Transcript:

TRAILS: A Collaborative Model to Meet the Mental Health Needs of All Students

Presenter: Elizabeth Koschmann
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ANN SCHENSKY: Hi, everyone, and welcome. We're going to give people a minute or so to get into the room and get settled, and then we'll get started.

OK, it is the top of the hour and we'll get started. Welcome again, everyone, to our webinar today. It is on TRAILS-- a collaborative model to meet the mental health needs of all students. Our presenter today is Elizabeth Koschmann.

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We will be using automated captioning for today's presentation. A copy of the PowerPoint slides as well as the recording and any handouts we might have will be available on the MHTTC website within two weeks. You will be directed to a link at the end of the presentation to a very short survey. We would really appreciate it if you could fill it out. It takes about three minutes, and it's how we report back to SAMHSA.

Certificates of attendance will be sent out to all who attend the full session. They will be sent out via email, and they usually take about 7 to 10 days. If you'd like to see what else we're doing, please follow us on social media. And if you're on our mailing list, you can look for our weekly email on information with upcoming events.

We are excited today that our presenter is Elizabeth Koschmann. Elizabeth is the faculty member at the U of M Department of Psychiatry and the director of TRAILS, a student program that works to implement evidence-based mental health practices into K12 schools. Elizabeth's research is focused on identification of ways to improve community access to effective mental health care, particularly by training school professionals in best practices.

Elizabeth's areas of clinical expertise is the treatment-- is in the treatment of depression, anxiety, and PTSD in children and adolescents, using cognitive behavioral therapy and mindfulness practices. She has worked extensively as a trainer and a consultant for a variety of academic and community-based audiences, including providers working primarily with youth in foster care, and is a lead investigator in a number of state and federal research grants evaluating mental health and implementation models. So I'm excited to turn it over to you, Elizabeth.

ELIZABETH KOSCHMANN: Thank you so much. And good afternoon. It's an honor to join you today and to have this opportunity to talk about the TRAILS program. My hope is just to provide a high level overview of the program, describe how our model works, how we feel it is responsive to the needs of schools pre-COVID and certainly during the pandemic and return to schooling in this coming fall and upcoming years.

There's so many people that we are grateful to, organizations, foundations, stakeholders, community partners. So I just really want to express my gratitude to all of these partners, without whom our work would not be possible. So just huge thanks to many of them, some of whom I hope are able to join us today.

So TRAILS is a training and implementation program, and our goal and mission is really to improve accessibility of effective mental health services, recognizing that there's currently a lack of equity in access to mental health services, that truly have an impact on the well-being of young people. And we really believe that the school is an optimal environment through which to deliver services and increase access to care that really makes a difference.

We know, over the past 12 to 18 months, we've really seen this enormous rise in awareness of the importance of mental health among school-age children and adolescents. But prior to COVID, the field of adolescent mental health put forward a number of research studies that really provided evidence of the incredible burden that child and adolescent mental illness has on our population.

And this data is taken from a national survey of over 10,000 young people. And you can see in that data that not only do we have unbelievable exposure to traumatic events among young people, but we also have exceedingly high rates of diagonalizable mental illness. So almost half of young people will experience a mental illness by the time they're age 18.

And you can see that anxiety disorders are among the most common illnesses, impacting about a third of young people, followed by depressive disorders, substance use disorders. And of course, many of these disorders more commonly co-occur than occur alone, so we often see among young people with anxiety they have secondary depression.

I think what's most alarming, really, about this data, though it's all concerning, most alarming about this data on this slide to me is this rate of severe impairment, so kids who are impacted by a mental illness to the degree that it's interfering with their ability to function on a day-to-day basis, to take care of their school responsibilities, to interact socially with peers, to get along with family members, to get out of bed, and to just engage developmentally in appropriate ways. So seeing that 22% of kids are experiencing severe impairment at some point from a mental illness, we know that mental illness is really an enormous contributor to poor public health among pediatric populations.

At the same time, we also know that there are significant barriers that prevent the vast majority of kids with a mental illness from accessing effective care.

So we-- the data is mixed on this, but most commonly we see that about 80% of young people that have symptoms of a mental illness, that warrant mental health intervention or treatment, receive no care. And my guess is that if you're joining us today, you are likely quite familiar with a lot of the barriers that stand in the way of young people accessing treatment.

So certainly we see insufficient penetration of evidence-based practices in community care, but also just low numbers of community clinicians. I'm based in Ann Arbor, Michigan, and we have looked at the data about availability of child psychiatrists, sort of as a proxy for availability of mental health intervention across the State of Michigan. And like many, many states in the United States, we see pockets of saturation, often near academic institutions or health care centers.

But as we fan out into rural and remote regions there is often no qualified mental health clinician in some of the really rural areas. And then certainly in urban areas where we have high density population, we also see insufficient numbers of providers. And so the impact of that is that we see long wait lists, difficulty scheduling appointments, lack of flexibility to accommodate parents' schedules, students' schedules, that may not allow for those 4:00 to 6:00 PM or 4:00 to 7:00 PM coveted appointments.

We also see, because of the poor saturation of available community mental health, we see that often it requires a car trip across a city. And for families that don't have adequate transportation just being able to get to a physical appointment can be problematic.

There's also a number of social barriers, certainly stigma, and also, really, a lack of trust, often, of clinical settings, health care settings, and particularly among populations of color that maybe have experienced instances of medical racism or not feeling safe or comfortable in clinical health care settings, so many, many barriers. Of course, many of these disproportionally impact different populations, based on a variety of demographic factors, certainly economics, and race, and ethnicity play a huge role.

I think we are all so mindful today about the impact of COVID. And I think when we talk about school mental health delivery, when I look back on pre-COVID conditions, we were already experiencing problems. So it's wonderful in many ways that there's now a spotlight on mental illness impacting young people.

Pre-COVID, I think educators, school mental health providers, administrators, they were already extremely aware of these challenging situations that were impacting all students, so really high rates of just normative stressors-- social pressure, academic pressure, again, high rates of trauma exposure, and those barriers to care, and really a concerning and rising rates of depression, anxiety, post-traumatic stress, and certainly suicidal ideation and behavior, which has seen its highest rates in many, many years, decades. We, in the past couple of years, have seen higher rates than ever before of student suicidal ideation and behavior.

Of course, today we are at a new tilt of stress and pressure facing young people, with exponential increases in the past 18 months of exposure to traumatic events, a lot of these, again, disproportionately impacting youth in a variety of community environments, kids who have not had adequate access to housing or have experienced food insecurity, kids who are experiencing family stress and the violence often related to job loss and poverty, and anticipated data that's going to show increased events that were abusive and neglectful towards children, and just a climate in which media messaging about COVID has been constant, sort of spiraling kids into a moment where they can't really take a break from messaging that can be frightening, concerning, upsetting.

And of course, those barriers to care have only intensified over the past 18 months, as certainly, kids were blocked from attending school in person, but also in-person clinical care has been difficult, often relying on virtual delivery which excludes many populations from accessing care. And the opportunities for self care, especially for adults, but also for students have really felt non-existent, that many of the things that young people do to take care of their wellness-- social engagements, sports, camps, activities, getting outside, playing with friends, those have been nonexistent. And so what we've experienced in the past 18 months have been just high, high rates that young people are reporting of a lot of really difficult emotions.

You've heard me comment already but I think needs to be underscored, that COVID and associated impacts on mental health certainly have a disproportionate impact on students of color. Not only do we see these disproportionate rates of virus transmission and access to vaccination in marginalized communities, but again, just this disproportionate impact on how, and where, and when young people can access care, and then just the past year's increased awareness on violence against Black Americans and people of color, just presenting, really, as we've all heard, I think, this idea of a dual pandemic, that our young people are just contending with so, so much.

So how does this impact educational outcomes? And TRAILS is really a model that is designed for the schools. So we are really focused on, how is our model impacting outcomes of interest to academic leaders, administrators, and those in the system of education reform and improvement. So we know that without access to effective mental health treatment, kids who are experiencing symptoms of a mental illness show poor school attendance and engagement, certainly poor academic achievement, less likelihood to move appropriately from grade level to grade level.

And then, also, we see that these kids are more likely to activate disciplinary systems and to be transferred out of a school for disciplinary reasons, and to be implicated in exclusionary disciplinary action, like suspension, detention, and expulsion. So we see a lot of this data showing that kids who have mental illnesses actually are excluded from their academic settings more often than kids that aren't experiencing mental illness.

And they're also really creating a resource burden on schools, as they are requiring time, attention, and care from not only mental health providers in their schools but also their teachers and administrators in their building, so just a huge impact not only on the personal lives of the young people who are experiencing these mental illnesses, but also on their whole school, culture, and climate, and larger, broader systems.

I think also really important to pause for a moment and note that mental illness, also, is deeply impactful on the morbidity and mortality of young people that this pie chart is showing, leading causes of death. In kids down to as young as age 10 we now see that suicide is the second leading cause of death. And that is only behind unintentional injury. And I think it's important to note that a lot of that unintentional injury could very likely have an underlying factor related in mental illness that may cause substance abuse resulting in an accident, or impulsivity, or poor decision making, poor safety planning in young people that's maybe related to helplessness or hopelessness.

So I think we are actually probably underestimating the way in which we are losing the lives of young people to mental illness. So at TRAILS we really think of mental illness not only as a public health threat, but also really we're in a public health emergency. Today, I think it sometimes can be difficult to conceive of something as an emergency when it has been ongoing for a long

time. We've seen this gradual creep in these high rates of mental illness, but I think there is no other way to describe the current state of depression, anxiety, and PTSD in young people, as a public health crisis.

As I mentioned at the outset of my comments, we really feel that schools are an incredible opportunity to provide mental health care services to all students across all tiers. And this approach is really well supported by implementation researchers, school mental health experts across the country, that schools provide this natural and logical setting in which to use a public health approach to promote well-being, thinking about the needs of each individual student and the particular challenges that they may present with, but ensuring that schools provide an access point for students to receive the health and mental health services that they need.

Of course, this is really a problem, that we see that schools cannot do this work alone. They cannot shoulder these burdens alone. Many schools have shared with us that they have open positions that they are unable to fill, or they don't have adequate funding to hire the individuals that they need. Many schools have shared with us that they have a small percentage of a full-time social worker, counselor, school psychologist, or nurse. And staff are experiencing high rates of burnout and really difficulty providing prevention or early intervention.

They often report to us that they feel that they are just completely mired in responding to crises, with very little ability to think intentionally about interventions that they're providing or how their overall system works to deliver care, the way it might be most impactful or effective.

So TRAILS has built a program over the past eight or 10 years that tries to be responsive to the needs that schools have identified as most important. And we divide our program across three primary tiers. So at tier 1 we really focus on programming for all students, promoting wellness, promoting awareness and appropriate help seeking, providing training for the whole staff in a school, the whole school community, to try to promote, overall, a climate of well-being and accessibility for young people to educational opportunity that will allow them the opportunity to be successful and to thrive.

At tier 2 we focus on early intervention, so training for school mental health professionals that are positioned within those buildings to support students impacted by mental health concerns. And at tier 3 we're considering training for school mental health professionals again, but maybe really focused on a smaller number of those in the building that interact most often with the students that present at highest risk of serious self-harm or suicide and ensuring that systems, and resources, and training are in place so that those individuals can provide effective and efficient identification of students at risk of suicide and also either intervention or coordination with outside sources of care.

Everything at TRAILS is grounded in evidence-based mental health practices.

So if you didn't catch it in our logo at the front, TRAILS is an acronym that stands for Transforming Research Into Action to Improve the Lives of Students. And really, our goal is to take what we are learning from empirical research, from best practice literature, and embed those practices into the school environment, where students can access them.

So to that end, TRAILS is really focused on two primary theoretical approaches to mental health promotion, cognitive behavioral therapy and mindfulness. Not only do these have the strongest empirical support for responding to the most common mental health concerns among young people, being depression, anxiety, and PTSD, but also, these are really appropriate approaches for a school setting.

So we know many administrators, really balk. School professionals even balk sometimes. They don't view their school mental health professionals, like school social workers and school counselors, as appropriate to be providing ongoing, in-depth psychodynamic therapy to students. But they're very amenable to having those mental health professionals in the building teaching skills and focusing on solution and strength based strategies that students can learn, pick up, and carry on sustainably, and sometimes very independently, that really have an impact on outcomes, again, that are meaningful to that school environment, so not only their health socially, emotionally, and physically, but also on their academic performance and engagement and on their ability to move through school successfully. So everything we do at TRAILS is grounded in these two practices, of cognitive behavioral therapy and mindfulness.

In addition, TRAILS is not only informed by the literature on what the most effective mental health interventions are, but we're also very much guided by implementation science and what the literature tells us about what works to disseminate and implement best practices in any new setting. So there's a pretty extensive body of research that points to the fact that it just does not work to provide one-time professional development trainings.

We can't bring overwhelmed, incredibly busy, often underpaid school social workers, counselors, psychologists, and their allied professionals to a one-day training or a couple of hours of training, hand them a binder of materials and say, OK, go ahead, go back to your jobs and expect them to implement these best practices that they have just learned. We know that that just doesn't work.

So the model at TRAILS is that we provide that training in evidence-based practices. And we have an extensive library of resources, most of which are available open access on the TRAILS website, trailstowellness.org. But we also have a rigorous coaching and consultation model. And you can see that tie there in the diagram to local resources.

So I'm going to talk later this morning about-- or I should say, this afternoon-- about that, how we build our coaching model by leveraging community-based mental health providers as expert coaches. But before I get to that, I wanted to pause and just share with you a brief documentary film, a few minutes long, that we made about the program a couple of years ago so that you can see it from some of our partners in the community, how this program has been for them. Let's see if I can get it to go here.

[VIDEO PLAYBACK]

[MUSIC PLAYING]

- Every day across the country students are walking through the doors of every school in every city who are severely impacted by mental illness. The student with depression, or anxiety, or post-traumatic stress disorder who actually makes it to the office of a qualified mental health professional is unbelievably rare. The vast majority of these kids deal with their symptoms alone. And often they don't even know that they have an illness.

School is often the only source of behavioral health care that these kids will get, which means that if care isn't effective, those students are never going to get better.

- Kids don't need complicated mental health treatments to get better. They need some really effective skills in their toolbox. Unfortunately, we know that of the kids who have these serious mental health illnesses, about 20% of them are accessing treatment. The rest of them can't get there, can't afford it, or are too ashamed to go and are dealing with their mental health symptoms alone.

- So on a typical day in my office I could really see students that are struggling with homelessness, depression for sure, every day, anxiety, students that are self harming, lots of suicidal ideation, really a lot of domestic disputes at home, and then also the environmental things just in a school, so bullying and friendship and relationship troubles.

- Well, we know that 60% of students are going to experience trauma of some sort, homelessness, violence, abuse, neglect. And about 40% are going to experience depression or anxiety before they graduate, which is exactly the reason why I think we need to be equipped in the schools to be able to help these kids.

What I found, after years of working with students, I have always felt I could connect with them, but I never really was feeling strong in actually being able to help them with whatever those issues might be effectively and efficiently, which is pretty imperative, I think, in the school setting. So I find with CBT, these skills. I can still form those relationships, but I'm able to help them

quicker, more efficiently, which I know is an important thing in a school setting.

- The talk therapy and the things that we are doing in the past were not working. We needed CBT. And we needed an expert to come in and help us do that. And so to have a group where we get to talk about these skills and to have an expert say like, actually, let me help with that one, takes the weight off of your shoulders and helps you collaborate, and you feel like a professional that's being supported.

- One of the things that we've really seen as an outcome of this program so far is that it's freeing up the time of the school professionals to really devote the time that they need to help students who are really in crisis.

- When I do the things that I've learned for CBT, I'm doing very quick relaxation exercises. I'm doing-- I'm implementing coping skills, because we don't have a lot of time because the student only has so much time in the school day. I think, most students, you just see them feel better and not as upset when they leave and be able to quantify that by, yeah, I was able to get back to class in 10 minutes today.

- I think we were really at a breaking point, where we were pretty overwhelmed with students struggling with different mental health concerns and really dealing with those issues one at a time. And I think this gave us an opportunity to work with students in a group environment. And I think it's powerful for students to work with other students who are going through some of the same things that they are.

I'm really grateful to the relationship that we formed with the University of Michigan. So the resources, and coaching, and just the support through the project has been phenomenal. And I think we're at a point now where I think we're really in a place where we've learned the skills. We've practiced them. They've been successful. And the program will just grow from here.

- If it were up to me, every kid in every school in America would be learning effective coping strategies. If we send our kids off to college and adulthood without any idea of how to manage rejection, or disappointment, or failure, we're setting them up for a disaster. I think that CBT and mindfulness are skills that everyone can benefit from.

We all have times in our life that are harder than others. And if you have an effective skill in your toolkit that can help you stay grounded, help you remember your goals, help pick you up when you're feeling really down, you're going to be able to not only survive those moments, but you're going to benefit from those moments. They're going to make you stronger. And those moments are not going to be setbacks. They're going to be the times when you've really got your footing and really knew where to go.

- Using the CBT program in schools, it helps getting past being embarrassed, because you are part of a group where everyone is going through something. And you don't feel so isolated or left out. And you don't have to feel embarrassed because other people are going through things that you are. I just feel like it's really a testament to who I am today compared to who I was.

Like graduation is in 11 days, and I'm speaking at graduation in front of everybody. And I just-- I feel like this group helped a lot.

- I personally, before the CBT, did not like any type of therapy, any type of anything because I felt like it was just scripted. And I felt like it wasn't genuine. And I didn't like it. But to look at the difference from therapy in one-on-one and then look at the difference to a CBT with a group, the whole room is just accepting, because everyone there has something to work on.

- I used to be really down on myself a lot. I was angry a lot. I never really thought things through. I just acted on emotion. You know, it really does help you, at least opens you up to different ideas or different ways of coping with whatever they may be dealing with. I think even just being aware that there is a way out is good enough.

- This program is truly changing the ways in which children and adolescents across the country will be able to access effective mental health care, enabling students to be healthier and more resilient no matter what hurdles they may encounter.

[END PLAYBACK]

OK, I'm going to move on. There are just a couple of little closing comments. You can watch the rest of that film on the TRAILS to Wellness website. But I can just share that the-- and I'll talk at the end of my comments today, that the pace of growth at TRAILS has been pretty unbelievable, even for us, exceeding some of our wildest hopes and expectations for how the program could have grown.

And one of the indicators of that is that at the time we made that film, not that long ago, a couple of years ago, we didn't even have the name TRAILS as our program. We were called CBT in the schools. So you never really hear anyone in the program say, my TRAILS group, or my TRAILS coach, or my TRAILS program in my school. They just say that program. So just a little insider's tip of the indication of our growth over the past couple of years.

OK, so you heard-- you've heard now from me and from the little film clip just an overview of the program. I don't want to spend enormous amount of time on the details but just to give you all today a sense of what we offer, each of these three tiers, and a little bit of the nuts and bolts of the program, and some of our-- a little bit about our future directions. And then, of course, we're happy to chat with you offline after the webinar today or through the chat

function, happy to take questions. And again, if you want to just ask your question at any point you can raise your hand, and our host today will recognize and they can pop in with a live question.

So again, TRAILS programming is delivered across these three tiers. At tier 1 we focus on-- first of all, focusing on the staff in a school. We know that we have to attend to the well-being of the educators and leaders in a building in order to really try to have an influence over the culture, and climate, and wellness of the students in any school.

We also have a complete social and emotional learning curriculum for the classroom that's designed to promote resiliency and also build those core competencies identified by CASEL. And we also focus on supporting schools to conduct appropriate ethical and efficient universal student mental health screening practices.

So I'm just going to speak about one of these components right now, our social and emotional learning curriculum. My guess is that I don't have to educate this group about what social and emotional learning is, but I can share with you that the TRAILS curriculum provides 20 short lessons at each of four different grade bands. And again, because everything we do at TRAILS is grounded in CBT and mindfulness, so is SEL curriculum. And I think, in many ways, that's what sets our school materials apart from some of the other curricula that are out there.

We are huge advocates and supporters of many, many SEL programs available nationwide. But we also saw, initially, a real need for an SEL curriculum that would move the needle on getting some of these best practices into the classroom space and helping teachers become proficient in this content.

The materials that accompany the curriculum include extremely comprehensive lesson plans, also, all the handouts and activities that students might participate in, videos and recommended websites and links, and also, family letters that accompany each lesson to go home, to summarize what was taught and to provide some recommended strategies for families to support that content that was taught in the lesson, also, lots of additional materials for ways to integrate the content that's taught in each lesson into the general classroom space, and then ways to adapt the lesson, breaking it down into smaller components, a 15-minute lesson that may be delivered in multiple sessions across the week instead of a one-time lesson that's designed to be between 30 or 60 minutes, so lots of materials accompanying that curriculum.

And of course, the curriculum is completely grounded in those CASEL core competencies, because we know that this is where the data is. The data has evaluated those curricula that build those core competencies and shown that

SEL programs that are aligned with those competencies improve academic and social and emotional outcomes in kids.

So again, there down the left-hand side of that table in orange, you can see those five CASEL core competencies. And those for our program become the modules. And then for each module there are anywhere from three to six lessons. And you can see that really some of our primary content is in that first module, or first competency of self-awareness, because CBT and mindfulness is so much about building awareness of our own wellness and functioning, our behaviors, our thinking, and how both thoughts and behaviors are ultimately impacting our behaviors and our decision making and choices. This is just a different way of looking at those modules and showing this alignment across the top and not only between those CASEL SEL competencies but then also with core components of CBT and mindfulness.

So we conceive of those core components, again, based on the data that's out there as including psychoeducation and relaxation, some of those more common approaches to mental health promotion and intervention, but also those more behavioral approaches, the cognitive restructuring, behavioral activation, exposure, and some problem solving skills, so just a little bit of a crosswalk between our SEL curriculum and common elements of CBT.

Training for our SEL curriculum is delivered to, typically, educators, classroom teachers, sometimes health teachers in a school, delivered over a two- to four-hour period, can be delivered in person or virtually. We begin with a core dive into SEL, the rationale, the evidence behind SEL programming. And then we really dive deeply into those core CBT and mindfulness skills, and then help educators and those who will be delivering the curriculum understand how the lessons work and how to guide kids through each of the components.

Just a quick few shots of some of our SEL materials so you can see what those look like, all of the materials include these components, the lesson objectives, the competencies as well as this say, do, ask kind of approach so that an instructor, we really tried to minimize preparation time that would fall to a teacher. They typically could pick up the lesson plan, give it a quick five- to 10-minute read through, and they should be ready to go, to deliver the lesson itself. It's extremely comprehensive in materials that are provided.

And of course, everything's provided in a PDF form, and anything that you see in blue is an internal link to a material, a resource, a handout, an activity, a video that is supportive of that lesson. And then you can see, in that last little screenshot, of supplemental materials, just additional resources to bolster, extend, or expand the lesson.

Here are just some examples of the student materials. For those of you that are familiar with CBT or SEL, you'll probably start to see some of the overlap there, again, building students' self awareness, their ability to cope with stress

and pressure, disappointment, rejection, failure really salient in this curriculum.

Again, because TRAILS is so focused on implementation and that data that we can't just hand this curriculum out and expect schools to pick it up and run with it, we have associated training for local champions as well as a ton of materials to support the role of a local educator or school professional in pre-implementation tasks, to build appropriate understanding, support, systemic and structural environments to enable SEL delivery as well as tasks to support ongoing implementation of the curriculum evaluation, generation of data and reports, so that schools can really see the impact of the curriculum, and then some post implementation at the end of the year, to gather feedback and understand where changes may need to be made.

We're also really excited that we've recently formalized a partnership with xSEL labs and their online direct assessment of those SEL core competencies using cell web, really innovative, exciting research that's been carried out by SEL labs. This comes out of Rush Medical School. And this is a new partnership for us, so we're really excited in the coming year to see the data that's produced through some direct assessment of students who are participating in our SEL curriculum.

I'm going to move now to tier 2, again, just trying to offer a really brief overview of some of the programs that TRAILS offers. So at tier 2, again, we're really focused on training, and resources. And implementation support, not for educators in this space but really for school mental health professionals, so those social workers, counselors, school psychologists, nurses, and thinking about programming that would be impactful for students who are experiencing symptoms of a mental illness.

So you can just see this coordinating tie between our SEL curriculum at tier 1 and our early intervention, or targeted program, at tier 2, that we're really shifting gears to be providing training and resources to individuals in a school that should have some prior training in counseling, social work, or other mental health care delivery format, and that the goals at tier 2 are not really prevention or wellness promotion but really symptom reduction. And so this is where our CBT really sort of hits that standard clinical benchmark.

I mentioned before our website, so TRAILS has made our CBT and mindfulness skills-- sorry, resources-- across two categories, both session-by-session manuals-- and you can see those up here in the top left corner-- we have session agendas in, I think, three session, seven session, and 12 session options across each of those grade levels, 3 through 5, 6 through 8, and 9 through 12.

But we also have our materials broken down by individual CBT component, because we know that not every school mental health professional has the opportunity to deliver a multi-session curriculum to students that are on their

caseloads or with whom they're working. Sometimes what they need is a one-page resource that really gets into exposure for a student that's struggling with anxiety or really gets into cognitive coping for a student that's getting stuck on some of those automatic thoughts.

So we have made our website organized in this way, by both multi-session manuals as well as stand alone resources. And I can just share that in the past year-- I think some of this is at the end of my comments as well-- we have had over a million page views on our website in a 12-- the past 12-month period.

And we are seeing that our resources are downloaded over 1,000 times a day. So we know that we are hitting a need that schools really have, that we see and hear from our school partners, that it is very difficult for them to find resources like this that are ready to go. They can pull them off, and they're free on our website. And we really work extremely hard to try to maintain open access to our materials.

And I think because of that, because our emphasis on equitable access and making access available to all communities, we have seen not only that here, in Michigan, where we're based, has our program been accessed by every county in the state, we also know that our website is accessed from every state in the country, and more recently, we've learned from 125 countries around the world. So we get requests often for translation of our materials. And we are really excited for some initiatives coming down the line, to get these materials into many different languages so that we can try to be responsive to that global need as well.

Just a couple of examples here, again, just to give you a little bit of a taste for what our materials look like. This is a pretty typical session agenda. And you can see some overlap stylistically with our tier 1 lesson plans, lots of materials for school mental health professionals and lots of materials for young people, as well, who might be participating in a TRAILS program at their school.

What I just want to draw your attention to on this screen is where you see these grayed-out boxes. I feel just incredibly grateful to our amazing TRAILS web team that, over the past 18 months, has transformed the vast majority of our clinical materials to be virtually accessible and PDF fill-able. So for a lot of our online delivery of TRAILS mental health services kids can gravitate to the resource that's being shared by their school professional or receive it in an email. They can just hop right in here to one of these boxes, enter the text, and then save it to their local desktop and email it or share it back with a school professional leading a group, or save it for their own record.

We have a wellness journal that we created also during COVID. And that wellness journal can be saved right onto a local computer. And kids can update the page every single day, adding new information and saving it with a new date, so really a great innovation that has come out of the COVID crisis.

To that point about COVID and its impact, we certainly heard from our school partners early on in the pandemic that they really wanted a brief, multi-session group manual that they could use to deliver those same CBT and mindfulness skills to students but with a pretty targeted focus on COVID-related stress and worry. So we built out-- there's that daily wellness journal that I was just mentioning-- but we built out a seven-session curriculum that is very much focused on COVID-related stress.

And we used this Google template and platform online that allows kids to view material on their screen, and then they can write in their answer. So you see right here, it says, students write your response. They can type in their answer right on their screen. And then what their group facilitator sees on their end is a list of all the names of the students participating in that group and the response that each student has entered, so a really great tool that just saw tons and tons of use during the last school year and continues to be utilized over the summer.

I mentioned at the beginning that we are really focused on ensuring that we are not just providing one-day professional development or didactic training and materials but that we're also really thinking about that implementation side of the three-legged stool. And this just gives you a quick view of the TRAILS training model.

The way our training and coaching works is, if you start over here on the left side of the screen, we provide training for community mental health providers. So take a moment here. We're coming outside of the school setting, and we're thinking about CMH clinicians who typically carry a caseload of kids and often those are Medicaid-enrolled clients.

After that training for those CMH providers, each one is asked to pick a case from their caseload who will be their practice case while they participate in a 10 to 15 week consultation phase with TRAILS. During that phase, the CMH provider is paired with a TRAILS staff consultant. And they practice all of the skills that were taught in that initial training using their real case from their patient caseload.

At the end of that consultation phase, our consultants have their CMH, we call them coaches in training, complete a number of assessments. And they're evaluated by our consultants. And then, by invitation only, some of them are invited back to what we call our coach protocol training. And this is where we move on from really shoring up those clinical CBT and mindfulness skills, and instead, we train those CMH providers in our own model for partnering with a school mental health professional, school social worker, psychologist in the role of a coach. How do you give feedback? How do you observe a session?

How do you help a school social worker plan for an upcoming session?

So pause there. Now we have this trained TRAILS coach who's completed this clinical training, this consultation phase, and this coach protocol training.

If we pause there and leave them waiting for a moment and jump over here, TRAILS then goes out to schools that are TRAILS participating schools. And we provide that one-day clinical training for school mental health professionals.

And at the end of that training, we pair those schools with these coaches. And together, the school professional and their coach facilitate about a 12-session student CBT and mindfulness group, using students that this school professional really is hoping to connect with and has been referred to them for services anyway.

It is through delivery of that multi-session group alongside their coach that we really see our school professionals really formalize their expertise in these CBT and mindfulness skills and really build that sustainable clinical skill.

Following that multi-session group, typically, the coach can pull away. TRAILS can pull back. And what we've left behind is sustainable, low-cost expertise in the school embedded into the staff that are already part of that school community fabric.

So the purpose of TRAILS is really to provide an affordable, sustainable solution to a workforce that is overwhelmed. And often what we see is staff that, just as you heard my school community partner, Brian, say in our film, he knows how to relate to kids. He's really great at connecting with kids. But he hasn't had an opportunity to receive really high quality professional development that will make him effective and efficient. And what TRAILS aims to leave behind, after we're done with a partnership, is that expertise in the hands of those folks who are part of the school community.

Just a couple of details here on this coaching, so the way that the coaching works, it's about a 10 to 12 session group manual. Each session is maybe 40 or 60 minutes long. Typically, there's somewhere between eight and 15 students per group and maybe one to three, we call these SPs, or school professionals, per group as well as their coach. And here you can just see the breakdown.

The school professional is really in charge of that group session with the students. They're the leader. They identify the students. They book the room.

They run the actual session. Whereas the coach is really there to support the school professional to be the CBT expert. You heard my school professional partner, Amy, say, sometimes we just need to turn to our coach and say, can you do this skill today? I'm not really sure I understand it. And then, of course, the coach is also there in an evaluative role, to observe fidelity, adherence,

quality, and to help that school professional make a determination of when they're ready to exit, or graduate, from coaching.

So there's our model, just some information about how to become a TRAILS coach, a little bit more detail than what I shared a moment ago. This is a little bit more detail about our consultation phase. You can see consultation is about 12 weeks. And here's just a pop out. If the coach, at this point, was learning about the skill of psychoeducation, you would see that they participate in some session planning with their consultant, some emailing.

They actually have the client session. And then they do some evaluation work at the end. So I can leave it to you, if you're interested, to dive in more deeply to this content. If you are interested, you'll have this slide deck in your hands at the end of the session.

Just a side note about some data, so TRAILS has really focused primarily on looking at outcomes among school mental health professionals and students, but along the way, we actually looked at some of our consultation findings.

And as we built a coach network across the State of Michigan, we looked at data from over 186 clients. And again, these are community mental health clients that are on the case loads of the CMH providers, who are training to become TRAILS coaches.

So first of all, what you can see is this incredible satisfaction with the TRAILS training and consultation model. But we also see really interesting findings, that these clients that are served by these coaches in training are showing remarkable reductions in depression and anxiety symptoms. And the coaches are showing remarkable increases in utilization of those core CBT skills. So we are learning that, as a side outcome, we are actually improving quality of care in those CMH settings as well.

And one thing I just want to draw your attention to-- this chart has a lot going on it-- going on in it, but what you see across the bottom are these CBT components that we're teaching and then a rating of how often our coaches use each of those component skills. Here we have before the consultation phase and after consultation.

And if you just pay attention here to the never, sometimes, or often, or always used this particular skill, what you see is that before they participated in consultation there was pretty widespread use of these three components, talking about CBT theory, teaching relaxation, maybe doing some cognitive restructuring. Those all went up substantially. But most importantly, what you see here is that the overwhelming majority of these CMH providers, prior to consultation, were not using exposure or behavioral activation, which we know convey a lot of the treatment effect of CBT. But following consultation, they were using those vastly more often.

So I want to move through my next set of slides pretty quickly here, to make sure that I can wrap up on time. But you can see that the TRAILS coach network, back in 2020, was the last time we made a graphic of this. Covers most of the State of Michigan. And there's our TRAILS school partners, so really expanding significantly across the State.

And we also have collected a fair amount of data about the impact of the program, showing that it is really deeply reducing symptoms of depression and anxiety in young people. Here you can see one of the publications from our NIMH clinical funded trial. So that program is currently being rigorously evaluated and in RCT, and we're hoping to have more data about the outcomes of that study soon.

I'm not going to spend a lot of time on tier 3 here. I'm pretty much out of time. But also, this is probably the most new element of TRAILS and the least developed. So I can just share, the purpose of our tier 3 model is really not intended to be suicide prevention but really system change at the school level.

We know that in the schools we see limited utilization of evidence-based practices and protocols to connect kids with needed supports, when they are presenting with risk of suicide.

So not only do we help schools engage with high quality gatekeeper training and improve their own internal practices, but we have also built out a protocol that helps improve communication and coordination with those external supports. So you see here an example. The top half of this form is information collected by the school and shared out to their local hospital or emergency department, when a referral is made to a higher level of care. And the bottom part here is for information to come back to the school. And the purpose of this is just to get rid of some of those communication breakdowns and improve referral networks and pathways.

So there, again, is our entire model. And what I just want to share with you briefly here is a way in which these models work together, that if we provide this training for classroom teachers at tier 1 and concurrently provide training for school mental health professionals up at tier 2, then we end up with a system that can internally support long-term sustainment of the program and best practice delivery within the school setting.

I'm going to jump ahead here and just share with you. We're really excited at TRAILS, Now, that we've been able to expand into two new states. And we have more states on the horizon that are asking for TRAILS. And if you are interested in bringing TRAILS to your community, please hop on to our website and you can get in touch with us and learn how to bring TRAILS to your community.

So thank you. I know we are out of time now. Really appreciate the opportunity to speak to you about the program. And I hope to have a chance to connect with you offline through email in the future. Thanks so much.

ANN SCHENSKY: Thank you, Elizabeth. This has been such an amazing program. It's very exciting to hear all about it and see how it's growing. We at MHTTC heard about it a couple of years ago and have been excited about it ever since. So we're happy to bring it to more people.

We will send out the information that we have. Meredith has been amazing about getting the links in the chat. So if people have missed them, we promise that they will be part of the posting that we do. So if people have questions, we will put these slides up. We will also provide the recording and any resources that we have on our website.

So I want to thank everyone for their time, especially you Elizabeth. And everyone who spent the afternoon with us, we are happy that you could spend this time to learn about this program. One really quick question-- oh, there you go. Elizabeth is all over that. OK.

So thank you, everyone. And have a fantastic afternoon.

ELIZABETH KOSCHMANN: Thank you so much.