

## Introduction

In this brief, Hanover Research discusses the nature of adolescent anxiety, formal and informal screening mechanisms, mental health service delivery models, and universal supports and targeted interventions to improve student well-being.

## Key Findings

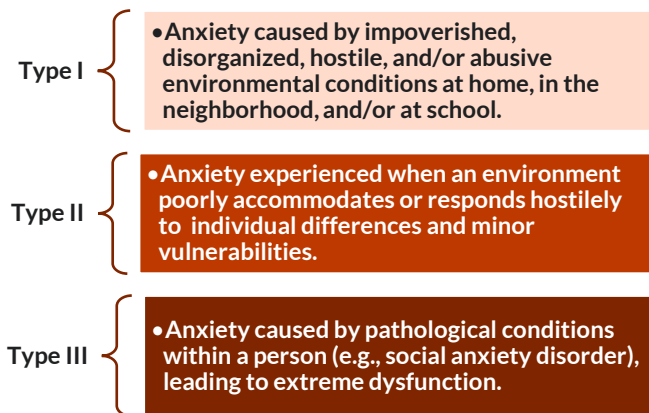
- **School-based screening should provide a complete picture of students' mental health, capturing both social-emotional strengths and symptoms of distress.** Conducting mental health screening on a universal instead of a case-by-case basis also supports schools' efforts to meet all students' needs. School-based mental health screening proves most effective when carefully-designed, well-resourced, and implemented with fidelity. When selecting from the array of available tools for mental health screening, schools should seek valid, reliable, and age-appropriate instruments with sufficient sensitivity to detect problems. After screening students and analyzing the resulting data, schools should respond to students on an appropriate timeline based on level of mental health risk.
- **Teachers also may screen students informally for mental health concerns by observing behavior in the classroom.** To observe students effectively, teachers need to understand how externalizing and internalizing behaviors differ and recognize when such behaviors affect student outcomes (even if classroom instruction continues uninterrupted). Directed toward others and one's surroundings, externalizing behaviors may include verbal and physical aggression, repeated rule-breaking, argumentativeness, sudden outbursts, disorganization, inability to focus, and lack of attention to detail. In contrast, students direct internalizing behaviors inward, making detection by teachers more difficult, though not impossible, since certain aspects of such behaviors may become manifest in the classroom.
- **By serving students in a school setting, school-based mental health (SBMH) programs maintain access to the core curriculum while meeting mental health needs. Meeting the full range of student needs often requires collaboration between schools and external partners.** Partnering with community-based organizations and external mental health providers (EMHPs) may enable schools to enhance or expand service delivery. When creating external partnerships, schools should consider the need for skills and experience beyond current staff competencies. If placing an EMHP in each school proves prohibitively expensive, a less-costly alternative may involve having a team of district-based EMHPs rotate among schools, advising school staff on the formation and management of school-based intervention teams.
- **SBMH programs often use school-level teams to oversee program implementation, as well as review individual student cases.** Depending on the SBMH delivery model used, school-level teams may or may not include EMHPs. School staff participating in school-level teams may include teachers, student support staff, school psychologists, and school administrators, while commonly-involved community partners consist of clinical psychologists, psychiatrists, and social workers. School-level teams may focus on implementing the SBMH program as a whole, addressing a specific aspect of that program (e.g., with separate school-level teams for school climate, mental health awareness, Tier 2 and Tier 3 interventions, etc.), and/or handling individual student cases.
- **Schools commonly rely on social-emotional learning (SEL) programs to promote the mental health of the general student population.** SEL refers to the skills and practical knowledge students need to communicate effectively, interact with peers, resolve conflicts, and manage emotional responses to stressful situations. To supplement SEL programs, schools should adopt strategies to minimize school-related causes of anxiety. Such strategies may focus on fostering students' self-efficacy and sense of autonomy, as well as healthy relationships with peers and school-based adults.
- **Students with anxiety disorders need a multimodal approach to treatment** that incorporates the following types of strategies where appropriate based on individual needs: educating students and parents about anxiety disorders; providing cognitive-behavioral therapy (CBT); offering psychodynamic psychotherapy; providing family therapy; and using pharmacotherapy.
- **Among psychotherapeutic interventions, CBT seems most effective for the treatment of youth anxiety disorders.** CBT may focus on skill development and relationship-building, as well as systematically expose an adolescent to anxiety-inducing situations, a process known as exposure therapy. Research also supports using CBT in school settings. School psychologists may provide small-group or individual treatment to students using CBT, as well as support teachers in implementing universal prevention strategies that align with CBT techniques.

## Understanding Anxiety

Many adolescents feel stressed and anxious. According to a 2018 Pew Research Center survey, 70 percent of 13- to 17-year-olds consider anxiety and depression a major problem among their peers.<sup>1</sup> Feeling some level of stress may seem normal or even healthy. However, for adolescents with an anxiety disorder, the anxiety persists or worsens over time and eventually interferes with daily activities, including schoolwork.<sup>2</sup>

### Types of Anxiety

In order to provide appropriate supports, educators need to understand the different types of anxiety students may experience. The Center for Mental Health in Schools at the University of California at Los Angeles (UCLA) distinguishes anxiety-related concerns based on cause. As illustrated below, Type I concerns primarily reflect environmental or external factors, whereas Type III concerns generally result from internal conditions.<sup>3</sup>



Source: Center for Mental Health in Schools, UCLA<sup>4</sup>

Type III concerns include the following anxiety disorders, as defined by the American Academy of Child & Adolescent Psychiatry. The [National Institute of Mental Health](#) and the [Anxiety and Depression Association of America](#) also provide useful overviews of commonly-diagnosed forms of anxiety. Indicative of the prevalence of anxiety disorders among adolescents, the 2016 National Survey of Children’s Health found that 10.5 percent of 12- to 17-year-olds currently have anxiety problems, as reported by their parents.<sup>5</sup>

Generalized Anxiety Disorder	<ul style="list-style-type: none"> <li>• Chronic, excessive anxiety about multiple aspects of a child’s life (e.g., family, school, social situations, health, natural disasters)</li> </ul>
Panic Disorder	<ul style="list-style-type: none"> <li>• Unexpected, brief episodes of intense anxiety without an apparent trigger, characterized by multiple physical symptoms (e.g., shortness of breath, increased heart rate, sweating)</li> </ul>

Obsessive-Compulsive Disorder	<ul style="list-style-type: none"> <li>• Mental acts or behaviors (“compulsions”) performed repetitively to alleviate anxiety caused by disturbing thoughts, impulses, or images (“obsessions”)</li> </ul>
Post-Traumatic Stress Disorder	<ul style="list-style-type: none"> <li>• Anxiety symptoms (e.g., nightmares, feelings of detachment from others) following exposure to a traumatic event</li> </ul>
Separation Anxiety Disorder	<ul style="list-style-type: none"> <li>• Excessive fear of being separated from a child’s home or caretakers</li> </ul>
Social Anxiety Disorder	<ul style="list-style-type: none"> <li>• Anxiety in social settings or performance situations</li> </ul>
Specific Phobia	<ul style="list-style-type: none"> <li>• Fear of a specific object or situation (e.g., spiders, needles, riding in elevators)</li> </ul>

Source: American Academy of Child & Adolescent Psychiatry<sup>6</sup>

### Sources of Anxiety

Among school-related factors, academic pressures – such as completing homework, taking tests, and preparing for college and a career – may cause the most anxiety among adolescents.<sup>7</sup> For example, 61 percent of 13- to 17-year-olds surveyed by the Pew Research Center feel a lot of pressure to get good grades.<sup>8</sup> Although 33 percent of 4,317 students at 10 high-performing high schools also cited grades as a primary stressor when surveyed as part of a 2013 study examining conditions that “support adolescent academic integrity, engagement, and mental and physical health,” even greater shares mentioned homework (56 percent) and tests (43 percent).<sup>9</sup> In addition to hindering performance on assessments, test anxiety may contribute to declining effort and motivation in school more generally.<sup>10</sup> Given that a 2014 pilot study exploring the social, cognitive, and physical components of test-related stress found that 30.4 percent of 1,133 Grade 11 students across five high schools shared a high-anxiety profile, a considerable number of students may experience such negative effects.<sup>11</sup>

The social climate at school also may make adolescents anxious. While pressure to engage in various extracurricular activities may generate some stress, gaining acceptance from and forming relationships with peers seems a more common source of adolescent social anxiety.<sup>12</sup> Among the 13- to 17-year-olds surveyed by the Pew Research Center, nearly 30 percent feel a lot of pressure to look good (29 percent) or fit in socially (28 percent).<sup>13</sup> Frequent expressions of support from peers and close friends may alleviate social anxiety, However, placing *too much* value on such support may leave adolescents emotionally vulnerable. A 2018 study of 377 high school students, for example, detected the highest levels of social anxiety among adolescents who attached great importance to support from classmates, yet received little.<sup>14</sup> The fact that 55 percent of 13- to 17-year-olds surveyed by the Pew Research Center consider bullying a major problem, implies that negative attention from and behaviors exhibited by peers also contribute to the anxiety many adolescents feel.<sup>15</sup>

Online activity, in general, and social media usage, in particular, may intensify such pressure, given a “substantial degree of overlap” between the perpetrators and victims of

offline and cyber forms of bullying.<sup>16</sup> Social media use also may worsen adolescent anxiety through other mechanisms, such as reduced emotional regulation, decreased social interaction, and increased fear of ostracization.<sup>17</sup> Social media use may even make adolescents more likely to experience anxiety by disrupting sleep patterns and leading to insomnia.<sup>18</sup>

**Beyond social media use, other non-school-related factors contribute to anxiety among adolescents.** Some adolescents may prove genetically predisposed to anxiety, and parenting style also may play a role.<sup>19</sup> Having an adverse childhood experience places adolescents at increased risk of anxiety as well. Childhood maltreatment, for example, may alter the brain’s “fear circuitry,” resulting in “increased internalizing symptoms by late adolescence” (especially among females).<sup>20</sup> Childhood experiences that may cause anxiety and other mental health issues include challenges related to: primary support groups (e.g., divorce, domestic violence, death of a parent); caregiving arrangements (e.g., abuse, neglect, foster care, adoption, parental illness); community influences (e.g., cultural assimilation, social discrimination); educational opportunities (e.g., parental illiteracy, inadequate school facilities); housing; financial security; access to (mental) health care; crime and violence; and natural disasters.<sup>21</sup>

**Even current events beyond an adolescent’s personal experience may cause stress.** Findings from the American Psychological Association’s 2018 Stress in America survey indicate that more than half of 15- to 21-year-olds feel stressed by mass shootings (75 percent), rising suicide rates (62 percent), climate change and global warming (58 percent), separation and deportation of migrant and immigrant families (57 percent), and reports of sexual harassment and assault (53 percent).<sup>22</sup>

## Screening Students

**School-based screening should provide a complete picture of students’ mental health, capturing both social-emotional strengths and symptoms of distress.**<sup>23</sup> Screening that only assesses risks to mental health incompletely measures “students’ functioning, overestimating or underestimating student needs in important areas.”<sup>24</sup> Thus, in addition to identifying students currently in need of interventions or at risk of future mental health problems, screening also should gauge external (e.g., caring relationships) and internal (e.g., problem-solving, self-efficacy, empathy) social-emotional assets.<sup>25</sup>

**Conducting mental health screening on a universal instead of a case-by-case basis similarly supports schools’ efforts to meet all students’ needs.** A universal approach enables schools to become more proactive and incorporate more preventive measures while continuing to focus on supports and symptom reduction for individual students as needed.<sup>26</sup>

Whether a population consists of a single classroom, an entire grade level, or a whole school, universal screening






may uncover mental health issues facing most, if not all, students that educators may succeed in addressing through universal forms of programming.<sup>27</sup> Even where unable to prevent adolescent mental health disorders from materializing, universal screening may improve outcomes by enabling schools to identify affected students earlier and respond with more targeted interventions.<sup>28</sup>

To summarize, school-based mental health screening:<sup>29</sup>

- Determines students’ strengths and weaknesses;
- Identifies students at risk for poor outcomes;
- Identifies students in mental or emotional distress;
- Determines which students require interventions;
- Informs decisions about the services provided;
- Supports student progress-monitoring; and
- Helps assess the efficacy of related programming

## Establishing a Formal Process

**School-based mental health screening processes prove most effective when thoughtfully-designed, well-resourced, and implemented with fidelity.** To establish an effective mental health screening process, schools should follow the six essential action steps outlined below.

 <p><b>Build a Foundation</b></p>	<ul style="list-style-type: none"> <li>-Assemble a team of stakeholders to plan and implement the screening process</li> <li>-Consider how mental health screening fits with other initiatives or goals</li> <li>-Review the current approach for identifying students in need of mental health services</li> <li>-Consider whether current practices over- or under-identify mental health problems</li> <li>-Generate buy-in and support</li> </ul>
 <p><b>Clarify Goals</b></p>	<ul style="list-style-type: none"> <li>-Decide how mental health screening will improve student outcomes at the district, school, and/or grade level(s)</li> </ul>
 <p><b>Identify Resources and Logistics</b></p>	<ul style="list-style-type: none"> <li>-Create a timeline for the process, including the frequency of screenings</li> <li>-Identify necessary staffing and budgetary resources</li> <li>-Define procedures (e.g., confirming consent; collecting data; monitoring student progress)</li> <li>-Understand existing school- and community-based mental health services</li> </ul>
 <p><b>Select an Appropriate Screening Tool</b></p>	<ul style="list-style-type: none"> <li>-Determine which students to screen</li> <li>-Identify reliable, valid screening tools</li> <li>-Investigate the requirements for successful administration (e.g., time; scoring)</li> <li>-Determine whether staff need training</li> <li>-Evaluate suitability for the age, risk factors, etc. of the students being screened</li> </ul>
 <p><b>Establish Consent</b></p>	<ul style="list-style-type: none"> <li>-Deliver a consistent message about the need for and goal of mental health screening</li> <li>-Use multiple methods to share information on screening practices</li> <li>-Decide whether to make consent active or passive</li> </ul>



**Address Data Collection and Progress-Monitoring**

- Determine who will support the screening process and provide training and resources
- Develop data collection and progress-monitoring systems
- Determine how to use scores/indicators to establish level of need
- Determine which interventions to provide

Source: National Center for School Mental Health<sup>30</sup>

## Selecting a Screening Tool

When selecting from the array of available tools for mental health screening, schools should seek valid, reliable, and age-appropriate instruments with sufficient sensitivity to detect problems.<sup>31</sup> Schools also should consider other criteria, such as cultural sensitivity and ability to inform referral paths, as outlined below:

APPROPRIATE	TECHNICALLY ADEQUATE	USEFUL
-Fit to context -Fit to need	-Validity -Reliability -Accuracy	-Generates new and useful data -Supports existing data
FEASIBLE	BENEFICIAL	
-Easily implemented -Has defined referral paths	-Does no harm -Equitable -Culturally responsive	

Source: Wisconsin Department of Public Instruction<sup>32</sup>

The screening tools listed in the [Appendix](#), administered by non-mental health professionals and “validated in a child or adolescent context,” generally require less than 30 minutes to complete.<sup>33</sup> Schools may select from other instruments as well. For example, the National Center for School Mental Health at the University of Maryland maintains a [Screening and Assessment Library](#) with more than 30 free or low-cost screening tools. After registering, schools receive access to the instruments and other related resources.

The aforementioned instruments screen for multiple mental health disorders, including anxiety. However, the following figure notes anxiety-specific screening tools. While a formal diagnosis may require a mental health professional’s opinion, such instruments should assist schools in determining which students may need further evaluation.

SCREENING TOOL	AGE (YEARS)
Revised Children’s Manifest Anxiety Scale <sup>S</sup>	6-19
Depression and Anxiety in Youth Scale <sup>P, T, S</sup>	6-19
Beck Anxiety Inventory for Youth <sup>S</sup>	7-14
Beck Anxiety Inventory <sup>S</sup>	7+
Self-Report for Childhood Anxiety Related Emotional Disorders <sup>P, S</sup>	8+
Multidimensional Anxiety Scale for Children <sup>S</sup>	8-19
Endler Multidimensional Anxiety Scales <sup>S</sup>	12-17

SCREENING TOOL	AGE (YEARS)
Anxiety Disorders in Children: A Test for Parents <sup>P</sup>	12-17
Anxiety Disorders in Adolescents: A Self-Test <sup>S</sup>	12-17
Liebowitz Social Anxiety Scale (Child/Adolescent) <sup>P, S, C</sup>	7+
Social Phobia and Anxiety Inventory for Children <sup>S</sup>	8-14

Source: Center for Mental Health in Schools, UCLA<sup>34</sup>

Note: Subscripts indicate whether a parent (P), teacher (T), student (S), and/or clinician (C) completes an instrument.

In addition to gathering students’ self-reflections, screening tools often ask parents and teachers to share perceptions of students’ mental health. Schools should understand the ways in which the information obtained from each group differs, based on the respondent’s perspective.<sup>35</sup> For example, students may provide information that more reliably identifies concerns related to “disturbed thought processes” and poor social adjustment.<sup>36</sup> In contrast, parents and teachers may more reliably observe hyperactivity, inattentiveness, misconduct, and “external manifestations of internal problems.”<sup>37</sup> The [Appendix](#) outlines various factors for schools to consider when determining how to use the information collected from different respondent group(s). Schools should recall that, instead of observing attitudes and behaviors in an objective sense, screening tools measure respondents’ perceptions.<sup>38</sup> Thus, schools need to place responses in the appropriate context and consider if further evaluation appears warranted.

## Collecting Data

When scheduling mental health screening, either during a particular school year or during a student’s entire academic career, schools should:<sup>39</sup>

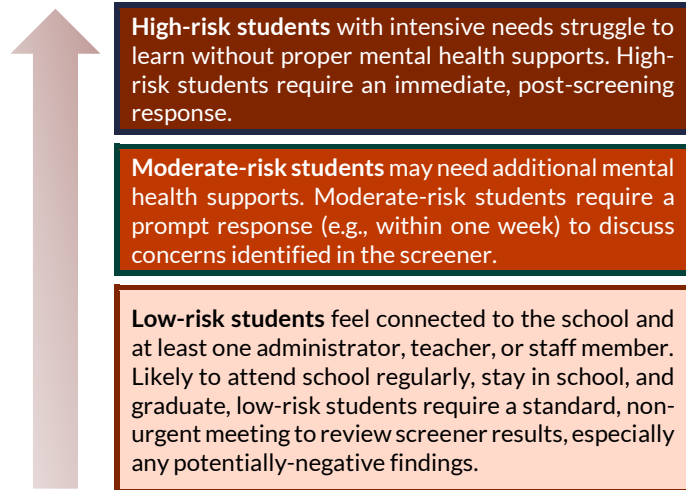
- Recognize the transition from middle to high school as a critical time when clinical symptoms may develop;
- Make screening part of a comprehensive plan to support all students;
- Distribute a screening calendar in advance;
- Provide alternative activities for any non-participants;
- Screen three times per year at a consistent time of day; and
- Administer screening tools, score responses, and interpret results during a normal school day.

Schools screening students three times per school year may choose to collect data on the following schedule to support identification and progress-monitoring efforts:

FIRST SCREENING	Four to six weeks after the school year starts
SECOND SCREENING	Before winter break
THIRD SCREENING	Four to six weeks before the school year ends

Source: Ohio PBIS Network<sup>40</sup>

After screening students and analyzing the resulting data, schools should respond to students on an appropriate timeline based on level of mental health risk. When using scores to determine risk levels, schools should follow any recommendations in the screening tool’s technical guide.<sup>41</sup> A student’s mental health risk level then should inform when and how a school responds with appropriate resources and supports.<sup>42</sup> The figure below illustrates how mental health risk levels relate to the urgency with which a school follows up with a student:



Sources: National Center for School Mental Health; Wisconsin Department of Public Instruction<sup>43</sup>

## Screening Informally in the Classroom

Teachers also may screen students informally for mental health concerns by observing behavior in the classroom.<sup>44</sup> However, to observe students effectively, teachers need to understand the differences between externalizing and internalizing behaviors and recognize when such behaviors affect student outcomes (regardless of whether classroom instruction may continue largely interrupted).

Directed toward other people and one’s surroundings, **externalizing behaviors** may include verbal and physical aggression, repeated rule-breaking, argumentativeness, tantrum-throwing, sudden outbursts, disorganization, inability to focus, and lack of attention to detail.<sup>45</sup> Teachers should monitor students for the types of externalizing behaviors related to specific mental health disorders listed in the following figure.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER
<ul style="list-style-type: none"> <li>✘ Student <b>constantly fidgets</b> (tapping hands or feet, making noises) while sitting and regularly gets out of seat.</li> <li>✘ Student <b>struggles to work on a single task for prolonged periods of time</b> and struggles to maintain statements on topic during class discussions.</li> <li>✘ Student’s materials are disorganized, and student regularly <b>forgets or loses assignments</b>.</li> <li>✘ Student often <b>misses details in assignments</b> and instructions from staff.</li> </ul>
CONDUCT DISORDER

<ul style="list-style-type: none"> <li>✘ Student <b>bullies, threatens, and verbally or physically attacks</b> (e.g., shouting, swearing hitting, kicking, spitting, throwing items,) other students and staff.</li> <li>✘ Student <b>destroys property</b> of other students and staff (e.g., books, pencils, and computers).</li> <li>✘ Student <b>leaves class, avoids going to class, or is truant</b> from school regularly.</li> <li>✘ Student <b>regularly steals</b> items from students and staff.</li> </ul>
OPPOSITIONAL DEFIANT DISORDER
<ul style="list-style-type: none"> <li>✘ Student <b>becomes annoyed easily and verbally attacks</b> (e.g., shouting, swearing, protesting) students and staff when annoyed.</li> <li>✘ Student <b>often argues</b> with teachers, school staff, or any perceived authority figures when demands are placed on him or her.</li> <li>✘ Student <b>refuses to follow any directives</b> from teacher, school staff, or other perceived authority figures.</li> <li>✘ Student <b>regularly attempts to bother other students</b> (e.g., making noises, name calling, poking, throwing pencils or papers) while they’re trying to listen or work in class.</li> </ul>

Source: Marsh<sup>46</sup>

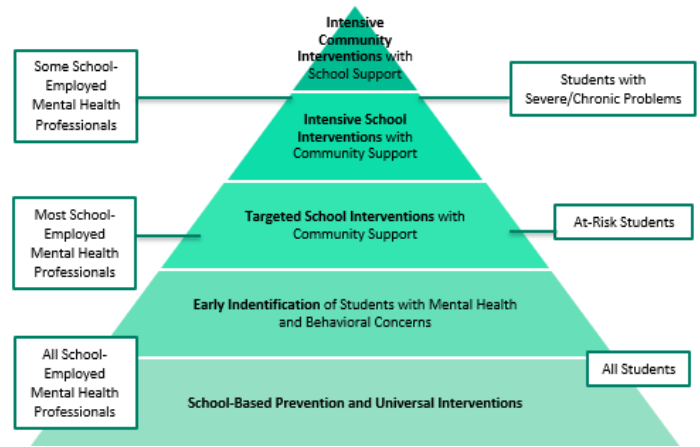
Students direct **internalizing behaviors** inward, making detection by teachers more difficult, though not impossible.<sup>47</sup> While largely internal, certain aspects of such behaviors may become manifest in the classroom. With respect to anxiety-related and mood disorders, the following behaviors or symptoms may alert teachers to students in need of mental health assistance.

ANXIETY-RELATED DISORDERS
<ul style="list-style-type: none"> <li>✘ Student has a <b>dramatic decrease in completion of schoolwork</b> and homework.</li> <li>✘ Student is <b>irritated easily by staff and peers</b>, which may result in yelling or fighting with staff and peers.</li> <li>✘ Student is <b>persistently tired</b> and complains of tiredness or falls asleep in class.</li> <li>✘ Student <b>regularly refers to himself or herself in a negative view</b> (e.g., “I’m a bad kid,” “everyone hates me,” “no one trusts me, I’ll just mess everything up”).</li> </ul>
MOOD DISORDERS
<ul style="list-style-type: none"> <li>✘ Student <b>suddenly quits current school activities</b> which he or she was once heavily involved.</li> <li>✘ Student <b>has trouble completing schoolwork</b> and consistently starts work over or has trouble beginning work.</li> <li>✘ Student <b>displays dramatic weight loss or gain</b> in a short amount of time.</li> <li>✘ Student is <b>persistently tired</b> and complains of tiredness or falls asleep in class.</li> <li>✘ Student <b>has a dramatically diminished ability to copy notes</b>, write during assignments, or complete class assignments.</li> <li>✘ Student <b>displays a sudden change in attitude</b> and becomes excessively talkative and enthusiastic about completing schoolwork for 2–3 school days.</li> <li>✘ Student <b>becomes disorganized</b>, loses schoolwork, and struggles to remain on topic during class discussions.</li> </ul>

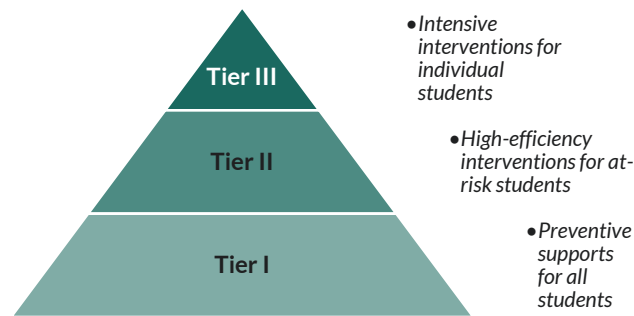
Source: Marsh<sup>48</sup>

## Supporting Students

Schools should provide access to a continuum of mental health services,<sup>49</sup> ranging from mental health promotion among the general student population, to “selective” services for students at-risk of mental health concerns, to “indicated” services for students with Identified mental health needs.<sup>50</sup> Professional associations, including the National Association of School Psychologists, refer to “a school-wide multi-tiered system of supports” (MTSS) as “the most effective way to implement integrated services.”<sup>51</sup> As seen below, to support students’ emotional well-being and detect and address mental health concerns (including anxiety), MTSS offers programs and interventions that escalate in intensity with individual needs.<sup>52</sup>



Source: National Association of School Psychologists<sup>60</sup>



Source: OSEP Technical Assistance Center<sup>53</sup>

## Delivery Models

### School-Based Mental Health Programs

By serving students in the school setting, SBMH programs seek to maintain access to the core curriculum while meeting mental health needs. While specific services may vary across schools, SBMH programs typically combine preventive measures with identification and treatment practices, balancing universal supports with individual interventions.<sup>54</sup> SBMH programs differ based on the extent to which districts rely on school staff (e.g., teachers, guidance counselors, school psychologists) or coordinate with external partners (e.g., mental health professionals, social workers) to deliver mental health supports to students.<sup>55</sup> Yet, as the following figure in the next column illustrates, meeting the full range of student needs usually requires some degree of collaboration between schools and mental health providers in the broader community.<sup>56</sup>

Partnering with community-based organizations and external mental health providers (EMHPs) may enable schools to enhance or expand the services delivered within SBMH programs.<sup>57</sup> In determining the appropriate intensity of any external partnerships, schools may consider the need for skills and experience beyond the competencies of current staff.<sup>58</sup> EMHPs may help staff “quickly identify student issues and immediately triage care based on the severity of circumstances,” for example.<sup>59</sup> However, available financial resources also may shape decision-making regarding EMHPs. Placing one or more EMHPs in each

school may become prohibitively expensive. Thus, an alternative, less-costly arrangement may involve having a team of *district*-based EMHPs that no longer provides “direct service (e.g., assessment and counseling) and direct consultation activity.”<sup>61</sup> Instead, the EMHPs may “rotate from school to school helping relevant on-site staff create and evolve school-based psychosocial consultation teams.”<sup>62</sup> Moving forward, the school-based teams “work together to identify, coordinate, and develop additional resources for meeting the psychosocial needs of students at the school.”<sup>63</sup> The school-based teams may further consult with other staff as needed regarding individual students.<sup>64</sup>

To create successful partnerships with EMHPs, regardless of the specific form such partnerships take, schools should adopt the strategies in the following figure, such as creating a shared vision, mission, goals, and objectives; offering training to school staff and EMHPs; and securing necessary funding.

<b>CREATE A SHARED VISION, MISSION, GOALS, AND OBJECTIVES FOR THE SCHOOL MENTAL HEALTH PROGRAM</b>
--Assess available resources to determine possible service offerings --Develop a mission statement --Determine measurable outcomes
<b>BUILD MUTUAL RESPECT AND TRUST BETWEEN SCHOOL STAFF AND MENTAL HEALTH AGENCY PARTNERS</b>
--Meet regularly to address concerns --Collaborate to refine services --Familiarize families and students with mental health clinicians --Regularly discuss the needs of students and plan interventions --Provide opportunities for school staff to consult mental health specialists
<b>CLEARLY DEFINE THE ROLES AND RESPONSIBILITIES OF SCHOOL STAFF AND MENTAL HEALTH COUNSELORS</b>
--Define the rules of engagement for school mental health counselors and program staff --Collaborate to develop school mental health program infrastructure --Determine the best avenues to introduce mental health providers to school staff, students, and parents
<b>PROVIDE PROFESSIONAL DEVELOPMENT OPPORTUNITIES FOR SCHOOL STAFF AND MENTAL HEALTH COUNSELORS</b>
--Survey each school to determine mental health topics of interest --Determine an appropriate timeframe for professional development --Develop annual plans for professional development courses related to mental health --Attend professional development together

DEVELOP A MEMORANDUM OF AGREEMENT OR CONTRACT TO DEFINE THE SCOPE OF WORK FOR THE SCHOOL AND MENTAL HEALTH AGENCY
--Outline a scope of work and develop a contract --Consent to contractual terms
WORK WITH THE MENTAL HEALTH STATE OVERSIGHT AGENCY TO ESTABLISH FUNDING STREAMS FOR SCHOOL MENTAL HEALTH PROGRAMS
--Invite state-level leaders to be consulting partners --Meet the overseeing state agency to review program construction, discuss program outcomes, and review a plan of sustainability --Develop and manage a data collection system to provide reports to stakeholders and local and state leadership --Identify potential revenue sources (i.e., federal, state, or local) or develop funding mechanisms to sustain the school mental health program

Source: Technical Assistance Partnership for Child and Family Mental Health<sup>65</sup>

**District-level leadership teams may facilitate coordination of mental health services within and across schools and the community.** District leadership teams, composed of school and community representatives, should act “collectively to provide advice to the school system on aspects of the school health program.”<sup>66</sup> Members should meet regularly to develop a common vision, set priorities for school mental health services, and plan, implement, and evaluate related initiatives.<sup>67</sup>

Meanwhile, **school-level leadership teams should oversee delivery of mental health supports at individual sites.** In addition to school staff, a school leadership team may comprise representatives from child-serving government agencies, EMHPs, and students’ families, as described in the figure below.<sup>68</sup> In the case of school staff, school leadership teams should recruit members with responsibilities related to: school governance; curriculum and instruction; discipline and behavior management; support service delivery; and community and family engagement.<sup>69</sup>



Source: Substance Abuse and Mental Health Services Administration<sup>70</sup>

**Schools often create a separate team to examine individual student cases and determine appropriate supports and interventions.**<sup>71</sup> As with SBHM program service offerings and delivery models, however, the structure, staffing, and responsibilities of such school-level teams vary considerably. Even the naming conventions differ: school mental health teams, student support teams, behavioral response teams, behavioral intervention team, etc.<sup>72</sup> Depending on the SBMH delivery model used, these school-level teams may or may not include community partners.<sup>73</sup> Instead of specifying a set membership, the literature recommends staffing school-

level teams “in such a way that expertise or practice areas can quickly be invoked when needed.”<sup>74</sup> That said, the school staff participating in school-level teams frequently include teachers, student support staff, school psychologists, and school administrators, while commonly-involved community partners consist of clinical psychologists, psychiatrists, and social workers (see below).

School Partners	Community Providers
<ul style="list-style-type: none"> <li>• Administrators</li> <li>• Nurses</li> <li>• Psychologists</li> <li>• Guidance counselors</li> <li>• Social workers</li> <li>• Behavioral interventionists</li> <li>• School resource officers</li> <li>• IEP team members</li> <li>• Referring teacher</li> </ul>	<ul style="list-style-type: none"> <li>• Psychiatrists / doctors</li> <li>• Clinical supervisors</li> <li>• Clinical counselors</li> <li>• Clinical psychologists</li> <li>• Social workers</li> <li>• Hospital inpatient / outpatient programs</li> <li>• Case managers</li> <li>• Juvenile probation</li> <li>• Court system</li> </ul>

Source: The National Center on Safe Supportive Learning Environments<sup>75</sup>

With respect to mandate, one or more school-level teams may focus on implementing the SBMH program as whole, addressing a specific aspect of that program (e.g., separate school-level teams for school climate, mental health awareness, Tier 2 and Tier 3 interventions, etc.), and/or handling individual student cases.<sup>76</sup> The National Center for School Mental Health at the University of Maryland outlines a sequence of action steps to follow when establishing school-level teams, as seen in the following figure. Notably, the guidelines recommend addressing team roles, using student data, and coordinating with community partners.

ACTION STEP	IMPLEMENTATION STRATEGIES
<b>Establish appropriate teaming structures and membership</b>	<ul style="list-style-type: none"> <li>• Map existing school mental health teams</li> <li>• Document the purpose, targeted outcomes of each team</li> <li>• Streamline teams</li> <li>• Clarify team members’ roles, responsibilities</li> </ul>
<b>Implement efficient and productive meeting practices</b>	<ul style="list-style-type: none"> <li>• Appoint a school mental health team leader</li> <li>• Scheduled a regular time, frequency for meetings</li> <li>• Utilize best practices for team meetings</li> <li>• Use exemplar teams to inform teaming quality improvement strategies</li> </ul>
<b>Use and share data</b>	<ul style="list-style-type: none"> <li>• Identify data collection sources and processes to track and review progress</li> <li>• Identify, address potential barriers to data sharing</li> </ul>
<b>Maintain working relationships with community providers</b>	<ul style="list-style-type: none"> <li>• Ensure the school mental health team membership includes community partners (school- and community-based)</li> <li>• Seek, establish, and maintain positive working relationships with community organizations and resources that match the mental health and wellness needs of the students, their families and the broader school community</li> <li>• Determine policies and procedures to refer, connect, and coordinate services and supports with providers for students whose needs cannot be fully met in school</li> </ul>

Source: National Center for School Mental Health<sup>77</sup>

## Community-Based Mental Health Programs

Schools may recommend a non-school placement for students unable to remain in a mainstream classroom due to severe mental health needs.<sup>78</sup> The policy statement on SBMH services issued by the American Academy of Pediatrics Committee on School Health cites “[s]evere conduct disorders, psychoses, and severe emotional problems” as “examples of mental health disorders that often impede [a] student’s ability to be educated in a general education program.”<sup>79</sup>

Common non-school placement options for students with severe mental health needs may include therapeutic day treatment (TDT) programs and residential treatment centers (RTCs). Off-site TDT programs may provide more intensive mental health services in self-contained settings separate from a student’s zoned school. Off-site TDT programs may combine academic instruction by licensed teachers with mental health treatment, therapy, and behavioral skills training from mental health professionals. Off-site TDT programs strive to return students to a SBMH program as soon as appropriate.<sup>80</sup> RTCs, meanwhile, may offer a placement option for students “with significant psychiatric, psychological, behavioral, or substance abuse problems who have been unsuccessful in outpatient treatment... but who do not yet merit commitment to a psychiatric hospital or secure correctional facility.”<sup>81</sup>

Effective RTCs encompass:<sup>82</sup>

- A comprehensive evaluation to assess emotional, behavioral, medical, educational, and social needs and support these needs safely.
- An individualized treatment plan that puts into place interventions that help the child or adolescent attain these goals.
- Individual and group therapy.
- Psychiatric care coordinated by a child and adolescent psychiatrist or psychiatric prescriber.
- Involvement of the child’s family or support system (e.g., encouraging and providing opportunities for family therapy and contact through on-site visits, home passes, telephone calls and other modes of communication).
- Nonviolent and predictable ways to help youth with emotional and behavioral issues (i.e., no use of physical punishment, manipulation, or intimidation).

According to the Office of Juvenile Justice and Delinquency Prevention (OJJDP), alternatives to RTCs “give such youths the benefit of remaining in their communities with greater access to needed resources (i.e., necessary treatments and medical services) without endangering the community and at much less expense than secure residential placement.”<sup>83</sup> In that context, the OJJDP recognizes a number of alternatives to residential placement, including:<sup>84</sup>

- Home confinement or house arrest;

- Day or evening reporting centers;
- Shelter care;
- Specialized foster care;
- Intensive supervision programs; and
- Wraparound case management.

## Supports and Interventions

### Universal Supports

Schools commonly rely on social-emotional learning (SEL) programs to promote the mental health of the general student population. SEL refers to the skills and practical knowledge students need to communicate effectively, interact with peers, resolve conflicts, and manage emotional responses to stressful situations.<sup>85</sup> The Collaborative for Academic, Social, and Emotional Learning (CASEL) defines SEL as:<sup>86</sup>

*...the process through which children and adults acquire and effectively apply the knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions.*

CASEL’s comprehensive framework for defining and implementing SEL consists of five core competencies, as seen in the [Appendix](#). Self-awareness and self-management skills help students recognize and regulate their emotional reactions and behavior. Social awareness and relationship skills strengthen students’ ability to assess others’ emotions and respond appropriately. Responsible decision-making skills enable students to judge their and others’ emotions and actions and work collaboratively to solve problems.<sup>87</sup>

Universal SEL programs may reduce unhealthy forms of anxiety, in particular. A 2017 meta-analysis examined 82 universal SEL programs serving students in Grades K-12.<sup>88</sup> The study found significant benefits in students’ self-reported levels of emotional distress in follow-up studies conducted at least six months after the programming’s implementation.<sup>89</sup> The study’s measure of emotional distress encompassed “internalizing difficulties, such as depression, anxiety, and stress.”<sup>90</sup>

The Center for Mental Health in Schools at UCLA advises schools to supplement SEL programs with strategies to minimize school-related causes of anxiety. Such strategies may focus on fostering students’ self-efficacy and sense of autonomy, as well as healthy relationships with peers and school-based adults.<sup>91</sup> To reduce cyberbullying, for example schools may:<sup>92</sup>

- Enact clear anti-bullying policies;
- Educate students, teachers, and parents about cyberbullying;



- Designate students to lead discussions of cyberbullying; and
- Provide small-group counseling to address issues such as victimization or perpetration of cyberbullying, self-esteem, social skills, conflict resolution, empathy, resilience, assertiveness, and stress management.

### Targeted Interventions

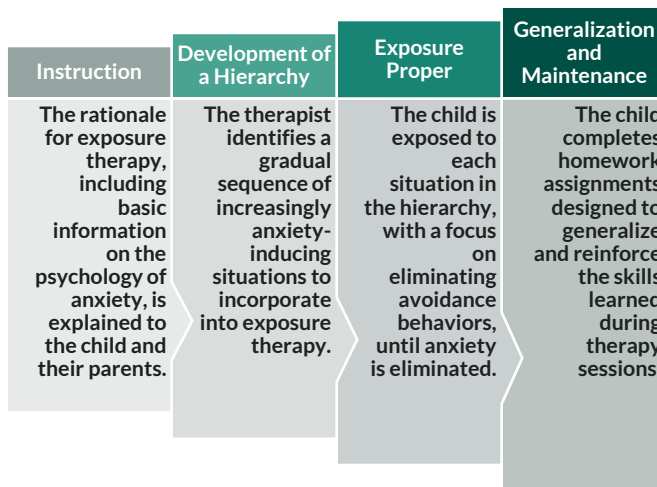
According to the American Academy of Child & Adolescent Psychiatry, **mental health professionals should use a multimodal approach to support students with anxiety disorders**, incorporating the following strategies where appropriate based on individual needs.<sup>93</sup>

- Educating students and parents about anxiety disorders
- Consulting with school personnel and primary care physicians
- Offering cognitive-behavioral interventions
- Providing psychodynamic psychotherapy
- Offering family therapy
- Using pharmacotherapy

Source: Connolly and Bernstein<sup>94</sup>

**The multimodal approach includes cognitive-behavioral therapy (CBT).** Among all psychotherapeutic interventions, “exposure-based CBT has received the most empirical support for the treatment of anxiety disorders in youths.”<sup>95</sup> A 2011 review of more than 40 empirical studies concluded that approximately two-thirds of youths receiving CBT for an anxiety disorder or anxiety symptoms “can expect to be free of their primary diagnosis with a course of treatment that

usually lasts between 12 and 16 weeks.”<sup>96</sup> In addition to focusing on skill development and building rapport with the therapist, CBT may systematically expose an adolescent to anxiety-inducing situations, a process known as exposure therapy (as illustrated below).<sup>97</sup> Research also supports using CBT in school settings. School psychologists may provide small-group or individual treatment to students with anxiety disorders using CBT, as well as support teachers in implementing universal prevention strategies that align with CBT techniques.<sup>98</sup>



Source: Seligman and Ollendick<sup>99</sup>

The American Academy of Child & Adolescent Psychiatry does not address school-based interventions for anxiety beyond noting that educators may include classroom accommodations into Individualized Education Programs and Section 504 Plans.<sup>100</sup> However, the [Appendix](#) lists various school-based interventions identified as effective for anxiety in research studies.<sup>101</sup> Such interventions address general (i.e., generalized anxiety disorder) and specific (e.g., post-traumatic stress disorder) forms of anxiety.

## Appendix

### Universal Screening Tools

MEASURE	AGE (YEARS)	RESPONDENT(S)	DESCRIPTION
<b>Achenbach System of Empirically Based Assessment</b>	1.5-18	Parent/carer, teacher, student	Covers the following domains: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behavior, and aggressive behavior. Also summed into internalizing and externalizing subscales
<b>Beck Youth Inventories (BYI)</b>	7-18	Student	Five child self-report inventories: depression inventory, anxiety inventory, anger inventory, disruptive behavior inventory, and self-concept inventory
<b>Behavior Assessment System for Children (BASC)</b>	2-21	Parent, teacher, student	Covers the following: hyperactivity, aggression, conduct problems, anxiety, depression, somatization, attention problems, learning problems, withdrawal, atypicality, adaptability, leadership, social skills, and study skills
<b>Behavioral and Emotional Rating Scale (BERS)</b>	5-18	Parent, teacher, student	Six factors: interpersonal strength, family involvement, intrapersonal strength, school functioning, effective strength, and career strength
<b>Child Symptoms Inventories (CSI)</b>	3-18	Parent/carer, teacher, student	Covers a range of disorders such as ADHD, Oppositional Defiant Disorder, Conduct Disorder, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Specific Phobia, Major Depressive Disorder and more.
<b>Child Health Questionnaire (CHQ)</b>	10 and older	Parent/carer, student	12 concepts (10 scales and 2 items), including physical functioning, bodily pain, general health perceptions, self-esteem, mental health, and behavior
<b>Kidscreen</b>	8-18	Primarily student, with proxy measure for parent/carer	Addresses physical well-being, psychological well-being, autonomy, moods and emotions, self-perception, parent relations and home life, peers and social support, school environment, social acceptance, and financial resources.
<b>Pediatric Symptom Checklist</b>	6-16	Parent/carer, student	Identifies psychosocial problems (both behavioral and emotional)
<b>Strengths and Difficulties Questionnaire</b>	4-17	Parent/carer, teacher, student	5 sub-scales: conduct symptoms, emotional symptoms, peer relationships, prosocial behavior, and hyperactivity.
<b>Youth Outcome Questionnaire</b>	4-18	Parent/carer, student	Cover 6 areas: intrapersonal distress, somatic, interpersonal relations, critical items, social problems, and behavioral dysfunction

Source: Deighton et al.<sup>102</sup>

### Considerations for Mental Health Screening Tools by Respondent Group

	STUDENT	PARENT	TEACHER
<b>Primary Benefit of Informant</b>	Possible to receive insight into personal information not visible to outsiders (e.g., thoughts, perceptions, feelings)	Observe children over whole life, have most knowledge of development and any past concerns	Observations in academic settings, particularly valuable for determining impact on learning or classroom behavior
<b>Setting of Knowledge</b>	All situations can be examined	Multiple situations (home, social life, homework time)	School-based settings (e.g., classroom, recess, lunch)
<b>Most Likely to Accurately Identify Potential Concerns</b>	Delinquent behaviors, disturbed thought processes, and issues with social adjustment	Externalizing behaviors (e.g., conduct problems) or external manifestations of internal problems (e.g., depressive symptoms)	Hyperactivity, inattentiveness, academic problems, conduct behaviors, and other school adjustment concerns
<b>Least Likely to Accurately Identify Potential Concerns</b>	Least likely to be accurate for inattentiveness or hyperactivity; tendency to underreport disruptive or externalizing behaviors	Not likely to be as accurate for internalizing behaviors and may underreport these symptoms due to lack of awareness	Less useful than other informant types for internalizing symptoms
<b>Reliability</b>	Some evidence suggests that self-reports are more likely to lead to extreme levels or socially desirable answers; a “jokester” effect may exist as well	Parents are still considered critical informants, despite evidence that parent reports may add little variance for behavioral problems above ratings reported by teachers	Evidence suggests that teacher input is reliable and valid for universal screeners and are more reliable than parents at all age levels

Source: Ohio PBIS Network<sup>103</sup>

### CASEL’s Core SEL Competencies

COMPETENCY	DESCRIPTION	ASSOCIATED SKILLS	
<b>SELF-AWARENESS</b>	Accurately recognizing one’s own emotions, values, strengths, and limits and how they influence behavior.	<ul style="list-style-type: none"> <li>Identifying emotions</li> <li>Accurate self-perception</li> <li>Recognizing strengths</li> </ul>	<ul style="list-style-type: none"> <li>Self-confidence</li> <li>Self-efficacy</li> </ul>
<b>SELF-MANAGEMENT</b>	Regulating one’s emotions, thoughts, and behaviors in different situations.	<ul style="list-style-type: none"> <li>Impulse control</li> <li>Stress management</li> <li>Self-discipline</li> </ul>	<ul style="list-style-type: none"> <li>Self-motivation</li> <li>Goal-setting</li> <li>Organizational skills</li> </ul>
<b>SOCIAL AWARENESS</b>	Empathizing with others and understanding behavioral norms.	<ul style="list-style-type: none"> <li>Perspective-taking</li> <li>Empathy</li> </ul>	<ul style="list-style-type: none"> <li>Appreciating diversity</li> <li>Respect for others</li> </ul>
<b>RELATIONSHIP SKILLS</b>	Communicating clearly, cooperating with others, negotiating conflict, and seeking and offering help if needed.	<ul style="list-style-type: none"> <li>Communication</li> <li>Social engagement</li> </ul>	<ul style="list-style-type: none"> <li>Relationship-building</li> <li>Teamwork</li> </ul>
<b>RESPONSIBLE DECISION-MAKING</b>	Making constructive choices about personal behavior and social interactions and evaluating the consequences of actions.	<ul style="list-style-type: none"> <li>Identifying problems</li> <li>Analyzing situations</li> <li>Solving problems</li> </ul>	<ul style="list-style-type: none"> <li>Evaluating</li> <li>Reflecting</li> <li>Ethical responsibility</li> </ul>

Source: CASEL<sup>104</sup>

### Effective School-Based Interventions for Anxiety

TREATMENT	FORMAT	TREATMENT COMPONENTS	OVERVIEW OF EFFECTIVENESS IN SCHOOLS
Cool Kids	Group	Psychoeducation, cognitive restructuring, graduated exposure, coping with bullying, social skills, assertiveness	Significantly greater decreases in self- and teacher- reported anxiety when compared to waitlist control
Baltimore Child Anxiety Treatment Study in the Schools (BCATSS)	Group and Individual	Psychoeducation, cognitive restructuring, graduated exposure, self-reward, contingency management, relaxation skills, problem-solving, relapse prevention	Significantly greater decreases in self- and clinician-rated anxiety compared to attention- support control in one small study. Another small study found no difference compared to usual care.
Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)	Group	Psychoeducation, cognitive restructuring, graduated exposure, processing of traumatic memories, relaxation skills, social problem-solving skills, adaptive coping skills	Two studies found significantly greater reductions in PTSD symptoms compared to a waitlist control. One study found significantly greater reductions in depressive symptoms compared to a waitlist control.
Support for Students Exposed to Trauma (SSET; an adaptation of CBITS)	Group	Psychoeducation, cognitive restructuring, graduated exposure, processing traumatic memories, relaxation skills, adaptive coping, problem-solving	Small improvements found in PTSD and depressive symptoms at 3- month follow-up in one study.
Skills for Academic and Social Success (SASS)	Group	Psychoeducation, cognitive restructuring, graduated exposure, social skills, peer generalization (through social events)	Significantly greater number of students were classified as responders to treatment compared to waitlist and attention control.

Source: Herzig-Anderson et al.<sup>105</sup>

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