Behavioral Health and Trauma-Informed Integration in Afterschool

An Innovative Approach to Prevention and Early Intervention

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The Centers for Disease Control and Prevention (CDC) suggest that 1 in 5 children and 1 in 2 adolescents experience a mental or behavioral health disorder. CDC studies show that people of color and other marginalized groups have higher rates of behavioral health challenges than White people (2022).

Barriers such as stigma, discrimination, lack of finances, limited numbers of providers, inadequate transportation options, and lack of health insurance keep these groups from accessing and using behavioral health services. In 2022, 4.2 percent of youth in the U.S.—more than 3 million young people—had no health insurance (Cohen & Cha, 2022). Without insurance, the cost of healthcare is out of reach for many families, especially low-income households. Even if a family does have the financial means to seek mental healthcare for their child, they face a nationwide shortage of providers. In 2022, 47 percent of the U.S. population lived in an area with a shortage of mental health providers (Kaiser Permanente, 2022). Families in rural areas face additional barriers to access, including transportation needs. Additional barriers exist for young people from minoritized backgrounds, including stigma, mistrust of healthcare systems, and families' attitudes toward seeking help (Mongelli et al., 2020).

Children with high levels of stress and adverse experiences are less likely than those with fewer challenges to develop emotional regulation skills (Burkholder et al., 2016). Lack of emotional regulation can negatively affect the family system, hamper peer relationships, interfere with learning and academic functioning, and put the child at risk for several mental

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health conditions (Cameron & Overall, 2018). Half of all mental health symptoms begin before age 14; when symptoms go untreated, mental health disorders impair teens' ability to function (World Health Organization, 2021).

Community-based youth-serving organizations are often seen by participants and their families as safe and supportive environments with no stigma attached to participation. Many children attend community-based afterschool programs five days a week. In such an environment, trusted adults can consistently monitor the moods and behaviors of participants. Thus, afterschool programs that successfully and effectively integrate behavioral health services can reduce barriers and increase equity in access to high-quality behavioral healthcare. My organization, Boys & Girls Clubs of St. Joseph County (BGCSJC) in South Bend, Indiana, has successfully implemented an integrated behavioral health model into its out-of-school time (OST) programming. Other OST organizations may consider integrating components of behavioral health into their programming in order to address the unmet mental health needs of their young participants.

Integrating Behavioral Health into Boys & Girls Club Programming

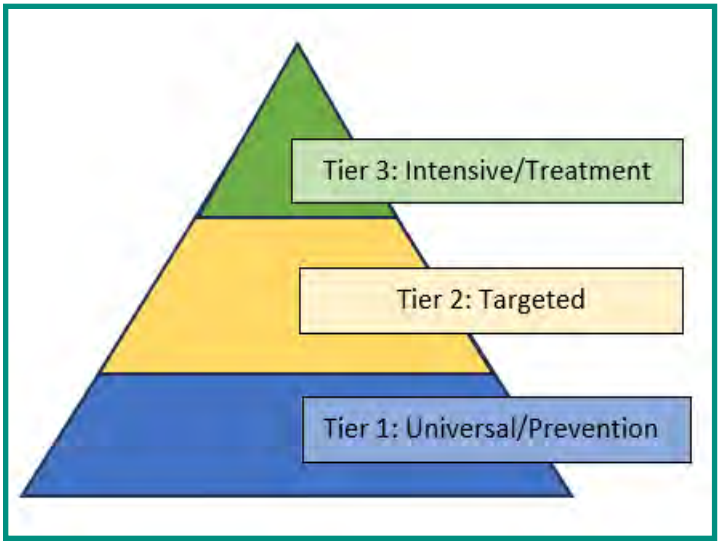
BGCSJC annually serves 3,000 youth, ages 5 to 18, through afterschool and summer programming at 30 sites, most of which are in school buildings. In early 2022, BGCSJC started working with a community partner to offer on-site mental health therapy to club members. We quickly saw the benefits and perceived that youth participants needed even more support. In August 2022, we adopted an integrated behavioral health model of care in the afterschool program, creating the Emotional Well-Being (EWB) program. EWB is a preventive mental health program whose goal is to provide emotional, social, and behavioral health consultation and treatment to club kids as well as to staff. Its early identification and intervention efforts aim to eliminate as many barriers as possible to mental healthcare.

A Three-Tiered Model

Integrated behavioral health in a community organization looks far different from traditional mental health therapy. Traditional therapy typically requires a diagnosis of a mental health condition, with marked symptoms that impair the young person's functioning. Integrated behavioral health in an afterschool program focuses on prevention and early intervention: providing care for individual young people at the earliest possible sign of distress and helping all youth develop skills that foster resiliency, grit, and healthy recognition and regulation of emotions. Trusted youth development organizations are well positioned to implement this proactive approach, which is much like a medical well-child visit or annual physical. Caring adults in the afterschool program regularly assess participants' emotional health regardless of whether the children exhibit diagnosable symptoms or express concerns. In the integrated model, mental health providers may provide some traditional therapy to young people with diagnosable conditions. However, they spend much of their time on prevention and early intervention efforts, including education and consultation with staff, youth, and families.

The integrated behavioral health model at BGCSJC was adapted from the positive behavioral interventions and supports framework (Center on PBIS, 2023). Its three-tiered approach is illustrated in Figure 1. Tier 1 reaches all participants through prevention strategies; these include properly training staff on trauma-informed behavior management and equipping staff and youth with tools to regulate emotions and foster resiliency. About 80 percent of youth should receive the support they need to be successful through Tier 1 interventions alone (Shapiro, 2014). Tier 2 interventions are targeted to participants iden-

Figure 1. Three-Tiered Model of Integrated Behavioral Health



tified as being at risk of developing a mental health disorder. Some Tier 2 programming and tools can be facilitated by properly trained nonclinical staff. Tier 3 is reserved for young people with more serious mental and behavioral health concerns. These interventions must be conducted by a licensed clinician or trainee under supervision.

The primary goal of BGCSJC's EWB program is to provide Tier 1 preventive programming and early intervention to all participants and staff, many of whom are at high risk of developing mental health disorders because of their life circumstances. EWB also offers services to young people who have mental health symptoms and concerns, without the barriers of referrals, stigma, waiting lists, and financial constraints. As director of EWB and member of the leadership team, I serve as the BGCSJC consultant and content expert on trauma-informed practices. I work with the leadership team to create a trauma-informed culture across all levels of the organization.

The EWB program currently has a full-time clinical staff of five: one director and four full-time mental health providers. The best practice ratio for school therapists is currently 250 students to one therapist (American School Counselor Association, 2023). For an organization serving 3,000 youth and over 400 staff members, this estimate equates to approximately 13 clinical providers. The unique and proactive EWB model, however, allows us to serve youth and staff effectively with far fewer clinical staff; we have approximately 600 youth for each full-time clinician. These clinicians have the support of two part-time clinical interns, who provide individual and small-group therapy; two full-time program specialists, who oversee some of the Tier 1 and 2 programming; and 12 part-time programming interns, who assist in facilitating Tier 1 educational programming. The shared responsibility and tiered model allow many adults in the organization to effectively implement nonclinical interventions, such as trauma-informed classroom management strategies, calming corners, and biofeedback. Furthermore, a trauma-informed lens is used in developing all training and programs across the entire organization. Figure 2 provides a brief overview of the programs and interventions under each of the three tiers at BGCSJC.

Promising Practices and Preliminary Outcomes

Over the past year, the EWB team has been assessing and collecting data on the effectiveness and feasibility of the tiered model of behavioral health integration. This section describes outcomes including information from a survey of club directors, data on youth

Figure 2. BGCSJC Tiered Emotional Well-Being Program

Tier 1, Staff Training

- **Staff Training**
  - Trauma-informed classroom practices
  - Behavior and classroom management
  - Conflict resolution
  - Behavior-specific praise
  - De-escalation of conflict situations
  - Suicide prevention
- **Staff Support**
  - Drop-in wellness workshops (stress management, healthy boundaries)
- **Social-Emotional Programming**
  - Zones of regulation (Kuypers, 2011)
- **Universal Screening**
  - Administration of Pediatric Symptoms Checklist-35 (parent and student self-report)
  - Tier 2 or 3 intervention (e.g., small-group or individual therapy) for young people with high scores (per PSC-35 scoring criteria)

Tier 2, Targeted Care

- **Staff Coaching**
  - Real-time coaching for front-line staff on use of prevention tools
- **Mightier Biofeedback**
  - 90-day biofeedback program on site or at home
- **Partnership with Local Applied Behavioral Analysis Center**
  - Behavioral therapy for youth as needed
- **Calming Corners**
  - Spaces in program areas where participants can go to regulate their emotions, using a variety of calming activities
- **Small-Group Intervention**
  - Determined by high scores on the universal screening
  - Psychoeducation-based group therapy with a focus on developing effective coping tools and emotional regulation strategies
  - Facilitated by licensed provider or graduate student under supervision
- **Tactile Behavior-Specific Praise**
  - Designed to help staff successfully implement what they learned in the behavior-specific praise training

Tier 3, Intensive Treatment

- **Individual Therapy Services**
  - Internal, brief, solution-focused therapy
  - External referrals as needed, with bridging services for children placed on waitlists
- **Crisis and Safety Assessment**
  - Assessment for safety concerns (e.g., suicidal ideation), with recommendations for care

referred to therapy services, and outcomes of two pilot programs: tactile behavior-specific praise and universal screening. The pilot programs are designed to improve shared responsibility and early access to interventions.

Club Director Satisfaction

After six months of implementation, the EWB team asked site directors for feedback. We asked about the effectiveness of EWB-facilitated training, the efficiency and effectiveness of the referral process, directors' comfort with seeking mental health support for themselves and for their clubs, and their satisfaction with the integrated program as a whole. In general, the directors were satisfied with the EWB program, with 11 out of 12 stating that they were satisfied or extremely satisfied with the program roll-out. Additionally, 10 club directors agreed or strongly agreed that the conflict de-escalation and communication trainings were beneficial to them as club directors; nine agreed or strongly agreed that the behaviors and responses training and suicide prevention policy training were beneficial. Nine club directors felt "pretty comfortable" or "extremely comfortable" asking the EWB team for personal support. All 12 indicated that they were comfortable asking the EWB team for support for their club. Furthermore, 11 club directors indicated that they understood the EWB program and knew the processes for submitting a youth referral or self-referral.

Improved Access

Since the start of EWB in August 2022, 140 youth have been referred to the program's individual initial consultations. Club directors make referrals when staff identify a concern with a child's emotional state or behavior so that the child can receive appropriate services in Tier 2 or 3. An initial consultation is typically a phone call among the EWB director, the site director, and the parent or guardian to discuss the referral, obtain additional information about the young participant, and make recommendations based on the three-tiered model of support. Referred participants always get support, ranging from training in coping skills to individual therapy, either in-house or externally. With this system, EWB has successfully provided timely access to mental health support. The average wait time from the referral to the initial EWB consultation was three days. After the initial consultation, individuals recommended for individual therapy waited an average of 21 days for the first appointment, as compared to average wait times nationally of three to 12 months (American Psychological Association, 2023). The EWB program continually takes on individual therapy clients without a waiting list.

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Tactile Behavior-Specific Praise Pilot

The BGCSJC tactile behavior-specific praise (BSP) program is a Tier 2 intervention to support behavior management across a club site. BSP is a positive statement, directed toward a child or group, that recognizes a desired behavior. The praise should be specific, contingent on actual behavior, and sincere. Previous research in classroom settings suggests that BSP benefits both students and teachers as an effective strategy for minimizing unwanted or disruptive behavior while increasing wanted behaviors (Cavanaugh, 2013; Gage & MacSuga-Gage, 2017). According to Downs and colleagues (2019), BSP is effective in supporting youth who are at risk of developing emotional and behavioral disorders. Tactile BSP at BGCSJC sites provides front-line staff with a tool for managing the behavior of groups and individuals through positive praise. We aim to create an environment in which positive peer and adult relationships serve as protective and restorative factors for youth who have experienced trauma. Increasing positive reinforcement through BSP is in direct alignment with this goal.

Research shows that praise is most effective in eliciting behavior change when it is given once every two minutes (O'Handley et al., 2023). We postulated that giving praise is not the difficult part for most staff. Rather, it is *remembering* to give the praise that is difficult. For one thing, giving praise is a habit, and it takes most people two months or more to establish a new habit (Gardner et al., 2012). Equally

important is the fact that our front-line workers are likely experiencing cognitive overload during club sessions. When a person receives too much information at once or has too many simultaneous tasks to perform, the resulting cognitive overload can impair performance. During club sessions, a staff member may simultaneously be overseeing several children, giving instructions to start an activity, welcoming a volunteer and giving them instruction, and trying to redirect youth who are off task. That is a lot for the brain to process at once. Adding another task—giving praise—is unlikely to inspire the desired action.

Tactile prompting allows staff members to perform a behavior, such as giving praise, without needing to remember to do so. Tactile prompting typically involves wearing a device that vibrates at certain intervals, giving a reminder to perform a behavior. Research consistently shows that tactile prompting is effective (Baddeley & Hitch, 1974; Rivera et al., 2015; White et al., 2021). White and colleagues (2021) note the need for continued research that investigates the effectiveness of tactile prompting in novel contexts. My literature review found no studies that examine the effectiveness of tactile prompting for BSP in OST; most research has focused on schools.

The BGCSJC EWB team conducted a comprehensive pilot program at one club site to measure the feasibility and effectiveness of tactile BSP. All staff at the pilot site were given a Gymboss timer, which was set to vibrate every two minutes as a tactile prompt, reminding them to give students BSP. Before starting the pilot, all staff were trained to give BSP effectively. Staff were asked to tally on paper every instance of BSP they gave every day for four weeks.

Preliminary results of the one-month pilot program indicated that the tactile reminders helped staff increase their BSP rates to a significant degree. Before starting the pilot, the site established a baseline number of BSPs. The baseline was zero; the staff did not provide any BSP statements on the day the baseline was assessed. At the end of the one-month trial, the BSP rates averaged 160 per day. To assess the impact on youth behavior, we examined the number of behavioral write-ups—behavioral concerns significant enough to warrant written documentation—before and after the pilot. Before the pilot program, write-ups occurred an average of nine times per month. In the two months immediately after the tactile BSP pilot, the average number of write-ups decreased to two.

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Universal Screening Pilot

The EWB program at BGCSJC has a strong emphasis on prevention and early intervention. We aim to identify youth with mental health and behavior symptoms as early as possible and to help them develop coping tools to decrease their symptoms before their functioning is impaired. Universal screening is an evidence-based approach to identifying individuals who may benefit from early intervention (Moore et al., 2022; Schaeffer, 2022). Despite recommendations that schools administer universal screening, only half of U.S. public schools offer mental health assessments, and less than half offer treatment (Schaeffer, 2022). With prevention and early intervention in mind, we developed and implemented a universal screening pilot program at three club sites. At these sites, we had participants and/or their caregivers complete the Pediatric Symptoms Checklist-35 (PSC-35), an evidence-based and psychometrically sound assessment tool (Jellinek et al., 1988; Liu et al., 2020). Of the 58 young people with completed screeners, 18 had results suggesting they were at risk of developing a mental health disorder. Of these 18 "elevations," 12 were placed in small-group therapy at their sites. Of the remaining six, two were already in counseling, two were referred out for specialty care, and two were assigned an individual therapist on site. The 12 small-group therapy participants took the PSC-35 again at the end of the six-week intervention; seven of them no longer had scores suggesting they were at risk.

Implementing Components of Afterschool Integration

Preliminary outcome data on staff satisfaction and improved access, as well as the BSP and universal screening pilots, are promising for BGCSJC's first year of behavior health integration. As the EWB program continues to collect outcome data on our programming and

initiatives, we aim to contribute to the afterschool professional community and to work collectively to establish evidence-based standards and best practices for integrated behavioral health in OST.

Getting Started

To integrate behavioral health means that all members of the organization share responsibility for the well-being of youth participants. Afterschool programs will be most successful in integrating mental health and emotional well-being programming when organization leaders and other key stakeholders support and are immersed in the integration. To obtain buy-in at all levels of the organization, we focused on the BGCSJC mission: "to inspire and enable all young people, especially those who need us most, to realize their full potential as productive, caring, and responsible citizens." We then used—and continue to use—the mission statement to highlight the importance of investing in the mental health of our youth, providing evidence on the direct link between emotional well-being and a young person's ability to "reach their full potential." Other organizations can similarly determine the extent to which investing in youth mental health and well-being is in line with their mission.

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Once leaders are engaged and invested, questions about funding and sustainability will arise. Organizations may benefit from taking a stepped approach into behavioral health integration. BGCSJC's first step in integrating mental health services started with a community partnership. We partnered with a grant-funded community program, through which graduate student clinicians saw youth clients at club sites at no cost to BGCSJC. Youth-serving organizations that are just getting started may want to reach out to local universities and community mental health centers to explore opportunities for low- or no-cost options for mental health services.

Starting small gives the organization time to assess the impact of the program and to discern areas of continued need. Both steps can help the organization obtain grant funding for more robust program development. If the organization recognizes the need to expand its mental health program offerings, exploring local and national grant funding is a next step. Collaborating with local colleges and universities, school districts, or community mental health providers may be an effective approach to securing grant funding. As the program grows and the organization shares evidence of efficacy, sustainable funding may be easier to obtain. Success stories build recognition of the organization's integrated behavior health program as an innovative part of the mission to improve the well-being of youth.

Tips for Implementation

Once an organization has acquired funding, two main needs emerge initially: finding partners to provide mental health services and supporting staff to help them integrate behavioral health into all aspects of club life. If their efforts find success, organizations may want to invest in their own mental health staff.

Partnerships

Partnerships with community organizations are key to the success of behavioral health integration. Specialty clinics, private practices, and community mental health centers can provide youth with accessible treatment opportunities, enabling the OST organization to remain focused on prevention and early intervention. The level of partner integration can vary widely; OST programs need to be flexible. Some partners may be able to offer program youth a priority spot on their waiting list. Others may offer co-located or integrated options, bringing their staff to the OST facility to offer treatment and programming.

Nearby colleges and universities can also be feasible partners for integrated behavioral health programs. Many university students seek internships for course credit and clinical experience. Because behavioral health integration focuses on prevention, students who are properly trained can learn to effectively implement programming, regardless of their college major. Besides benefiting the program, the internship opportunity may benefit the students as well, exposing them to career opportunities they may not have

considered. Giving students an opportunity to learn aspects of clinical behavioral health work, preventive education, or case management may help to combat the mental health provider shortage by provoking interest in these career pathways.

Staff Support and Training

Staff members can best support the health of the young people they serve when their own mental and physical health needs are met. Staff members who are healthy and thriving can model healthy coping strategies and support young people's emotional growth, thereby serving as a protective factor against future mental illness (VanBronkhorst et al., 2024). Support for staff can include referrals to community mental health partners, in-house well-being workshops, in-house mental health services, and intentional use of trauma-informed supervision strategies. Organizations should continually educate staff about their health-related employment benefits, such as telehealth, paid time off, and coaching.

All staff at all levels should be trained so that they fully understand behavioral health integration and trauma-informed care. They need to know what actions they can take to monitor participants' mental health and implement prevention and early intervention. Staff who learn tangible strategies to foster resilience and emotional regulation in the youth they serve will be more successful and satisfied in their work (Sapin, 2009). Training should recur throughout the year with the goal of educating staff on trauma-informed cultural change goals; empowering staff to take the lead in prevention efforts through modeling, programming, and health communication; and increasing understanding of shared responsibility.

Ways Forward

Many Boys and Girls Clubs and other youth organizations are working more intentionally to support the emotional well-being of the young people in their care. A cultural shift may be underway, but sustainable impact is still a long way away. In addition to OST programs, more organizations should consider offering some level of behavioral health prevention, starting as young as possible. Preschools, daycare centers, houses of worship, community centers, and other community organizations can join in this site-based model of care to reach more young people, especially those who most need help.

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