



New England (HHS Region 1)

**MHTTC**

Mental Health Technology Transfer Center Network  
Funded by Substance Abuse and Mental Health Services Administration



# A Compassionate School Response to Mental Illness

A Childhood-Trauma Learning Collaborative Resource Guide

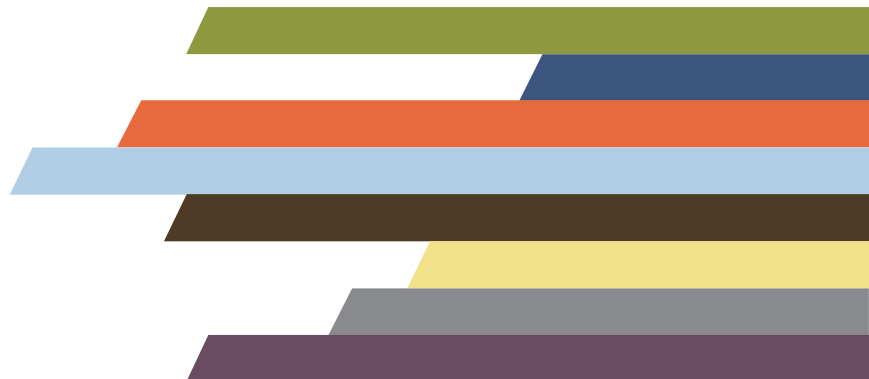
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**SAMHSA**  
Substance Abuse and Mental Health  
Services Administration



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## A Compassionate School Response to Mental Illness

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### An Increasing Concern

Educators, parents, and youth themselves are increasingly concerned about how mental health affects children's daily lives and their development throughout life. (MHTTC, 2019b). Teenage suicide rates are climbing, to the point that it is now the second leading cause of death for individuals ages 10-24 (Abbott, 2019). Most mental health conditions appear during youth or young adulthood, with 50 percent of all conditions developing by age 14 and 75 percent by age 24 (NAMI, 2020a). One in five youth have a mental health condition, but sadly under half receive any mental health services (NAMI, 2020a). Only 45 percent of teenage girls who had an episode of depression in 2019 received any treatment, and just 33 percent of teenage boys with depression did. In contrast, two-thirds of adults with a recent episode of depression received treatment (Friedman, 2020). The clear discrepancy in lack of treatment for youth is both startling and tragic. The earlier mental health conditions are identified and treated, the more effectively they can be managed and the more their negative effects can be mitigated.

Trauma is part of our lives with violence in the media, graphic descriptions of torture, student lock-down drills, news of school shootings, and opioid addiction being the new normal. Yet, many leaders continue to develop plans that hopefully will help us move beyond this grave status quo.

*The trauma-informed school movement is gaining momentum.*

Teachers, administrators, and parents are realizing that children experiencing severe trauma and toxic stress simply can't learn effectively. Their bodies and brains are on the defensive, experiencing physiological changes that interfere with learning. In response, schools are beginning to weave trauma-sensitive approaches and activities into the school community (Stevens, 2012).



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Educators are becoming more *trauma-informed*, understanding the neurobiology of trauma, and becoming more *trauma-sensitive*, enacting practices that take into consideration the nature and best practices for working with trauma-impacted youth. While much work remains to be done, educators are also becoming *trauma-responsive* or *trauma-skilled*, developing compassionate school environments and systems of care that support the mental, social, and emotional health of all students, including those who have experienced or are experiencing trauma (Mersky, Topitzes, & Britz, in press).

On almost a daily basis, neuroscientists and other medical researchers report new findings regarding trauma, stress, and health. The Centers for Disease Control (CDC), in addressing childhood trauma, declared it “a preventable public health crisis” (Chatterjee, 2019).

“ We now know that adverse childhood experiences (ACEs) have a significant impact on an individual’s future health. Preventing traumatic experiences in childhood and initiating key interventions when they do occur will lessen long-term health consequences and benefit the physical and emotional well-being of individuals into adulthood.”

~ CDC Director Robert R. Redfield, M.D.

The CDC found that preventing Adverse Childhood Experiences (ACEs) has the potential to reduce leading causes of death such as heart disease, cancer, respiratory disease, diabetes, and suicide, while improving levels of education and employment (CDC, 2019).

The tentacles of trauma reach out in many directions, reaching young and old alike, with many looking for ways to escape as it tightens its hold. To address these concerns, the Substance Abuse and Mental Health Services Administration’s (SAMSHA) strategic plan for 2019-2023 outlines five priority areas, including priorities for advancing prevention and strengthening health practitioner training and education.

Under its recent strategic plan, SAMHSA is facilitating access to quality care through service expansion, outreach, and engagement. This includes increasing professional development and partnering with the Department of Education to increase student access to and engagement in mental health services and supports and to increase public mental health literacy.

SAMHSA is leveraging its resources, partnering with many, and funding innovative initiatives to improve care across the lifespan for individuals who are experiencing significant trauma and are most at-risk for developing serious mental illness. An important part of its plan is prioritizing early identification and intervention for youth by promoting evidenced based practices and technical assistance for mental health screening and school based services (SAMHSA, 2019).





## Mental Health: The Role of Schools

Over the past twenty years, there has been a consistent and growing effort to heighten awareness and understanding of mental health concerns (NAMI, 2020b). This dedicated effort has resulted in an array of products and resources to help educators understand the role they could play in strengthening the supports of children and youth who are most in need.

In fact, in the past year and a half alone, SAMHSA's Mental Health Technology Transfer Center (MHTTC) initiative—just one of hundreds of organizations across the country focused on mental health literacy—has produced several useful resources for schools, ranging from a macro, systems viewpoint to niche resources for specific topics. Some highlights include:

- **MHTTC National School Mental Health Curriculum:** Guidance and Best Practices for States, Districts and Schools, a comprehensive guide to creating mental health support systems that effectively serve students with evidence-based practices.
- **Supporting Student Mental Health: Resources to Prepare Educators,** a brief about the current best-practices in mental health literacy training for educators and the needs they have expressed.
- **After a School Tragedy...Readiness, Response, Recovery, & Resources,** a guide to prevention, preparing for, and responding to school tragedies such as school shootings, suicide completion of a staff member or student, or natural disasters.
- **Seasonal Affective Disorder: Responding to the Winter Blues in the Classroom,** a toolkit for educators and school leaders to ward off, recognize, and treat seasonal affective disorder.

## Best Practices for the 21<sup>st</sup> Century

One of the primary premises of the SAMHSA resources above and those being disseminated by other agencies, non-profit organizations, and various stakeholders is that schools are a critical component for prevention and treatment of mental illness and its precursors. These collaborative efforts have resulted in an expansion of many promising practices such as screening for mental illness and identification of youth who are most at-risk, establishing Multi-Tier Systems of Support (MTSS), and developing comprehensive systems of support (August, Piehler, & Miller, 2018). Many of the initiatives that have been developed include a range of services: chief among them provisions to strengthen collaborations with community mental health providers, expand the role of school psychologists, provide training for teachers and school personnel, and offer direct services to children and youth in schools.



Each of these approaches takes time, effort, and funding. Some involve an assessment of systems capability (resource mapping), others rely on the availability of community supports, and yet others require more personnel and/or staff training and professional development. Some focus on providing services to children and youth who are most at-risk, while others take into consideration the potential for anyone to experience trauma and become at-risk.

Each approach has value and serves schools at different levels. To be effective, schools should include a variety of stakeholders in initial needs assessments to capture everyone's voice. Each unique school will need to design the mental health support system that works for their population; however, best practices can be borrowed, revised, and built upon rather than building everything from scratch.

Resource mapping can be an informal or formal approach (Center for Mental Health in Schools at UCLA, 2015). It begins with identifying people/agencies, programs, and resources that are available to support mental health needs. This may include examining the role of social workers, school psychologists, therapists, as well as after-school programs, school breakfast and lunch, crisis prevention and intervention, peer mediation, mentoring, parental involvement, and conflict resolution programs. Schools also benefit from reviewing curricula they are using for social-emotional learning as well as school discipline policies and procedures. Identifying these resources can help locate gaps in service delivery and identify other service providers who may be available to support unmet needs. It may also highlight potential for reallocation of resources and guide budgetary decision-making. Resource mapping is also a valuable step in determining priorities for professional development and strengthening existing capacity (Center for Mental Health in Schools at UCLA, 2015).

## **Adapting a Gold Standard of Practice for Modern Times**

Over the past two decades, MTSS has provided a framework to connect students with the necessary resources based on their unique level of academic, social emotional, and behavioral needs. Tier 1 encompasses screening, high quality instruction, and universal services provided to all students.



Tier 2 encompasses more intensive support for specific students. Tier 3 encompasses the highest level of support for a small percentage of students who need more frequent, intensive, and individualized support (Pechacek, 2019). Good implementation involves integrating interventions into instruction, not disrupting it. Interventions can take many forms, such as a homework club, goal setting meeting, classroom observation, home visit, substance abuse counseling, peer tutor, or a daily check in (Buckle, n.d.).

## Supporting Student Mental Health

Taking a step back from the prevalent use of MTSS, we would like to consider another way to view student mental health. In essence, schools have a variety of options that fall into the following areas:

- Prevention
- Support the Child
- Develop Protective Factors
- Build Resiliency

### Options for Addressing Mental Health Concerns in Schools

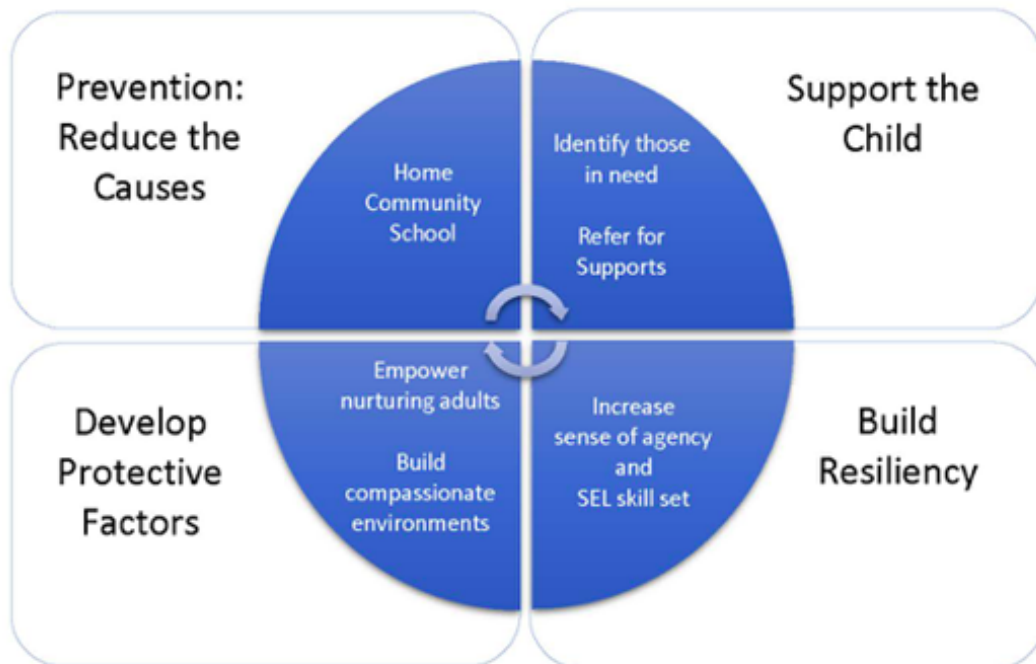


Figure 1.

Traditionally, a mental health approach has followed a medical model and focused on prevention and treatment of the individual child (Macklem, 2014). However, research on trauma and neurobiology, as well as results from implementing systems that focus on environmental change, confirm the importance of strengthening the environment and helping to build positive interpersonal relationships (Center on the Developing Child, 2017). While each of the factors in Figure 1 will help children and youth cope with stress and alleviate factors exacerbating mental and emotional challenges, they each have different costs and benefits.



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Consider the following:

- 1. Prevention:** Certainly, a focus on prevention can be useful; however, prevention is a long-term proposition, particularly when we examine societal and familial violence and trauma. Within a school setting, enhancing student self-esteem, and helping children feel good about themselves can be useful and productive. Additionally, teaching teachers and other adults to recognize the signs and warning signals of deteriorating mental health can lead to earlier service provision and possibly ward off more serious mental health concerns.
- 2. Treat the Child:** Therapy is the traditional mental health approach to helping children and youth cope. Most recently there has been a move to deliver therapy in school settings, which offers several advantages in terms of access and the potential impact of high-quality services for the individual student. However, it can be expensive since it is often delivered in one-on-one or small group settings. There are other concerns such as the match between the counselor and the child, getting the child to the therapy sessions if they are outside the school building, and whether there is carryover from therapy to day-to-day realities. In addition, this approach does nothing to address the resiliency or life skills of the general student population.
- 3. Develop Protective Factors:** As Harvard’s Center on the Developing Child has indicated (2017), one nurturing adult can make a world of difference in the life of the child impacted by trauma. Nurturing adults can help rebuild pathways to positivity, connectedness, and trust that have been damaged by attachment disorders, chaotic parenting, and abuse. Compassionate environments also provide a gateway to healing in that they give children and youth direct experience in environments where children can learn rules, experience limits, and learn social skills to enhance their communication with others, their awareness of their unique talents and capabilities, and their ability to build friendships and feel a sense of well-being. For students who are most in need, this can be helpful; however, it is often more fully supported with individual treatment/therapy.
- 4. Build Resiliency:** Resiliency is an amazing ingredient in the recipe for well-being. Resilient individuals encounter the inevitable potholes in life’s roadway and are able to navigate through situations with grace and ease. Fortunately, resiliency is a factor that can be built, and can be strengthened in classrooms and community settings. Resilient children and youth both have a conscious awareness of their own capabilities—a confidence in their capabilities—and also the accompanying skill set that they can turn to as needed when disappointments, stress, conflict, and even trauma arise. When teachers and other school staff collaborate to build resiliency, we are not only focusing on the power of “now” and helping a child feel good in the moment, but we are also helping students prepare for adversities they may face in the future. As with strengthening protective factors, this component will be enhanced with treatment/therapy services for children and youth who have the greatest needs.

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*Is there a way to approach mental health concerns in schools, with some focus on each of the four approaches using a best practices lens?  
If so, what might that look like?*

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## Trauma and Toxic Stress Are Universal Problems

Trauma, stress, and mental health concerns touch all of us. They negatively affect learning, happiness, well-being, employment, and community. None of us are immune to trauma—it can strike any of us at any time. It may be the death of a grandparent, a school shooting, a relentless bully, a sudden or prolonged illness, or a catastrophic event that takes stress levels from being manageable to becoming overwhelming or toxic.

Added stress often results in elevated cortisol and adrenaline levels, signaling the brain to focus not on learning and happiness, but on anxiety and perceived threats (NIH, 2002). Chronically elevated cortisol levels result in hyperarousal, hypervigilance, and an overly sensitive threat-detection system, which can lead to sleep troubles, anxiety, fear, and reactive anger (Greenberg, 2018).



**We need to find better ways to identify and address trauma, stress, and mental health concerns.**

Fear, anxiety, and depression are common symptoms of individuals experiencing complex or chronic trauma (Rousseau, 2018), along with specific concerns such as suicide and non-suicidal self-injury. Significant trauma exposure can undermine normal development and lead to a 76 percent higher likelihood of delay or impediment in cognitive, emotional, and behavioral development (SAMHSA, 2018; Perry, 2001; Perry, 2009). As a result, children exposed to trauma experience substantial educational obstacles that have lifelong ramifications.

## The Intersection of Trauma and Mental Illness

The ground-breaking ACEs research identified the correlation between the number of adverse childhood experiences and later mental illness (Felitti et al., 2019). While there is a genetic component (Fryers & Brugha, 2013), trauma is often a precursor to mental illness. Exposure to trauma and adversity negatively impact cognitive, academic, and socio-emotional-behavioral functioning in school across a range of indicators (Perfect, Turley, Carlson, Yohanna, & Saint Gilles, 2016). Such exposure also undermines the normal development of brain circuits needed for children to create positive relationships, cope with stress, and regulate attention, emotions, and behavior (Perry, 2009); reduces gray matter in the brain; and interferes with cognitive development, particularly executive functioning (Hair, Hansen, Wolfe, & Pollack, 2015).

Consider children in your school or classrooms who have experienced considerable stress and anxiety. Their anxiety is often manifested as inattention, fear, or hypervigilance, making it difficult for them to tune into traditional classroom instruction. Over time, as children and youth experience more episodes of stress and trauma, their vulnerability and distress also increase.



**However, mindset, environment, and resiliency play a huge role in whether stress shifts to become trauma or an event triggers post-traumatic stress disorder, which may include components of depression, anxiety, helplessness, dysregulation, and thought disorders.**

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*If Sarah is stressed out, she is less likely to be fully engaged with academic learning, and more likely to experience withdrawal, anger, or feelings of isolation and alienation. Over time, she is also more likely to feel a deepening sadness or depression, leading her to lash out at others, freeze into a numbness to avoid her feelings, or seek ways to escape the harshness of the realities that are a part of her day-to-day existence.*

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## **Equity in Trauma and Mental Health Incidence and Support**

As Dr. Lyndonna Marrast, author of *Racial and Ethnic Disparities in Mental Health Care for Children and Young Adults: A National Study (2016)*, rightfully states, “It has become increasingly clear that minorities are overrepresented in the criminal justice system and underrepresented in the receipt of mental health care. We need to look closely at how equitably our health care institutions are serving all segments of society.” An increased layer of complexity—including higher levels of stigma, underrepresentation of diverse mental health service providers, and lack of access—affects marginalized groups, including LGBTQ youth and youth of color. LGBTQ youth are three times more likely to experience mental health conditions, four times more likely attempt suicide or engage in self harm, and two to three times more likely to misuse substances (NAMI, n.d.). This may be in part because they are at a higher risk of harassment and bullying, including physical assaults (Centers for Disease Control, 2017). LGBTQ youth are also more likely than their peers to experience homelessness (National Alliance to End Homelessness, 2012).



“ Youth of color are less likely than their white peers to receive mental health services. Black and Latinx children in America in need of mental health support made 49% and 37%, fewer visits, respectively, than white children” (Marrast, 2016).

Early interventions for mental health concerns are effective, given the increased plasticity of the early child’s brain. There is always capacity for change, but that change is faster and longer lasting the earlier it is implemented. For children of color, many mental health challenges are misdiagnosed as defiance. The disciplinary approaches that schools use in reaction to students’ automatic trauma reactions, such as detention, suspension, and expulsion, are ineffective. Students of color, sadly, are more often funneled into the “Schools to Prison Pipeline,” either through the mechanism of involving a school resource officer in a school discipline issue, which can bring the youth into the criminal justice system, or suspending or expelling students who spend time and find community in more dangerous groups, such as gangs, rather than in the classroom. Rather than having harsh and ineffective punishment, any student experiencing mental health challenges needs communities to respond with compassionate practices and skill-building opportunities.

Black students, especially girls, are particularly vulnerable to adultification—seeing children so much older than they are that they appear as adults—that results in harsher treatment and higher standards (Georgetown Law, 2017).

It’s unclear exactly why, but the suicide rate for Black girls rose an alarming 182 percent between 2001 and 2017 (Preidt, 2019).



James Price, professor emeritus of health education and public health at the University of Toledo’s research showed that these girls “...report their attempt to suicide is a cry for help. Two-thirds of the kids didn’t really want to die...” (Preidt, 2019). All youth, but especially marginalized youth, are crying out to their communities for help. Schools are a logical place to provide that compassionate, holistic care before preventable and treatable mental health issues lead to tragedy.



## Suicide: The Culmination of Multiple Risk Factors



Trauma has many effects, including anxiety, depression, hopelessness, despair, anger, hostility, social isolation, impulsiveness, alcohol or substance abuse, self-destructive behavior, shame, guilt, lessened self-esteem, a loss of personal beliefs, and feeling ineffective, distrustful, or threatened, which are associated with increased suicide risk. Trauma often leads people to feel hopeless, depressed, and less connected to others, which can reduce their will to live (MCES, n.d.).

In an interview on NBC Nightly News, Christine Moutier, the Chief Medical Officer of the American Foundation for Suicide Prevention, explained that “suicide happens as a culmination of multiple risk factors, always multiple, that pile on top and sort of converge at a moment in time” (Fox, 2017). Economic recessions, similar to the infamous downturn during 2007-2009, have drastic effects that extend past the adults in family units. Often overlooked, teens are also extremely affected by these difficult times, and this may be one link to teen suicides. Up to 50-75 percent of teens in need of mental health support and treatment, due to financial limitations, don’t have the means to receive adequate treatment.

Access to care is one obvious risk factor that can be remedied when it comes to reducing suicide and treating mental illness from the start (Lewis, 2017). To help achieve this goal, teachers can convene with their local unions or other interested staff members at your school to vision for how to increase access at the school level. This may look like hiring some additional school mental health support staff like counselors, social workers, and school psychologists. This may also look like organizing a letter writing campaign, getting students involved in advocating for their own rights to quality mental health care, or lobbying for funding in a meeting with district, state, or federal leaders. The higher the level of collaboration with like-minded organizations, big and small, the more likely your vision is to inspire others to reach a goal and be a sustainable goal that many people actually want. The climb in mental health issues amongst teens shows us that the status quo is not saving enough lives or reaching students before they come to the point of harming themselves.



## Non-Suicidal Self-Injury

Of the approximately two million cases of non-suicidal self-injury reported annually in the U.S., 90 percent of them begin during teen or pre-adolescent years (Gluck, 2012). Most frequently, the self-injury is an attempt to reduce, manage, or escape intense and intolerable negative emotions (Laye-Gindhu & Schonert-Reichl, 2005).

Common risk factors include:

- Child maltreatment (Riggi, Moumne, Heath, & Lewis, 2016)
- Bullying and victimization (Noble, Sornberger, Toste, Heath, & Mclouth, 2011)
- Suicide ideation and attempt (Guan, Fox, & Prinstein, 2012)
- Mental health difficulties, including anxiety, depression, substance abuse and eating disorders (Stewart, Baiden, & Theall-Honey, 2014)
- Genetic predispositions to high emotion reactivity (Nock, 2009)
- Low distress tolerance and high rumination (Slabbert, Hasking, & Boyes, 2018)
- High self-criticism, low self-esteem, disordered eating (Zelkowitz & Cole, 2019)

Students who report being bullied and threatened and who have less trust in school staff are more likely to engage in self-injury (Noble et al., 2011). However, the incidence of self-injury is reduced when students feel supported by their teachers and are part of a positive peer climate (Madjar et al., 2017).

## Mental Health Crises

Schools are not only concerned about students who are at-risk for developing behavioral and emotional challenges, but they also want to know how to handle mental health crises when they arise. When mental health concerns escalate to the point of crisis, families and other caregivers often have little choice regarding treatment. Frequently, they turn to hospital emergency departments and inpatient treatment for help. The number of children and youth treated in emergency departments for psychiatric concerns increased by 26 percent from 2001 to 2010; and by an additional 28 percent (from 31-40%) from 2011 to 2015 (Kalb et al., 2019; Pittsenbarger & Mannix, 2013). The largest increases were among adolescents (54%), African Americans (53%), and Hispanics (91%) (Kalb et al., 2019).

However, there is no assurance that being seen at an emergency room will result in the much needed treatment. According to one report, only 37 percent of the adolescents who visited emergency rooms for a suicide attempt or self-injury were actually seen by a mental health provider. Data for psychiatric emergency room visits are similar—only 16 percent resulted in youth being seen by a mental health provider (Kalb et al., 2019). Moreover, if a youth is admitted to a psychiatric inpatient facility, results are often mixed. Being admitted increases the stigma that youth face and may lead to feelings of separation from normal life or acquisition of unhelpful or destructive behaviors (Edwards et al., 2015).



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**In addressing how schools should handle crises, the MHTTC urges schools to consider how they can better prepare, respond, and support recovery.**



Creating compassionate school communities where students feel engaged, supported, and connected is a powerful preventative measure. Moreover, having established processes and structures in place will make crisis response much smoother.

Providing all staff with mental health literacy training through organizations such as Mental Health First Aid turns everyone into a mental health first aid responder as well as teaching them how to interact with all students more compassionately. Finally, providing non-judgmental support, a safe and supportive environment, and professional services and counseling can help the community recover following a crisis (MHTTC, 2019a).



### **What is Needed?**

Eccles, Barber, Stone, and Hunt (2003) suggest programs are most likely to promote positive youth development when they provide the following:

1. Physical and Psychological Safety
2. Appropriate Structure
3. Supportive Relationships
4. Opportunities to Belong
5. Positive Social Norms
6. Support for Efficacy and Mattering
7. Opportunities for Skill Building
8. Integration of Family, School, and Community Efforts

These components are consistent with the literature on how to help children with attachment disorders and our understanding of the building blocks that are necessary for students to feel safe.

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## First Steps for Individuals



For individuals, the first step in addressing mental health concerns is recognizing warning signs. Behaviors such as extreme sadness, mood swings, and aggressive actions can often be red flags that something deeper is going on internally (U.S. Department of Health and Human Services, 2019).

**Simply letting students know that you are there is the first step to creating a strong foundation of trust and openness.** Children spend a majority of their formative years in the classroom, so being able to feel a sense of comfort with peers and teachers is imperative to their mental health. The National Alliance on Mental Illness (NAMI) offers funding to schools to set up training for faculty and staff as well as provide services within the schools (NAMI, 2020a). With resources and funding available, teachers and students can better understand the issues surrounding mental illness. MHTTC and the National Center for School Mental Health compiled an extensive list of mental health resources to help prepare educators (2020).

### A Snapshot: What Children Need

Children need more compassionate communities, better coping strategies, and accessible resources to stay mentally healthy.



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Having strong role models, healthy relationships, positive self-images, a growth mindset, and effective ways to cope with stress will reduce their risk of mental illness.

Cultivating resiliency will help protect them throughout their lives.

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## Neuroplasticity and Resiliency



- According to a meta-study conducted in 2012, students with an ability to understand their emotions were also able to find effective regulation strategies for their emotions. They in turn were less likely to exhibit disruptive behavior within the classroom (Lopes Mestre, Kremenitzer, & Salovey, 2012).
- Early intervention is crucial due to the ease with which new neural pathways form during the ages of 0-5 years (National Scientific Council on the Developing Child, 2014).

### **The drive for resiliency is advanced by our understanding of brain neuroplasticity.**

Critical periods of neuroplasticity occur between the ages of preschool and elementary school, making these years are the most essential time to teach children how to regulate their emotions. Resiliency, learning, and achievement for children who experience trauma can be improved through trauma-informed, child-centered interventions that impact self-regulation, executive functions (EF), and the brain's recovery from stress (Buckner, Mezzacappa, & Beardslee, 2003; Davidson & Begley, 2013; Zolkoski & Bullock, 2012).

Research has also shown that calming, nurturing, consistent, and compassionate environments contribute to healing trauma (Ford & Courtois, 2013; Siegel, 2010; Zelazo & Cunningham, 2007). In recent years, a portfolio of techniques involving breathwork, yoga, mindfulness and meditation has been introduced in schools. As further substantiated by the research, mindfulness interventions improve student outcomes including cognitive performance and resilience, student achievement, EF, prosocial behavior, and socioemotional competence (Bakosh, Snow, Tobias, Houlihan, & Barbosa-Leiker, 2016; Franco, Manas, Cangas, & Gallego, 2010; Flook, Goldberg, Pinger, & Davidson, 2010; Schonert-Reichl & Lawlor, 2010).



Teaching students about neuroplasticity and the research that shows that people change their skill levels through effective practice, not some innate sense of “intelligence,” empowers them to be persistent and take appropriate risks. While screening can identify students who may have the most urgent need for these skills, we know that all children benefit from building resiliency. When youth are more resilient, they are more likely to have academic success (DeBaca, 2010).

For children, especially those who have one or more ACEs, resiliency is also cultivated through establishing a growth mindset, building a compassionate and educated school community that supports all students, and developing coping skills and strategies.





## The Role of the New England MHTTC

To address the issues of trauma and mental illness in schools, in 2018, SAMHSA established a network of School Mental Health Initiatives, funding one initiative in each of ten geographic regions. The intent of this effort was to provide evidence-based resources and technical assistance to educators and school mental health service providers. This project was intended to reach a large number of educators interested in free training, support, and guidance on issues related to mental health in the school setting. In New England, the Program for Recovery and Community Health (PRCH) at Yale University was awarded funds to further positive mental health in the six New England states (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont).

“Love, positive regard, and the support of others are essential to providing a foundation for the person’s efforts at recovery.”

~ Larry Davidson, Ph.D., Professor of Psychiatry, Yale School of Medicine and Director, PRCH

(Davidson, Tondora, Lawless, O’Connell, & Rowe, 2007, p. 207)

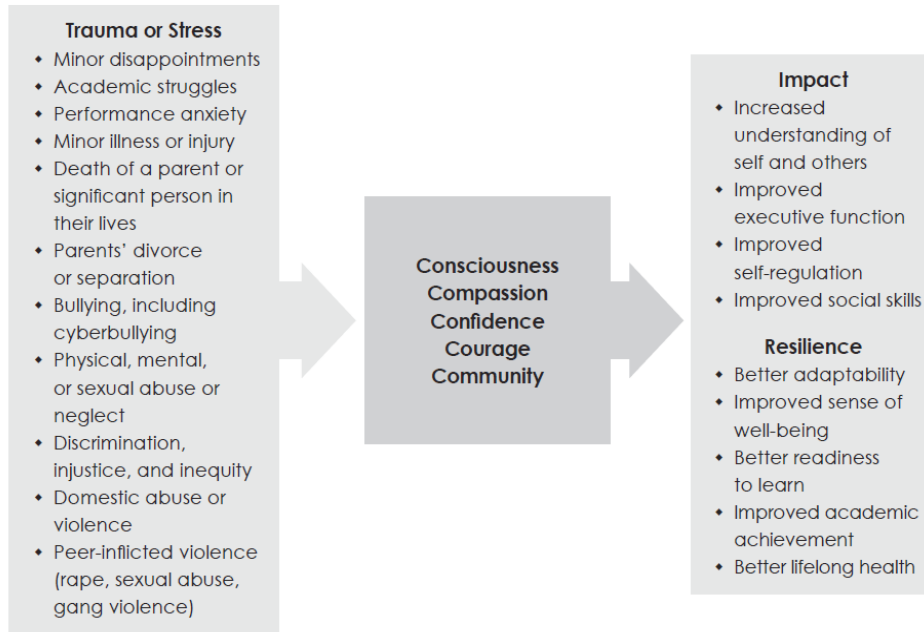
The aim of the New England MHTTC school initiative was “to enhance school culture and prepare school personnel to improve the mental health of school-aged children in the New England region” using an approach that is consistent with PRCH’s focus on helping people who are in recovery in ways that honor a “meaningful sense of belonging to one’s community” (Ibid, p. 29). The New England MHTTC has three goals:

Goal 1	Foster alliances to address the needs of children and youth who have experienced or are at risk of experiencing significant trauma.
Goal 2	Provide publicly available, free training and technical assistance to early childhood, elementary, and secondary teachers, principals, school psychologists, and other school staff.
Goal 3	Accelerate adoption and implementation of mental health evidenced-based practices through the C-TLC for New England.





To implement its approach to children’s mental health in schools, PRCH contracted with the Center for Educational Improvement (CEI), a small non-profit organization whose signature program is Heart Centered Learning®, a theoretical framework for social emotional learning and community-building.



**Figure 2.**  
**Relationship between trauma and stress and Heart Centered Learning**  
(Mason, Rivers Murphy, & Jackson, 2020, p. 21)

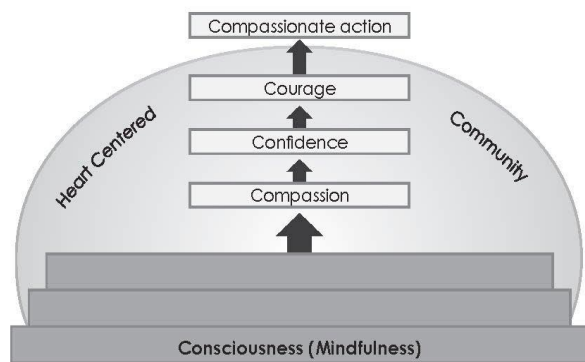
The approach that CEI and the New England MHTTC are using is based both on the framework established by PRCH at Yale University and the underlying beliefs, vision, and mission of CEI.

“ For PRCH, recovery is nested in the belief that individuals with mental illness can be ‘in recovery’ as they are working through life’s issues. So, recovery is not an event, but rather a journey.”

~ **Maria Restrepo-Toro, BNS, M.S. Manager, New England MHTTC and Program Manager, Training and Education, PRCH**

The New England MHTTC favors a holistic and personalized approach, promoting the development of self-acceptance, belief in oneself, and belief in one’s ability to make positive and meaningful contributions to one’s family and community. The ideal level of autonomy and independence is chosen by each individual. Personalized “care plans” build on the knowledge and skills of invested friends and family as well as the community. Individuals in recovery, in addition to practicing self-care, can also find strength in the social responsibility to share their experiences with their peers.

CEI’s approach, which is guiding the New England MHTTC school initiative to develop compassionate schools, is explained in *Mindfulness Practices: Cultivating Heart Centered Learning for Students to Focus and Flourish* (Mason, Rivers Murphy, & Jackson, 2019) and *Mindful School Communities: The Five Cs that Nurture Heart Centered Learning* (Mason, Rivers Murphy, & Jackson, 2020). This approach relies on what we know about the physiology of the heart and its importance in decision making as well as the power of focusing on five key elements: consciousness (mindful awareness), compassion, confidence, courage, and community. With this approach, schools and districts are encouraged to use S-CCATE (the School-Compassionate Culture Analytic Tool for Educators, Mason, et al., 2018) a nationally validated instrument for school staff to use to assess needs and progress towards becoming a trauma-skilled, culturally competent, compassionate school community. As Michele Rivers Murphy explains in her description of using S-CCATE in schools in Massachusetts, S-CCATE “paved the path for core learning teams to think beyond their own students’ needs and classroom walls, with a wide-eyed lens of possibility and opportunity, extending to the greater good of the school community or whole” (in Mason, Liabenow, & Patschke, 2020, p. 181). S-CCATE allows comparison of an individual school’s results with a national sample.



**Figure 3. The Five Cs of Heart Centered Learning.**  
(Mason, Rivers Murphy, & Jackson, 2020, p. 16)

## Capacity Building in New England

During the initial months of the New England MHTTC project in 2019, C-TLC staff found through a needs assessment—individual interviews, school visits, in-person meetings of the fellows and regional policymakers and stakeholders, and use of S-CCATE—that the biggest need in New England was “strengthening skills for compassionate leadership and community building.” This did not surprise CEI staff as their years of working with principals throughout the nation using S-CCATE showed a similar concern throughout all regions of the U.S.

Using these data, C-TLC staff designed topic-based webinars, resource libraries, newsletters and blog post series, and regional convenings to specifically address the needs educators saw in their schools. Once C-TLC Fellows received initial training on the neurobiology of stress and the foundational aspects of mindfulness, Fellows were asked to develop Action Plans to guide their work in developing compassionate school communities. Through discussions, presentations, and study groups, Fellows and C-TLC staff learned from each other about which evidence-based practices best supported their students and staff.

## C-TLC Fellows and Feedback on our Approach

The C-TLC is supported by a diverse group of educational leaders who disseminate trauma-informed, child centered resources that improve resilience, learning and achievement for children who have experienced/are at risk of experiencing trauma. C-TLC Fellows include assistant superintendents, principals and assistant principals, school psychologists and counselors, social workers, and teachers from each of the six states in the New England region.

As local ambassadors, C-TLC Fellows help school staff to vision, plan, and monitor implementation of compassionate practices. This work is designed to ameliorate the effects of trauma, amplify protective factors, and increase the availability of educated and nurturing adults and teachers within schools who can meet the mental health needs of students. Fellows also assist in strategic planning and communications within their state to alleviate the impact of trauma and help schools understand their role in building supportive classrooms to help children who are most at-risk.

“

*Schools of now and schools of the future need to welcome and embrace supports into all of our schools, not just a few... Schools that are proactive and responsive, schools that begin and end with compassion. A place where adults care so deeply and are so transparent about mental health that every member believes and feels that tending to [students'] mental well-being is at minimum as important as every other academic area taught.”*

**C-TLC Fellow Susie DaSilva  
Assistant Superintendent  
Darien, Connecticut**

“

*Through a variety of activities, such as Cross the Line and a student choice initiative, the community is working to reach everyone. With more choice, we find that students are more engaged and excited about learning. Our school also has a ropes course that offers a team building activity to dually build staff morale and prepare teachers to use activities to increase a sense of community with their peers and students.”*

**C-TLC Fellow Jim O'Rourke, Principal  
Hillsboro-Deering High School  
Concord, NH**

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Over the past year, C-TLC Fellows have participated in webinars and in-person meetings, implemented Heart Centered Learning compassionate projects in their schools/districts, and created and monitored community projects to increase local capacity to address the needs of children and youth with the most serious emotional and behavioral challenges.

“

*There is much work needed towards teacher self-care and making sure they are taking the time to take care. There was unspeakable trauma in our school last year (with a young child who died via suicide) and consequently, the school culture is suffering as a whole because of this tragedy.”*

**C-TLC Fellow Heather Pach, School Psychologist, Cheshire, CT**

Heather’s goal is to increase the capacity of staff to understand and respond to trauma. One of the first steps was to learn where staff strengths and areas of need are in relation to the tragedy and its impact on the school culture. To date, 25 out of approximately 35 staff at her school have completed the S-CCATE.

Broad Street Elementary School in Nashua, NH used S-CCATE results to plan staff professional development. The school received a Heart Centered Learning Stipend through the C-TLC to bring training on the neurobiology of trauma and a staff set of *Mindfulness Practices* (Mason, Rivers Murphy, & Jackson, 2018). A core learning team from the school participated in a six part book study with two of the book’s authors and other C-TLC Fellows who shared their experiences of bringing compassionate practices to themselves and their schools. The school is eager to retake the S-CCATE, now nine months later, to see if the systems and practices put in place have affected the school’s S-CCATE scores.

“

*Our staff received training from the Trauma Center at the Justice Resource Institute in Brookline, MA to learn more about the effects of trauma on the brain and executive functioning. This brought so much awareness to staff about how and why students behave the way they do. Since then, staff are much more open to bringing student names forward for assistance in their classroom when they are unsure how to help. Teams collaborate and help staff plan for these children. Staff now also implement social emotional curriculum as a Tier 1 practice to be proactive and assist ALL students.”*

**C-TLC Fellow Stacy Bachelder-Giles, Principal  
Broad Street Elementary School, Nashua, NH**



Responses to a survey conducted in December 2019 indicated that Fellows had most frequently participated in furthering heart centered/compassionate practices in local schools (78%), attending our annual in-person meeting (78%), and sharing C-TLC resources with their local community (67%). Ninety-five percent of the Fellows have increased their knowledge around the implementation of yoga, mindfulness, and meditation in classrooms and trauma, brain development and neuroplasticity.

Eighty-nine percent have increased their knowledge of early intervention; 84 percent increased their knowledge of the needs/concerns of parents/families, student self-regulation, mental health concerns, and compassionate discipline. Currently, they are most interested in learning more about reducing stress for staff and students (95%), furthering compassionate practices (84%), alleviating the impact of childhood trauma (79%), and understanding and responding to early psychosis (79%). Eight-four percent are quite interested in learning skills/techniques to help guide visioning for infusing compassion and building healthy communities.

In Year 2 of its project, the C-TLC is focused in part on making deeper connections between educators and state level agencies. The New England MHTTC and the C-TLC convened a meeting that allowed Fellows to share their projects from the past year with each other and allowed state agencies and non-profit organizations to present effective projects that are transforming how New England responds to youth mental health challenges. Participants discussed various mental health topics through facilitated discussions focused on sharing ideas and solidifying connections with prospective collaborators. In the winter and spring of 2020, Fellows are meeting with state level officials and community organizations to discuss increased funding, staff, and public health campaigns to alleviate the impact of childhood trauma.

The New England Advisory Team (NEAT) of the New England MHTTC is an advisory board for our projects that includes experts in mental health and education on the ground in each of the six New England states. They have come together to support some of our collaborative work with state agencies, as well as several other projects, including a needs assessment for children's mental health in the New England region, a Zero Suicide initiative in New Hampshire, and an open forum hosted by UMass Boston focusing on how to connect young men of color with mental health services. The NEAT members' expertise and connections in their communities has enhanced the New England MHTTC's ability to bring free technical assistance and training on the specific kinds of topics mental health service providers and educators want and need. By working together, we all work more effectively towards the same goal: providing evidence-based, holistic, compassionate practices that both prevent and alleviate the effects of trauma, which can lead to mental health challenges.





## District Model: Comprehensive Behavioral Health Model (CBHM) in Boston Public Schools

The Comprehensive Behavioral Health Model (CBHM) prioritizes the need for schools and educators to remain responsive to student strengths and needs. This holistic approach to meeting students' needs in Boston Public Schools (BPS) exemplifies a compassionate response to the need to help cultivate social, emotional, behavioral, and mental health skills in all students.

BPS currently serves over 50,000 students from diverse backgrounds in 125 schools. Approximately 42 percent of the students identify as Hispanic and another 30 percent identify as Black; 60 percent are economically disadvantaged. English Language Learners make up one third of the student population, with students and families coming from 139 countries and speaking more than 75 languages (**Massachusetts Department of Elementary and Secondary Education, 2019**).

### The Boston Public School Experience

*Imagine a school in which children, families, faculty and community partners feel welcome and valued. All children experience a social emotional learning curriculum as part of their classroom and school experience.*

Teachers periodically review each of their students' behavioral health strengths and needs, and students in need of additional support are provided appropriate services quickly.

Teams of teachers and administrators review student behavioral health data and progress on a regular basis. Community partners, families, and school personnel meet periodically and communicate regularly about children who are receiving additional support.

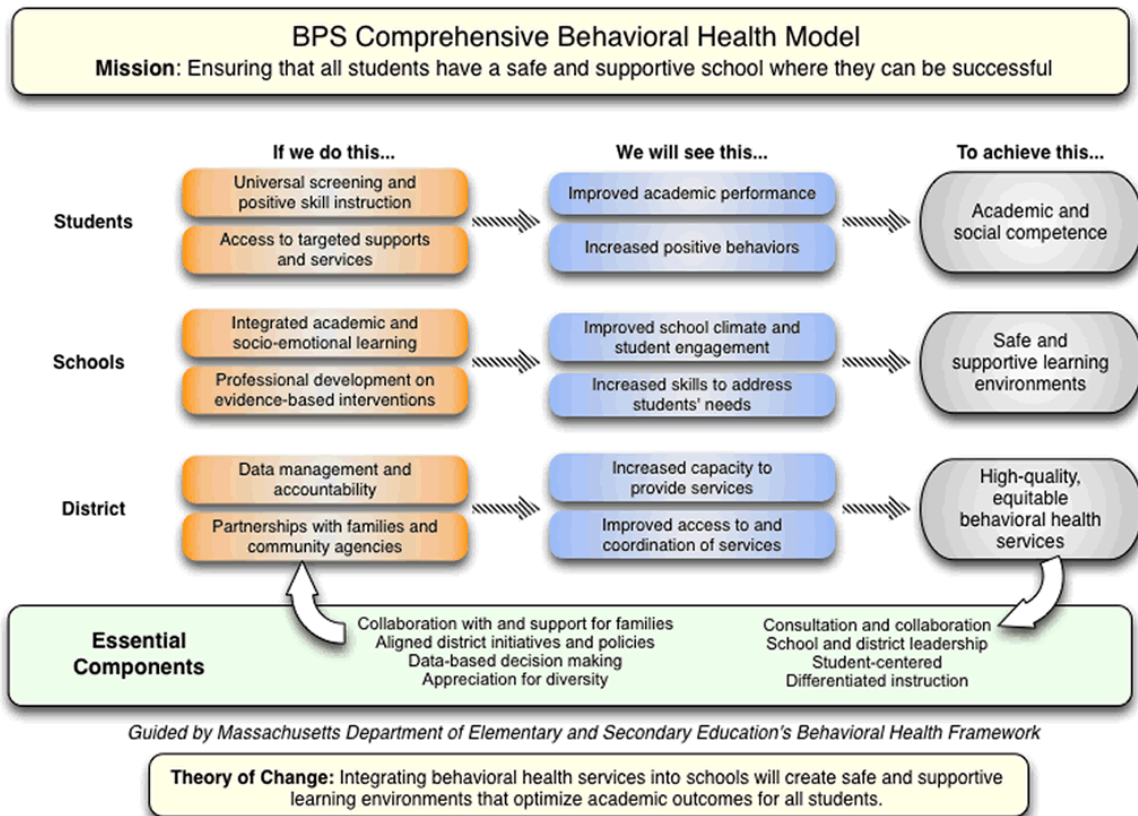
**You don't have to imagine it. This is already happening in many of Boston's public schools!**

**Boston Public Schools**

**BPS partners with 25 community-based organizations that provide therapeutic services in 90 BPS schools.** In a collaboration with Boston Children’s Hospital (BCH) and University of Massachusetts Boston (UMass-Boston), it has implemented a service delivery framework that is inclusive of both school and district provided services and community mental health partners to address the needs of students with behavioral and emotional challenges. Following Brofenbrenner’s (1977, 1979) theory, the approach began with:

1. A review of contextual variables at the macro-level (i.e., cultural context, social and culture values),
2. The exosystem (settings or events such as caregiver’s employment, media, or politics that are not directly connected to the child), and
3. The meso and microsystems (direct influence on the child and the relationship among those entities—health services, family, peers, and teachers).

After six months of district planning and interviewing key stakeholders, CBHM was launched during the 2012–2013 school year in 10 schools. Each year, another 10 schools join the model. At this writing, there are **sixty-nine schools, serving more than 34,000 students, currently participating in CBHM.**



**Figure 4. Theory of Change BPS Comprehensive Behavioral Health Model**

Figure 4 outlines the approach taken by BPS for improving behavioral health and creating safe and supportive learning environments.



**Staff from Boston Public Schools, UMass-Boston, and Boston Children’s Hospital Neighborhood Partnerships Program (BCHNP) have been key drivers in designing and implementing the CBHM.**

Forming an advisory committee called Executive Work Group (EWG), these partners met weekly to review research, construct the model, design the implementation plan, and conceptualize a logic model as a core learning team. They also planned professional development, compiled training materials, determined policies and protocols, and discussed new research opportunities.

During its early years of implementation, the CBHM increased the number of school psychologists providing services to participating schools. It also emphasized the importance of recommended staffing ratios from the National Association of School Psychologists (NASP, 2010) to expand the services provided by school psychologists. With coordinated pre-service and in-service experiences and increased staffing capacity, school psychologists gradually shifted their role from administering and interpreting psychological assessments to providing comprehensive services in 10 domains of practice, consistent with the NASP practice model. School psychologists received training in evidence-based practices to reach all students through prevention services and supports. They also deepened their knowledge of Positive Behavior Intervention Supports (PBIS), functional behavioral assessments, crisis intervention, leadership, and implementation strategies.

In BPS, the Second Step social-emotional learning curricula was used with students in grades Pre-K through 8<sup>th</sup> (Second Step, n.d.). At the high school level, topical curricula, as well as *DBT Skills in Schools* (Mazza et al., 2016), *Break Free from Depression* (BCHNP, 2017), and *Signs of Suicide* (SPRC, 2016) were used. *DBT Skills in Schools* includes 30 lesson plans with explicit instructions for teaching mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness (Mazza, Dexter-Mazza, Miller, Rathus, & Murphy, 2016).





**When Boston Children’s Hospital completed its initial resource mapping, it found that 30 percent of schools did not have a relationship with a community behavioral health services agency.**

The CBHM approach integrates social, emotional, and behavioral health services into schools and outlines strategies for high-quality services. By expanding the role of school psychologists and social workers, services can be equitably accessed by all students.

This systematic, data-driven approach of screening all students, targeting interventions to meet their needs, and partnering with community agencies has built an infrastructure that supports the district as it strives to meet the social, emotional, and behavioral needs of all students.



For participating schools in Boston, the Multi-Tiered Systems of Supports is implemented as follows:

- Classroom teachers implement explicit instruction in social, emotional, and behavioral skills, and school and classroom communities are organized to support student’s success through the use of School-wide Positive Behavior Intervention Supports (SWPBIS).
- Identification strategies informed by data from the BIMAS-2 (see page 27), a universal social, emotional, and behavioral health screener that allows students with increased risk for developing behavioral issues to be identified and matched to appropriate targeted/Tier 2 evidence-based interventions. As of 2019, screening has been completed for 93 percent of the students in 69 participating schools.
- Intensive Tier 3 interventions and progress monitoring is used for students who exhibit serious needs or are not responding to Tier 2 interventions.
- When appropriate, students are referred to partnering behavioral health community services, as CBHM has also created effective referral mechanisms.

During 2018-2019, extensive professional development was provided to the BPS Behavioral Health Services Department, which included 67 school psychologists and eight school social workers who are dedicated to supporting the MTSS approach in all 125 BPS schools.



## Efficient and Effective Screening Leading to Appropriate Services



Another important CBHM feature is an insistence on getting services to children in a timely manner. The process of screening is used efficiently and effectively to match students to appropriate services. The "identification to service delivery" process takes place through school teams. Grade level teams of teachers reflect on their whole grade/class to consider ways to strengthen Tier 1 instructional programs.

Additionally, grade level teams of teachers review students flagged with risk and develop appropriate interventions and supports. In some cases, these methods work and the teacher may discontinue interventions when the student is successful with only Tier 1 programming. In other cases, the teacher-developed interventions and supports may be either inappropriate or ineffective. In these cases, multi-disciplinary teams (through "student support systems" and/or integrated referral systems for outside partners) can be activated to match students with appropriate services.

The *Behavior Intervention Monitoring Assessment System* (BIMAS-2; McDougal, Bardos, Meier, 2011) is the primary measure BPS uses to screen students and monitor progress with CBHM. The teacher report, the primary tool used, includes 34 items comprising two adaptive scales (social functioning and academic functioning) and three behavioral concern scales (conduct, negative affect, and cognitive attention). The BIMAS-2 measure is sensitive to small changes when services are provided, but scores remain stable in the absence of supports/services. Therefore, in schools with evidence of implementation fidelity, significant student growth illustrates how teachers and educators are collaboratively and compassionately responding to students' needs in meaningful ways. BIMAS-2 includes five scales (See Figure 5).

Figure 5. BIMAS-2

### THE BIMAS-2 INCLUDES FIVE SCALES:

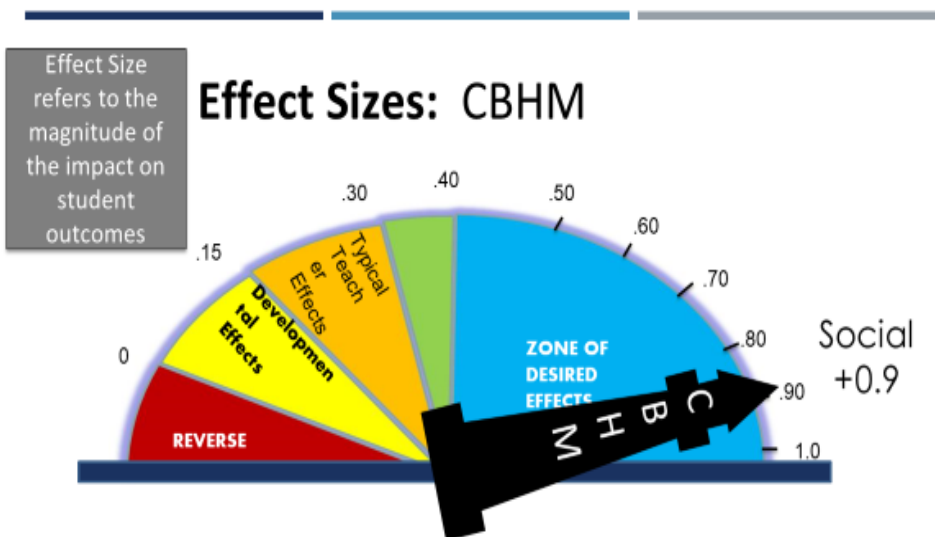
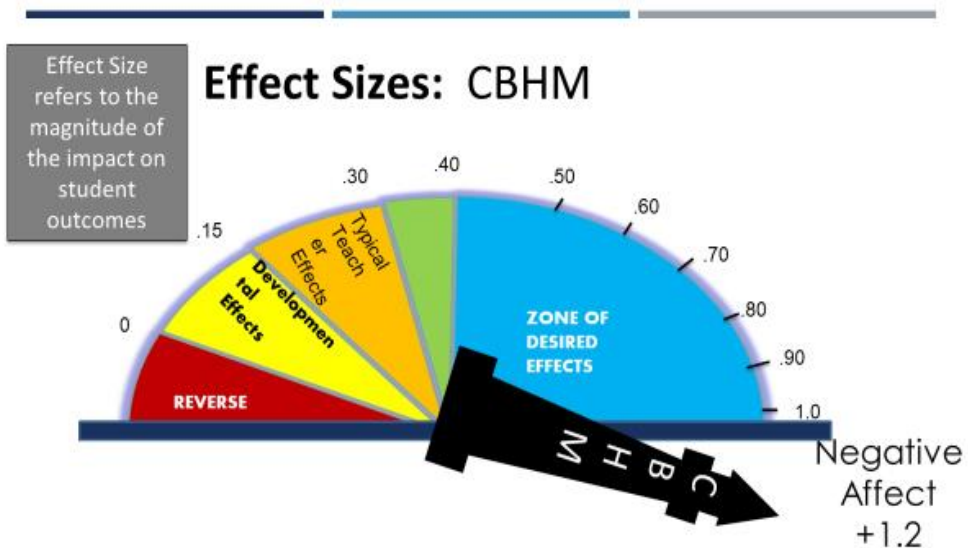
	BIMAS-2 Scale	Measures...
CONCERN SCALES (Identify Risk)	Conduct	Anger management, bullying behaviors, substance abuse
	Negative Affect	Anxiety, depression
	Cognitive/Attention	Attention, focus, organization, planning, memory
ADAPTIVE SCALES (Strengths)	Social	Friendship maintenance, communication
	Academic Functioning	Academic performance, attendance, ability to follow directions



**With CBHM, BIMAS-2 is administered twice yearly.**

Results over the course of implementation (8 years) show significant changes in all five areas of the BIMAS for students found with risk.

For example, effect sizes for Negative Affect and the Social scale are +1.2 and +.9 accordingly.





“ School psychologists have historically had a limited role, generally focusing on student eligibility for special education programs. But we’ve begun changing that in the Boston Public Schools so that we can concentrate our energy on preventing behavioral issues from taking hold and, if they do take place, intervening early on.”

~ Andria Amador, Senior Director, Behavioral Health Services  
Boston Public Schools, Boston, MA

**CBHM has had a significant, positive impact on students and schools. Scores on the Massachusetts Comprehensive Assessment System for participating schools are higher than scores for other Boston schools.**

- ✓ Attendance rates and social skills of CBHM students have improved.
- ✓ Disciplinary referrals have also decreased.
- ✓ A majority of students demonstrated “low risk” on the BIMAS concerns scales.
- ✓ Students with the highest level of risks demonstrated the greatest gains.

**For additional information on CBHM, contact Andria Amador via email at [aamador@bostonpublicschools.org](mailto:aamador@bostonpublicschools.org).**



# insights & Elaboration

In today's world, we're experiencing widening disparities in school achievement, economic productivity, children's well-being, and health outcomes. Schools can provide critical support to our youth to help them develop the skills and strategies they will need to succeed, to help them thrive in the moment, and develop the capacity to be fully present to learning opportunities.

However, to have the greatest impact, we also need to address the violence and trauma that are so prevalent today. By focusing on the whole child, we can help build resiliency, emotional regulation, and a general sense of purpose, belonging, and wellbeing. Providing stable relationships and compassionate, safe, and supportive environments will foster healthy development and reduce the risk of mental illness. School leaders must, however, engage parents, teachers, and the wider community in discussions around mental health awareness and concrete ways they can help students who are most at risk.

Leaders need to better prepare our schools to identify students experiencing or at risk of mental illness and connect them with the services and resources they need as early as possible. Access to timely and cost-effective care and providing multiple tiers of support based on students' needs is a part of the solution. We also need to better support teachers. They can build positive relationships with students, create safe and welcoming classroom environments, promote positive behaviors and social emotional skills, and identify and refer students and assure that wrap around supports are provided when needed.

By improving teachers' mental health literacy and confidence, we can help them make a positive impact on countless lives. To stem the tide of suicides, lift the veil of depression and anxiety, and create a brighter today and tomorrow will take consistent and prolonged effort. However, much can be done within the course of a school day. Much begins with connecting with children and youth in authentic ways that don't shy away from or ignore the trauma they experience, but rather through giving voice to concerns and then providing nurturing comfort and guidance to children and youth who are struggling. Through raising awareness of our internal worlds, helping children and youth understand their emotions, and modeling compassion as we *teach with* kindness and caring, and as we *teach* kindness and caring, we can shift the burden and erase the dis-ease—all of which is needed for our students to thrive.





New England (HHS Region 1)

MHTTC

Mental Health Technology Transfer Center Network  
Funded by Substance Abuse and Mental Health Services Administration

## ABOUT US

**New England MHTTC serves Health and Human Services (HHS) Region 1, which includes the states of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.**

New England MHTTC offers support at local, regional, and national levels on recovery-oriented practices, including recovery supports, within the context of recovery-oriented systems of care. These include, but are not limited to, person- and family-centered care planning and shared decision-making; peer support; supported employment, education, parenting, and spirituality; and other strategies to promote the community inclusion of children/youth and adults with serious mental illnesses and their loved ones.

Support is provided to educators and schools in New England through the Childhood Trauma-Learning Collaborative (C-TLC), a school mental health initiative collaborating with twenty-four C-TLC Fellows (administrators, educators, school psychologists, and social workers) in the six New England states. The goals of this collaborative are to accelerate learning about and implementation of best and promising practices to improve supports and services to students with behavioral and emotional challenges who are most at-risk. We further services in New England through the Fellows who act as ambassadors providing a conduit to their local communities and as exemplars of some of the best and most promising practices.



The Substance Abuse and Mental Health Services Administration (SAMHSA) has funded the New England Mental Health Technology Transfer Center in part to “heighten awareness, knowledge, and skills of the Region 1 mental health workforce to implement evidence-based prevention, mental health promotion, treatment, and recovery support services across the continuum of care” (New England MHTTC, 2019).

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# ADDITIONAL RESOURCES

## MHTTC NATIONAL SCHOOL MENTAL HEALTH CURRICULUM

*National Center for School Mental Health (ND)*

<http://csmh.umaryland.edu/Resources/Needs-Assessment--Resource-Mapping/>

*If you are interested in learning more about the New England MHTTC and/or the Childhood-Trauma Learning Collaborative and related training and technical assistance provided free of charge, email us at [newengland@mhttcnetwork.org](mailto:newengland@mhttcnetwork.org).*

To help states, districts, and schools across the United States understand the core components of comprehensive school mental health, as well as engage in a planning process, the Mental Health Technology Transfer Center (MHTTC) Network Coordinating Office and National Center for School Mental Health (NCSMH) developed a national school mental health curriculum focused on the core features of effective school mental health initiatives. The curriculum is intended to be used with district teams that can influence, develop, and oversee school mental health systems at the school district and building levels. It contains trainer and participant manuals and slide decks, divided into eight modules that are each designed for delivery in one-hour in-person sessions or can be adapted for shorter or longer sessions. Also included are five recorded virtual learning sessions that are each about 75 minutes long and include a deeper dive into some of the curriculum content with additional examples from states and districts across the MHTTC Network.

**To access the curriculum, please visit:**

<https://mhttcnetwork.org/centers/mhttc-network-coordinating-office/national-school-mental-health-projects>



New England (HHS Region 1)

MHTTC

Mental Health Technology Transfer Center Network

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## About the Mental Health Technology Transfer Network (MHTTC)

The purpose of the MHTTC Network is technology transfer - disseminating and implementing evidence-based practices for mental disorders into the field.

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the MHTTC Network includes 10 Regional Centers, a National American Indian and Alaska Native Center, a National Hispanic and Latino Center, and a Network Coordinating Office.

This collaborative network supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. We work with systems, organizations, and treatment practitioners involved in the delivery of mental health services to strengthen their capacity to deliver effective evidence-based practices to individuals.

MHTTC services cover the full continuum spanning mental illness prevention, treatment, and recovery support.

**For more information, contact the MHTTC Network Office.**

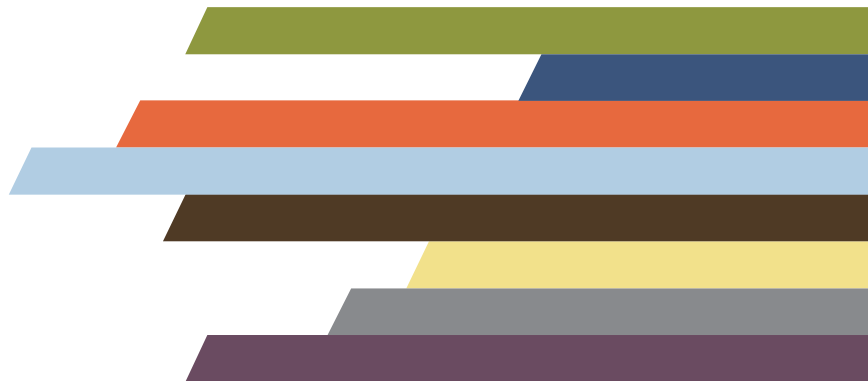
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