervention, and intervention for the positive development of students’ social, emotional, and behavioral health. The foundational elements drive districts’ and schools’ abilities to engage in comprehensive school behavioral health efforts.

Foundation Best Practices

Districts and schools have strong family-school-community partnerships.


The district and school teams engage families, community members, and community organizations to advance student behavioral health and learning. Families are aware of their individual student’s social and emotional development and know how to support behavioral learning at home, and families are included in intervention and counseling efforts. Family-school-community partnerships provide a foundation to leverage resources for students’ behavioral health needs. Research explains that “mental health resides not only within the child but also within the influential web of interactions surrounding the child, including the family, the school, and the neighborhood and community in which the child lives” (Kellam, Ensmiger, & Branch, 1975, from SAMHSA, 2011, p. 5).¹² One of the critical success elements of creating comprehensive systems of care in education is the stakeholder relationship, especially among school leadership, the behavioral health provider, community members, and families. In Colorado, evidence of family and community involvement is required to renew accreditation. Learn about Colorado’s new family-school-community partnership legislation in the  tools and resources section.



District, school, and community leaders ensure pointed efforts to reduce the stigma around mental health.

Over the past decade, state-wide and national campaigns have helped reduce the stigma of mental health; yet, there is still a major need for school systems to address the stigma. “The Surgeon General identified the stigma surrounding mental illness as one of the primary reasons that individuals and families don’t seek help” (U.S. Public Health Service, 1999 from SAMHSA, 2011, p. 8).¹³ Along with staff professional development, the school, community, families, and students should engage in mental health stigma reduction efforts. Students can do this through project-based learning assignments (see the  tools and resources section for examples), and school personnel can work closely with the community to engage in joint efforts to reduce the stigma around mental health by providing Youth Mental Health First Aid Trainings (MHFA) and creating a culture of care. Youth MHFA trainings are discussed on page 19.

Staff professional development opportunities address social, emotional, and behavioral health systems.

Staff must acquire the knowledge, tools, and resources to promote the positive development of students’ social, emotional, and behavioral health. Because social, emotional, and behavioral health interrelate to academic success and school climate and culture, school leaders should schedule staff professional development for behavioral health throughout the entirety of the year. Professional development should include:

- **Working within a comprehensive school behavioral health system:** The staff should be trained on who will refer and how to refer students for services, how to speak with families about their concerns, how to promote mental health stigma reduction and mental health awareness, and how to universally screen and progress monitor students. These elements of a comprehensive school behavioral health system will be discussed further in the guide, and there are tips in the  tools and resources section that address these professional development needs.

- **Creating trauma-sensitive and culturally-responsive schools:** “A trauma-sensitive school is a safe and respectful environment that enables students to build caring relationships with adults and peers, self-regulate their emotions and behaviors, and succeed academically, while supporting their physical health and well-being” (Lesley University and Massachusetts Advocates for Children 2012).¹⁴ Research increasingly reveals that students who have experienced trauma or adverse childhood experiences¹⁵ struggle to regulate emotions, attend to classroom activities, and/or achieve normal developmental milestones (Wisconsin Department of Public Instruction).¹⁶ Culturally responsive classrooms acknowledge the lived experiences of all students in a classroom, including those in poverty, LGBT students, and students who are culturally and linguistically diverse. School leaders must provide opportunities for teachers to learn about creating trauma-sensitive and culturally-responsive classrooms. For tips on how to help teachers create trauma-sensitive and culturally responsive classrooms see  the tools and resources section.
- **Understanding child and adolescent development:** Through the Building Bridges for Children’s Mental Health pilot in Mesa County, school staff developed rubrics to help school and community agency staff as well as families and teachers “talk the same language” and understand social/emotional stages in a student’s development. The rubrics were developed from the national Counseling Standards and cross walked with Colorado’s Emotional Social Wellness Standards. The rubrics are included in the  tools and resources section.



“A trauma-sensitive school is a safe and respectful environment that enables students to build caring relationships with adults and peers, self-regulate their emotions and behaviors, and succeed academically, while supporting their physical health and well-being.”¹⁴

- **Promoting staff self-care:** Many educators and behavioral health practitioners burnout, and as a result, negatively impact students, suffer health consequences, and leave their profession. Now, research is pointing to vicarious trauma and compassion fatigue that can result from burnout. Vicarious trauma and compassion fatigue can lead to changes in one's psychological, physical and spiritual well-being (Headington Institute).¹⁷ Staff self-care is not only part of the coordinated school health model, it is a necessary ingredient to the success of students. School leaders must provide their staff the knowledge, tools, and resources about being self-aware and maintaining one's own care; a healthy staff is necessary to create a positive learning environment for all students. For tips on improving staff self-care see the 🧩 tools and resources section.

District and school leaders prioritize a positive school climate and culture. The interplay of environment and pathology is unquestionable. School climate refers to patterns of people's experiences of school life; it reflects the norms, goals, values, interpersonal relationships, teaching, learning and leadership practices, as well as the organizational structure that comprise school life.¹⁸ School culture is a critical factor in school success. For nearly two decades, a growing body of research has described the link between positive school climate and student absenteeism, suspension, feeling connected and attached to school, student self-esteem, positive self-concept and motivation to learn. A school's culture, in short, either promotes or undermines student learning (CLF, Transforming School Climate Toolkit, 2013). To learn more about improving school climate and culture see: CLF's school climate toolkit at <http://colegacy.org/resource/transforming-school-climate/>.

As part of building a positive school climate, behavioral health professionals, both within and outside of the school, should be embedded into the culture of the school. These professionals should work closely with educators to create a collaborative support system for students. They should also play a meaningful role on the school team tasked with guiding this work. The school behavioral health professionals should have clear roles, which are now clarified as a result of Colorado's Great Teachers and Leaders Act of 2010 (SB 10-191).

It is also critical that school efforts focus on creating trauma-informed and culturally responsive classrooms as discussed on

page 11. There should be district- and school-wide efforts to implement PBIS, Positive Behavior Interventions and Supports. CDE has trained over 900 schools across Colorado in PBIS. For more information about PBIS, visit <http://www.cde.state.co.us/pbis/>.

Social, emotional, and behavioral health efforts are included in accountability systems. Schools focus on current accountability measures regarding academic achievement, which often means that students' social, emotional, and behavioral health do not receive the priority they deserve. Yet, research reveals that behavioral health interrelates to academic outcomes¹⁹ and school climate and culture. Therefore, schools must include comprehensive behavioral health strategies in their school improvement plans to ensure behavioral health initiatives are prioritized and evaluated. But simply including them in a plan will not suffice. School leaders must create a supportive context²⁰ for this work, include social, emotional, and behavioral health in policies, and hold themselves and their staff accountable to effectively implement behavioral health systems.

Schools use data-based decision making to guide their behavioral health efforts. Schools need to begin assessing their behavioral health needs through multiple measures. To do so, The Substance Abuse and Mental Health Services Administration (SAMHSA) suggests that schools:

1. Conduct a comprehensive assessment of mental health problems and concerns in the school and community and the existing policies and resources to meet these needs.
2. Use the public health approach; focus on the larger school population to maximize the program's effectiveness.
3. Use existing data to identify problems, analyze related risk and protective factors in the school and community, and determine the gaps between the current situation and the coalition's vision for a whole-school approach.
4. Share results with the community, proposing recommendations that build on community strengths and resources (SAMHSA, 2011, p. 22).²¹

Once districts and schools have begun implementing behavioral health systems by assessing their local needs, they should create systems to examine the interplay between behavioral health outcomes and school outcomes, such as suspension rates, academic achievement, and discipline referrals.



Tier 1-Universal Supports for ALL STUDENTS

Tier 1 includes the supports that all students should receive within a district and school to build their social and emotional skills.

Positive behavior supports are implemented across the district. Rather than focus on control and punishment, schools should focus on creating positive classroom environments that focus on social, emotional, and behavioral health skill building with clear and consistent expectations.²² As part of PBIS, positive behavior supports for all students is emphasized.

Evidence-based/practice based social, emotional learning opportunities are included across classes and curriculum. Districts and schools should include evidence-based or practice-based social and emotional learning throughout the curriculum, across content, and across grade levels. Research reveals that when schools integrate skills-based social and emotional learning opportunities throughout the school day, across classes, and across grade levels, the impacts are greater than if schools simply set aside twenty minutes a week for social and emotional learning.²³ However, even if full integration of SEL is not feasible, any opportunity for social and emotional learning can be impactful for students. Also, with Colorado's new Emotional and Social Wellness Standards (ESW), which are embedded in the Comprehensive Health and Physical Education Standards, schools now have more guidance about how to implement social and emotional learning across grade levels so that students build the necessary skills, such as resiliency, advocacy, and knowing one's self, to succeed in school, in the community, and in life. Research supports partnering with families to support these skills at home, helping to generalize and expand learning. To learn more about SEL and the Colorado Department of Education's ESW Standards, see the 🧩 tools and resources section.

CLF also promotes practice-based work in schools. These practices are created within a district or school, based on local need and show positive results.

Schools include universal behavioral health screening.

Currently, very few schools in Colorado use formal measures to screen students for behavioral health needs. Instead, too often, students' behavioral health needs are addressed only from a reactionary and punitive approach rather than a preventative one, and internalizing students' needs are overwhelmingly not addressed. Districts and schools must be very thoughtful in their approach to universal screening and ensure that appropriate tiered interventions are in place and that students are not over-pathologized or labeled (Adelman and Taylor, 2010, p. 34-43).²⁴ Read more about how to approach universal screening in the 🧩 tools and resources section and in the spotlight stories on Aurora Public Schools and Boston Public Schools on pages 14 and 15.

Districts and schools have a formal referral process in place.

School leaders must work with all school staff and behavioral health experts outside of the school to create a streamlined referral system for students with Tier 2 and Tier 3 needs. Additionally, schools must ensure they have adequate systems in place so that students who are referred for Tier 2 and 3 interventions have the support they need. All school staff members need training to know how to and who should refer students for more specialized services, and families need to know how to access the referral system and support services. Each school may vary in its referral process, but all schools must include appropriate documentation and ensure student and family confidentiality. For an example of a referral form see the 🧩 tools and resources section.



Universal Screening

When it comes to data sharing and universal screening for school behavioral health systems, Aurora Public Schools (APS) and Boston Public Schools (BPS) have worked tirelessly to create systems change with existing practitioners and resources.



After only 10-15 weeks of intervention, around 50% of students showed significant behavioral improvement based on pre- and post-assessments.



Aurora Public Schools, 2012-2013 School Year

Jessica O'Muireadhaigh, a Board Certified Behavior Analyst and Special Education Consultant of APS, took an idea to the superintendent to conduct a social, emotional learning pilot at APS elementary schools. That idea has taken off and shown positive early outcomes. Jessica recognized a need to scale up prevention, early intervention, and intervention efforts at elementary schools in the district, so she brought on Shannon Kishel, a school psychologist, and Adria Young, a school social worker, to begin helping schools implement the evidence-based social and emotional learning curriculum for all students called *Caring School Communities*. In addition to using a school-wide social and emotional curriculum, they helped teachers use a universal screener to determine the top three externalizing and top three internalizing students. Those students were then screened using the BASC-2, a behavior assessment, in order to identify the elevation status of each of the identified students. Students screened extremely elevated were the focus of the pilot. To improve students' social, emotional, and behavioral health, the Tier 2 evidence-based curriculums they used are *I Can Problem Solve* and *Social Skills Improvement System*. Tier 3 curriculum that was used included *Skill Streaming*. After only 10 to 15 weeks of intervention, around 50% of students showed significant behavioral improvement based on pre- and post-assessments. Hoping to grow their work across APS, staff members involved in the pilot remain reflective about how to improve their practices and translate those across the district. Overall, school staff members have seen initial improvements as a result of the pilot and hope to increase the program to more schools in the future.



Boston Public Schools, 2012-2013 School Year

Massachusetts comprehensive health care legislation has existed since 2006, which has helped bridge the gap between schools and behavioral health service providers. However, while legislation can play an important role in driving district level work, the Student Services Department for Boston Public Schools (BPS) has found another impetus for its behavioral health systems change. According to Andria Amador, Acting Director of Special Education and Student Services, the pressing unmet need for comprehensive behavioral health services in schools drove the creation of its comprehensive behavioral health model (CBHM), called the Lighthouse Model in 2012. Between an executive planning committee and strong partnerships with Boston Children's Hospital and the University of Massachusetts, Boston is finding much success with its model in its 10 pilot schools and plans to expand its work over the next couple of years until all schools throughout BPS have comprehensive behavioral health systems.

After piloting various universal screeners, BPS selected the BIMAS,²⁵ a screener created here in Colorado, to screen every student for both externalizing and internalizing behaviors. Because teachers were highly engaged in the piloting process, there has been instrumental buy-in from the teaching staff to help create the systems change. BPS staff members have found the BIMAS to have very few false positives and false negatives (i.e. the incorrect results of a universal screener), and they have also explained that the screener is user friendly.


Along with deciding to use the BIMAS, BPS had to figure out many logistics, including: acquiring parental consent, figuring out when to do the screening, finding the right space for screening, deciding which grade levels to screen, and providing alternative activities for youth who did not have parental permission for screening. Each school in the pilot made these decisions according to their own needs.

Once students were screened, in the fall and once in the spring, BPS had to ensure supports were in place for students who needed supplemental services. Because the BIMAS has substantial progress monitoring built into its system, which includes an online data collection system, the district has been working on integrating the BIMAS data with other school outcome measures to create transformational school climate and culture change.

Along with the universal screening and the interventions at Tier 2 and Tier 3 levels, all schools in the pilot engaged in 30 minutes of social and emotional learning using the evidence-based Second Step or *Open Circle* programs.



The school psychologists in the district are leading the pilot, and they attend monthly Professional Learning Communities (PLCs) to learn from each other about what is working and what is not at each of the pilot schools. Pre-service school psychologists from local universities are being trained in the CBHM to leverage their practicum hours and to ensure they are prepared to work within a school comprehensive behavioral health system. In addition, monthly principal breakfasts ensure the principals participating in the pilot program are receiving the support they need to implement comprehensive school behavioral health systems. BPS staff are very excited about integrating a comprehensive school behavioral health system into the district, and because of the positive early outcomes, they have the energy to keep moving forward with the pilot.

To learn more about how your district/school can implement universal screening, see the universal screening toolkit in the  tools and resources section.



Tier 2-Secondary or Targeted Interventions for SOME STUDENTS

For too long, students needing early intervention services go unnoticed because they may not exhibit externalizing behaviors. At the same time, those who do externalize a behavioral health issue are often dealt with through a disciplinary and reactionary approach. Truly, without comprehensive behavioral health systems in place that link Systems of Care with Tier 2 students, schools often fail to intervene early. The unfortunate result is that Tier 2 students do not receive the support they need and either continue to go unnoticed or spiral downward. These students experience increasing challenges during youth and adolescent years, and likely, increased challenges in their adult life.

Schools offer evidence-based group and/or individual interventions. School behavioral health professionals and local behavioral health experts should work together with the school and the team guiding the behavioral health work to ensure the interventions they are using are effective. Interventions should (a) be sustained, flexible, positive, collaborative, culturally appropriate, and regularly evaluated; (b) build on the strengths of the students and their families; and (c) address academic as well as social behavioral deficits (Bullock and Gable, 2006).²⁶ It is important to strategically plan for how students will receive interventions throughout the school day.

Progress monitoring is integrated into the school day. Progress monitoring is most effective when it occurs in natural settings throughout the school day and when it includes multiple measures, including those from the home and community. Behavioral health professionals should work closely with the school to share adequate information with educators to ensure students are transferring their behavioral health skills in multiple environments, and they are receiving the interventions they need.



Tier 3-Tertiary or Intensive Interventions for FEW STUDENTS


When Tier 1 and Tier 2 interventions do not meet students' needs, other interventions should be used. Tier 3 interventions should be linked with the System of Care principles discussed further on in the guide.


Schools offer opportunities for individual and group counseling/therapy during the school day.

Students who have tertiary needs will struggle to learn without the proper support in place. Schools need to include opportunities throughout the school day for students to receive the therapy and counseling services they need.

Schools have a re-entry program for students transitioning back from hospitalization or residential treatment.

Districts and schools should have a thorough plan in place that supports students and their families transitioning back to school from hospitalization or residential treatment. Colorado HB 10-1274 highlights that schools should help ensure a successful transition for students back into the public school system after receiving care in day treatment facilities, facility schools, or hospitals. For


an example of a school program for students transitioning back to school from residential or hospital treatment see the  tools and resources section.

Schools have a crisis response plan in place. Schools must establish a crisis response protocol and have a plan in place for events that affect multiple students and that address the need for grieving and coping. Some districts and schools in Colorado have used Psychological First Aid, which is designed to reduce the initial distress caused by traumatic events and help students cope with disaster. In addition to district- and school-wide crisis plans, with the recent passage of Colorado SB 13-266, Colorado is developing a coordinated behavioral health crisis response system as discussed in in the  tools and resources section.



System of Care

A System of Care (SOC) requires multiple agencies working together to improve students' outcomes. SOCs should be youth guided and family driven and promote the SOC concept and philosophy. For information about the SOC Concept and Philosophy, see the  tools and resources section.

Schools ensure adequate information sharing between the behavioral health professional, other youth-serving agencies, families, and necessary school staff. For many districts and schools, the lack of adequate information sharing has kept students from receiving the services they need in school and has made progress monitoring of school's behavioral health efforts difficult. Yet, districts and schools have many options to address this barrier through tiered consent forms from families and children and adolescents about what information should and can be shared with the schools. This consent form is fluid and allows students and families the ability to change how much information they want shared. Plus, with the new State of Colorado Authorization-Consent to Release Information Form, schools can now use a streamlined information sharing form between all agencies. At the same time, district, school, and behavioral health professionals must comply with the Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA). Without adequate information, schools cannot collect and analyze the data that is necessary to track and improve their behavioral health efforts to meet students' needs. For more information on this topic see the  tools and resources section.

Constant and effective communication loops exist between the behavioral health professionals and the team leading the behavioral health work. As part of a comprehensive school behavioral health system, schools need a strong communication loop with the behavioral health professional(s) serving the school and other youth-serving systems. The team guiding this work should ensure constant and effective communication among staff who interact with the students, so the students' needs are met, and students transfer the skills they have gained in their social, emotional, or behavioral health interventions across multiple settings.

Schools ensure opportunities exist for "warm hand-offs" between school staff and behavioral health professionals. A warm hand-off is an empathetic process where an educator, school social worker, school psychologist, school counselor, or school nurse introduces a student to the local behavioral health specialist and helps that student navigate the process of care coordination between

the behavioral health professionals within and outside of the school. Before a warm hand-off is initiated, schools must ensure families have provided consent for services. However, per Colorado statute, youth who are fifteen years or older can consent to their own behavioral health treatment.

Wraparound services are available for students with Tier 3 needs. Wraparound services are individualized, community-based services that bring multiple systems together with the child or adolescent and their families to provide a highly individualized plan to meet the unique needs of the student. A team, consisting of a teacher, other school staff, a service provider, family member, and student, should work closely together to develop an individualized-care plan that includes intervention, culturally and linguistically relevant services, and progress monitoring. Wraparound services are often provided in the community, home, or school setting.²⁷

School leaders ensure youth-guided services and family partnerships for students with Tier 2 and Tier 3 needs. As part of the System of Care principles, youth-guided services and family partnering are integral to the success of student interventions. Family partnering is a critical piece to help families navigate the complex behavioral health system. Family members should help develop local policies and serve on committees in relationship to this work, and families should partner with teachers and school staff throughout the 3 Tiers. In Colorado, there are family navigators throughout the state who help families learn how to better access services. Through the Colorado Department of Human Services Trauma-Informed System of Care, which are county- or area-wide initiatives to build Systems of Care, each selected Community of Excellence throughout Colorado must have a family advocate in place. A family advocate must have experience caring for youth with mental health issues while family navigators do not require this qualification.


School behavioral health services best practices must be youth-guided and should link to one of three models for specialized behavioral health service delivery.



Three Models for Specialized Service Delivery

There are three models that Colorado districts and schools use for specialized services within a comprehensive school behavioral health system. Depending on location, resources, and need, the three models include delivering early intervention and intervention evidence-based services through: 1. co-located services within a school-based health center; 2. a school-based therapist who comes to the school to deliver services; and 3. a community-based therapist who delivers services in a Community Mental Health Center. In the following section, there are best practices and spotlight stories about each model in Colorado. While the three models vary in setting, they have common best practices.

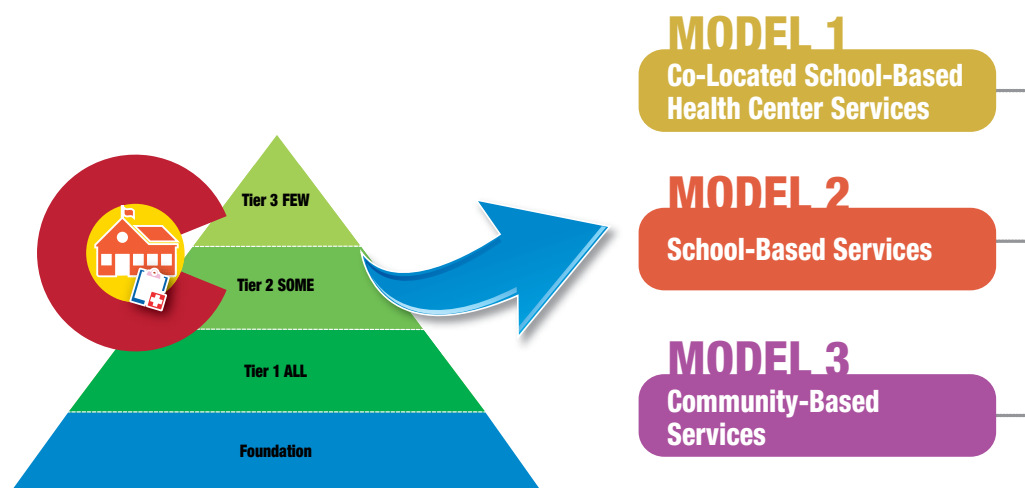
Common Best Practices for Specialized Service Delivery Models

1. A memorandum of understanding (MOU) exists between the CMHC or local behavioral health professional and the district and school.
2. Culturally and linguistically appropriate (CLAS) services are delivered.²⁸ “More than 5.5 million students in U.S. schools are English-language learners (ELLs)...ELLs are expected to comprise more than 40 percent of elementary and secondary school students by 2030” (Thomas & Collier, 2002 from SAMHSA, 2011, p. 8).²⁹ For information on the CLAS Standards, see the  tools and resources section.
3. Local and school behavioral health professionals are integrated into the school culture, and a common language between the school staff and behavioral health professionals exists.
4. Local and school behavioral health professionals have a strong working relationship with clear boundaries and specific role differentiation.
5. School staff, leaders, and local and school behavioral health professionals agree about when to provide student services during the school day based on student need and thoughtful collaboration between educators, families, and behavioral health professionals.
6. School staff and school behavioral health professionals have a clear understanding of how they communicate with and work with local behavioral health professionals.
7. Appropriate physical space is allocated within the school for behavioral health care service delivery. Rooms include adequate space and privacy.
8. Local and school behavioral health professionals help schools implement effective progress monitoring within the school setting.

9. Local and school behavioral health professionals help bridge the gap in communication between the school staff, families, and students.
10. Local and school behavioral health professionals help school staff build capacity to identify and refer students in need of behavioral health services.
11. The district and school leaders and the behavioral health professionals have a common understanding of legal responsibility.
12. A local and school behavioral health professional sit on the school team that leads the behavioral health work for the district and school.
13. Local behavioral health professionals work directly with school staff members to train them in mental health stigma reduction and help them better understand how to identify students who may be struggling by educating them about expected measurable behaviors a child might exhibit at certain stages of development. Various educators, bus drivers, and other school staff in Colorado have found the Mental Health First Aid Youth Curriculum Training to be very helpful.
14. Local and school behavioral health professionals work closely with other youth serving agencies to improve student behavioral health. This is happening throughout many Communities of Excellence, which are county- or area-wide initiatives to build Systems of Care through a Grant from the Colorado Department of Human Services. Current Communities of Excellence are: Adams, Arapahoe, Boulder, Chaffee, Eagle, El Paso, Garfield, Gunnison/Hinsdale, Jefferson, Lake, Larimer, Montezuma/Dolores, Montrose, Pueblo, and Weld counties and the San Luis Valley.
15. Local and school behavioral health professionals ensure that prevention and early intervention are emphasized and, if needed, ensure coordination of existing intervention and service plans, such as RtI, IEP, and 504 plans, with behavioral health interventions.



“More than 5.5 million students in U.S. schools are English-language learners (ELLs)...ELLs are expected to comprise more than 40 percent of elementary and secondary school students by 2030”²⁹



“Youth Mental Health First Aid (MHFA) is a public education program which introduces participants to the unique risk factors and warning signs of mental health problems in adolescents, builds understanding of the importance of early intervention, and most importantly – teaches individuals how to help a youth in crisis or experiencing a mental health or substance use challenge. Mental Health First Aid uses role-playing and simulations to demonstrate how to assess a mental health crisis; select interventions and provide initial help; and connect young people to professional, peer, social, and self-help care” (Mentalhealthfirstaid.org).³⁰ For more information about MHFA in Colorado visit www.mhfacolorado.org.

MODEL 1

Co-Located School-Based Health Center Services Model

A School-Based Health Center “is a health care facility located within or on school grounds. It is staffed by a multi-disciplinary team of medical and behavioral health specialists. . . School-Based Health Centers serve students whose access to care is limited. Services are designed to identify problems early, provide continuity of care, and improve academic participation” (Colorado Association of School Based Health Centers).³¹

There are 54 SBHCs in Colorado, and the need for them continues to grow.

Because students are much more likely to seek services when school-based services are available, SBHCs are ideal for students with behavioral health needs. To learn more about Colorado SBHCs, visit <http://www.casbhc.org/>.



Referral to Co-Located Services

Spotlight on Pueblo City Schools—

As part of the Safe Schools/Healthy Students federal grant, Pueblo City Schools (PCS) created a System of Care by partnering with the CMHC, the police department, justice systems, community organizations, and families.

Through its efforts, PCS bolstered its behavioral health services by placing school-based mental health therapists at four co-located wellness centers, two at middle schools and two at high schools throughout the district. School leaders trained staff, including support staff, to implement Positive Behavioral Interventions and Supports (PBIS) and a bully prevention program with fidelity.

To complement the work in the schools, Pueblo police continues to train officers in de-escalation techniques, and School Resource Officers participated in bully prevention and crisis response trainings. Police trainers have also provided the de-escalation training for district and building administrators, counselors, school psychologists, community advocates, and nurses. There is now trust building between the police and students, resulting in less punitive approaches to discipline for youth.

By blending the System of Care principles with the co-located services in the schools, over 600 students per year received services (approximately 3,000 encounters). Interestingly, the number of youth clients at the same mental health organization's other community-based

outpatient facilities did not decrease, indicating that the services in the school reached a population of youth who were not previously accessing services. Through the PBIS efforts, schools reduced office discipline referrals significantly and therefore increased classroom time for students and reduced administrative time for discipline issues. Not only do Multi-Tiered Systems of Support blended with Systems of Care help students, but also they create cost savings. The system they designed saved the community an estimated \$239,000 because of decreased student Emergency Room visits.

While PCS found much success and learned invaluable lessons, PCS leaders said that data continues to be a barrier because currently, there are not a lot of data collection efforts for behavioral health in schools. However, PCS has attempted to address that gap by generating a data system that ties office referrals, suspension rates, and absences to the behavioral health system data. Another challenge that PCS leaders have noted is the need to tie comprehensive behavioral health practices, not programs, to Unified Improvement Plans (UIPs) and accountability measures. Without a planning and accountability piece, PCS found that schools will not implement comprehensive behavioral health supports to standard.

SBHCs should have fully integrated care—the coordination of services between the primary and behavioral health care provider—where the primary and behavioral health providers should have a formal process for sharing student information.

MODEL 2

School-Based Services Model

A district and school may have a community behavioral health therapist or private behavioral health therapist come to the school to deliver group and/or individual based therapy during the school day.

- The district and school should ensure that, if private therapists are used, they can bill Medicaid.
- There are 17 Community Mental Health Centers (CMHC) across the state in addition to other non-profit CMHCs.
- Less stigma is associated with seeing a behavioral health professional at school.
- When a local behavioral health professional is integrated into the school climate and culture, the stigma of mental health is greatly reduced.



Referral to a School-Based Therapist

Spotlight on Metro Denver –

Community Reach Center and Jewish Family Service

Community Reach Center

Community Reach Center, a CMHC in north metro Denver, operates one of the largest school-based service programs in Colorado by providing therapy and case management services to students and families within Adams County School Districts 1, 12, 14, and 27J. Community Reach Center hires, screens, and trains the school-based therapists. While the therapists practice in schools, Community Reach Center is their employer and collaborates with the schools to create an integrated care approach. At the start of the school year, school-based therapists from Community Reach Center visit the schools to help students and families learn about their services and inform them about resources to meet students' social, emotional, and behavioral health needs.

The school is an ideal environment for providing students services because it is a collaborative environment where students can feel supported by various professionals. Even more noticeable, by having school-based therapists present in schools, the mental health stigma is greatly decreased, as the school-based therapist is there to support the entire school. The school-based therapist can be beneficial for students who may move quickly between Tiers 1, 2, and 3 as well as for some students who may

simply need one session to access the right resources. School-based therapists can also be integrated into the school community by serving as a member of a restorative justice circle at the school, and they can be a beneficial resource for helping students acquire practical skills to improve their behavior.

School-based therapists from Community Reach Center also host family dinners and family game nights at the schools for their consumers because they realize the importance of family and peer support in overcoming behavioral health challenges.

As students' behavioral health needs are on the rise, it is now more important than ever for communities of professionals to work together to create healthy environments where all students feel safe to learn. To meet this need, Community Reach Center plans to offer the Mental Health First Aid Youth Curriculum, a public education program that helps participants better understand how to help adolescents who may be struggling with a mental health challenge or crisis, free of charge to schools in Adams County. Providing the MHFA Youth Curriculum is an effective strategy for supporting the *Colorado Framework for School Behavioral Health Services*.



Jewish Family Service

Jewish Family Service (JFS) has played a leading role in helping to create school environments that support positive academic performance and developmental success by addressing the mental health challenges that often compromise student performance in school. In 1995, JFS's Counseling Center began providing school-based intervention services when a local Denver Public Schools (DPS) middle school asked the agency to address bullying and anger management among a small group of girls. The counseling was so successful that not only did the middle school ask JFS to continue its bully-proofing services for the following school year, but it also asked the agency to provide services for a wider range of students and include consultation with families and staff. Upon learning of JFS's impact, another DPS school also engaged JFS to provide mental health services for their students. Within a few years, the program now known as *KidSuccess* was formalized, and today it operates in 12 Denver Public Schools.

The goal of *KidSuccess* is to provide a safety net for the entire school community by removing barriers to learning and, in turn, giving low-income, underinsured, and/or uninsured students the tools they need to succeed in school and in life. *KidSuccess* services include individual, group, and family counseling; family case management; family psychoeducational presentations; staff consultation and training; psychiatric services and intervention and prevention services as indicated.

Highlights from JFS survey results from the 2012- 2013 school year

- **83% of students** surveyed report that they are much more able to cope with problems.
- **75% of students** surveyed report they have greatly improved their ability to deal with others.
- **100%** of students surveyed report their counselor was very responsive to their personal issues.
- **100%** of parents surveyed report the counselor was very responsive to the needs of their child.
- **75%** of parents surveyed report there was a significant improvement in their child's behavior.
- **100%** of school staff surveyed report very adequate collaboration between the JFS counselor and school personnel.
- **82%** of school staff surveyed report there significant improvement in the desired behaviors of students.

Having therapists placed in schools helps the students they work with feel more connected to school. In addition, school-based therapists can provide teacher consultation through one-on-one support, which has increased various educators' abilities to help students with behavioral health challenges. In the 2012-2013 school year, JFS conducted a mental health intervention at a school to help school staff members learn how to respond to students with behavioral health needs.

Overall, *KidSuccess* Program at JFS provides access to mental health services that would typically be much more costly and difficult for students and families to access. Through *KidSuccess*' collaboration, students and their families have found many positive outcomes.

🔗 See the tools and resources section for an informational one-pager about HIPAA/ FERPA.

MODEL 3

Community-Based Services Model

When districts and schools do not have a SBHC and do not have access to school-based therapists, they may create a strong relationship with a CMHC to ensure there are streamlined referral processes and communication loops with the center to create a seamless service delivery model for children and adolescents.

- District and school leaders should establish a strong relationship with the CMHC.
- District and school leaders should ensure there is a way to embed the community behavioral health professional into the culture of the school.
- Local behavioral health professionals should help school staff build the capacity to identify and refer students with behavioral health challenges.



Referral to a Community-Based Therapist

Spotlight on Mesa County

In 2009, CDE selected Mesa County to pilot Building Bridges for Children's Mental Health—a system that integrated a System of Care within a Positive Behavioral Interventions and Supports (PBIS) model. Building Bridges helped the school district make a much stronger connection to its community partners, particularly the mental health provider, Colorado West (now Mind Springs Health), by emphasizing school-community collaboration to improve behavioral health supports. As a result of Building Bridges, teachers and school staff—including bus drivers—were trained on how to identify and refer students while supporting those students in the classroom through a PBIS model. This allowed students to receive the services they needed as well as the school community—teachers, administrators, counselors, and social workers—the collaboration necessary to provide wraparound services (see wraparound services defined on page 17) to Mesa County students.

According to student services leaders in Mesa County, the first step to create an effective system of supports is to build strong relationships with the community provider and the schools. This involves communicating frequently with the community provider; including the community provider as a member of the school and/or district student services team; and partnering with the community provider to deliver professional development to school staff.

While many districts/schools have expressed that HIPAA and FERPA regulations are difficult to navigate, preventing necessary information sharing between the service provider and school, those involved in the Mesa County project have not found these regulations to be a barrier. In fact, they said, through the Building Bridges project they have found that integrating a member from

the CMHC onto the school student services' team has helped streamline information sharing efforts.

Along with CDE, Mesa County student services professionals created tip sheets for teachers about how to call families whose students were exhibiting behavioral health problems; this helped teachers feel more comfortable with calling families to express their concerns about students' behavioral health. A common referral form and informational one-pagers about various mental health issues were developed, and school staff members were trained on how to refer students to services. The Building Bridges resources are included in the 🔗 tools and resources section of the *Framework*.

The largest project that resulted from the work of Building Bridges is a Social/Emotional Standards rubric outlining the expected measureable behaviors a child might exhibit at certain stages of development. These rubrics help school and community agency staff as well as families and teachers "talk the same language" and understand social/emotional stages in a student's development. The rubrics were developed from the national Counseling Standards and cross walked with the state's Emotional Social Wellness Standards, and the rubrics are included in the 🔗 tools and resources section.

Despite multiple successes, there are barriers that Grand Junction continues to face, and those include: sustaining systems due to lack of funding; ensuring that schools have effectively implemented PBIS/MTSS; and providing the data to show the direct link of the services provided to students' academic growth. While Mesa County continues to address these challenges by being more proactive about implementing PBIS and using data to guide their decisions, Mesa County continues to face some of the aforementioned key systemic barriers for all districts and schools in Colorado working to sustain comprehensive school behavioral health systems.



Spotlight on a Community of Excellence

Chaffee County is one of Colorado's System of Care Communities of Excellence.

Chaffee County has been delivering high fidelity wraparound services for the past six years to provide integrated services. In its approach to school-based therapy, various schools throughout the area partner with West Central Mental Health Center (WCMHC) so that students can receive therapeutic services at the school. The counselors in the schools serve as the link between the teachers and the WCMHC behavioral health therapists to ensure a streamlined referral process. In addition to the therapeutic services offered, WCMHC has conducted various Mental Health First Aid Youth Trainings to help community members better identify and refer children and adolescents who may be in need of behavioral health services. Teachers and bus drivers have attended these trainings, and they have reported that the trainings have been very beneficial.



See definitions **Chaffee County High School**

on page

17 about

Colorado's

Communities of

Excellence and

Youth Mental

Health First Aid.

As part of Chaffee County's Communities of Excellence initiatives, students at a local alternative school took part in many social and emotional skill building opportunities, including youth-guided work, a powerful instrument for change. Teachers and school counselors serve as supporters for the youth to empower students' social and emotional health. Some students formed a youth advisory council to ensure youth voice and support for LGBTQ youth. The youth-led initiative was successful, as other community members helped support students in this effort. Now, students will connect with a member from Southwest Conservation Corps to work collaboratively on the LGBTQ initiative, and a business in Buena Vista will host events and have speakers to support the students' efforts. Another youth-guided project in Chaffee County includes training youth at the alternative high school in restorative justice, a mediation approach that focuses on rehabilitation of offenders through the restoration of relationships with the victims and community. A student leading the restorative justice work at the school facilitated this initiative as a truly peer-guided opportunity and will continue the work with the project in the 2013-2014 school year.

In addition to youth-guided social and emotional efforts, at the beginning of the school year, students at the alternative school take part in intensive social and emotional skill building for half a day for an entire month and again at the beginning of the new semester. Erin Dziura, a former school counselor at the alternative high school and now a counselor at Salida Middle School, would provide students an emotional intelligence assessment, and based on the assessment, students selected two social and emotional goals for the school year. Students showed growth data of 67% in one or more of the target goals. Also, WCMHC conducted Mental Health First Aid Youth training with students over the course of several days. While it was emotionally challenging for many of the students, the students positively evaluated the training, explaining they really liked it and thought it was culturally empowering. To build relationships with students, a therapist from the CMHC conducted a yoga class at the alternative high school every Thursday afternoon, emphasizing life skills for breathing, centering, and finding space for one's self. The yoga class helped students become familiar with the WCMHC therapist, which decreased the stigma associated with seeing a behavioral health professional. Finally, alternative school staff also took part in a trauma-informed training to improve their skill and knowledge base about creating a trauma-informed school.

Salida Middle School

Another key to the work that Chaffee County is currently doing as a Community of Excellence is to build systemic support systems for the appropriate identification of children and adolescents in need of social, emotional, or behavioral health support. Now, school counselors in Chaffee County are working to create systems-level change by examining data to develop specific tiered interventions to intentionally identify students earlier and build a school behavioral health system through a preventative lens. As part of holistic change to school climate and culture, restorative justice will be implemented at Salida Middle School in the 2013-2014 school year with alternative and elementary schools in the area showing interest in developing similar systems.

Buena Vista School District

In addition to partnering with the CMHC, Buena Vista School District has partnered with a private therapist to provide school-based services. When Karla Carroll came to the Buena Vista community in 2011, she quickly learned of the unmet behavioral health needs of many students, so she approached the district about a potential partnership to deliver her services within the school. Because she is a private practitioner, and she can bill Medicaid, the district was very excited to enter into an agreement with her for her therapeutic services.

The district/school leaders recognized the pressing need for students' behavioral health and, specifically, the continued unmet needs of Medicaid and CHP+ students and were very pleased that services would now be accessible for students who traditionally did not access them. Therefore, in September of 2011, Karla began delivering child and adolescent therapy in a counselor's office at an elementary school.

A flier was given to families, so they could learn about Karla's services, and the response to Karla quickly took off as more and more families contacted her about their children's needs. In addition, teachers continue to ask for the flier to speak with a family about a student concern. Realizing the extent of need, Karla has expanded her services across elementary, middle, and high schools in the district. Now, every week, Karla sees approximately 22 children and adolescents, and she has a case load capped between 35 and 40 students.

To help students, Karla met with each of the families to determine which children/adolescents needed to be seen at the school and which ones could be seen during her private practice hours. Working collaboratively with the school staff, times were decided upon for when Karla should see each student. The teachers were just as excited as the administrators and families to have this type of support, and Karla spent a lot of time in teacher and IEP meetings.

While many positive outcomes have been realized, Chaffee County has learned a lot. For one, Karla had to be clear that the liability with regard to the service delivery lies solely with her, not the school district. When students are referred for services in the school, the school is not legally liable for the actual service delivery. Also, there must be strong communication among Karla, families, and teachers to share the right amount of information to positively support students in a school setting; this often entails Karla meeting with families and children/adolescents to discuss how best information can be shared to support the student. Finally, due to a high case load, sometimes Karla must deliver *pro bono* services, and she has performed some threat assessments for which she cannot get reimbursed, which can lead to an overbearing workload and practitioner burnout. This, again, reveals the pressing need for more streamlined partnerships with schools and behavioral health professionals.






Because of the success, principals and administrators have been huge supporters of her work, and teachers are now implementing classroom strategies to create classroom environments that are responsive to students' behavioral health needs. Also, a health teacher at the middle school has invited Karla to the girls' 8th grade health class to speak on mental health issues that may come up at that age. This has been useful for the students, as students like to self-diagnose on the Internet without professional support, often misdiagnosing and self-medicating themselves. Overall, by coming to the health classes, Karla has built a strong rapport with the students.

For other schools/districts looking for a similar partnership with a private practice therapist, Karla suggests they find a therapist with strong child/adolescent experience and one who is highly passionate about working with schools to help students succeed in school, in the community, and in life.

Overall, through the Community of Excellence initiative in Chaffee County, school counselors and other behavioral health professionals hope to build the cultural foundation, knowledge, and language to embed positive school climate and culture and behavioral health practices throughout the county schools.

While many local and national schools are finding success with school behavioral health systems, districts and schools are faced with common gaps.


Based on an analysis from academic literature, state policy documents, and interviews and focus groups with educational and behavioral health professionals in Colorado and across the nation, CLF has recognized the top systemic barriers that provide substantial challenges to implementing comprehensive behavioral health systems. To see the complete gaps and barriers analysis, see the  tools and resources section.

What is needed for success:

- Collaboration and information sharing between agencies and schools for youth, especially youth involved in multiple systems
- The ability to tie student-level and school-level behavioral health data with other student-level and school-level outcome measures
- The acquisition of knowledge and skills for school staff to support the positive development of students' social, emotional, and behavioral health
- A common understanding that schools are not legally or financially liable when they refer students for services
- An increased capacity of—including number, culturally and linguistically appropriate, and quality of—youth- and adolescent-serving behavioral health professionals, especially in rural areas
- Adequate funding and resources to support comprehensive services, especially in rural areas



Linking to Early Childhood

“Beginning in the fall of 2013, local education providers are required to ensure all children in publicly-funded preschool or kindergarten receive an individual school readiness plan” (Colorado Department of Education Office of Early Learning and School Readiness, 2013). To help schools implement school readiness plans, CDE has assembled a School Readiness Assessment Guidance for Kindergarten. As part of Colorado’s Achievement Plan for Kids (CAP4K), local education providers must administer the school readiness assessment to each student in kindergarten. See the  tools and resources section for CDE’s School Readiness Assessment Guidance for Kindergarten.

As leaders in Colorado in the field of early childhood mental health, Sarah Hoover and Lorraine Kubicek with JFK Partners, an interdepartmental program of the departments of Pediatrics and Psychiatry of the University of Colorado School of Medicine, developed an environmental scan of challenges, progress, and recommendations for the social and emotional health of Colorado’s children. A condensed version of the report can be found here: <http://www.rcfdenver.org/reports/EarlyChildhoodMentalHealthinColoradoExecutiveSummary2013.pdf>.

As part of the Early Childhood Colorado Initiative, social, emotional, and mental health are emphasized. The Early Childhood Colorado *Framework* emphasizes: increased availability and use of high quality social, emotional, and mental health training and support; increased number of supportive and nurturing environments that promote children’s healthy social and emotional development; increased number of environments, including early learning settings, providing early identification and mental health consultation; improved knowledge and practice of nurturing behaviors among families and early childhood professionals; increased number of mental health services for children with persistent, serious challenging behaviors; and decreased number of out-of home placements of children.

As early childhood mental health initiatives have stressed relationship building and social and emotional learning, children moving from an early childhood system to kindergarten and first grade may struggle because of the lack of emphasis on relationship building and social and emotional learning in the education system. Therefore, it is important to create a system of social and emotional supports from early childhood through and beyond K-12 education so that students receive a consistent continuum of care to enhance their social and academic outcomes.



Communities will reap many positive outcomes when they integrate comprehensive behavioral health systems change from early childhood through and beyond k-12 education.



Students should not be labeled Tier 1, Tier 2, or Tier 3; many students will move in between tiers in one area while others may move in between the tiers based on another area. Remember, while the pyramid is fixed; students' needs are not.




In Summary

Along with the best practices, districts and schools need a person in-district who can champion creating comprehensive school behavioral health systems and work to integrate local and school behavioral health services into a continuum of care. While planning to implement a comprehensive school behavioral health system, it is important to remember that an individual student can fall anywhere on the three-tiered pyramid depending on individual circumstances. Therefore, students should not be labeled Tier 1, Tier 2, or Tier 3; many students will move in between tiers in one area while others may move in between the tiers based on another area. Remember, while the pyramid is fixed; students' needs are not.

Once districts and schools have worked through the phases of thoughtfully planning and implementing comprehensive behavioral health systems, they should identify how they will sustain the most effective practices they have implemented.

Overall, district and school leaders must prioritize behavioral health efforts for any systemic change to be found.

To help district and school leaders get started, the accompanying  tools and resources section includes a needs assessment along with the tools and resources listed on the following page.

Getting Started

- Identify a champion to lead the school behavioral health work.
- Garner buy-in from various stakeholders, including school- and district-level staff, community agencies, and families.
- Create—or embed in an existing team—a school behavioral health services team.
- Assess your local systems and need (see the needs assessment in the tools and resources to help get you started).
- Create an action plan that includes goals, objectives, methods, and a timeline; identifies responsible people; and pinpoints resources required to implement the plan.
- Begin implementing your plan and continually assess progress toward your goals.



Tools and Resources on the CD

* = CLF-Created Resources

Additional Resources – *Additional Resources Compendium

Building Bridges Resources – Behavioral health facts and classroom tip-sheets for parents and teachers about: Attention Deficit Hyperactivity Disorder, Anxiety Disorder, Bipolar Disorder, Conduct Disorder, Depression, Oppositional Defiant Disorder, Substance Use Disorder, and Post Traumatic Stress Disorder

Flip-chart script for calling parents, Managing Challenging Behaviors for Parents and Teachers tip-sheet, Mandated Reporting for School Professionals tip-sheet, Daily Transition Support in School tip-sheet, Building School Teams tip-sheet, Family-Driven Care informational one-pager, An Introduction to Colorado's Emotional and Social Wellness (ESW) Standards one-pager, National Assembly on School-Based Health Care Assessment Tools for School Mental Health Capacity Building, and Spark Policy Institute's legal memo regarding referrals

***District- and School-Level Needs Assessments**

Family-School-Community Partnerships – See Building Bridges Resource on family-driven care and script for calling parents, “On the Team and At the Table” family partnering toolkit and Colorado's State Advisory Council for Parent Involvement in Education (SACPIE) resource

***Gaps and Barriers Analysis**

Information Sharing and Consent – Information Sharing tip-sheet, State of Colorado Consent to Share Information Form, Colorado Association for School-Based Health Care's Understanding Minor Consent and Confidentiality in Colorado, An Adolescent Provider Toolkit, and West Virginia Sample-Parental Consent form

Mental Health Stigma Reduction – *Mental health stigma reduction tip-sheet for school leaders, school board members, school staff, students, families, and community members

Memorandum of Understanding (MOU) – MOU example between Pueblo City Schools and Spanish Peaks and School-Based Mental Health Services Contract

Programs for Transitioning Back to School from Residential or Hospitalization Treatment – PACE and BRYT example programs

Referral Form – Colorado West school referral form and West Virginia sample referral form

School Readiness for Kindergarten – CDE School Readiness Assessment Guidance

Social and Emotional Learning (SEL) – *SEL guide and Mesa County Social and Emotional Continuum for preK-12th grade

***Staff Self-Care Tip Sheet**

System of Care Concept and Philosophy One-Pager

***The Colorado Context**

***The National Context**

Trauma-Sensitive and Culturally-Responsive Schools – *Tip-sheet for creating trauma-sensitive and culturally-responsive classrooms and Responding to traumatic events tip sheet

***Universal Screening Toolkit**



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