TRAILS™

Effective mental health services,
accessible in all schools

Mental illness in children and adolescents

57%

Exposure to trauma

Physical assault
Sexual victimization
Abuse or neglect
Victimization
Witnessing violence

49%

Any mental illness

31.9%

Anxiety disorders

14.3%

Depressive disorders

11.4%

Substance use disorders

22%

Severe impairment

18%

Consider suicide

Nationally, sucide is the 2nd leading cause of death for children 10-14, and the 3rd leading cause of death for teens 15 and older.

Significant Disparities

Disproportionately impacted groups:

LGBTQ+
Youth experiencing homelessness
BIPOC
and others

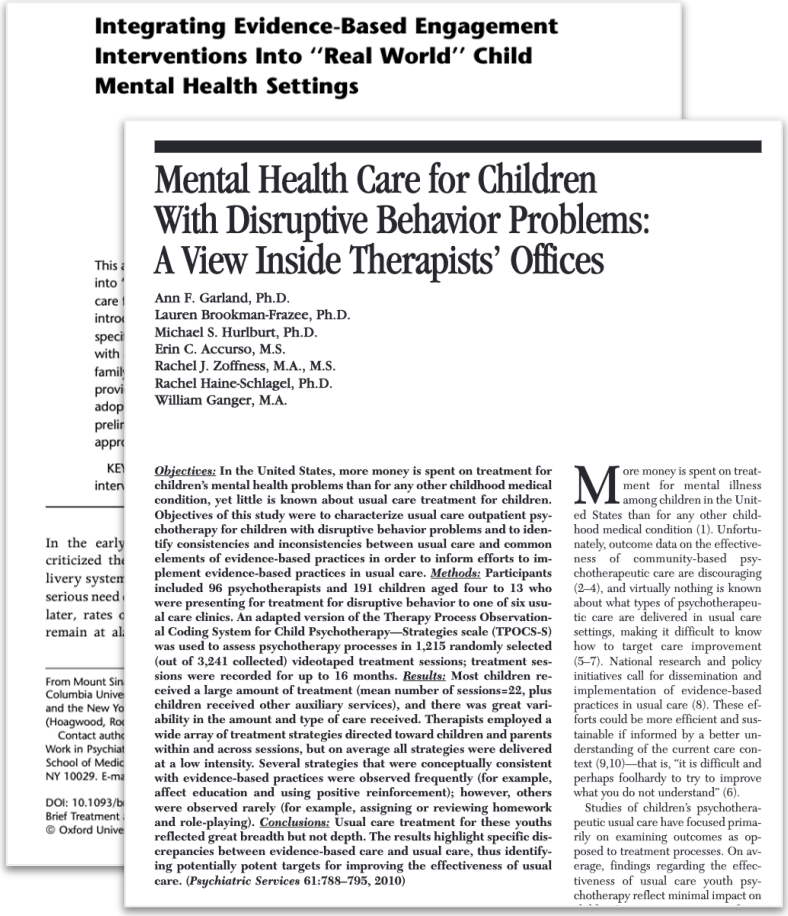
CDC FastStats, 2021
Finkelhor, 2015; Merikangas et al., 2010; Koschmann et al., 2022

80% of youth lack access to care

- Few trained clinicians
- Scarce appointments
- Long waitlists
- Inadequate insurance coverage
- Lack of transportation

- Limited information among families
- Insufficient time for appointments
- Social stigma & Medical racism
- Distrust of clinical settings
- Low availability of effective treatments

Low availablity of evidence-based treatments in community care



Integrating Evidence-Based Engagement Interventions Into "Real World" Child Mental Health Settings

Mental Health Care for Children With Disruptive Behavior Problems: A View Inside Therapists' Offices

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Objectives: **In the United States, more money is spent on treatment for children's mental health problems than for any other childhood medical condition, yet little is known about usual care treatment for children. Objectives of this study were to characterize usual care outpatient psychotherapy for children with disruptive behavior problems and to identify consistencies and inconsistencies between usual care and common elements of evidence-based practices in order to inform efforts to implement evidence-based practices in usual care.** ***Methods:*** **Participants included 96 psychotherapists and 191 children aged four to 13 who were presenting for treatment for disruptive behavior to one of six usual care clinics. An adapted version of the Therapy Process Observational Coding System for Child Psychotherapy—Strategies scale (TPOCS-S) was used to assess psychotherapy processes in 1,215 randomly selected (out of 3,241 collected) videotaped treatment sessions; treatment sessions were recorded for up to 16 months.** ***Results:*** **Most children received a large amount of treatment (mean number of sessions=22, plus children received other auxiliary services), and there was great variability in the amount and type of care received. Therapists employed a wide array of treatment strategies directed toward children and parents within and across sessions, but on average all strategies were delivered at a low intensity. Several strategies that were conceptually consistent with evidence-based practices were observed frequently (for example, affect education and using positive reinforcement); however, others were observed rarely (for example, assigning or reviewing homework and role-playing).** ***Conclusions:*** **Usual care treatment for these youths reflected great breadth but not depth. The results highlight specific discrepancies between evidence-based care and usual care, thus identifying potentially potent targets for improving the effectiveness of usual care. (*Psychiatric Services* 61:788–795, 2010)**

More money is spent on treatment for mental illness among children in the United States than for any other childhood medical condition (1). Unfortunately, outcome data on the effectiveness of community-based psychotherapeutic care are discouraging (2–4), and virtually nothing is known about what types of psychotherapeutic care are delivered in usual care settings, making it difficult to know how to target care improvement (5–7). National research and policy initiatives call for dissemination and implementation of evidence-based practices in usual care (8). These efforts could be more efficient and sustainable if informed by a better understanding of the current care context (9,10)—that is, "it is difficult and perhaps foolhardy to try to improve what you do not understand" (6).

Studies of children's psychotherapeutic usual care have focused primarily on examining outcomes as opposed to treatment processes. On average, findings regarding the effectiveness of usual care youth psychotherapy reflect minimal impact on

"Overall **penetration rates of EBTs were low (1% - 3%)** and EBT adoption by states showed flat or declining trends.

Research, Data, and Evidence-Based Treatment Use in State Behavioral Health Systems, 2001-2012 (Bruns et al.),

KFF Report on School Mental Health:

Figure 1

Ment

Service

Individua

Case Ma

External

Group-ba

Needs As

Family-b

Outreach students

Telehealt

Other

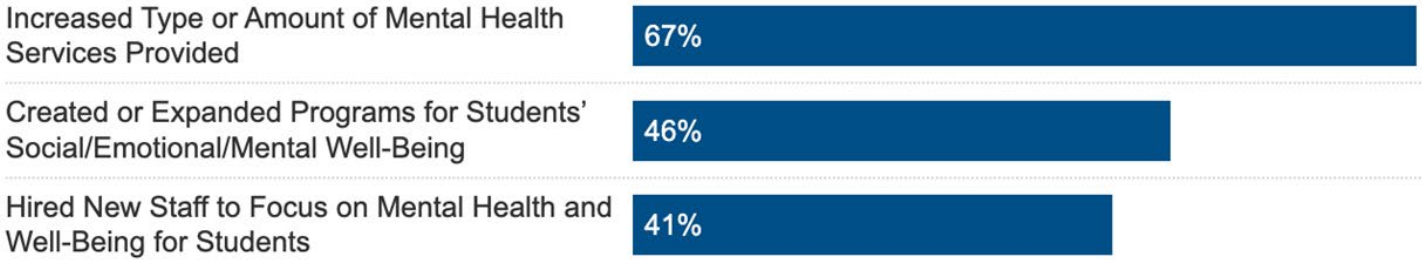
School-B Provided

NOTE: Re provided to

SOURCE: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, School Pulse Panel 2021-22. • PNG

Figure 2

Changes Schools Have Made Related to Student Mental Health Since the Pandemic Began



NOTE: Respondents were asked to report on changes that began after March 2020.

SOURCE: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, School Pulse Panel 2021-22 • PNG

KFF

Surgeon General's Advisory: The essential role of schools

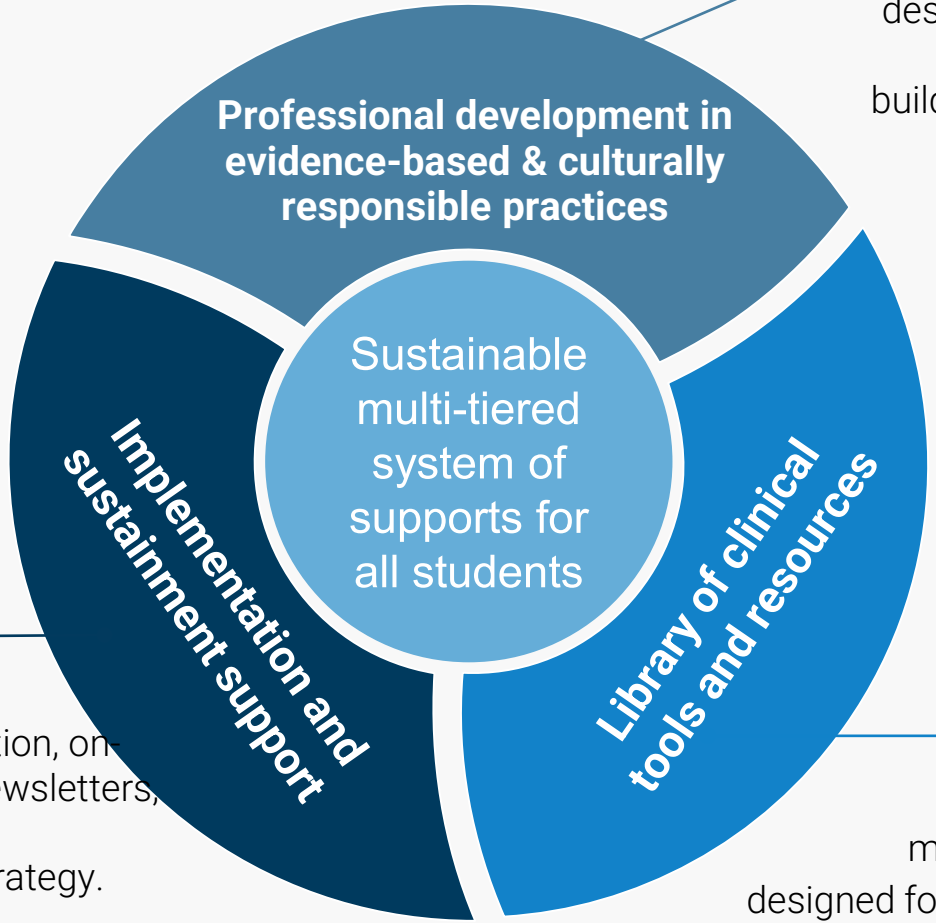
Saul Loeb/AFP/Getty Images, Adobe Stock

1. Create positive, safe, and affirming school environments.
2. **Expand social and emotional learning programs** and other approaches that promote healthy development.
3. Learn how to **recognize changes in mental and physical health** among students. Take appropriate action when needed.
4. Provide a **continuum of supports to meet student mental health needs**, including evidence-based prevention practices and culturally responsive mental health care.
5. Expand the school-based mental health workforce and support the mental health of all school personnel.
6. Protect and prioritize students with higher needs and those at higher risk of mental health challenges.

The TRAILS model

Core pillars of TRAILS

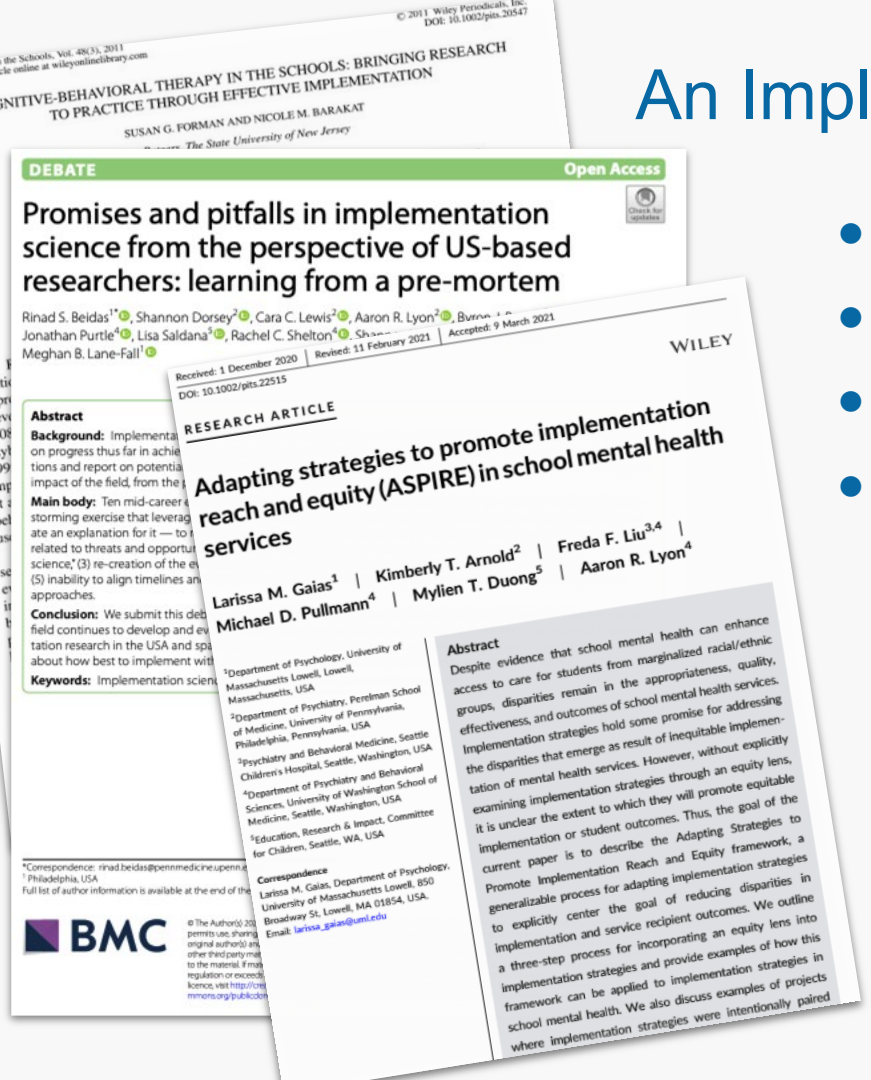
Live, pre-recorded, and autonomous training options designed to meet the needs of every staff member in the building and cover content that maximizes their impact for students.



Pre-implementation planning, training, coaching & consultation, on-demand technical support, newsletters, advance practice trainings, and sustainment strategy.

More than 1200 curriculum materials, tools, and resources designed for educators and school staff.

An Implementation Science framework



- Training **format is accessible**
- Training **content is tailored** to staff needs
- **Resources are easy to access**
- **Implementation strategies** are modular
  - Pre-implementation support
  - Coaching & consultation
  - Sustainment planning

Tier 1

Social and Emotional Learning

K-2 3-5 6-8 9-12

Who we train: teachers and student support staff

- 5-unit curriculum aligned with CASEL competencies:
  - Self-awareness
  - Self-management
  - Social awareness
  - Relationship skills
  - Responsible decision-making
- 20 individual lessons, ~30 minutes each
- Grade-appropriate content, handouts, and activities; caregiver letters to send home

SEL significantly improves:

- Academic performance
- School engagement
- Classroom behavior
- Self-regulation skills
- Emotional health

Tier 2

CBT and Mindfulness

3-5 6-8 9-12

Who we train: school mental health professionals (counselors, social workers)

- Best-in-class materials grounded in evidence based practices cognitive behavioral therapy and mindfulness
- Individual or small group sessions
- 7- or 10-session manuals designed to help students cope with depression symptoms, anxiety, symptoms, or both
- Implementers receive direct support from a local TRAILS Coach

Coping strategies include:

- Mindfulness
- Relaxation
- Cognitive Coping
- Behavioral Activation
- Exposure

Tier 3

Suicide Prevention and Risk Management

Who we train: all school staff

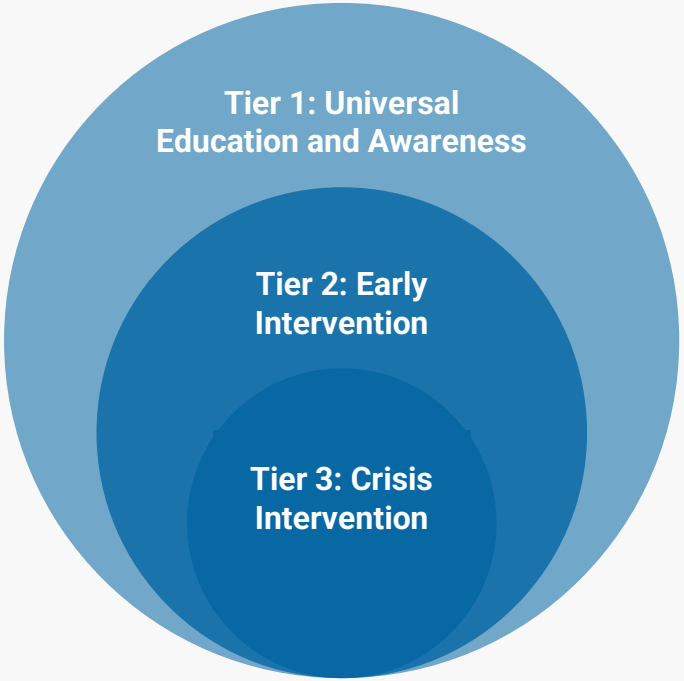
- 4 audience-specific training options:
  - For school leadership
  - For school mental health professionals (e.g., counselors, social workers)
  - For teachers and paraprofessionals
  - For families and community members

Training covers 3 essential categories of support:

- Prevention
- Intervention
- Postvention

- Implementation of the TRAILS **Student Suicide Risk Management Protocol**: a clear set of steps for responding to suicidality in students and coordinating their care across education and healthcare settings

A multi-tiered system of supports:



- All 3 tiers grounded in **evidence-based, culturally responsible practices**
- **Schoolwide system of mental health** aligned with MTSS and PBIS frameworks
- **Referral systems** that quickly connect students to the right care
- **Care coordination and communication** across settings
- **Stigma reduction** throughout the school community

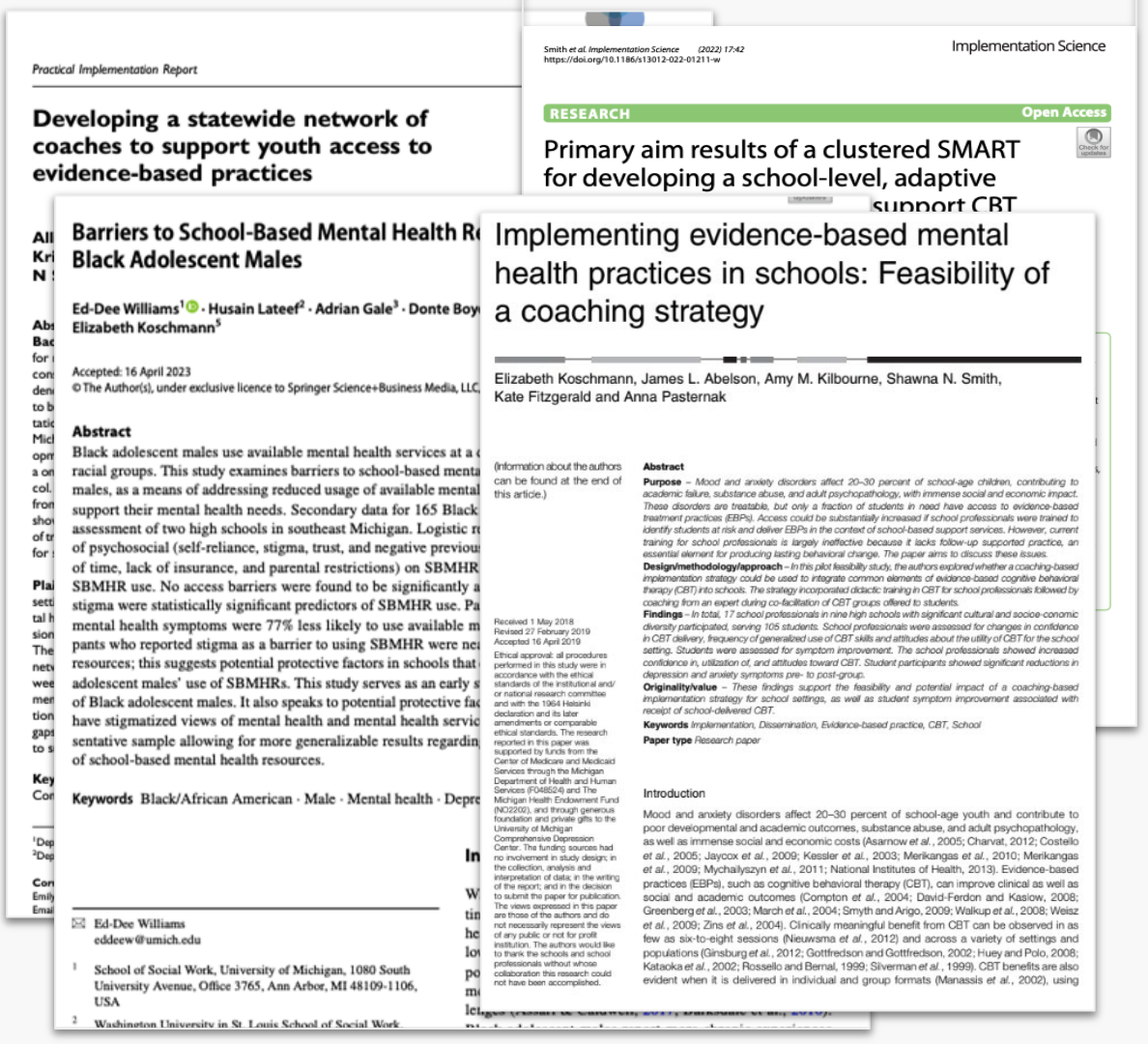
Evidence of Impact

Seminal TRAILS study:

- **105 Michigan students (grades 9-12)**
- Increased use of CBT by SMHPs (n=17)
- Significant decreases in student depression and anxiety (p<.001)
- Strongest effects for students with trauma exposure

3-year NIMH-funded study:

- **968 Michigan students (grades 9-12)**
- One fourth showed a ≥50% reduction in symptoms of depression and anxiety
- Increased use and long-term sustainment of CBT by SMHPs (n=169)



Practical Implementation Report

Developing a statewide network of coaches to support youth access to evidence-based practices

Smith et al. Implementation Science (2022) 17:42
https://doi.org/10.1186/s13012-022-01211-w

Implementation Science

RESEARCH Open Access

Primary aim results of a clustered SMART for developing a school-level, adaptive support CBT

Barriers to School-Based Mental Health R
Black Adolescent Males

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Elizabeth Koschmann[5]

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Abstract

Black adolescent males use available mental health services at a
racial groups. This study examines barriers to school-based menta
males, as a means of addressing reduced usage of available mental
support their mental health needs. Secondary data for 165 Black
assessment of two high schools in southeast Michigan. Logistic r
of psychosocial (self-reliance, stigma, trust, and negative previou
of time, lack of insurance, and parental restrictions) on SBMHR
SBMHR use. No access barriers were found to be significantly a
stigma were statistically significant predictors of SBMHR use. Pa
mental health symptoms were 77% less likely to use available m
pants who reported stigma as a barrier to using SBMHR were ne
resources; this suggests potential protective factors in schools that
adolescent males' use of SBMHRs. This study serves as an early s
of Black adolescent males. It also speaks to potential protective fa
have stigmatized views of mental health and mental health servic
sentative sample allowing for more generalizable results regardin
of school-based mental health resources.

Keywords Black/African American · Male · Mental health · Depre

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Implementing evidence-based mental health practices in schools: Feasibility of a coaching strategy

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Abstract

Purpose – *Mood and anxiety disorders affect 20–30 percent of school-age children, contributing to academic failure, substance abuse, and adult psychopathology, with immense social and economic impact. These disorders are treatable, but only a fraction of students in need have access to evidence-based treatment practices (EBPs). Access could be substantially increased if school professionals were trained to identify students at risk and deliver EBPs in the context of school-based support services. However, current training for school professionals is largely ineffective because it lacks follow-up supported practice, an essential element for producing lasting behavioral change. The paper aims to discuss these issues.*

Design/methodology/approach – *In this pilot feasibility study, the authors explored whether a coaching-based implementation strategy could be used to integrate common elements of evidence-based cognitive behavioral therapy (CBT) into schools. The strategy incorporated didactic training in CBT for school professionals followed by coaching from an expert during co-facilitation of CBT groups offered to students.*

Findings – *In total, 17 school professionals in nine high schools with significant cultural and socioeconomic diversity participated, serving 105 students. School professionals were assessed for changes in confidence in CBT delivery, frequency of generalized use of CBT skills and attitudes about the utility of CBT for the school setting. Students were assessed for symptom improvement. The school professionals showed increased confidence in, utilization of, and attitudes toward CBT. Student participants showed significant reductions in depression and anxiety symptoms pre- to post-group.*

Originality/value – *These findings support the feasibility and potential impact of a coaching-based implementation strategy for school settings, as well as student symptom improvement associated with receipt of school-delivered CBT.*

Keywords *Implementation, Dissemination, Evidence-based practice, CBT, School*

Paper type *Research paper*

Introduction

Mood and anxiety disorders affect 20–30 percent of school-age youth and contribute to poor developmental and academic outcomes, substance abuse, and adult psychopathology, as well as immense social and economic costs (Asarnow *et al.*, 2005; Charvat, 2012; Costello *et al.*, 2005; Jaycox *et al.*, 2009; Kessler *et al.*, 2003; Merikangas *et al.*, 2010; Merikangas *et al.*, 2009; Mychailyszyn *et al.*, 2011; National Institutes of Health, 2013). Evidence-based practices (EBPs), such as cognitive behavioral therapy (CBT), can improve clinical as well as social and academic outcomes (Compton *et al.*, 2004; David-Ferdon and Kasiow, 2008; Greenberg *et al.*, 2003; March *et al.*, 2004; Smyth and Arigo, 2009; Walkup *et al.*, 2008; Weisz *et al.*, 2009; Zins *et al.*, 2004). Clinically meaningful benefit from CBT can be observed in as few as six-to-eight sessions (Nieuwsma *et al.*, 2012) and across a variety of settings and populations (Ginsburg *et al.*, 2012; Gottfredson and Gottfredson, 2002; Huey and Polo, 2008; Kataoka *et al.*, 2002; Rossello and Bernal, 1999; Silverman *et al.*, 1999). CBT benefits are also evident when it is delivered in individual and group formats (Manassis *et al.*, 2002), using

Evidence of Impact: Current & Next Steps

Tier 1 Randomized Controlled Trial (2022 - 2024)

- 45 Michigan K-12 schools
- 15+ Massachusetts schools

Tier 2 Randomized Controlled Trial (US Department of Education / 2022 - 2026)

- Detroit Public Schools Community District
- 11 schools completed the Y1 pilot
- 75 schools participating in Y2-3 clinical trial

Cost-Effectiveness Study: (2022-2026)

- Jointly led by the UM School of Public Health & UM School of Public Policy

TRAILS Michigan expansion

2021

$5.4 million legislative appropriation

$1.3 million philanthropic seed funding

2022

$50 million legislative appropriation

2023

Partnership with **750 Michigan schools** across all 56 intermediate districts

Strong legislative and governor's office support for further expansion

2026

Partnership with **~2,400 Michigan schools (82%)**

blue meridian partners

Participants in The Studio

The Studio will support accelerating readiness for scaling across a range of strategies that address issues of poverty and lack of economic mobility. To date, we have funded 23 exemplary organizations that are working on a range of barriers to scale over a two- to three-year period.

Transforming the life trajectories of young people and families living in poverty.

Why We Do This Work

TRAILS envisions *a future in which all children and teens have equitable access to effective mental health services.*

Our mission *is to transform the landscape of youth mental health care delivery by equipping school staff with the training and resources they need to provide evidence-based and culturally responsible programming to their students.*

Thank you!

Contact: Elizabeth Koschmann
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