Interim Report to the Legislature:
The Behavioral Health and Public Schools Task Force

Chapter 321 of the Acts of 2008, Section 19
December 2009
December 31, 2009

Dear Members of the General Court:

I am pleased to submit this Interim Report to the Legislature regarding the Task Force on Behavioral Health and the Public Schools pursuant to Section 19 of Chapter 321 of the Acts of 2008 (the Act), subsection (a) that reads in part:

“There shall be a task force on behavioral health and public schools…to build a framework to promote collaborative services and supportive school environments for children, to develop and pilot an assessment tool based on the framework to measure schools’ capacity to address children’s behavioral health needs, to make recommendations for using the tool to carry out a statewide assessment of schools’ capacity, and to make recommendations for improving the capacity of schools to implement the framework…”

As chair of the Task Force on Behavioral Health and the Public Schools (Task Force), I first convened members on December 18, 2008. Since then, the Task Force has focused on building a framework to increase the capacity of schools to collaborate with behavioral health providers as well as provide supportive school environments that improve educational outcomes for children with behavioral health needs. The framework addresses areas such as leadership; professional development for school personnel and behavioral health providers; clinically, linguistically, and culturally appropriate behavioral health services; as well as policies and protocols for referrals. In addition to the framework, the Task Force created an assessment tool to measure, first on a pilot basis, schools’ capacities in these areas. Work conducted by the pilot sites provided the Task Force with useful information regarding efforts undertaken by a diverse group of schools to address students’ behavioral health needs.

As required by the Act in subsection (f), this interim report is being submitted to the Governor, the Child Advocate, and to the General Court by filing the report with the Clerks of the Senate and the House of Representatives; the Joint Committee on Mental Health and Substance Abuse; the Joint Committee on Children, Families, and Persons with Disabilities; and the Joint Committee on Education, on or before December 31, 2009. As guided by the Act, this interim report describes the framework, explains the assessment tool and the results of its pilot use, and proposes methods of using the tool to assess statewide capacity of schools to promote collaborative services and supportive school environments.

Associate Commissioner John L.G. Bynoe III and Task Force members are available to answer questions pertaining to details of the interim report.

Sincerely,

Mitchell D. Chester, Ed.D.
Commissioner of Elementary and Secondary Education
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NOTE: This report is now also available on the Department’s website at
http://www.doe.mass.edu/research/reports/1209behavioralhealth.doc
1. Introduction

Section 19 of Chapter 321 of the Acts of 2008, an Act Relative to Children’s Mental Health (the Act), required the creation of a Task Force on Behavioral Health and Public Schools (Task Force). This Task Force is chaired by Commissioner Mitchell Chester of the Department of Elementary and Secondary Education (Department), and includes professionals representing a variety of state agencies and organizations, as outlined in the legislation (see Appendix A for a complete list of Task Force members and participating guests).

Between December 2008 and December 2009, the Task Force met nine times (see Appendix E for a brief summary and timeline). As directed by the Act, the Task Force was charged with:

- building a framework to promote collaborative services and supportive school environments for children,
- developing and piloting an assessment tool based on the framework to measure schools’ capacity to address children’s behavioral health needs,
- making recommendations for using the tool to carry out a statewide assessment of schools’ capacity, and
- making final recommendations for improving the capacity of schools to implement the framework.

The Task Force was also required to submit this interim report to the governor, the child advocate, and to the general court by December 31, 2009. Per the legislation, the interim report includes a description of: 1) the framework, 2) an explanation of the assessment tool and the results of its pilot use, and 3) a proposal for methods of using the tool to assess statewide capacity of schools to promote collaborative services and supportive school environments. This report also includes the versions of the framework and assessment tool (Appendices C and D, respectively) that were piloted this fall (2009) through the process described in section 4 below.

The Task Force will continue to meet in 2010 to complete the remaining requirements articulated in Section 19 of Chapter 321 of the Acts of 2008. These requirements are due by June 30, 2011 and include submitting a final report that details the findings of the statewide assessment, and that recommends a plan for statewide utilization of the framework.

2. Framework Description

During 2009, the Task Force drafted a pilot framework on behavioral health and public schools, which will be revised and finalized in 2010 based on the results of the pilot process. The framework reflects the intent of the Act and the Task Force to enhance school success for all students by creating a statewide infrastructure to improve behavioral health in public schools. The Task Force
designed the organizational structure of the framework to encourage schools to tailor local solutions to address the needs of their communities.

This framework is based on a three part design, with each part supporting the others. These three parts are: 1) **supportive school environments** that promote the behavioral health of all students through whole-school supportive environments, 2) **early interventions** that provide collaborative approaches to identify and address symptoms of behavioral health issues early, and 3) **intensive services** that coordinate intensive interventions for students with significant needs.

This three part design is woven through each of the six main sections of the framework (that are based on the areas outlined in the Act). The six framework sections are as follows.

I) **Leadership** by school and district administrators to create supportive school environments and promote collaborative services in the interest of students' behavioral health.

II) **Professional development** for school administrators, educators, and behavioral health providers on topic areas needed to enhance schools’ capacity to improve students’ behavioral health.

III) **Access to resources and services** through the identification, coordination, and creation of school and community behavioral health services that improve the school-wide environment. The framework recognizes the need for resources that are clinically, linguistically and culturally appropriate for students and their families.

IV) **Academic and non-academic approaches** that enable all children to learn, including those with behavioral health needs, and that promote success in school.

V) **Policies and protocols** that provide a foundation for schools to implement and support work that promotes behavioral health.

VI) **Collaboration with families** in order to increase schools’ capacity to improve students’ behavioral health.

It is important to note that section VI of the pilot framework – collaboration with families – was not mandated as a framework section in the Act. This section was added by Task Force members to highlight and focus on the importance of school-family partnerships for addressing the needs of students with behavioral health concerns.

The only framework section required by the Act that was not included in the piloted version is the section on policies and protocols for a truancy prevention program certification. Research on the best practice in truancy prevention programs is underway, and the Task Force anticipates that a complete set of policies and protocols will be developed and piloted with schools in the spring of 2010. The implementation of the voluntary truancy prevention program certification process is expected to begin in school year 2010-11.
3. Assessment Tool Description

The Task Force drafted a pilot assessment tool on behavioral health and public schools, based on the six framework sections described above. Based on the results of the pilot process, this tool will be revised for use during the statewide assessment in 2010. The Task Force designed the assessment tool to meet the following two main objectives:

1) To assist schools with reflecting on and documenting their current practices that support students' behavioral health at all intervention levels, ranging from prevention efforts for the whole school community to intensive supports for some individual students.

2) To provide a “road map” to schools and districts for strategies to consider implementing in the future.

For each action step described within the framework's six sections, the tool prompts schools to evaluate their current level of implementation, and to identify which areas are priorities for increased attention and improvement. Additionally, the tool includes opportunities for open-ended responses regarding areas of strength and challenge, as well as a final section for overarching information related to improving students’ behavioral health.

4. Pilot Process

Section 19 of Chapter 321 of the Acts of 2008 required the Task Force to pilot the assessment tool in at least 10 schools. A total of 15 schools completed the pilot tool in fall 2009 through the process described below.

During the spring 2009, Task Force members identified a diverse group of sites to invite to participate in this pilot. These sites included representation from urban, suburban, and rural districts; a mix of traditional school districts, charter schools, and regional vocational technical schools; a range of grade levels served; and a combination of sites that do and do not currently receive state level support to implement behavioral health approaches.

A letter from Commissioner Chester was sent to each pilot invitee in September 2009. The formal invitation letter was followed by phone calls from Task Force members to answer questions from prospective pilot sites, and to confirm interest in the pilot. Of the 28 invited pilot sites, 21 expressed interest in participating in the pilot. The Task Force provided each of the confirmed sites with the pilot versions of the framework and assessment tool.

This interim report includes data analysis (see section 5 below) of the responses received from the 15 pilot sites that submitted their completed tool to the Task Force by December 4, 2009. Additional completed tools have, and will be, submitted to the Task Force after this date and the information from these additional pilot sites will be reviewed and considered by the Task Force in 2010. An updated list of all of the pilot sites that submitted a completed tool will be provided in the final report of the Task Force.
To gain insight into the assessment tool process and the value of the assessment tool and framework to schools, Task Force members conducted follow-up interviews with each of the pilot sites that completed the tool. The purpose of the interviews was to learn more about how each site completed the tool, to hear feedback about the usefulness of the structure and content of the tool, and to learn if any new actions or plans resulted. Some highlights from these follow-up interviews are described in section 5 below.

5. Pilot Results

Task Force member Melissa Pearrow, Ph.D., Assistant Professor at the University of Massachusetts Boston’s Department of Counseling and School Psychology Graduate College of Education, took the lead in analyzing the data from the 15 submitted pilot tools mentioned above (see Appendix B for the list of pilot sites included in this analysis). This section reviews the findings based on the pilot sites’ completion of the tool and examines the statistical properties of the tool. All of the data collected from the 15 schools in this pilot phase were compiled and presented in aggregate form to protect the anonymity of the individual schools.

Pilot Participants – School Type

Of the 15 completed pilot sites included in the analysis:
- More than one-half were high schools
- Middle schools and elementary schools were equally represented
- One early childhood center participated
- One vocational-technical high school participated
- One charter school participated

Pilot Process Results

Each participating school site was instructed to organize a team of school and community members to examine its current level of implementation of behavioral health action steps. The following information was provided by the pilot sites about the members of the teams completing the assessment tool:
- Eleven of the pilot site teams were organized by a school or district administrator, and the remaining teams were organized by a school support staff member (e.g., school psychologist, school adjustment counselor, school guidance counselor).
- A range of team members participated in the self-assessment process, and almost every team involved a school administrator (13), and a general education teacher/staff (10).
- The majority of teams included guidance counselors (8) and special education teachers/staff (8), as well as school psychologists (6), and district administrators (5).
- Fewer teams included school nurses (3), community members (2), speech/language pathologists (2), adjustment counselors (2), parent/family members (1), and teacher assistants (1).
The pilot sites reported that they completed the assessment tool in a variety of ways. Below are some of the highlights about the process pilot sites used to complete the tool:

- Most team members were invited to participate by the team organizer, while a few team organizers allowed members of the school community to participate through a self-selection process.
- An average of five members participated on each team, with teams ranging from three to eight members.
- The expectation was for sites to spend approximately five hours completing the assessment tool, with additional time being devoted only if desired. Participants indicated that they spent anywhere from four to eight hours completing the tool.
- Some teams met as a group to complete the tool, while in other schools individual team members completed the tool and then met as a group to discuss and compile their findings.

**Assessment Tool Analysis**

In total, the assessment tool was comprised of 148 action steps, organized into 26 implementable strategies based on the 6 framework sections mentioned above. The participating schools were asked to indicate 2 responses for each action step: 1) the degree to which the action step was implemented, and 2) the degree to which this action step was a priority for future action. The current level of implementation was scored on a four-point scale, with higher scores indicating more skilled implementation. The following metric was used in calculating scores for current implementation levels:

- “We do not do much of this” = 1
- “We do this to some extent” = 2
- “We do this to a great extent” = 3
- “We do this in a highly skilled way” = 4

In responding to the priority for future action, the schools were offered three options: increase, maintain, or decrease their efforts or actions to address the item. This last option (decrease) was selected only once and was eliminated from further analysis. Thus, the level of priority for future action was scored on a two-point scale, with higher scores indicating greater need to actively address this strategy. The following metric was used to calculate scores:

- “We plan to sustain current level of action” = 1
- “We plan to enhance or increase current level of action” = 2

Mean scores were calculated for each of the six sections, for each strategy, and for the individual action steps (items), for both the current level of implementation and the priority for future action. The findings provided below examine the highest and lowest levels of implementation for each of these areas, and identify the priorities of the pilot schools.

Out of the maximum of 4.0 (“We do this in a highly skilled way”) implementation, the pilot schools reported that:

- They most skillfully implement strategies that address the Academic and Non-academic Supports (2.75) for students – Section IV of the framework – particularly for students with an indicated need for additional support services.
- They implemented to the least extent Professional Development (1.93) opportunities – Section II of the framework.
Out of a maximum of 2.0 (“We plan to enhance or increase current level of action”) for priority for future implementation, the pilot schools reported that:

- The area of Professional Development – Section II of the framework – was ranked as the highest priority (1.68).
- The area of Policies and Procedures – Section V of the framework – was indicated as the lowest priority (1.45).

The following table provides a brief summary of the pilot results within each section.

<table>
<thead>
<tr>
<th>Framework Section</th>
<th>Overall Current Implementation Level (1-4 scale)</th>
<th>Overall Current Priority Level (1-2 scale)</th>
<th>Highest implemented action step within the section</th>
<th>Lowest implemented action step within the section</th>
</tr>
</thead>
<tbody>
<tr>
<td>I – Leadership</td>
<td>2.62</td>
<td>1.62</td>
<td>School administrators create leadership, vision, and support for building students’ strengths.</td>
<td>School leaders develop a professional development plan to increase the capacity of school health staff to promote behavioral health.</td>
</tr>
<tr>
<td>II – Professional Development</td>
<td>1.93</td>
<td>1.68</td>
<td>Compliance with mandated certification and licensure procedures. <em>The findings in this domain were noteworthy in that the compliance with certification and licensure procedures was much higher than all of the other items, with a full one-point drop to the next item mean.</em></td>
<td>Family involvement in generating professional development opportunities and evaluating these trainings.</td>
</tr>
<tr>
<td>III – Access to Resources and Services</td>
<td>2.73</td>
<td>1.48</td>
<td>Compliance of confidentiality of student behavioral health records.</td>
<td>Two action steps were equally low in their implementation: 1) schools had mapped resources and created recommendations to address gaps in resources and services, and 2) community-based teams included school personnel with parental consent.</td>
</tr>
<tr>
<td>IV – Academic and Non-academic Supports</td>
<td>2.75</td>
<td>1.53</td>
<td>Compliance with medical treatment plans that impact school success.</td>
<td>Student involvement in evaluation of programs and services.</td>
</tr>
<tr>
<td>V – Policies and Protocols</td>
<td>2.65</td>
<td>1.45</td>
<td>Appropriate reporting and documentation of suspected child abuse or neglect under section 51A of chapter 119 of the Massachusetts General Laws.</td>
<td>Organization of protocols for families using Intensive Coordination, Mobile Crisis Intervention, and other resources through the MassHealth Community Service Agencies.</td>
</tr>
<tr>
<td>VI – Collaboration with Families</td>
<td>2.63</td>
<td>1.53</td>
<td>Families can communicate the needs of their families and children with school staff and leaders.</td>
<td>Monitoring family involvement by systematically examining attendance and inviting family feedback about areas of concern and interest.</td>
</tr>
</tbody>
</table>
Overall, the two most frequently implemented action steps reflected state-wide mandated procedures, particularly reporting and documenting suspected child abuse (3.79) and pursuit of professional certification and licensure (3.67). The two greatest priorities for school personnel involved creating systems and structures to partner with MassHealth Community Service Agencies (CSAs) to address the needs of students with the most intensive behavioral health needs, particularly as it relates to generating protocols to ensure effective communication between CSAs and school personnel (2.00), and procedures for interfacing Children’s Behavioral Health Initiative (CBHI) services with Special Education laws and services (2.00).

When examined by strategy, the participating schools indicated they were most skilled in implementing policies and protocols that ensure appropriate and effective filing of state reporting [e.g., child abuse and neglect reports (CHINS) petitions: 3.50], which was also the lowest priority for increased action (1.20). The strategy that is the least frequently implemented was joint professional development opportunities for school-based and community-based behavioral health providers (1.83), which was the strategy with the highest priority for action (1.82). This level of priority was shared with policies and protocols that ensure student access to a full range of behavioral health services (1.82).

The findings from the schools were further examined based on the school level (e.g., early or elementary versus secondary). On the whole, the elementary schools indicated higher levels of implementation of the behavioral health action steps, and they were significantly higher in two of the domains. The elementary schools reported more Access to Resources and Services (3.08 vs. 2.43) and greater Collaboration with Families (2.90 vs. 2.43) when compared to secondary schools.

**Assessment Tool Construction and Implications**

In addition to exploring the findings from the pilot schools, the statistical properties of the assessment tool itself were examined. As previously mentioned, the tool consisted of 148 self-report survey items with each item answered on two dimensions – current level of implementation and priority for action to address their level of implementation. As expected, there was an inverse correlation (-.67) between the two dimensions. In other words, the more frequently the action step was implemented, the less it was a priority to address it. The opposite was also true in that the less frequently the item was implemented, the higher a priority it was for action.

A noteworthy finding was that the priority for action dimension was dichotomously indicated, thus reflecting a need to alter this dimension of the tool. Instead it may be helpful to assess the level of immediacy to implement the action step; for example, the scoring could assess sustaining the current level of implementation, enhancing/increasing in the next month, enhancing/increasing in the next year, or enhancing/increasing in the next five years.

The internal consistency reliability coefficient (Cronbach’s alpha) was calculated to ascertain the degree to which the items in each section correlated with one another, or measured the same construct. Generally a cut-off of .80 is required for a “good scale”, and five of the six sections demonstrated at least this level of reliability. The next page shows the reliability coefficients that were found.
Upon more thorough examination, the Leadership section was weaker as it had the fewest number of items and assessed many levels of school leadership. For example, the items assessed areas such as a district vision statement to address behavioral health services; outcome goals generated by the school committee and superintendent; system-wide data systems to collect, track, and analyze behavioral outcome goals; school-based leadership to implement and assess strategies regarding behavioral health needs; and, school-based leadership to develop professional development to increase capacity of school staff regarding behavioral health needs. While each of the items reflects the broader concept of leadership, the current items are too expansive and assess many levels of school structures. This suggests that these items may need to be more focused on the school-level of leadership, with a separate strategy for assessing the leadership from district and community levels.

Similarly, the comparison between elementary and secondary level schools suggest a need to refocus two domains, “Access to Resources and Services” and “Collaboration with Families” in particular, to more aptly reflect the developmental level of the students as well as the expectations of schools as they address the students’ and families’ behavioral health needs.

The length of the assessment tool was frequently identified as a problem by the participating schools. This was demonstrated by the increase in the number of items with no response (NR) after approximately item number 100. By item 124 there was a 38 percent NR rate on the priority dimension. This suggests there is a need to reduce the number of items in the assessment tool, while still ensuring that schools can indicate a range of locally appropriate approaches to supporting behavioral health.

Finally, it was noteworthy that the pilot phase consisted of a convenience sample with no systemic sampling procedures. Though the sampling methods limit the ability to generalize the findings, they do provide critical information that informs procedures necessary for scaling up this assessment tool to conduct a statewide assessment. These include the need for altering components of the assessment tool to offering recommendations for team construction.

Feedback from Pilot Site Interviews
Feedback garnered through the follow-up interviews conducted by Task Force members with each of the completed pilot sites provided further evidence regarding the value of the tool. Overall, pilot sites commented that they thought the tool was appropriate and helpful, and that completing the tool generated dialogue, expanded thinking, provided a place to confirm what they have in place, and helped them create a vision for the future. Several pilot sites mentioned sections that were particularly helpful for their team to consider.
Many of the pilot sites also stated that they plan to implement new or revised strategies as a result of completing the assessment tool, and that they would like to use the tool again in the future. Pilot sites indicated that in order to implement their priorities for future action they would need increased access to experts, funding, training, and a greater emphasis on the importance of this topic from the state level.

Similar to what was noted under the Assessment Tool Construction and Implications discussion (pages 8-9), pilot sites indicated that the weaknesses of the assessment tool included the number of questions, as well as some questions that were unclear or redundant. Pilot sites also felt that the tool could be tailored for different school type or grade levels. Pilot participants suggested that training or technical assistance may be helpful for schools completing the assessment tool in the future.

6. Recommendations for the Statewide Assessment

During the ninth Behavioral Health and Public Schools Task Force meeting on December 9, 2009, the Task Force members shared feedback and suggestions from the piloted schools. After taking into consideration all the shared comments, the Task Force members discussed statewide assessment recommendations for the Commonwealth of Massachusetts.

Task Force recommendations include the following for a statewide assessment:

- The assessment tool should be in an online format, with hyperlinks in the document to relevant framework areas throughout the tool.
- The sample of schools filling out the tool for the statewide assessment must be stratified as best as possible based upon geography, grade level, socioeconomic status, school type (charter school, public school and vocational technical), school size, and the degree of significant support for behavioral health issues.
  - There are 380 communities and approximately 20% of the 380 should be represented (about 60-100 schools).
  - As a guide, the Task Force will look at the Youth Risk Behavioral Survey process conducted by Centers for Disease Control and Prevention (CDC) and Massachusetts Department of Public Health (DPH) in order to consider their methods when determining how to best obtain a stratified sample for this context.

The next page outlines more details regarding recommendations for a timeline and process for conducting a statewide assessment and submitting a final report based on the assessment.
BEHAVIORAL HEALTH AND PUBLIC SCHOOLS TASK FORCE  
PROJECTED TIMELINE FOR 2010

Below are recommendations from the Task Force regarding a process and timeline for conducting a statewide assessment and submitting a final report.

<table>
<thead>
<tr>
<th>TASK</th>
<th>TIMEFRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Confirm process for conducting the statewide assessment.</td>
<td>End of January 2010</td>
</tr>
<tr>
<td>➢ Form a new Document Revision Work Group to make adjustments to the most current versions of the framework and assessment tool, based on the feedback from the pilot schools. The work group should include a number of Task Force members as well as representatives from schools that piloted the tool in the fall 2009.</td>
<td>January 2010 to February 2010</td>
</tr>
<tr>
<td>➢ Create a web-based format for the assessment tool, so that schools can fill it in online and so that the responses can be automatically entered into a database for more efficient analysis.</td>
<td>February 2010 to March 2010</td>
</tr>
<tr>
<td>➢ Invite and confirm schools to complete the tool for the statewide assessment.</td>
<td>March 2010</td>
</tr>
<tr>
<td>➢ Accept through the web-based system the completed assessment tools from schools.</td>
<td>Early April 2010 to Mid-July 2010</td>
</tr>
<tr>
<td>➢ Analyze data from the statewide assessment.</td>
<td>Mid-July 2010 to Late August 2010</td>
</tr>
<tr>
<td>➢ Draft and get feedback on the final report.</td>
<td>Early September 2010</td>
</tr>
<tr>
<td>➢ Submit the final report.</td>
<td>Early October 2010</td>
</tr>
</tbody>
</table>

*Note: The Task Force is not required to submit the final report in October, but will aim to submit it in early Fall 2010.*

For more details about this report or Task Force work, please contact Associate Commissioner John L.G. Bynoe III, via jbynoe@doe.mass.edu or 781-338-6300. Upon request of members of the legislature, Associate Commissioner Bynoe is available, along with Task Force members, to answer questions, make a presentation, or engage in discussions regarding this topic.
Appendix A. List of Task Force Members and Participating Guests

As chair of the Behavioral Health and the Public Schools Task Force, the Commissioner of Elementary and Secondary Education, Mitchell Chester, thanks all Task Force members, designees, guest participants, and presenters who have contributed to the efforts of the Task Force between December 2008 and December 2009. Those individuals are listed below (alphabetically by organization), after staff from the Department of Elementary and Secondary Education.

Massachusetts Department of Elementary & Secondary Education
Commissioner Mitchell D. Chester, Ed.D. (Task Force chair)
Associate Commissioner John L.G. Bynoe III, Center for Student Support, Career & Ed. Services
Rachelle Engler Bennett, Director of Student Support
Emily Caille, K-3 Education Specialist, Elementary School Services
Jane Chang, Office for Nutrition, Health and Safety Programs
Dianne Curran, Legal Office
Jenny Caldwell Curtin, Coordinator of Alternative Education & Trauma Sensitive Schools
Carol Goodenow, Director of Coordinated School Health
Madeline Levine, Assistant Director of Special Education Planning & Policy
Marcia Mittnacht, Director of Special Education Planning & Policy
Barbara Solomon, Director of Elementary School Services

TASK FORCE MEMBERS

American Federation of Teachers, Massachusetts
Angela Cristiani, School Psychologist

Children’s Hospital Boston
Karen Darcy, Registered Nurse
Shella Dennery, Children’s Hospital Neighborhood Partnerships (CHNP) Director
John Riordan, Director, Community Partnerships

CQI: Consumer Initiatives
Jonathan Delman, Executive Director

Cutchins Programs for Children and Families, Inc.
Andrew Pollock, Executive Director

East Street School (Ludlow Public Schools)
Brett Bishop, Principal

Executive Office of Education
Michele Norman, Director of Strategic Planning and Collaboration

Executive Office of Human & Health Services
Emily Sherwood, Director of Children’s Behavioral Health Initiative (CBHI)
Jack Simons, Assistant Director of CBHI
Margot Tracy, Policy Analyst
Appendix A

Interim Report for the Behavioral Health and Public Schools Task Force, December 31, 2009
Office of the Child Advocate
Elizabeth Armstrong, Deputy Director

Parent/Professional Advocacy League
Lisa Lambert, Executive Director

Parent advocate
MaryAnn Tufts

Parent representatives
Chantell Albert
Denise Robertson

South Shore Mental Health Center, Inc.
Aymssley Brien
Harry Shulman, President & CEO

University of Massachusetts, Boston
Melissa Pearrow, Assistant Professor in the Department of Counseling and School Psychology

Youth Opportunities Upheld (Y.O.U.), Inc.
Maurice Boisvert, President & CEO

PARTICIPATING GUESTS

Assabet Valley Collaborative
Nicki Logan, LICSW, Family Success Partnership (FSP) Coordinator

The Blue Cross Blue Shield of Massachusetts (BCBSMA) Foundation
Katelin Lucariello
Marcy Ravech, Associate Director of Policy & Research

Massachusetts Administrators for Special Education (ASE)
Carla Jentz, Executive Director

Massachusetts Appleseed
Sandra Carter, Research & Policy Associate
Christina Kim
Alex O’Sullivan

Quincy Public Schools
Joseph Boss, Behavioral Growth and Development Program Administrator
Peggy Farren, North Quincy High School Psychologist
Deborah Parrish, Casa Start Counselor
Janet Powell, Director of Pupil Personnel Services
Ruth Whitmer, Lincoln-Hancock Community School Principal
Adam Wolf, Atlantic Middle School Assistant Principal

Rhode Island College
Thomas Kochanek, Professor of Special Education
Appendix A

Ropes & Gray
Susan Wilker, Fellow

South Shore Educational Collaborative
Deborah Jean Parsons, Program Director

University of Massachusetts
Phakdey Chea Yous, Graduate Assistant, School Psychology MEd/EdS, 2011
Evelyn Frankford, Visiting Fellow
Esther Seibold, Assistant Professor, College of Nursing and Health Sciences

The Winchendon Project
Catherine Apostoleris, Co-Director
Susan Buchholz, Coordinator
Joanne Bunnell, Teacher, Murdock Middle-High School
Gail Casavant, Learning Supports Facilitator
Brooke Clenchy, Superintendent of Winchendon Public Schools
Nicholas DeSimone, Principal, Murdock Middle-High School
Bethany Duval, School-Based Behavioral Health Clinician
Jane Greenleaf, School Adjustment Counselor, Winchendon Public Schools
Christine Philput, Chair, Winchendon School Committee
Appendix B. Sites Included in Pilot Analysis as of December 31, 2009

The following 15 school sites were among the 28 invited by the Commissioner of Elementary and Secondary Education to complete the pilot version of the assessment tool for the Behavioral Health and the Public Schools Task Force in the fall 2009. The Task Force’s interim report includes data analysis (see section 5 of the report) of the responses received from these 15 pilot sites that submitted their completed tool to the Task Force by December 4, 2009. Additional completed tools have, and will be, submitted to the Task Force after this date and the information from these additional pilot sites will be reviewed and considered by the Task Force in 2010. An updated list of all of the pilot sites that submitted a completed tool will be provided in the final report of the Task Force.

Commissioner Chester and the Task Force are grateful to all the schools and participating team members for their willingness and effort undertaken to use the tool to reflect upon and document their current strategies, action steps, and priorities for improvement. Their contributions to the work of the Task Force are extremely helpful and appreciated.

Angelo School, Brockton Public Schools

Atlantic Middle School, Quincy Public Schools

Ayers Ryal Side School, Beverly Public Schools

Barnstable High School, Barnstable Public Schools

Blackstone Valley Regional Vocational Technical High School, Upton

Boutwell School, Groton-Dunstable Regional School District

Collins Middle School, Salem Public Schools

Holyoke High School, Holyoke Public Schools

Ludlow High School, Ludlow Public Schools

McAuliffe School, Lowell Public Schools

Murdock Middle-High School, Winchendon Public Schools

New Bedford High School, New Bedford Public Schools

Randolph High School, Randolph Public Schools

Seven Hills Charter School, Worcester Public Schools

William Seach Primary School, Weymouth Public Schools
Appendix C. Behavioral Health and the Public Schools Framework – Pilot Version

INTRODUCTION

Too many students with behavioral health challenges are doing poorly in school. Some are missing school, failing tests, falling behind, and eventually dropping out. Others experience punitive responses and are suspended or expelled in record numbers. Research tells us that behavioral health is intricately connected to academic, social, and emotional success at school. Yet, the needs of students with behavioral health challenges have only recently gained state and national attention. The call to integrate behavioral health and educational supports to promote the healthy development of all students is seen in the 2003 national report from the New Freedom Commission on Mental Health and Massachusetts’ 2008 Act Relative to Children’s Mental Health (M.G.L. Chapter 321, Section 19.)

This framework reflects the Commonwealth’s intent to enhance the school success of all students by creating a statewide infrastructure to improve behavioral health in public schools. This framework is based on a three-part design, in which each part builds on and supports the other two parts: 1) supportive school environments: promote the behavioral health of all students through whole-school supportive environments, 2) early interventions: provide collaborative approaches to identify and address behavioral health symptoms early, and 3) intensive services: coordinate intensive interventions for students with significant needs.

This three-part design is woven among each of the six main sections of the framework:

I) Leadership by school and district administrators to create supportive school environments and promote collaborative services that reliably address each of the three levels.

II) Professional development for school administrator, educators, and behavioral health providers, both together through cross-disciplinary trainings and separately.

III) Access to resources and services by identifying, coordinating, and creating school and community behavioral health services to improve the school-wide environment.

The framework recognizes the need for resources that are clinically, linguistically and culturally appropriate for students and their families.

IV) Academic and non academic approaches that enable all children to learn, including those with behavioral health needs, and that promote success in school.

V) Policies and protocols that provide a foundation for schools to implement and support this work.

VI) Inclusion of parents and families in all aspects of their children’s education.

The organizational structure of the framework is designed to enable schools to tailor local solutions to address the needs of their communities. It recognizes that in some communities districts may be the catalyst for implementing the recommendations, and in others leadership will start at the school level but will require district backing.

1 Citations to be added during revisions.
GUIDING PRINCIPLES

1) Behavioral health refers to the social, emotional, and behavioral well-being of all students, including but not limited to students with mental health needs. Behavioral health concerns both the reduction of problem behaviors, and the optimization of positive and productive functioning.

2) Students’ behavioral health has a major impact on learning. If behavioral health needs are neglected, schools will contend with emotional and behavioral issues reactively and ineffectively, with a reduction of resources available to promote educational goals.

3) A positive and supportive school environment reduces the prevalence of challenging, dangerous, and disrespectful behaviors; resulting in better student attendance, attention, motivation, and consequently, better educational outcomes.

4) School leaders and school administrators acknowledge the importance of behavioral health issues and dedicate resources accordingly as part of an overall effort to reduce barriers to learning.

5) Schools establish and use measurable goals and objectives to determine whether behavioral health initiatives, programs, and services are successful.

6) Schools, in providing behavioral health services and supports for students and families, recognize and make use of the expertise of school mental health professionals.

7) Behavioral health needs are best addressed when a school, and/or school district, convenes a support services, or behavioral health, team to assess the behavioral health needs of the school community, and to plan, coordinate, and evaluate programs and services. For efficiency and to minimize redundancy, schools use existing, well functioning teams with coinciding goals for this purpose.

8) Schools identify ways in which community service providers, state and local agencies, and other community resources (e.g., faith community, recreation programs, colleges and universities, business partners) can help address behavioral health services gaps. Schools facilitate access to such services and supports by establishing ongoing relationships with outside service providers, and by providing families with relevant information about community services.

9) Schools provide an array of behavioral health services and programs throughout the continuum of student needs, including: (1) prevention and promotion for all students, (2) early intervention for at-risk students, (3) intensive intervention for students with serious needs, and (4) crisis intervention for students with acute needs.
10) The school curriculum systematically addresses behavioral health needs that help prepare students for lifelong success in the workplace, in the community, and in personal relationships. This includes instruction in areas such as social problem solving, life skills, social-emotional development, interpersonal communication, self-regulation, and violence prevention.

11) Families are essential partners in schools’ efforts to support behavioral health needs. Parent input helps identify and prioritize needs of the school community. Parents are included to the greatest extent possible in the planning and evaluation of programs and services.

12) Behavioral health programs and services are provided so as to respect ethnic and cultural diversity, language differences, and the unique nature of specific disabilities and risk factors. Services are also strength-based, child-centered, and family-driven.

13) School districts offer continuing education for all school personnel on behavioral health issues to help them (1) interact sensitively, respectfully, and supportively with students and families, (2) identify students at risk for behavioral health needs, (3) help support and deliver behavioral health services.
THE SIX FRAMEWORK SECTIONS IN DETAIL

I) LEADERSHIP

This section addresses leadership by school administrators and other school personnel to create structures within schools that promote supportive school environments and collaboration between schools and behavioral health providers within the scope of confidentiality laws to reduce barriers to learning.

This section describes the district and school leadership actions steps necessary to enhance the school’s capacity to improve students’ behavioral health through supportive school environments, early interventions, and intensive services. Please note that in some communities districts may be the catalyst for implementing the recommendations, and in other communities the leadership will start at the school level but will require district backing.

A. District leadership. District leadership, in partnership with the school committee, will play an essential role in this process of supporting behavioral health in schools by developing the vision, outcome measures, and a plan to implement the framework in its district. Regular communication between the school committee, the superintendent and other district administrators, and school administrators regarding any district-wide and school-based plans is strongly encouraged to support the comprehensive implementation of this framework.

1) District vision statement. District administrators and school committees can develop and approve, with staff, student, family, and community input, a written vision statement for implementing this framework. A vision statement can address approaches that meet the framework’s three-part design to implement: 1) supportive school environments: promoting the behavioral health of all students through whole-school supportive environments, 2) early interventions: providing collaborative approaches to identify and address behavioral health symptoms early, and 3) intensive services: coordinating intensive interventions for students with significant needs.

2) Outcome goals. The district administrators and the school committee should set outcome goals for areas that need improvement. Suggested outcomes measures include: attendance; school engagement; grade progression; high school graduation rates; time spent on learning; and rates of suspensions, expulsions, office referrals for discipline; and/or other areas of concern related to the entire district or specific schools. The outcome goals will inform district and school plans and be regularly reviewed to monitor progress and to re-assess their relevance.

3) District-wide action plan. After the development of a district vision statement, it is the role of the Superintendent and other school administrators to carry out the vision statement for implementing the behavioral health framework by leading principals,
school staff, community partners, and families to create a district-wide plan for addressing behavioral health supports.

- District plans will instruct schools to weave the approaches to supportive school environments, early intervention, and intensive services into School Improvement Plans with the goal of achieving the designated educational outcomes.
- These district plans can also set forth how the district will (alone or in collaboration with others such as a public educational collaborative) coordinate services for students in all district schools, designate staff responsible for monitoring access to services and resources, and support collaboration between school-based teams and community services.
- Plans can also identify which leadership tasks are best addressed at the district level and what topics are best suited for school leaders, as well as mechanisms for enhancing coordination regionally.

4) **Data Systems.** Districts should consider their current data system’s capacity to collect, track, and analyze data related to their behavioral outcome goals. Effective data collection will allow districts to evaluate the effectiveness of programs, identify best practices, and drive the decision making process. Additionally, districts should consider the internal structure, specifically personnel, needed to collect meaningful and accurate data.

**B. School leadership.** Principals and other school administrators play an important leadership role in establishing, monitoring, and improving the organizational structure and functions of a school in order to effectively to integrate approaches to supportive school environments, early interventions, and intensive services into existing school operations. Many of the leadership tasks and activities described in this section fall naturally into pre-existing structures; for others it may be necessary to create new teams or forums. It is the role of the principal and other school administrators to establish goals and objectives that align with district goals, and to regularly communicate with all school staff on activities and progress related to these goals and objectives. The school level activities include but are not limited to:

1) **School-based leadership team.** A school-based team, led by a principal or other school administrator, and including parents, students, staff representing various perspectives, and community organizations, should be identified to determine how best to incorporate District Plan (or if there is not a district plan, the framework elements) into existing School Improvement Plans. The incorporation of these recommendations can be accomplished through a strategic planning process or a needs analysis activity. The team can identify potential barriers or challenges to implementing these recommendations and create a process to continually oversee and evaluate the effectiveness of any plans.

2) **Professional development.** School leaders, with staff input, should develop a long-term professional development plan to increase skills among school staff and other stakeholders to implement the district’s three-part approach—supportive school environments, early interventions, and intensive services— to promoting students’
behavioral health. (See Framework Section II for the complete description of professional development recommendations.)

3) **Access to resources and services.** This function involves school leaders setting up structures to enhance the school’s capacity and resources to promote behavioral health through supportive school environments, early interventions, and intensive services. There are three basic components to this function: 1) a “mapping” process to identify the adequacy of the schools’ resources to meet this task and to reallocate resources within the school to address these gaps; 2) a structure for exploring partnerships with community agencies (including recreational, cultural, and behavioral health) to address needs in each of the three areas (supportive school environments, early interventions, and intensive services); and 3) a structure for confidential conferencing on individual students at school, and as appropriate in the community. (See Framework Section III for a complete description of access to services recommendations.)

4) **Academic and non-academic supports.** School leaders can provide the vision and support for implementing effective activities and strategies that build on students’ strengths and promote success in school. Strategies fall into three-part structure – supportive school environments, early interventions, and intensive services. (See Framework Section IV for the complete description of academic and non-academic support recommendations.)

5) **Policies and protocols.** The creation and revision of behavioral health policies and protocols involves school leaders, with the input of staff, to address topics such as – but not limited to – discipline, filing abuse and neglect reports, students transitions to school from hospitals and residential or day schools, students entering or exiting foster care, or homeless students. In particular, it is school leaders who can ensure that staff understand and use best practices for maintaining confidentiality of individual students with behavioral health needs. (See Framework Section V for the complete description of policy and protocol recommendations.)

6) **Collaboration with families.** School leaders are encouraged to effectively partner with families in supporting the educational success of their children. This includes promoting behavioral health through supportive school environments that partner with families, and supporting parents to identify and address needs early, and to participate in coordinated intervention services when needed. This also includes ensuring that staff are culturally proficient and have the skills and resources to communicate and collaborate with families. (See Framework Section VI for the complete description recommendations for collaboration with families.)
II) PROFESSIONAL DEVELOPMENT

This section addresses professional development for school personnel and behavioral health service providers that: clarifies roles and promotes collaboration within the scope of confidentiality laws; increases cultural competency; increases school personnel’s knowledge of behavioral health symptoms, the impact of these symptoms on behavior and learning, and the availability of community resources; enhances school personnel’s skills to help children form meaningful relationships, regulate their emotions, behave appropriately and succeed academically, and to work with parents, who may have behavioral health needs; increases providers’ skills to identify school problems and to provide consultation, classroom observation and support to school personnel, children and their families; and increases school personnel’s and providers’ knowledge of the impact of trauma on learning, relationships, physical well being and behavior, and of school-wide and individual approaches that help traumatized children succeed in school.

This section describes the professional development guidelines and professional development topic areas that are needed to enhance the school’s capacity to improve students’ behavioral health through supportive school environments, early interventions, and intensive services.

A. Guidelines for professional development. Schools and districts are encouraged to offer professional development opportunities that meet the following guidelines:

1) All members of the school community, including the school committee, administrators, staff, parents, and behavioral health providers understand this Framework and the district and school’s roles in utilizing the Framework to improve educational outcomes for all students.

2) Administrators, school staff, and behavioral health providers receive coordinated training that address multiple skill levels and cross-disciplinary topics, and incorporate diverse approaches for staff development such as coaching, team teaching, and mentoring.

3) School-based and community behavioral health providers train together and learn from each other to promote collaboration.

4) Trainings seek to increase staff familiarity with relevant child-serving systems, including state agencies and state sponsored behavioral health resources (e.g., MassHealth, etc.), and their potential intersections with education.

5) Trainings seek to increase external behavioral health providers’ familiarity with school and district structures and requirements.

6) Professional development plans recognize that school-based behavioral health staff, irrespective of their titles, may have skills that bridge the divide between the educational and health systems, or may have specialized skills that can be put to use in the cross training of educators and community behavioral health providers.
7) There is professional development *time designated each school year* to address behavioral health issues and resources are made available (e.g. substitute teachers, release time, stipends) to support staff participation.

8) Issues of *cultural competence* are addressed, including sharing school behavioral health expectations with families, while also communicating that the skills students learn at school are not meant to undermine cultural values or social skills expected at home.

9) *Families are actively reached out to* in the identification/selection of topics, families can participate in professional development opportunities along with staff, and they have a role in the evaluation of any training activities.

10) *Pursuit of certification, licensure, and professional distinctions are encouraged* and supported.

**B. Professional development for all staff.** It is recommended that the school/district offer trainings for *all school and district staff* to build skills in:

1) The ability to help students develop safe, caring relationships with adults and peers, and to manage their emotions, behaviors and attention to achieve academic success.

2) Building relationships and communicating with all families.

3) Understanding the separate roles and common objectives of behavioral health providers and educators that promote supportive school-wide environments and that address the needs of individual students.

4) Knowledge of the impact of trauma and other risk factors for learning, relationships, behavior, physical health, and well being.

5) Knowledge and training in school-wide and individualized approaches/services that help at-risk students succeed in school.

6) Implementing policies and protocols recommended in Framework Section V.

7) Proficiency in strategies and interventions that are alternatives to physical restraints.

8) Learning the respective roles of school-based teams (Child Study, Student Support, IEP) and team processes connected with other state agencies and services (e.g., MassHealth teams – Care Planning Teams), and how to jointly participate in and coordinate the work of these teams.

9) The recognition of behavioral health symptoms, including those related to stress and trauma, to aid in early identification.
10) Best practice for discussing sensitive, confidential, and/or privileged student information.

C. **Professional development for administrators and other school leaders.** It is recommended that the school/district offer trainings for *administrators and other school leaders* to build skills in:

1) Engaging school staff in their role to support the well-being and healthy development of all students.

2) Disciplinary approaches that balance accountability with an understanding of behavioral health needs of students.

3) Managing and evaluating the policies and protocols related to supporting students’ behavioral health as recommended in Framework Section V.

4) Ways to support the well-being of educators and behavioral health staff.

5) Ways to meaningfully engage a broad range of students in school planning and decision-making groups with staff.

6) Analyzing and using data to inform decision making about services and interventions.

7) Developing flexible approaches that support external behavioral health providers who offer services in the school setting (e.g., making space available).

D. **Professional development for teachers and instructors.** It is recommended that *teachers and instructors* receive support to become skilled in:

1) Strategies and approaches to improve instruction that support students with or who may be at risk for developing behavioral health needs.

2) The ability to create a caring classroom community and manage classroom behaviors, including ways to de-escalate behavior to reduce the need for crisis intervention.

3) Understanding a teacher/instructor’s particular role in crisis intervention for an individual student or group of students and the role of behavioral health providers in crisis situations.

E. **Professional development for school and community behavioral health providers.** It is recommended that *all school-based and community behavioral health providers* receive support to become skilled in:

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2 Broadly defined to include nurses, psychologists, school adjustment counselors, social workers, guidance counselors, therapists or clinicians employed by a school, district or community agency.
1) Identification of school problems and how behavioral health symptoms may manifest in a school setting.

2) Understanding of how behavioral health problems impact all aspects of a student’s functioning, including learning and behavior in school, at home, and in the community.

3) Strategies for positive and appropriate responses to student’s needs, in the classroom and throughout the school

4) Providing classroom observations, consultations with educators, and ways to support school personnel, students and their families.
III) ACCESS TO RESOURCES AND SERVICES

This section addresses access to clinically, linguistically and culturally-appropriate behavioral health services, including prevention, early intervention, crisis intervention, screening, and treatment, especially for children transitioning to school from other placements, hospitalization, or homelessness, and children requiring behavioral health services pursuant to special education individual education plans.

This section describes the supports and services necessary to enhance the school’s capacity to improve students’ behavioral health through supportive school environments, early interventions, and intensive services. Approaches in all three parts should be clinically, linguistically, and culturally appropriate.

A. Identifying gaps and re-allocating resources within the school.

1) **Mapping resources.** This involves a process to identify the school’s capacity to provide resources across the three-part approach. It is recommended that as part of any strategic planning or review of school improvement plans, school leaders, with input from families and staff, assess the adequacy of behavioral health approaches. Behavioral health approaches are defined broadly, and should include supports to create supportive school environments and provide early interventions, and intensive services. This “mapping process” should recognize that school staff, irrespective of their titles, may have skills to assist in providing these behavioral health supports.

The mapping process should address the following areas:

- **Strengths and unmet needs.** An analysis of the existing and needed resources and services to promote a positive school-wide culture and to develop effective social and emotional skills in all students can be done.

- **Communication.** As assessment of strategies for maintaining and improving communication processes among school staff, including but not limited to general education, special education, school administrators, professional support personnel, and the Homeless Liaison; with families; with other youth serving state agencies (e.g., the Department of Children and Families, the Department of Youth Services, and the Department of Mental Health); and with community behavioral health providers.

- **Roles of school/district staff and community providers.** An analysis of the roles, functions, and availability of school/district and community staff, including behavioral health staff, in order to identify gaps in programs and services.

2) **Developing recommendations to fill resource and services gaps.** Once the mapping process is complete, schools can develop recommendations and action steps to fill resource and service gaps. This may include decisions on new curriculum, reorganization of staff (either within the school or within the district), and identifying...
other agencies to provide services to meet the remaining needs. The process recognizes that school nurses, teachers, and administrators, in addition to traditional behavioral health staff, may have skills that bridge the divide between the educational and health systems, or have specialized skills that can be put to use in the cross training of educators and behavioral health staff. This assessment may lead, as needed, to redeployment of behavioral health resources within the school and district or to form new partnerships.

The recommendations should, at a minimum, address the school’s ability to implement the following components:

- Promoting a positive school wide environment
- Establishing ongoing relationships with families
- Developing effective social and emotional skills in all students
- Intervening early with at-risk students through small group and individual approaches
- Obtaining appropriate evaluations
- Arranging consultations and observations in classrooms
- Providing referrals to community resources where needed
- Addressing student’s health needs
- Responding quickly and comprehensively to students in crisis
- Communicating regularly with student’s community-based providers
- Providing coordinated interventions to students with significant needs
- Supporting students’ transition to and from other placements, e.g. hospitals, Department of Youth Services, foster care, and home tutoring

B. Access to resources and services in schools. School-wide and district-wide supports promote a positive school culture to develop effective social and emotional skills in all students.

1) All students in need of resources and services have access to resources that are clinically, linguistically, and culturally appropriate.

2) Services include district-wide, school-wide, classroom-based, small group, and individual student activities and supports.

3) There is a shared standard and practice around confidentiality of student behavioral health records.

C. Access to resources and services with community organizations. To the extent the mapping process identifies gaps in resources that can be filled by community agencies, schools can explore partnerships with community agencies. Formal or informal partnerships can be formed with community agencies and behavioral health providers to fill gaps to provide supportive school environments, early interventions, and/or intensive services.

1) All students in need of external services have access to resources that are clinically, linguistically, and culturally appropriate.
2) External resources and services include the potential for both individual and group services for students who need them.
3) The school and district supports the participation of school staff in individual student’s treatment planning processes with external providers.

4) Particular attention should be paid to those community-based services that are available for some students through MassHealth. *(Additional information is outlined in Section V.)*

5) Partnerships with community organizations reflect the variety and scope of student needs and gaps in services. Coordinated efforts include addressing student specific issues, referrals for services, classroom consultation on general as well as student-specific scenarios, diverse interventions (e.g., small group, individual supports, school re-entry from a hospital), and plans for school and community provider responses when necessary. Partnerships may include:
   - **Relationships** with community agencies to bring in *recreational, cultural, financial resources, after-school, youth development, art, culture and literacy opportunities.* *(e.g. libraries, museums, local volunteers).*
   - **Referral Systems** to ensure student access to appropriate and timely services, including services through MassHealth/ Children’s Behavioral Health Initiative. This will require clear policies and protocols that assist school staff and families to overcome barriers to making effective, confidential referrals. *(See Section V for a discussion of needed protocols)*
   - **Formal agreements** between schools and community behavioral health providers. *When formal agreements are necessary* they should specify the details of the collaborative relationship and outline the services to be provided to individual or groups of students, in the community or at school. Such agreements can address a number of components outlined in the “Policies and Protocols” section of this framework. Agreements can also identify cost effective arrangements, including maximizing the benefits of 3rd party insurance for behavioral health services and mechanisms for flexible funding. *(See Section V for detailed information on establishing a formal agreement)*

**D. Confidential conferencing on individual students.** Conferencing on individual students work is confidential and often carried out by Student Support Teams, Child Study Teams, IEP teams, or a similar structure for students who require specific support programs and services.

1) Parents/guardians should be re-assured that confidentiality will be respected in all of these settings.

2) A student’s external behavioral health provider should participate in these groups upon consent from the parent/guardian or a student age 18 and older.

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This framework was developed by the Behavioral Health and Public Schools Task Force formed by Section 19 of Chapter 321 of the Acts of 2008. This draft version was piloted by 15 schools in the fall 2009 – revisions and companion resource documents are to be completed by the Task Force during 2010.
3) At the parent/guardian’s request, school staff should also participate in community-based teams, for example, the Individual Care Planning Teams formed for youth in the MassHealth Intensive Care Coordination program.

4) These groups should work together to establish common goals for the student’s success, and to ensure that student needs are being addressed in a comprehensive and well-coordinated manner at each of the three levels. The common work of these individual student-focused groups includes continuously monitoring the growth of each student and calibrating strategies (in addition to individual services), that take place within the classroom, the school-wide environment, and as appropriate, in the community.
IV) ACADEMIC AND NON-ACADEMIC SUPPORTS

This section addresses effective academic and non-academic activities that build upon students’ strengths, promote success in school, maximize time spent in the classroom and minimize suspensions, expulsions, and other removals for students with behavioral health challenges.

The overarching goal is to ensure that classrooms enable all students to experience success in the school environment. The school environment is a unique setting that can address the development of the whole child. The academic and non-academic supports indicated in this section are organized based on the three-part design of supportive school environments, early interventions, and intensive services. The recommended strategies indicated throughout this section are designed to be implemented in collaboration with families and caregivers. Additional recommendations about collaborating with families are provided in Section VI.

A. Supportive school environments. Supportive school environments encompass the universal supports, strategies, and programs available to all students in the school that promote overall well-being and positive educational outcomes. These strategies and programs include school-wide behavioral supports, classroom-wide prevention initiatives, and community programs that are available to students.

1) High quality instruction with school-wide academic standards. Students come to school with a variety of skills and abilities, and the mantra “All children can learn” highlights the capacity for students to obtain new skills to be successful in life. Setting high standards and expectations for all students means recognizing the individuality of each student and identifying instructional techniques that support his/her growth. This requires maximizing time spent on learning with opportunities for individualized instructional supports.

2) Screening of academic and behavioral development. Monitoring the academic and social, emotional, and behavioral development of each student can foster effective learning of all students and can identify situations when additional supports are needed. Through universal systematic screening procedures, early intervention and support services can be put into place that can prevent the development of academic or social/emotional difficulties. This student data can be used by teachers to inform and improve classroom environments, instruction techniques, etc.

3) Predictability. Classroom and school environments that are predictable can be particularly helpful for all students, but especially for those with behavioral health needs. This includes:
   - clear expectations of students,
   - established school and classroom routines;
   - clearly communicated class schedules;
   - predictable and positive responses/reinforcement, even when students require correction on behavior or academics; and
4) **Effective primary prevention programs.** There are numerous evidence-based prevention programs that support and promote the development of behavioral health that have been recognized by federal agencies. The unique needs of each school and classroom should be considered when planning and implementing one of these programs. These programs are most effective when consistently implemented by teachers and also require the involvement of the entire school community (e.g. bus drivers, lunch, and janitorial staff, etc.). A focus on the following skills is recommended when making a selection for a primary prevention program:

- Model, teach, and reward pro-social, healthy and respectful behaviors. Similarly, problem behaviors and consequences are clearly defined.
- Utilize positive approaches to promoting behavioral health, including collaborative problem solving, resiliency, team work, and positive behavioral supports that aid in social and emotional development.
- Sensitively address behavioral issues in classroom so that learning can continue and the child is not unnecessarily removed from class.
- Teach student to modulate emotions, recognizing the association between positive peer relations, adult connections, and self-regulation and the impact on academic success.
- Utilize effective approaches to address difficult emotional states (e.g. anger, jealousy) and address underlying reasons for difficult behaviors by identifying and processing feelings.
- Develop collaborative discipline approaches that include student input, which balance accountability with an understanding of underlying behavioral health needs.

5) **Positive relationships between students and adults.** Supportive connections between adults and students can serve as a foundation for the development and promotion of behavioral health. Supports to encourage positive relationships between students and adults can include:

- Opportunities for staff and students to develop relationships that extend beyond the academic role (e.g., at lunch time or with an extracurricular project).
- Promotion of student engagement in school events and extracurricular activities (e.g., sports, clubs).
- Thoughtful attention to fostering relationships with adults with whom the student already has a natural affinity.

6) **Students’ strengths (islands of competence).** Where appropriate, work from students’ abilities, strengths, and interests in specific academic classes or extracurricular activities as a base for helping them with academic or behavioral health challenges. Communication with families and any after-school and community

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3 See Companion Document: Resources Section for examples.
programs that support development in these areas of interest can reinforce student learning and build opportunities within the school environment.

7) **Physical well-being.** Students’ physical health, including dental and nutritional needs, greatly impacts their ability to meet the academic and social demands of the school environment. The involvement of the school nurse as part of the Behavioral Health Support Team is critical to identifying students with somatic difficulties stemming from behavioral health needs.

8) **Safe learning environments.** School environments should be physical, socially, and psychologically safe for all students. Safe classrooms have clearly established behavioral expectations and crisis or safety plans in place to deal with difficult and unsafe situations. Safe classrooms also have clear distinctions between office-referral and classroom-managed behavioral difficulties to prevent unnecessary or excessive disciplinary referrals. In situations where problem behaviors occur, options exist to allow for classroom instruction to resolve the situation. In cases of emergency in the classroom, all students should be familiar with the school’s emergency plans.

9) **Involvement of students in evaluating the effectiveness of programs and services.** Students hold a unique and critical perspective on the school experience and the programs and services available. Creating opportunities to hear the perspective of the students is critical to maintaining effective programs; yet this also requires hearing from students who are not necessarily experiencing success in school. Fostering student leadership and supporting positive youth development may require school staff to accept feedback that creates discomfort but this feedback also has the potential to identify challenging situations for struggling students. Enabling a broad range of students, not just the “typical leaders” to participate in evaluation and decision-making is beneficial.

### B. Early interventions

Early interventions provide collaborative approaches to identify and address behavioral health symptoms early. These targeted interventions are the supports, strategies, and programs available to students that need additional services to be successful in the school environment. The universal, systematic screening procedures, referenced above under “universal supports,” can be the foundation for data-based decision making and identifying students who are in need of targeted intervention and support services. Using a Behavioral Health Support Team recommended in Section 1, school staff can come together using a problem solving approach to identify short-term interventions for students at-risk of academic or social-emotional challenges to reduce present and future barriers to learning.

1) **Targeted Academic supports.** Targeted interventions can address areas in which the students experience academic difficulties (e.g. math, reading, and writing). Difficulties in one of these basic areas can impact the skill development in the other academic content areas (e.g. science, history), therefore it may be helpful to consider
a range of academic supports. Academic supports may include interventions such as small group tutoring, after school programming, and classroom-based strategies that provide targeted academic supports.

2) **Social-emotional supports.** Small group settings that are focused on social-emotional development can be organized to support students at-risk for socio-emotional difficulties. These supports can reinforce the lessons from the primary prevention curriculum discussed above. These supports can also be used to target vulnerable populations, such as students who are homeless, in foster care, or returning from out-of-home placements. Social-emotional supports may include strategies such as mentoring programs, group counseling, art therapy classes, and targeted lessons on topics such as conflict resolution and self regulation.

3) **Flexible programming.** While predictability is needed in the school and classroom environments, this can be complemented with flexible implementation of programming and services needed for targeted students to meet educational goals. Allow scheduling flexibility to accommodate additional supports, including the academic and social-emotional supports described above, may successfully engage and support students at-risk of academic and behavioral challenges.

4) **Ongoing monitoring of progress.** Along with the implementation of targeted interventions is the need for continuous monitoring of progress to determine the effectiveness of the implemented strategy. Strategies that do not demonstrate meaningful student progress should be reviewed to determine how the approach could be refined; including analyzing if the strategy is an appropriate match for addressing the targeted student needs. It can be the role of the Behavioral Health Support Team to monitor student progress in collaboration with classroom-based staff and behavioral health staff.

C. **Intensive services.** Intensive services are the supports, strategies, and programs that address the behavioral health of the students demonstrating significant needs. The educational outcomes of students identified as having an emotional disturbance continue to be the worst of any disability group. These students have significant deficits in academic achievement and approximately 50 percent drop out of high school. These programs and strategies can include structured behavioral programs, Alternative Education programs and schools, diagnostic placements, case management, and psychiatric hospitalization re-entry strategies.

1) **Intensive academic supports.** Intensive academic supports can connect with and build on the targeted academic supports described above. Intensive academic supports provide individualized academic strategies that are tailored to a student’s specific academic strengths and challenges. Effective intensive supports merge academic skill

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4 Bradley et al., 2004
5 Reid, Gonzalez, Nordness, Trout, & Epstein, 2004
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development with strategies that develop socio-emotional competence. Intensive academic supports may include strategies such as individual academic coaching and tutoring as well as Alternative Education programs and schools.

2) **Crisis situations.** While all students should be familiar with the schools emergency plans in the event of a disaster or crisis (e.g., exit from or return to the school building – see Section 5 for more information), particular strategies may be needed for students with significant behavioral health needs. Specific behavioral intervention and crisis support plans may need to be developed, shared, and coordinated with the school and community-based behavioral health providers. These plans identify strategies to support the student in a respectful and helpful way, while also ensuring the safety of all students, if: 1) the student is personally involved in a crisis situation and 2) there is a school or community crisis or disaster.

3) **Transitions to and from out-of-home placements.** Carefully planned transitions to and from school are critical to ensure school connection for students who have been in, or are going to, an out-of-home or intensive placement. Out-of-home or intensive placements include hospitalizations; foster care; state agency or residential school; or coming to school after experiencing a situation or crisis where there was unable housing – such as homelessness, house fire, house foreclosure, and domestic violence situations. These transitions should demonstrate flexible academic programming to support successful school exit and re-entry.

4) **Collaboration and coordination around medical treatment plans.** Students with significant behavioral health needs may be receiving medical treatments and may be impacted by the effects of these treatments. For example, a student who is prescribed a new psychototropic treatment may experience side effects that require modifications in their school plan (e.g., access to gum or water throughout the day, a delayed school start). Coordination between the school staff and community behavioral health providers can promote consistency and continuity of care, enhance generalization of coping skills across settings, and increase the opportunity for the student with behavioral health needs to be successful in the school environment.

5) **Referral procedures to Community Service Agencies (CSA).** For students who are identified as having an emotional disturbance, the school has procedures in place to educate the family and/or caretakers on the services available through the CSA as part of the Children’s Behavioral Health Initiative *(Refer to Sections III and V, as well as Framework Appendix on page 27 for additional information).*
V) POLICIES AND PROTOCOLS

This section addresses policies and protocols for referrals to behavioral health services that minimize time out of class, safe and supportive transitions to school, consultation and support for school staff, confidential communication, appropriate reporting of child abuse and neglect under section 51A of chapter 119 of the General Laws, and discipline that focuses on reducing suspensions and expulsions and that balances accountability with an understanding of the child’s behavioral health needs and trauma.

Policies (a set course of actions) and protocols (plans) provide the foundation for schools to implement the recommendations outlined in this framework to address supportive school environments, early interventions, and intensive services. As suggested in Section I, school leaders and administrators are encouraged to engage staff in determining which of its district and school policies and protocols require review and to identify new ones that will ensure the success of all students. The following are policies and protocols that can be considered or reconsidered.

A. Confidential communication. To respect student and family privacy and to increase collaboration between schools and behavioral health programs, it is critical to create clear protocols around confidentiality. School and district leadership should establish action steps that will be taken if the protocols for confidential communication are not followed.

1) Communication best practice. In particular, school leaders can ensure that staff understand and use best practice for maintaining confidentiality of individual students with behavioral health needs. This includes refraining from conversations about specific students while in audible range of others, and refraining from disclosing specific student information to outside sources without explicit permission from the family. This work is often carried out by school-based teams, such as Child Study, student support, child protective, and/or IEP teams for identified students who require support programs and services. School leaders oversee these different groups and can work to improve appropriate communication and coordination of services while implementing measures to ensure student confidentiality.

2) Information release forms. The use of Release of Information Forms allow families to address concerns about sharing personal material and can outline specific means the school will employ to limit access and monitor use of any protected school or health information in the student record. It is recommended that forms allow families to easily specify both what information they are allowing the school to obtain and what information they are allowing the school to release. A separate form can be filled out for each collaborating organization. Federal confidentiality regulations restrict the use of a single blanket release form, therefore this practice is not recommended.

B. Consultation Protocols. The schools can develop protocols that facilitate support for educators through case consultations with internal and external experts. Policies establish parameters for classroom observations that balance the reasonable needs of school staff with the evaluator’s need for access. The opportunities for consultation and/or classroom
observation on individual students is increased when parents are informed and/or offered the opportunity to participate in consultations about their own children. (See ESE’s guidance on classroom observations.)

C. Early identification policies. Policies and protocols can ensure the early identification of students’ behavioral health needs, the availability of referral information for parents/caretakers seeking behavioral health screening or diagnostic evaluations, and ongoing reassessment of students’ behavioral health needs. These needs may include but are not limited to issues related to substance abuse, violence, and physical well being.

D. Flexibility of scheduling. Student engagement and connection to school is enhanced when scheduling policies afford students access to an area of interest6 (see Section IV for more information about building on students strengths and interest and allowing flexible schedules to allow access to programs and services that are connected to student needs and interests). Flexibility around school policies for access to academic and extracurricular activities, particularly for disengaged students and students in out-of-district placements, can afford them an opportunity to access an area of strength, maintain community and peer connections, and ultimately experience increased engagement in school. School protocols can foster opportunities for a broad range of students to take on leadership roles in planning and decision-making.

E. Ensuring safety for children when domestic violence has occurred. Schools can set policies that support the implementation of laws regulating restraining orders, safety plans, and records release (See Appendix XX DVASS Checklist for Domestic Violence – to be added.) Additional information about policies for safety plans, and crisis intervention plans. Crisis intervention protocols are in place and all staff are knowledgeable about the components and procedures. Policies clearly articulate how to access mobile crisis intervention teams, funded through the Children’s Behavioral Health Initiative, and specify working relationships with the local police departments.

F. Appropriate reporting of child abuse and neglect under section 51A of chapter 119 and filing of Child in Need of Services (CHINS) petitions under the Massachusetts General Laws. Policies can create specific procedures to ensure that documentation of suspected child abuse or neglect based on guidelines that are consistent with the Department of Children and Families (DCF). Policies should also specify protocols for referrals to local Juvenile Courts for a Child in Need of Services (CHINS), and should include documentation of these referrals, notification of parents, and outcomes of referrals. (Email achievement@doe.mass.edu for updates on ESE guidance regarding best practices in filing suspected reports of abuse or neglect; DCF Interagency Protocol with MassHealth and the Children’s Behavioral Health Initiative)

G. Discipline policies balance accountability with an understanding of students’ behavioral health needs. Reducing the number of suspensions and expulsions will be

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6 http://www.renniecenter.com/research_docs/0902-DropoutBrief-final.pdf

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enhanced by discipline policies that recognize underlying difficulties children may have with forming relationships, modulating emotions and behaviors, and achieving academic and non-academic success. It is recommended that discipline policies also consider ways to:

1. Implement universal interventions and supports to establish a safe and positive school climate. Rather than a “zero tolerance” approach to problem behaviors, discipline policies should promote a proactive approach to understanding students with challenging behaviors and providing them with a differential response with the aim of keeping these students in class and in school.

2. Use mobile crisis intervention services through the Children’s Behavioral Health Initiative for eligible students in order to support the management and de-escalation of behavioral health crises before a disciplinary response occurs.

3. Develop and use alternatives to suspensions, expulsions, and physical restraints whenever possible, such as in-school suspensions and referral to community services and/or public agencies.

4. Implement a range of academic and non-academic supports and prevention approaches (see Section IV) to address school violence and to build positive behaviors.

5. Collect and analyze data on office referrals, suspensions, and expulsions in order to inform and refine discipline approaches.

6. Develop intervention networks that reduce and/or prevent truancy, suspensions, expulsions and dropouts, such as: school-based behavioral health services, linkages to community services, referrals to wraparound programs (Intensive Care Coordination), and other programs for students who are at risk of dropping out or school failure.

H. Policies and protocols that promote access to a full range of resources and services.
These policies and protocols support the continuum of services needed to address student needs and include the following. (Additional information on accessing resources and services is included in Section III)

1) Well-established referral systems. Policies and protocols for referrals to behavioral health services in the school or to community behavioral health providers, including to Community Service Agencies (CSAs as part of MassHealth) will help ensure students have access to appropriate and timely services. Making effective confidential referrals requires clear policies that assist staff and families to overcome barriers to accessing services for students. For example, protocols can address accessing services such as crisis intervention, interpreter and transportation resources, mental health services community resource maps, single intake forms, facilitated referral processes, and knowledge of where there are openings for services, etc. (See Appendix XX – to be added – for The South Shore Collaborative Pathways’ single intake form for school,

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community, and state providers whereby families may have one intake interview at a school or agency that can be used to begin services by the most appropriate provider.)

2) **Formal agreements with community providers.** Such formal agreements between schools and community providers should be established to provide specific school-based or external services to individual or groups of students. The formal agreement should outline the nature of the relationship and address the following. *(Additional protocols for schools collaborating with community partners are outlined in Section III)*

- Agreement on release of information forms, ensuring confidentiality.
- The provision of services that are strength-based, family-driven, and child-centered.
- Ensuring that families are involved in all aspects of educational decision-making, including assessment of needs and development of intervention plans.
- Ensuring that services are linguistically and culturally competent to the greatest extent possible, materials are written for students and families in their language of origin are conveyed appropriately, and ensuring the availability of interpretive services.
- Providing outreach and education to engage families as appropriate and the delivery of services directly to families, including training and support.
- Creating a structure for establishing and maintaining frequent communication, protocols for classroom observations, consultation and attendance at team meetings.
- Maintaining contact information for and liaisons with local community and state agency services (e.g. behavioral health & emergency services providers; Department of Mental Health and Department of Children and Families area offices).
- Ensuring that community partners maintain cost-effective arrangements, including maximizing the benefits of 3rd party insurance for behavioral health services and mechanisms for flexible funding.
- Logistics of space, co-location of service delivery, scheduling, and ensuring that services provided at school do not conflict with students’ class work or non-academic opportunities (e.g. sports, arts, after-school programs), and that services are calibrated to further students’ educational goals.
- The role of community providers in: 1) student-specific crisis intervention plans, 2) transition plans for students returning to school or leaving school, 3) assessment of school needs, and/or 4) planning of services to achieve the goals and outcomes in the *School Improvement Plan*.

3) **Children’s Behavioral Health Initiative protocols regarding MassHealth services.** These policies assist districts and schools in establishing communication, information gathering, and problem-solving regarding local experiences with MassHealth referrals, access to services, and coordination with the provider network. It is strongly recommended that:

- A student’s behavioral health and/or ICC (Intensive Care Coordination) providers participate in any school-based team meetings upon consent from parents/guardians or a student age 18 and older. At the family’s request, school staff are also encouraged to participate in community-based meetings, including the Individual...
Care Planning Teams formed for children and youth in the MassHealth Intensive Care Coordination program.

- Schools establish an effective referral system for all behavioral health services, including Intensive Care Coordination (ICC) and Mobile Crisis Intervention (MCI) services that outline the following elements:
  - Education and outreach to parents
  - Clear expectations
  - Facilitated referrals for interested families/students
  - Structures for frequent communication between school and families
  - Mechanisms for coordination with providers of specific MassHealth behavioral health services, especially ICC and MCI
  - Guidance for participation in the ICC Wraparound team process
  - Guidance for collaboration with MCI related to behavioral health crises
  - Resources for understanding the interface between MassHealth and special education entitlements.

- Districts designate a school administrator or other high-level staff to oversee the operation and implementation of CBHI protocols.
- Protocols include specific procedures related to CBHI and the interface with Special Education laws and services.

I. Transitions and school exit and re-entry. Established procedures to support and integrate students with behavioral health needs exiting to or returning from out-of-home placements are important. Protocols can designate a contact person to coordinate transitions, including welcoming and checking in on a student, informing appropriate staff of transition plans and/or flexible academic schedules, and ensuring access to needed services. (See Appendix XX for North River Collaborative’s Transition Protocol – to be added.)

J. Emergency plans in the event of a crisis or disaster. All students and staff should be familiar with the schools emergency plans in the event of a disaster or crisis, including procedures for: exiting and returning to the school building, school staff roles and points of contact, and techniques to maintaining a positive environment that increases the sense of security and safety for students. Specific behavioral intervention and crisis support plans should be developed and in place for students with intensive needs (see Section IV). Emergency plans should also include socio-emotional supports for students in staff when needed, including how to access grief counselors and emergency food and shelter options.

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VI) COLLABORATION WITH FAMILIES

Families from all cultures, languages, and socio-economic levels can participate as partners in every facet of the education and development of their children. Collaboration between schools, behavioral health providers, and families is a central theme of each section of this Framework.

This section describes the strategies to effectively engage and collaborate with students’ families in order to increase the school’s capacity to improve students’ behavioral health through supportive school environments, early interventions, and intensive services.

A. Building the foundation for productive relationships. Schools can work to optimize student success by engaging families as partners in achieving educational and behavioral health goals for their children, which includes providing behavioral health services and supports in culturally and linguistically appropriate ways. A strong foundations for school–family partnerships can be supported by the following tasks:

1) Vision statements and/or School Improvement Plan include goals and activities that pertain to the involvement of families in a variety of school activities and avenues. Families are invited and encouraged to participate in the development of the priority goals and activities.

2) School personnel receive professional development on and demonstrate awareness and sensitivity to cultural, linguistic, and other aspects of family diversity (e.g., disability, socioeconomic level, and gender roles).

3) School staff show respect for the families and their values and cultures by using their preferred terms and phrases. This is often reflected in “people-first” language (e.g. using “student with bipolar illness,” rather than “mentally ill student”).

4) School staff create a safe, welcoming environment in which all families feel that their voices are valued. Examples of this include: 1) stocking waiting areas with reading material of interest to families; 2) setting up a family center where they can meet, talk, get information on subjects that concern them, or pick up materials; 3) creating mechanisms where families can voice their thoughts and suggestions, including opportunities for anonymous feedback.

5) School-based and community behavioral health providers are reflective of the student population, to the greatest extent possible.

6) The school tracks and analyzes family involvement through measures such as attendance; feedback requested following activities; and surveys asking families to indicate what methods of communication, times of day, topic areas, and activities would be of most interest to them.

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B. **Communication and collaboration with families.** Establishing set policies that meet the individual needs of families can promote stronger involvement in school activities and services. The goal of strong collaboration and communication with families is to inform and enhance the educational services provided to students.

1) School policies and protocols allow for flexibility to schedule parent meetings at various locations (including outside of the school environment), and at times that are convenient for families who work several jobs or who cannot leave work to meet with the school. Home visits or parent meetings may be scheduled during the school day and teachers are provided coverage to meet with parents.

2) School staff regularly communicate with families to update them on academic progress, discuss concerns, and ask for assistance in meeting needs of all students. This includes a system for regularly sharing information on student strengths and good news. Communication reflects each family’s preferences for how information is conveyed (e.g., phone calls, letters, in-person meetings).

3) The school has mechanisms in place to regularly share information about school-wide programs and school efforts to address the behavioral health of all students.

4) The school maintains and communicates the philosophy that families: are the single greatest influence on their children’s achievement, know their children best, know their family culture the best, and that the schools wants the best for their children.

5) Families are engaged in shared-decision making about their children and in shared decision-making on other school policies. Families help schools identify, encourage, and build upon students’ strengths.
   - Protocols are in place for meaningfully and effectively involving families in educational planning for children with special needs, in accordance with legal mandates, and for integrating families – especially those that represent linguistic and cultural minorities – into the school’s behavioral health services.

6) Families have an opportunity to communicate the needs of their family and their children (e.g. sensitivity to adoption, domestic violence, etc) with classroom-based staff and school leaders. School staff demonstrate an understanding of the family’s perspective on the situation.

7) The school collaborates with families to learn about quality and helpful community resource and service options.

8) The school provides families with access, and when necessary referrals, to needed community resources and services (e.g. behavioral health services, housing, medical, public assistance, etc.).

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FRAMEWORK APPENDIX - ADDITIONAL INFORMATION AND DEFINITIONS

1. **The Children’s Behavioral Health Initiative (CBHI).** CBHI is an interagency initiative of the Commonwealth’s Executive Office of Health and Human Services. Its mission is (1) to strengthen, expand and integrate Massachusetts state services into a comprehensive system of community-based system of care, and (2) to ensure that families and their children with significant behavioral, emotional and mental health needs obtain the services necessary for success in home, school, and community. CBHI and MassHealth (the Massachusetts Medicaid Program) are responsible for implementing the remedy in the Rosie D lawsuit, which involves the creation of several new MassHealth services to members under 21, along with enhancement of emergency behavioral health services for members under 21, known as Mobile Crisis Intervention (MCI). Among the new MassHealth services is Intensive Care Coordination (ICC), a team-based and family-centered process for developing sustainable Individualized Care Plans for children and youth with complex behavioral health needs, using the Wraparound care planning process. ICC is provided by local entities called Community Service Agencies (CSAs), which also provide Family Partners to work with families of children and youth. Family Partners are caregivers who have received special training to engage families and help them navigate the complexities of the service system. In addition, CSAs are responsible for convening local System of Care (SOC) committees, which provide a forum for local stakeholders to make Wraparound and collaborative, family-centered approaches work effectively in their community. Finally, between October 1 and December 1, 2009, MassHealth will begin to pay for three new home and community-based services for members under 21: In Home Therapy, In Home Behavioral Services and Therapeutic Mentoring.

2. **Behavioral Health Support Team.** The term Behavioral Health Support Team is used to refer to any school-based team that is established or created to deal with behavioral health issues in schools. These can include but are not limited to Crisis Intervention Team, Wrap-Around Services Team, Student Support Teams, IEP Teams, etc. In small districts, the need for one team to serve all schools may be appropriate. In larger districts, a team may be needed in each school with all teams coordinated across the district by administration. It is important for the school-based teams to coordinate and communicate with the MassHealth Intensive Care Coordination teams (ICC) which are convened by the regional Community Service Agencies.

3. **Behavioral health providers** are defined broadly to include school nurses, school psychologists, school adjustment counselors, social workers, and guidance counselors and community-based behavioral health providers, including therapists, social workers and clinicians. State certification information for these types of positions is categorized under Professional Support Personnel.
Appendix D. Behavioral Health and Public Schools Self-Assessment Tool – Pilot Version

Introduction

This self-assessment tool for schools is in pilot (draft) form and is designed to assess current activities and strategies that the staff and programs in your school engage in to create a supportive school environment. This tool is intended to assist with documenting current practices that support students' behavioral health at all intervention levels, ranging from the whole school community to individual students that require more intensive supports. It also examines the role of various school professionals and staff in providing these supports. This tool provides a general guideline for strategies to implement in the future. The Task Force on Behavioral Health and Public Schools drafted this tool and recommends revisiting your school's responses to this tool on a regular (e.g., quarterly, annual) basis to review progress and continually work towards full implementation on a range of practices that address and remove the barriers to learning.

Behavioral Health and Public Schools Assessment Tool: General Instructions

1. Coordinate a school-based team of 3-10 people, which should include a variety of staff and perspectives, including but not limited to: school administrators, district administrators, guidance, teachers, nurses, students, parents/family of students, and community providers. Base your responses to this tool on the collective experiences/perspectives of the team.

2. The following materials from your school may be of assistance to you as you complete this tool: student handbook, school improvement plan, social skills instructional materials, behavioral incident reports, office discipline referrals, health program curriculum, and community resource map.

3. The assessment tool is divided into six main sections:

<table>
<thead>
<tr>
<th>I) Leadership</th>
<th>III) Access to resources and services</th>
<th>V) School policies, procedures, and protocols</th>
</tr>
</thead>
<tbody>
<tr>
<td>II) Professional development</td>
<td>IV) Academic and non-academic supports</td>
<td>VI) Collaboration with families</td>
</tr>
</tbody>
</table>

For your reference, these sections are parallel to the sections described in the Behavioral Health and Public Schools Framework. Each of the six main sections contains two parts.
4. **Part I** for each section includes strategy tables to mark your current levels of implementation, as well as your priorities for action/implementation for a variety of action steps. Following every table there are two open-ended questions on your greatest strength and greatest challenge related to the strategy.

   a. To assess your school’s behavioral supports, first evaluate the current level of implementation for each action step given for each strategy. Indicate the most accurate response by typing an “X” in the appropriate column on the left-hand side of survey. Note that not all action steps will be appropriate or feasible for each school; this includes some action steps that reference the use of the framework (which pilot sites have not had the opportunity to use/implement).

   b. Next, for each action step example, indicate your current priority level for action/implementation of the action item. Indicate the most accurate response by typing an “X” in the appropriate column on the right-hand side of survey.

   c. For each strategy, provide a brief description of your school’s main strength and main challenge relative to the strategy. These responses will help explain your selections for the current levels of implementation. Feel free to use as much space as you need.

5. **Part II** within each section includes three open-ended general questions related to the section as a whole. These questions are followed by a chart to help your team plan for the action steps you rated in Part I as a priority for enhanced or increased implementation. For both the open-ended questions and the chart, please feel free to use as much space as you need.

6. Following the six main sections of the tool there are two brief sections: **Outcomes Data** and **General Questions**. These sections are intended to provide an opportunity to provide some overarching information regarding addressing behavioral health in your school.

Name of school: __________________________________________

Name of the main organizer/contact for the Team: ____________________________

District: ____________________________________________

Role of the main organizer/contact: ___ School Administrator ___ District Administrator ___ Special Education Teacher/Staff ___ General Education Teacher/Staff ___ School Psychologist ___ Parent/Family member ___ Teacher Assistant ___ Other ____________________________

Roles of other people on the team involved with completing this tool (check all that apply).

___ School Administrator ___ District Administrator ___ Special Education Teacher/Staff ___ General Education Teacher/Staff ___ Guidance Counselor ___ School Psychologist ___ Parent/Family member ___ Teacher Assistant ___ Community member ___ Student ___ Parent/Family ___ Other ____________________________

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I) School Leadership

Leadership by school and district administrators creates systems and services within schools that promote collaboration between community-based behavioral health providers and school staff to support positive outcomes and success of students.

### Leadership: Part I

<table>
<thead>
<tr>
<th>Current Implementation Level</th>
<th>Strategies and Action Step Examples</th>
<th>Priority for Action/Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>We do…</td>
<td>STRATEGY A: District leadership, in partnership with the school committee, plays an essential role in this process of supporting behavioral health in the district's schools.</td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>Not do much of this</td>
<td></td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td></td>
<td>Reduce level of action</td>
</tr>
<tr>
<td>This to a great extent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributors</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>i. The district has a written vision statement, based on the input of students, families, staff, and the community, that addresses approaches to supportive school environments, early interventions, and intensive services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ii. The school committee and superintendent set measurable outcome goals that reflect the contributing factors to success in school and life (attendance, school engagement, grade progression, graduation rates, etc.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>iii. The superintendent and other administrators created and administered a district plan that addresses the three-part approach of supportive school environments, early interventions, and intensive services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>iv. The district has a data system that allows for the collection, tracking, and analysis of data related to behavioral outcome goals.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other action steps used to address this strategy (insert as many lines as needed):</td>
<td></td>
</tr>
</tbody>
</table>

**A1. What is your greatest strength related to implementing this strategy?**

**A2. What is your greatest challenge or weakness related to implementing this strategy?**

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### Current Implementation Level

<table>
<thead>
<tr>
<th>We do…</th>
<th>Strategies and Action Step Examples</th>
<th>Priority for Action/Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not do much of this</td>
<td>STRATEGY B: School administrators work in partnership with other key personnel to play a leadership role in the integration of behavioral health supports and services into existing school operations.</td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td></td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to a great extent</td>
<td></td>
<td>Reduce level of action</td>
</tr>
<tr>
<td>This in a highly skilled way</td>
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</tr>
</tbody>
</table>

i. A principal or other school administrator leads a school-based team to determine how best to incorporate the recommendations described in the framework into existing School Improvement Plans.

ii. School leaders develop and oversee a professional development plan to increase skills among school staff and behavioral health providers to implement the district's/school's approach to promoting students' behavioral health.

iii. School leaders set up structures to enhance the school's capacity to promote students' behavioral health through resource mapping, partnerships with community agencies, and confidential conferencing on individual students.

iv. School leaders provide the vision and support for implementing effective activities and strategies that build on students' strengths and promote success in school.

v. School leaders are involved in the creation and revision of behavioral health policies and protocols, with the input of staff, to address a range of topics connected with supporting the behavioral health needs of students.

vi. School leaders partner with families in supporting the educational success of their children, including supporting family involvement in the implementation of supportive school environments, early interventions, and intensive services.

Other action steps used to address this strategy (insert as many lines as needed):

**B1.** What is your greatest strength related to implementing this strategy?

**B2.** What is your greatest challenge or weakness related to implementing this strategy?

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Leadership: Part II
The following questions are intended to provide additional information related to the strategies noted above.

1. Does the district currently have a vision for implementing 1) supportive school environments, 2) early interventions, and 3) intensive services for students with behavioral health needs? If so, what is the vision and how is this vision currently communicated to staff, parents, and community partners?

2. Does the school currently incorporate the District Plan or the elements of the behavioral health framework into existing School Improvement Plans? If so, what is included in School Improvement Plans and how are these plans currently communicated to staff, parents, and community partners?

3. Are there any current school/district groups that address behavioral health programs and services? If so, what are they and Indicate if the committees are district-wide or school-based.

Use the following chart to provide a description of your school plans, if any, to address the action steps that you rated above (in Part I for this section) as a priority for enhanced or increased implementation.

<table>
<thead>
<tr>
<th>For the action step areas that you marked as a priority for enhanced or increased implementation in Part I - describe any specific plans related to these items.</th>
<th>Timeline</th>
<th>Person(s) Responsible</th>
</tr>
</thead>
<tbody>
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</table>

(Add as more lines as needed.)

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II) Professional Development

Professional development opportunities increase capacity of schools to address behavioral health issues and skills in working with students and parents with behavioral health issues.

### Professional Development: Part I

<table>
<thead>
<tr>
<th>Current Implementation Level</th>
<th>Strategies and Action Step Examples</th>
<th>Priority for Action/Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>We do...</strong></td>
<td>STRATEGY A: <em>Professional development opportunities follow a range of core guiding principles.</em></td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>Not do much of this</td>
<td>i. All members of the school community, including the school committee, administrators, staff, parents, and behavioral health providers understand the role of the Massachusetts Behavioral Health Framework and the district and school’s roles in utilizing the Framework to improve educational outcomes for all students.</td>
<td></td>
</tr>
<tr>
<td>This to some extent</td>
<td>ii. Administrators, staff, and behavioral health providers receive coordinated training that address multiple skill levels and cross-disciplinary topics, and incorporate diverse approaches for staff development such as coaching, team teaching, and mentoring.</td>
<td></td>
</tr>
<tr>
<td>This to a great extent</td>
<td>iii. School-based and community behavioral health providers train together and learn from each other to promote collaboration.</td>
<td></td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td>iv. Trainings seek to increase staff familiarity with relevant child-serving systems, including state agencies and state sponsored behavioral health resources (e.g., MassHealth, etc.), and their potential intersections with education.</td>
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<tr>
<td></td>
<td>v. Trainings seek to increase external behavioral health providers’ familiarity with school and district structures and requirements.</td>
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<td></td>
<td>vi. Professional development plans recognize that school-based behavioral health staff, irrespective of their titles, may have skills that bridge the divide between the educational and health systems, or may have specialized skills that can be put to use in the cross training of educators and community behavioral health providers.</td>
<td></td>
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<tr>
<td>Current Implementation Level</td>
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</tr>
<tr>
<td>We do...</td>
<td>STRATEGY A: <em>Professional development opportunities follow a range of core guiding principles.</em></td>
<td>We plan to...</td>
</tr>
<tr>
<td>Not do much of this</td>
<td></td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td></td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to a great extent</td>
<td></td>
<td>Reduce level of action</td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td></td>
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<tr>
<td>vii. There is professional development time designated each school year to address behavioral health issues and resources are made available (e.g. substitute teachers, release time, stipends) to support staff participation.</td>
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<tr>
<td>viii. Issues of cultural competence are addressed.</td>
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<tr>
<td>ix. Families are involved in the identification/selection of topics, can participate in professional development opportunities, and have a role in the evaluation of any training activities.</td>
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<tr>
<td>x. Pursuit of certification, licensure, and professional distinctions are encouraged and supported.</td>
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<tr>
<td>Other action steps used to address this strategy (insert as many lines as needed):</td>
<td></td>
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</table>

A1. What is your greatest strength related to implementing this strategy?

A2. What is your greatest challenge or weakness related to implementing this strategy?
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<tbody>
<tr>
<td><strong>We do...</strong></td>
<td><strong>STRATEGY B: Sufficient and appropriate professional development opportunities are offered to all school and district staff.</strong></td>
<td><strong>We plan to...</strong></td>
</tr>
<tr>
<td>Not do much of this</td>
<td>Sustain current level of action</td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This to a great extent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Professional development opportunities address staff skills in the ability to help students develop safe, caring relationships with adults and peers, and to manage their emotions, behaviors, and attention to achieve academic success.</td>
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<tr>
<td>ii. Professional development opportunities address staff skills in building relationships and communicating with all families.</td>
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<tr>
<td>iii. Professional development opportunities address staff skills in understanding the separate roles and common objectives of behavioral health providers and educators that promote supportive school-wide environments and that address the needs of individual students.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv. Professional development opportunities address staff skills in understanding the impact of trauma and other risk factors for learning, relationships, behavior, physical health, and well being.</td>
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</tr>
<tr>
<td>v. Professional development opportunities address staff skills in school-wide and individualized approaches/services that help at-risk students succeed in school.</td>
<td></td>
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<tr>
<td>vi. Professional development opportunities address staff skills in implementing policies and protocols related to supporting students’ behavioral health.</td>
<td></td>
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<tr>
<td>vii. Professional development opportunities address staff skills in strategies and interventions that are alternatives to physical restraints.</td>
<td></td>
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<tr>
<td>viii. Professional development opportunities address staff skills in learning the respective roles of school-based teams (Child Study, Student Support, IEP) and team processes connected with other state agencies and services (e.g. MassHealth teams - Care Planning Teams), and how to jointly participate in and coordinate the work of these teams.</td>
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<td><strong>STRATEGY B: Sufficient and appropriate professional development opportunities are offered to all school and district staff.</strong></td>
<td><strong>We plan to...</strong></td>
</tr>
<tr>
<td>Not do much of this</td>
<td></td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td></td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to a great extent</td>
<td></td>
<td>Reduce level of action</td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ix. Professional development opportunities address staff skills in recognizing behavioral health symptoms, including those related to stress and trauma, to aid in early identification.</td>
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<tr>
<td>x. Professional development opportunities address staff skills in best practice for discussing sensitive, confidential, and/or privileged student information.</td>
<td></td>
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</tr>
<tr>
<td>Other action steps used to address this strategy (insert as many lines as needed):</td>
<td></td>
<td></td>
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</table>

B1. What is your greatest strength related to implementing this strategy?

B2. What is your greatest challenge or weakness related to implementing this strategy?
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<td><strong>We do…</strong></td>
<td><strong>STRATEGY C: Sufficient and appropriate professional development opportunities are offered to administrators and other school leaders.</strong></td>
<td><strong>We plan to…</strong></td>
</tr>
<tr>
<td>Not do much of this</td>
<td>i. Professional development opportunities address administrator skills in engaging school staff in their role to support the well-being and healthy development of all students.</td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td>ii. Professional development opportunities address administrator skills in disciplinary approaches that balance accountability with an understanding of behavioral health needs of students.</td>
<td></td>
</tr>
<tr>
<td>This to a great extent</td>
<td>iii. Professional development opportunities address administrator skills in managing and evaluating the policies and protocols related to supporting students’ behavioral health.</td>
<td></td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td>iv. Professional development opportunities address administrator skills in ways to support the well-being of educators and behavioral health staff.</td>
<td></td>
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<tr>
<td></td>
<td>v. Professional development opportunities address administrator skills in ways to meaningfully engage a broad range of students in school planning and decision-making groups with staff.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>vi. Professional development opportunities address administrator skills in analyzing and using data to inform decision making about services and interventions.</td>
<td></td>
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<tr>
<td></td>
<td>vii. Professional development opportunities address administrator skills in developing flexible approaches that support external behavioral health providers who offer services in the school setting (e.g., making space available).</td>
<td></td>
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<tr>
<td></td>
<td>Other action steps used to address this strategy (insert as many lines as needed):</td>
<td></td>
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C1. What is your greatest strength related to implementing this strategy?

C2. What is your greatest challenge or weakness related to implementing this strategy?

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<tbody>
<tr>
<td><strong>We do...</strong></td>
<td>STRATEGY D: Sufficient and appropriate professional development opportunities are offered to teachers and instructors.</td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>Not do much of this</td>
<td>i. Professional development opportunities address teacher/instructor skills in strategies and approaches to improve instruction that support students with or who may be at risk for developing behavioral health needs.</td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td>ii. Professional development opportunities address teacher/instructor skills in the ability to create a caring classroom community and manage classroom behaviors, including ways to de-escalate behavior to reduce the need for crisis intervention.</td>
<td>Reduce level of action</td>
</tr>
<tr>
<td>This to a great extent</td>
<td>iii. Professional development opportunities address teacher/instructor skills in understanding a teacher/instructor’s particular role in crisis intervention for an individual student or group of students and the role of behavioral health providers in crisis situations.</td>
<td></td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td>Other action steps used to address this strategy (insert as many lines as needed):</td>
<td></td>
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</tbody>
</table>

**D1. What is your greatest strength related to implementing this strategy?**

**D2. What is your greatest challenge or weakness related to implementing this strategy?**
### Current Implementation Level

<table>
<thead>
<tr>
<th>We do...</th>
<th>Current Implementation Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not do much of this</td>
<td>This to some extent</td>
</tr>
<tr>
<td>This to a great extent</td>
<td>This in a highly skilled way</td>
</tr>
</tbody>
</table>

### Strategies and Action Step Examples

**STRATEGY E: Sufficient and appropriate professional development opportunities are offered to school-based and community behavioral health providers.**

- **i.** Professional development opportunities address behavioral health professional skills in identification of school problems and how behavioral health symptoms may manifest in a school setting.
- **ii.** Professional development opportunities address behavioral health professional skills in understanding of how behavioral health problems impact all aspects of a student’s functioning, including learning and behavior in school, at home, and in the community.
- **iii.** Professional development opportunities address behavioral health professional skills in strategies for positive and appropriate responses to student’s needs, in the classroom and throughout the school.
- **iv.** Professional development opportunities address behavioral health professional skills in providing classroom observations, consultations with educators, and ways to support school personnel, students and their families.

Other action steps used to address this strategy (insert as many lines as needed):

### Priority for Action/Implementation

<table>
<thead>
<tr>
<th>We plan to...</th>
<th>Sustain current level of action</th>
<th>Enhance or increase current level of action</th>
<th>Reduce level of action</th>
</tr>
</thead>
</table>

E1. What is your greatest strength related to implementing this strategy?

E2. What is your greatest challenge or weakness related to implementing this strategy?
Professional Development: Part II

The following questions are intended to provide additional information related to the strategies noted above.

1. If your district has created or conducted cross-disciplinary training to build capacity in addressing behavioral health issues, describe what has been done.

2. Provide information about consultants or other professionals that have trained by or presented to school staff on behavioral health issues, including their backgrounds and topics addressed.

3. Discuss any evaluation or assessment activities of professional development offered to school staff, and address any conclusions or resulting actions taken by your school or district.

Use the following chart to provide a description of your school plans, if any, to address the action steps that you rated above (in Part I for this section) as a priority for enhanced or increased implementation.

<table>
<thead>
<tr>
<th>For the action step areas that you marked as a priority for enhanced or increased implementation in Part I - describe any specific plans related to these items.</th>
<th>Timeline</th>
<th>Person(s) Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

(Add as more lines as needed.)
## III) Access to Resources and Services

Supportive school environments provide easy and effective access, as needed, to clinically, linguistically and culturally-appropriate behavioral health services. The services include efforts towards prevention, early intervention, crisis intervention, screening, and treatment, especially for children transitioning to school from other placements, hospitalization, or homelessness, and children requiring behavioral health services pursuant to special education individual education plans.

### Access to Resources and Services: Part I

<table>
<thead>
<tr>
<th>Current Implementation Level</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>We do...</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not do much of this</td>
<td>STRATEGY A: The school’s capacity to promote students’ behavioral health through supportive school environments, early interventions, and intensive services is enhanced through a process of understanding current resources/services and making recommendations to fill any resource/service gaps.</td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td></td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to a great extent</td>
<td></td>
<td>Reduce level of action</td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. The school maps its resources, and the process includes identification of strengths and unmet needs, communication protocols, and the roles of school/district staff and community providers.</td>
<td></td>
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<tr>
<td>ii. The school has recommendations to fill the resource/service gaps identified in the mapping process.</td>
<td></td>
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<tr>
<td>Other action steps used to address this strategy (insert as many lines as needed):</td>
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</tbody>
</table>

### A1. What is your greatest strength related to implementing this strategy?

### A2. What is your greatest challenge or weakness related to implementing this strategy?
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</thead>
<tbody>
<tr>
<td>We do...</td>
<td>STRATEGY B: School-wide and district-wide services and resources promote a positive school culture to develop effective social and emotional skills in all students.</td>
<td>We plan to...</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not do much of this</th>
<th>This to some extent</th>
<th>This to a great extent</th>
<th>This in a highly skilled way</th>
<th>Sustain current level of action</th>
<th>Enhance or increase current level of action</th>
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</table>

i. All students in need of services have access to resources that are clinically, linguistically, and culturally appropriate.

ii. Services include district-wide, school-wide, classroom-based, small group, and individual student activities and supports.

iii. There is a shared standard and practice around confidentiality of student behavioral health records.

Other action steps used to address this strategy (insert as many lines as needed):

B1. What is your greatest strength related to implementing this strategy?

B2. What is your greatest challenge or weakness related to implementing this strategy?
### Current Implementation Level

<table>
<thead>
<tr>
<th>We do…</th>
<th>This to some extent</th>
<th>This to a great extent</th>
<th>This in a highly skilled way</th>
</tr>
</thead>
</table>

### Strategies and Action Step Examples

**STRATEGY C: The school/district explores partnerships with community agencies to fill any gaps in school-based resources/services to promote students’ behavioral health.**

1. All students in need of external services have access to resources that are clinically, linguistically, and culturally appropriate.
2. External resources and services include the potential for both individual and group services for students who need them.
3. The school and district supports the participation of school staff in individual student’s treatment planning processes with external providers.
4. The school pays particular attention to those community-based services that are available for some students through MassHealth.
5. Partnerships with community organizations reflect the variety and scope of student needs and gaps in services.

### Priority for Action/Implementation

<table>
<thead>
<tr>
<th>We plan to…</th>
<th>Sustain current level of action</th>
<th>Enhance or increase current level of action</th>
<th>Reduce level of action</th>
</tr>
</thead>
</table>

### Other action steps used to address this strategy (insert as many lines as needed):


### C1. What is your greatest strength related to implementing this strategy?

### C2. What is your greatest challenge or weakness related to implementing this strategy?
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<tbody>
<tr>
<td>We do…</td>
<td></td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>Not do much of this</td>
<td>STRATEGY D: Confidential conferencing on individual students ensures that well-coordinated supports are available for the student and that common goals for success are established.</td>
<td></td>
</tr>
<tr>
<td>This to some extent</td>
<td>i. School-based teams convene to address student-specific support programs and services, and include the student's community behavioral health providers, if parent/caregiver consents to such involvement.</td>
<td></td>
</tr>
<tr>
<td>This to a great extent</td>
<td>ii. Community based teams convened by behavioral health providers include school staff, if parent/caregiver consents to such involvement.</td>
<td></td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td>iii. Conferencing on students ensures that comprehensive supports and services are available to the student.</td>
<td></td>
</tr>
<tr>
<td>i. School-based teams convene to address student-specific support programs and services, and include the student's community behavioral health providers, if parent/caregiver consents to such involvement.</td>
<td>iv. Conferencing on students ensures that supports and services are coordinated and that goals for student success are consistent for both school and community team members.</td>
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Other action steps used to address this strategy (insert as many lines as needed):

<table>
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<th>Priority for Action/Implementation</th>
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<tbody>
<tr>
<td>Sustain current level of action</td>
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</table>

D1. What is your greatest strength related to implementing this strategy?

D2. What is your greatest challenge or weakness related to implementing this strategy?
The following questions are intended to provide additional information related to the strategies noted above.

1. Describe any activities and supports in place that promote students’ behavioral health through supportive school environments, early intervention and coordinated services.

2. Identify existing school community-partnerships that address gaps in resources/services that cannot be met in the school/district.

3. Describe the efforts of the school staff and community providers to participate in confidential conferences? How does each group maintain the confidential nature of these child-specific meetings? How are parents assured of confidentiality?

Use the following chart to provide a description of your school plans, if any, to address the action steps that you rated above (in Part I for this section) as a priority for enhanced or increased implementation.

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<thead>
<tr>
<th>For the action step areas that you marked as a priority for enhanced or increased implementation in Part I - describe any specific plans related to these items.</th>
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(Add as more lines as needed.)
IV) Academic and Non-Academic Supports

Effective academic and non-academic activities build upon students' strengths, promote success in school, maximize time spent in the classroom and minimize suspensions, expulsions, and other removals for students with behavioral health challenges.

Academic and Non-Academic Supports: Part I

<table>
<thead>
<tr>
<th>Current Implementation Level</th>
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<th>Priority for Action/ Implementation</th>
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</thead>
<tbody>
<tr>
<td>We do...</td>
<td>STRATEGY A: The school has universal supports, strategies, and programs to create supportive school environments that promote overall well-being and positive educational outcomes for all students.</td>
<td>Sustain current level of action Enhance or increase current level of action Reduce level of action</td>
</tr>
</tbody>
</table>

- **STRATEGY A:**
  - i. The school maintains high quality instruction and high academic standards are set for all students. Instructional techniques that support individual student growth are identified and implemented.
  - ii. The school monitors the academic and social/emotional development of each student through systematic screening procedures in order to foster effective learning and identify situations when additional supports are needed.
  - iii. All classrooms in the school create relatively predictable environments for students, and include efforts to provide components such as:
    - a. clear expectations,
    - b. established routines,
    - c. clearly communicated class schedules;
    - d. predictable positive responses, even when students require correction on behavior or academics; and
    - e. carefully planned transitions involving previewing new people and new places, and reminding students of classroom rules as they move on to new activities.
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<tr>
<td><strong>We do...</strong></td>
<td><strong>STRATEGY A: The school has universal supports, strategies, and programs to create supportive school environments that promote overall well-being and positive educational outcomes for all students.</strong></td>
<td></td>
</tr>
<tr>
<td>Not do much of this</td>
<td>iv. The school has primary prevention programs in place that include efforts to address the following:</td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td>a. Modeling, teaching, and rewarding pro social/healthy and respectful behaviors. Similarly, problem behaviors and consequences are also clearly defined.</td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to a great extent</td>
<td>b. Using positive approaches to promoting behavioral health, including collaborative problem solving, team work, and positive behavioral supports that aid in social and emotional development.</td>
<td>Reduce level of action</td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td>c. Sensitive addressing behavioral issues in classrooms when they arise, so that learning can continue and students are not unnecessarily removed from class.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Teaching students to modulate emotions, recognizing the association between positive peer relations, adult connections, and self-regulation and the impact on academic success.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. Using effective approaches to address difficult emotional states and addressing underlying reasons for difficult behaviors by identifying and processing feelings.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>f. Developing collaborative discipline approaches that include student input which balance accountability with an understanding of underlying behavioral health needs.</td>
<td></td>
</tr>
<tr>
<td>v. The school encourages and supports the development of positive relationships between students and adults. Supports include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Opportunities for relationships to form between staff and students beyond the academic role (e.g., during lunch time or with an extra curricular project).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Promotion of student engagement in extracurricular activities.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Fostering relationships with adults with whom the students already have a natural a</td>
<td></td>
</tr>
<tr>
<td>vi. Where appropriate, the school builds on students’ abilities, strengths, and interests in specific academic classes or extracurricular activities as a base for helping them with academic or behavioral health challenges (islands of competence).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>vii. The school promotes physical and emotional health and well-being. The school nurse and other school support staff play a critical role in identifying students with somatic difficulties stemming from behavioral health needs.</td>
<td></td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>We do...</td>
<td>STRATEGY A: <em>The school has universal supports, strategies, and programs to create supportive school environments that promote overall well-being and positive educational outcomes for all students.</em></td>
<td>We plan to...</td>
</tr>
<tr>
<td>Not do much of this</td>
<td>viii. The school creates safe learning environments through clearly established behavioral expectations and emergency safety plans. The learning environment includes measures to ensure physical, social, and psychological safety.</td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td>ix. Students are involved in evaluating the effectiveness of programs and services.</td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to a great extent</td>
<td>Other action steps used to address this strategy (insert as many lines as needed):</td>
<td>Reduce level of action</td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A1. What is your greatest strength related to implementing this strategy?

A2. What is your greatest challenge or weakness related to implementing this strategy?

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<tr>
<td><strong>We do...</strong></td>
<td><strong>STRATEGY B:</strong> <em>The school has early interventions that include supports, strategies, and programs available to targeted students who need additional supports in order to help them be successful in the school environment.</em></td>
<td><strong>We plan to...</strong></td>
</tr>
<tr>
<td></td>
<td>i. The school has in place <em>targeted academic supports</em> for students at-risk for academic difficulties.</td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td></td>
<td>ii. The school has in place <em>socio-emotional supports</em> for students at-risk for socio-emotional difficulties.</td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td></td>
<td>iii. The school allows for <em>flexible programming</em> to meet the diverse needs of students in order to provide the educational requirements for school successful school completion.</td>
<td>Reduce level of action</td>
</tr>
<tr>
<td></td>
<td>iv. The school continuously monitors the progress of targeted interventions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Other action steps used to address this strategy (insert as many lines as needed):</strong></td>
<td></td>
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</tbody>
</table>

B1. What is your greatest strength related to implementing this strategy?

B2. What is your greatest challenge or weakness related to implementing this strategy?

---

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<tbody>
<tr>
<td><strong>We do...</strong></td>
<td><strong>STRATEGY C: The school has intensive services that include supports, strategies, and programs available to students who have the most significant needs in order to help them be successful in the school environment.</strong></td>
<td><strong>We plan to...</strong></td>
</tr>
<tr>
<td>Not do much of this</td>
<td></td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td></td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to a great extent</td>
<td></td>
<td>Reduce level of action</td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. The school has <strong>intensive academic supports</strong> in place specifically tailored for students with the most significant behavioral health needs. Effective supports are tailored to an individual student’s needs and merge academic skill development with strategies that develop socio-emotional competence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. The school has <strong>specific behavioral interventions and crisis support plans</strong> in place for students with the most significant needs. The plans identify strategies to support the student in a respectful and helpful way while also ensuring the safety of all students. The plans address individual student strategies if a student is personally involved in a crisis situation as well as if there is a school or community crisis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. Procedures are in place to <strong>support and integrate</strong> students with behavioral health needs returning from or going to an out-of-home placement such as hospitalizations and juvenile justice placements. These transitions demonstrate flexible academic programming to support successful school exit and re-entry.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv. The school <strong>collaborates and coordinates around medical treatment plans</strong> to provide a streamlined and complete set of supports for students with the most significant needs that are receiving medical treatments that may impact their success in school.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>v. The school has <strong>referral procedures</strong> in place to educate the family/caretakers on the services available through the Community Service Agencies (CSA) as part of the Children's Behavioral Health Initiative (CBHI).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other action steps used to address this strategy (insert as many lines as needed):</td>
<td></td>
<td></td>
</tr>
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C1. What is your greatest strength related to implementing this strategy?

C2. What is your greatest challenge or weakness related to implementing this strategy?

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Academic and Non-Academic Supports: Part II

The following questions are intended to provide additional information related to the strategies noted above.

1) Describe school/district wide universal supports currently in place and their success.

2) Analyze targeted interventions currently being implemented.

3) Identify community behavioral health providers that can partner with the district around intensive interventions.

Use the following chart to provide a description of your school plans, if any, to address the action steps that you rated above (in Part I for this section) as a priority for enhanced or increased implementation.

<table>
<thead>
<tr>
<th>For the action step areas that you marked as a priority for enhanced or increased implementation in Part I - describe any specific plans related to these items.</th>
<th>Timeline</th>
<th>Person(s) Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

(Add as more lines as needed.)
V) Policies and Protocols

Effective policies and protocols provide for referrals to behavioral health services minimize time out of class, safe and supportive transitions to school, consultation and support for school staff, confidential communication, appropriate reporting of child abuse and neglect under section 51A of chapter 119 of the General Laws, and discipline that focuses on reducing suspensions and expulsions and that balances accountability with an understanding of the child’s behavioral health needs and trauma.

Policies and Protocols: Part I

<table>
<thead>
<tr>
<th>Current Implementation Level</th>
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<th>Priority for Action/ Implementation</th>
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</thead>
<tbody>
<tr>
<td>We do...</td>
<td>STRATEGY A: Policies and protocols ensure confidential and effective communication to meet student needs.</td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>Not do much of this</td>
<td>i. A form is available for parents/guardians to release student information to inform programming and service delivery decisions. The information release forms acknowledge parent/guardian concerns about sharing student information and outline specific strategies the school will employ to limit access and monitor use of information.</td>
<td></td>
</tr>
<tr>
<td>This to some extent</td>
<td>ii. There is an information release protocol between the district/school and state agencies and community organizations to confidentially and efficiently share student information.</td>
<td></td>
</tr>
<tr>
<td>This to a great extent</td>
<td>iii. Communication protocols address individual family needs, such as, flexibility in scheduling the time and place for meetings and the availability of interpreters and translated materials.</td>
<td></td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td>iv. Protocols include strategies to engage all families in shared decision-making about their children and on school policies, procedures, and systems.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other action steps used to address this strategy (insert as many lines as needed):</td>
<td></td>
</tr>
</tbody>
</table>

A1. What is your greatest strength related to implementing this strategy?

A2. What is your greatest challenge or weakness related to implementing this strategy?
### Current Implementation Level

<table>
<thead>
<tr>
<th>We do...</th>
<th>Not do much of this</th>
<th>This to some extent</th>
<th>This to a great extent</th>
<th>This in a highly skilled way</th>
</tr>
</thead>
</table>

### Strategies and Action Step Examples

#### STRATEGY B: Policies and protocols are in place to provide consultation and support for school staff.

- i. Protocols are in place to facilitate support for educators through case consultations with internal and external experts.
- ii. Policies establish parameters for classroom observations that balance the reasonable needs of school staff with evaluators’ needs for access.

Other action steps used to address this strategy (insert as many lines as needed):

<table>
<thead>
<tr>
<th>Priority for Action/Implementation</th>
<th>We plan to...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustain current level of action</td>
<td></td>
</tr>
<tr>
<td>Enhance or increase current level of action</td>
<td></td>
</tr>
<tr>
<td>Reduce level of action</td>
<td></td>
</tr>
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</table>

### B1. What is your greatest strength related to implementing this strategy?

### B2. What is your greatest challenge or weakness related to implementing this strategy?
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<th>Current Implementation Level</th>
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<th>Priority for Action/ Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>We do...</td>
<td><strong>STRATEGY C: Early identification policies and protocols.</strong></td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>Not do much of this</td>
<td>i. Policies ensure the early identification of students’ behavioral health needs.</td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td>ii. Referral information is made available to parents/caretakers seeking behavioral health screening or diagnostic evaluations.</td>
<td>Reduce level of action</td>
</tr>
<tr>
<td>This to a great extent</td>
<td>iii. Protocols support ongoing reassessment of students’ behavioral health needs.</td>
<td></td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td>Other action steps used to address this strategy (insert as many lines as needed):</td>
<td></td>
</tr>
</tbody>
</table>

C1. What is your greatest strength related to implementing this strategy?

C2. What is your greatest challenge or weakness related to implementing this strategy?
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<th>Priority for Action/ Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>We do…</td>
<td>STRATEGY D: <em>Policies and protocols promote flexible scheduling to encourage student engagement.</em></td>
<td>We plan to…</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not do much of this</th>
<th>This to some extent</th>
<th>This to a great extent</th>
<th>This in a highly skilled way</th>
<th>Sustain current level of action</th>
<th>Enhance or increase current level of action</th>
<th>Reduce level of action</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. School policies encourage student engagement through flexible scheduling of academic classes and extracurricular activities.</td>
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<td></td>
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<tr>
<td>ii. School protocols foster opportunities for a broad range of students to take on leadership roles in planning and decision-making.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Other action steps used to address this strategy (insert as many lines as needed):</td>
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D1. What is your greatest strength related to implementing this strategy?

D2. What is your greatest challenge or weakness related to implementing this strategy?
<table>
<thead>
<tr>
<th>We do…</th>
<th>Strategies and Action Step Examples</th>
<th>Priority for Action/Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not do much of this</td>
<td>STRATEGY E: Policies and protocols ensure school safety</td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td>i. Policies ensure the safety for students who are impacted by domestic violence, and include protocols for implementing laws regulating restraining orders, safety plans, and student records release.</td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to a great extent</td>
<td>ii. A crisis intervention protocol is in place and all staff is knowledgeable about the protocol components. This policy clearly articulates the services of the Mobile Crisis Intervention and designates school personnel who are responsible for coordinating services for students during a crisis.</td>
<td>Reduce level of action</td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td>iii. Policies and procedures to identify and address student behavioral health needs that are related to and include, but are not limited to, substance use, violence, and general physical well being.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other action steps used to address this strategy (insert as many lines as needed):</td>
<td></td>
</tr>
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E1. What is your greatest strength related to implementing this strategy?

E2. What is your greatest challenge or weakness related to implementing this strategy?

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</thead>
<tbody>
<tr>
<td>We do...</td>
<td>STRATEGY F: Policies and protocols ensure appropriate and effective filing of state reporting.</td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>Not do much of this</td>
<td>i. Policies are in place to ensure the appropriate reporting and documentation of suspected child abuse or neglect under section 51A of chapter 119 of the Massachusetts General Laws.</td>
<td></td>
</tr>
<tr>
<td>This to some extent</td>
<td>ii. Policies are in place to ensure effective, sensitive, and appropriate use of a Child in Need of Services (CHINS) report under Chapter 119 of the Massachusetts General Laws.</td>
<td></td>
</tr>
<tr>
<td>This to a great extent</td>
<td>Other action steps used to address this strategy (insert as many lines as needed):</td>
<td></td>
</tr>
<tr>
<td>This in a highly skilled way</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We plan to...</td>
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F1. What is your greatest strength related to implementing this strategy?

F2. What is your greatest challenge or weakness related to implementing this strategy?
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</thead>
<tbody>
<tr>
<td><strong>We do...</strong></td>
<td><strong>STRATEGY G: Policies and protocols establish discipline practices that focus on reducing students' time away from the educational setting, and balance accountability with an understanding of students’ behavioral health needs.</strong></td>
<td><strong>We plan to...</strong></td>
</tr>
<tr>
<td>Not do much of this</td>
<td></td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td></td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to a great extent</td>
<td></td>
<td>Reduce level of action</td>
</tr>
<tr>
<td>This in a highly skilled way</td>
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<tbody>
<tr>
<td>i. Discipline policies support behavioral interventions to establish a safe and positive school climate. Some examples are:</td>
</tr>
<tr>
<td>a. Positive Intervention Supports (PBIS)</td>
</tr>
<tr>
<td>b. Response to Intervention (RTI)</td>
</tr>
<tr>
<td>c. Collaborative for Academic, Social, Emotional Learning (CASELS)</td>
</tr>
<tr>
<td>Social Emotional Learning (SEL)</td>
</tr>
<tr>
<td>d. Second Step</td>
</tr>
<tr>
<td>e. In School Suspension (ISS) with a teacher or tutor as overseer and assignments from class the student is expected to work on.</td>
</tr>
<tr>
<td>f. Detention, which extends the student’s school day and keeps them within a structured environment longer.</td>
</tr>
</tbody>
</table>

Note: This is not mutually exclusive, nor is this a comprehensive list.

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<tbody>
<tr>
<td>ii. Discipline policies create opportunities to intervene early and develop a range of de-escalation strategies to prevent disciplinary referrals.</td>
</tr>
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</table>

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</thead>
<tbody>
<tr>
<td>iii. Discipline policies promote the use alternatives to suspensions, expulsions, and physical restraints whenever possible.</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>iv. Discipline policies implement a proactive approach to bullying prevention, create a safe school environment and aim at keeping students in class, rather than a zero tolerance approach which tends to remove students from class.</td>
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<tbody>
<tr>
<td>v. Policies are in place to ensure that accurate and comprehensive data collection and recording are in place for any student disciplinary action taken including in school and out of school suspensions.</td>
</tr>
<tr>
<td>Current Implementation Level</td>
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</tr>
<tr>
<td><strong>We do...</strong></td>
</tr>
<tr>
<td>Not do much of this</td>
</tr>
<tr>
<td>This to some extent</td>
</tr>
<tr>
<td>This to a great extent</td>
</tr>
<tr>
<td>This in a highly skilled way</td>
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**G1. What is your greatest strength related to implementing this strategy?**

**G2. What is your greatest challenge or weakness related to implementing this strategy?**

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<tr>
<td>Not do much of this</td>
<td>STRATEGY H: <em>Policies and protocols ensure student access to a full range of behavioral health services.</em></td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td></td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to a great extent</td>
<td></td>
<td>Reduce level of action</td>
</tr>
<tr>
<td>This in a highly skilled way</td>
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#### STRATEGY H: *Policies and protocols ensure student access to a full range of behavioral health services.*

**We plan to...**

<table>
<thead>
<tr>
<th>Sustain current level of action</th>
<th>Enhance or increase current level of action</th>
<th>Reduce level of action</th>
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</table>

- Protocols establish an effective referral system to behavioral health services both inside the school setting as well as to community organizations and agencies.

- Protocols encourage effective partnerships through formal agreements with community-based providers that outline elements such as the following:
  - clear expectations,
  - confidentiality/consent forms,
  - provision of strength-based, family-driven, child-centered services
  - a structure for frequent communication with the school and family,
  - culturally competent services,
  - appropriate outreach and education for families,
  - protocols for classroom observations, consultation, and attendance at team meetings,
  - cost effective arrangements including access to third party benefits,
  - logistics for space and scheduling to avoid conflict with student activities,
  - the role of community behavioral health providers in student-specific plans.

- Protocols are in place to ensure effective communication and information for families using Intensive Care Coordination at a MassHealth Community Service Agency.
  - Behavioral health providers participate in school-based team meetings,
  - Schools establish protocols for coordinating with Intensive Care Coordinators providers and services.
  - Clear procedures are in place for accessing Mobile Crisis Intervention services for students and all relevant school personnel know the Crisis Team telephone number.

- Protocols include specific procedures related to CBHI and the interface with Special Education laws and services.

- Other action steps used to address this strategy (insert as many lines as needed):

**H1. What is your greatest strength related to implementing this strategy?**

**H2. What is your greatest challenge or weakness related to implementing this strategy?**

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</thead>
<tbody>
<tr>
<td>Not do much of this</td>
<td>STRATEGY I: Policies and protocols support student transitions during exits and re-entries</td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td></td>
<td></td>
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<tr>
<td>This to a great extent</td>
<td></td>
<td></td>
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<tr>
<td>This in a highly skilled way</td>
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</tbody>
</table>

i. Procedures are established that support and integrate students with behavioral health needs that exit or return to school from out-of-home placements.

ii. A point person has been designated to coordinate transitions including welcoming and checking in on a student, informing appropriate staff of transition plans, and ensuring access to needed services.

Other action steps used to address this strategy (insert as many lines as needed):

### I1. What is your greatest strength related to implementing this strategy?

### I2. What is your greatest challenge or weakness related to implementing this strategy?

---

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### Current Implementation Level

<table>
<thead>
<tr>
<th>We do...</th>
<th>Not do much of this</th>
<th>This to some extent</th>
<th>This to a great extent</th>
<th>This in a highly skilled way</th>
</tr>
</thead>
</table>

### Strategies and Action Step Examples

**STRATEGY J: Emergency plans in the event of a crisis or disaster.**

- i. All students and staff are familiar with emergency plans in the event of a disaster or crisis.
- ii. Specific behavioral intervention and crisis support plans are in place for students with intensive needs.
- iii. Social/emotional supports are in place for students and staff including access to grief counselors and emergency food and shelter options.

Other action steps used to address this strategy (insert as many lines as needed):

### Priority for Action/Implementation

<table>
<thead>
<tr>
<th>We plan to...</th>
<th>Sustain current level of action</th>
<th>Enhance or increase current level of action</th>
<th>Reduce level of action</th>
</tr>
</thead>
</table>

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**J1. What is your greatest strength related to implementing this strategy?**

**J2. What is your greatest challenge or weakness related to implementing this strategy?**
Policies and Protocols: Part II

The following questions are intended to provide additional information related to the strategies noted above.

1) Discuss the results of a recent school climate survey and the strengths and weaknesses.

2) Describe how the policies and protocols strengthen the school/district's vision to support students' behavioral health needs, pro-social behavior and a positive school climate.

3) Consider how the policies and services can support the behavioral health needs of children who are not MassHealth eligible.

Use the following chart to provide a description of your school plans, if any, to address the action steps that you rated above (in Part I for this section) as a priority for enhanced or increased implementation.

<table>
<thead>
<tr>
<th>For the action step areas that you marked as a priority for enhanced or increased implementation in Part I - describe any specific plans related to these items.</th>
<th>Timeline</th>
<th>Person(s) Responsible</th>
</tr>
</thead>
<tbody>
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(Add as more lines as needed.)

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VI) Collaboration with Families

Families from all cultures, languages, and socio-economic levels can participate as partners in every facet of the education and development of their children. Collaboration between schools, behavioral health providers and families is a central theme of each section of this Framework.

Collaboration with Families: Part I

<table>
<thead>
<tr>
<th>Current Implementation Level</th>
<th>Strategies and Action Step Examples</th>
<th>Priority for Action/Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>We do…</strong></td>
<td><strong>STRATEGY A: Schools work to increase student success through creating a strong foundation to engage families as partners in achieving student goals.</strong></td>
<td><strong>We plan to…</strong></td>
</tr>
<tr>
<td>Not do much of this</td>
<td>Sustain current level of action</td>
<td>Enhance or increase current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td></td>
<td></td>
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<tr>
<td>This to a great extent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This in a highly skilled way</td>
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</tbody>
</table>

- i. The school’s vision statement and/or School Improvement Plan includes goals and activities that pertain to the involvement of families in a variety of school activities.
- ii. School personnel receive professional development on and demonstrate awareness and sensitivity to cultural, linguistic, and other aspects of family diversity (e.g., disability, socioeconomic level, and gender roles).
- iii. School staff show respect for the families and their values and cultures by using their preferred terms and phrases. This is often reflected in “people-first” language (e.g. using “student with bipolar illness,” rather than “mentally ill student”).
- iv. The staff creates a safe, welcoming environment in which all families feel that their voices are valued.
- v. School and community behavioral health providers are reflective of the student population to the greatest extent possible.
- vi. The school tracks and analyzes family involvement through measures such as attendance, feedback requested following activities, and surveys asking families to indicate what topics and activities would be of most interest to them.

| Other action steps used to address this strategy (insert as many lines as needed): |

A1. What is your greatest strength related to implementing this strategy?

A2. What is your greatest challenge or weakness related to implementing this strategy?

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### Current Implementation Level

<table>
<thead>
<tr>
<th>We do...</th>
<th>Strategies and Action Step Examples</th>
<th>Priority for Action/Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not do much of this</td>
<td>STRATEGY B: Communication and collaboration with families</td>
<td>Sustain current level of action</td>
</tr>
<tr>
<td>This to some extent</td>
<td></td>
<td></td>
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<tr>
<td>This to a great extent</td>
<td></td>
<td></td>
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<tr>
<td>This in a highly skilled way</td>
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</table>

- **STRATEGY B: Communication and collaboration with families**
  - i. School policies and protocols allow for flexibility to schedule parent meetings at various locations (including outside of the school environment), and at times that are convenient for families who work several jobs or who cannot leave work to meet with the school.
  - ii. The staff communicates regularly with families to update them on academic and behavioral health progress, discuss successes and concerns, and ask for assistance in meeting student needs.
  - iii. The school has mechanisms in place to regularly share information about school-wide programs and school efforts to address the behavioral health of students.
  - iv. The school maintains and communicates the philosophy that families are the single greatest influence on children, know their children best, and want the best for their children.
  - v. Families are engaged in shared-decision making about their children and on other school policies. Families help schools identify, encourage, and build upon students’ strengths.
  - vi. Families have an opportunity to communicate the needs of their families and their children (e.g. sensitivity to adoption, domestic violence, etc) with classroom-based staff and school leaders.
  - vii. The school serves as a resource for families so that they may access outside resources (e.g. behavioral health services, housing, medical, public assistance, etc.).
  - viii. The school collaborates with families to learn about quality and helpful community resource and service options.

- Other action steps used to address this strategy (insert as many lines as needed):

### B1. What is your greatest strength related to implementing this strategy?

### B2. What is your greatest challenge or weakness related to implementing this strategy?
Collaboration with Families: Part II

The following questions are intended to provide additional information related to the strategies noted above.

1) Describe which activities have worked best to engage families in school and their students education.

2) Identify behavioral health providers that offer a variety of culturally and linguistically appropriate services for your school/district’s families.

3) Consider how families can be included in shared decision making on school policies.

Use the following chart to provide a description of your school plans, if any, to address the action steps that you rated above (in Part I for this section) as a priority for enhanced or increased implementation.

<table>
<thead>
<tr>
<th>For the action step areas that you marked as a priority for enhanced or increased implementation in Part I - describe any specific plans related to these items.</th>
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One of the major goals of the Behavioral Health Framework and Behavioral Health Assessment Tool is for it to be used to help schools increase students’ school performance. School performance may be measured through a variety of available data. By implementing new or enhanced strategies aligned with the Behavioral Health Framework, it is expected that your school’s outcome data will be positively impacted over time.

Please use the table below to track your current data, your priorities for improvement, and your goal numbers/rates. Please feel free to include any additional data that provides an increased understanding of your school’s outcomes.

Date completed: __________

<table>
<thead>
<tr>
<th>Available Data Type</th>
<th>Current Data* (number and/or rate)</th>
<th>Priority for Improvement (Low, Medium, High)</th>
<th>Goal (number and/or rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance rate</td>
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<tr>
<td>Number of disciplinary referrals</td>
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<tr>
<td>In-school and out-of-school</td>
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<tr>
<td>suspension rates.</td>
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<tr>
<td>District high school graduation rate</td>
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*Consider noting any subgroups with particularly different or alarming data.
General Questions

This section includes questions in areas not covered by the framework sections above. It also provides the opportunity for schools to identify additional related areas that are important for you to address that are not described above.

- Is your school implementing any activities related to improving the behavioral health of students that was not captured by this tool? If yes, please briefly describe.

- After completing all sections of the tool, what topic areas or activities are your top priorities to address first?

- How does the information provided in this tool relate to other school or district initiatives, strategies, or priorities?

- How can the Department of Elementary and Secondary Education (ESE) or other state agencies or systems support your work to improve the behavioral health of students?

- Please provide any general information or specific examples for how the district supports the school's efforts to improve the behavioral health of students.
November 26, 2008
The following documents were mailed:
- Letters inviting select personnel to participate in the Behavioral Health and Public Schools Task Force
- Chapter 321, Section 19

December 18, 2008
The first Behavioral Health and Public Schools Task Force convened on Thursday, December 18, 2008. Commissioner Mitchell D. Chester, Ed.D opened the meeting by discussing and providing background information of the grounding charge. Existing tools and programs were presented as resources and reference points for Task Force attendees.
- Dianne Curran gave an overview of Chapter 321 of the Acts of 2008 and details of Section 19. Dianne Curran discussed how the task involves coordination and collaboration among state agencies, behavioral health personnel, counselors, teachers, parents, and other related professionals. The framework areas and the timeline for completion were presented as well.
- Existing initiatives within the Commonwealth of Massachusetts were shared:
  - Safe and Supportive Learning Environments (SSLE) grant program presented by Jenny Caldwell Curtin: Assist school districts with creating comprehensive programs to promote school safety; and/or in-school programs and services. Eligible applicants include learning and/or classroom behavior impacted by trauma; and/or high levels of school-based violent incidents.
  - Integrated Resources for Schools - ICRS Program presented by Susan Stelk and Tom Kochanek: To enhance school capacity components (resource areas, school principal leadership, classroom teachers, community engagement, and state agencies) in order to cooperate accordingly.
- The last portion of the meeting called for the formation of two subcommittees. Associate Commissioner John L.G. Bynoe III closed the meeting by explaining the purpose and goals for each subcommittee.

February 12, 2009 & March 3, 2009
Associate Commissioner John L.G. Bynoe III created a Work Group consisting of ESE staff and four to six volunteers (two to three from each subcommittee) to establish recommendations for the framework and assessment tool formats. During each Work Group meeting, members brainstormed ideas as well as reviewed existing frameworks and assessment tools as guides in order to create the first draft formats of the framework and assessment tool.
February 18, 2009
During the second Behavioral Health and Public Schools Task Force meeting, members’ roles and responsibilities were clarified by Associate Commissioner John L.G. Bynoe III. For reference and guidance for Task Force members:

- Susan Cole and Anne Eisner gave a presentation on the importance of collaboration between education professionals and behavioral health. This presentation provided background information and historical context for the passing of Section 19 of Chapter 321.
- Emily Sherwood and Jack Simons provided an overview of Rosie D. v. Romney & Implementation Plans: Implications for Primary and Secondary Education.
- Progress reports were shared by each subcommittee.

April 1, 2009
The third Behavioral Health and Public Schools Task Force meeting was dedicated to The Winchendon Project. This project is a 3 year endeavor implemented in the Winchendon School District. Representatives from the project presented the design and progress of a “demonstrating project” geared towards improving the mental health status and reducing substance abuse rates among middle and high school aged youth. Time was allotted for a question and answer session between The Winchendon Project Panel and Task Force members. During the last portion of the meeting, the first draft formats of the framework and assessment tool were distributed for Task Force members to review. Members were broken into small groups to discuss and give feedback on the different sections of each document.

May 13, 2009
During the fourth Behavioral Health and Public Schools Task Force meeting, Barbara Solomon distributed the list of districts/schools invited to pilot the assessment tool. The list was generated collectively by both subcommittees. The remainder of the meeting was left for subcommittees to brainstorm content for the framework and assessment tool as well as share the progress of each subcommittee.

May 27, 2009
An extra meeting was scheduled to begin the process of putting the content of subcommittee discussions into the framework and assessment tool formats.

June 24, 2009
The fifth Behavioral Health and Public Schools Task Force meeting was dedicated for reviewing and discussing the framework and assessment tool drafts for improvements. In addition, the next steps for the framework and assessment tool for piloting purposes were discussed and determined.

July 9, 2009
An additional meeting was called for a small group from the Task Force to continue working on the next steps of the framework and assessment tool drafts.
**August 5, 2009**
Task Force members reviewed the recent versions of the framework and assessment tool for feedback purposes during the sixth Behavioral Health and Public Schools Task Force meeting. Volunteers were also solicited to draft and edit certain sections of the framework and assessment tool. A timeline was generated as well in order to visually see the next processes.

**September 16, 2009**
In the beginning of the seventh Behavioral Health and Public Schools Task Force meeting, a status report was given on the pilot school invitation process. The meeting was designated for reviewing and finalizing the most recent versions of the framework and assessment tool for piloting purposes. The final portion of the meeting was focused on discussing the timeline and process for collecting and analyzing the assessment tool data, and to begin brainstorming the content for the interim report due December 31, 2009.

**September 21, 2009**
Letters inviting 28 schools to participate as pilots were mailed and emailed.

**September 30, 2009**
Letters, frameworks and assessment tools were mailed and emailed to 21 confirmed pilot sites.

**October 28, 2009**
Throughout the eighth Behavioral Health and Public Schools Task Force meeting, attendees were allotted time to share information, initiatives, or events relevant to the work of the Task Force. Jenny Caldwell Curtin also gave a status report on the confirmed pilot sites and overall pilot process. During the final session of the meeting, attendees discussed the next steps of the Task Force including follow-up interviews with pilot sites, data analysis from completed surveys and the draft of the interim report.

**December 9, 2009**
The ninth Behavioral Health and Public Schools Task Force meeting focused on the post-pilot process. Melissa Pearrow, Esther Seibold and Phakdey Chea Yous conducted the initial analysis of the data received from the completed assessment tools. Melissa Pearrow presented data from 15 out of 16 assessment tools that were received. In addition to the data analysis, Task Force members shared feedback and suggestions made by the piloted schools concerning the format and context of the framework and the assessment tool. After considering all the data and feedback, Task Force members brainstormed and discussed statewide assessment recommendations. The completion and submission process of the Interim Report was discussed as well.