Healthy Students and Thriving Schools:

A Comprehensive Approach for Addressing Students' Trauma and Mental Health Needs

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CHDI

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About the Child Health and Development Institute of Connecticut:

The Child Health and Development Institute of Connecticut (CHDI), a subsidiary of the Children's Fund of Connecticut, is a not-for-profit organization established to promote and maximize the healthy physical, behavioral, emotional, cognitive, and social development of children throughout Connecticut. CHDI works to ensure that children in Connecticut, particularly those who are disadvantaged, will have access to and make use of a comprehensive, effective, community-based health and mental health care system.

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Executive Summary

Schools are increasingly viewed as a critical setting for the delivery of mental health services. Many children's behavioral health needs are not identified and the majority of children with identified challenges do not receive services in traditional community-based settings. In fact, in a typical classroom of 25 students, approximately five will meet criteria for a mental health disorder but most of them are not receiving appropriate mental health treatment or support. Among those who do access care, approximately 70% receive services through their schools. Integrating mental health services in school settings promotes significant benefits for both schools and students. School-based mental health services:

- increase access to a continuum of quality health care services and supports;
- reduce barriers to family and community engagement;
- improve students' social and academic outcomes;
- support healthy child development; and
- result in cost savings for school districts and communities.

A comprehensive and coordinated statewide approach to guide development, implementation, and sustainability of school-based mental health services provides needed support for districts interested in expanding their capacity to improve student outcomes.

This IMPACT report describes a comprehensive framework to advance policy and strategic school district planning to more effectively address the mental health and trauma needs of students and promote student success.

The framework outlined in the IMPACT is based on the Comprehensive School Mental Health Systems (CSMHS) approach developed by the Center for School Mental Health at the University of Maryland. CHDI expanded and applied this approach for use in Connecticut and other states by identifying existing trauma-informed strategies and collaborative partnerships within and across the behavioral health, education, and juvenile justice systems. The IMPACT provides a blueprint and resources to guide state policymakers and school district leaders, including:

- an overview of core components of the CSMHS model structured around family-school-community partnerships and the delivery of evidence-based mental health services within a multi-tiered system of supports;
- examples of best practice strategies to develop, implement, and sustain CSMHS;
- a model for a trauma-informed multi-tiered system of supports for school mental health;
- creative approaches to advance policy and funding structures to sustain CSMHS; and
- recommendations for state-level policymakers, districts, and schools to advance a comprehensive statewide system of school mental health to improve outcomes for all students.

Introduction

In recent decades, research highlighting the connection between mental health and educational outcomes has prompted student mental health services and supports to be increasingly integrated into education systems. Many districts, schools, and communities have partnered to promote student wellness and social emotional competence, and to identify and address mental health problems. As part of these collaborative systems-level efforts, school-based staff are trained to screen for and identify children with mental health concerns, refer them to mental health professionals, and effectively work with and respond to students with mental health needs, including youth suffering from exposure to potentially traumatic events (e.g., abuse, sexual victimization, violence) and other forms of adverse childhood experiences (e.g. neglect, discrimination, household dysfunction).

Federal, state, and local interest in school-based health services accelerated following the tragic school shooting in Newtown, Connecticut in 2012, and has continued to accelerate following additional school shootings and high-profile cases of youth suicide associated with bullying over the past several years. Despite significant advances in integrating mental health into education, there remain challenges with respect to securing necessary funding, developing sustainable state and local school mental health infrastructure, developing effective models of care, and embedding professional development and other supports to establish a continuum of mental health supports in schools. A systems-level approach through Comprehensive School Mental Health Systems, defined as strategic collaborations between school systems and community programs that provide a full array of evidence-based and tiered services (i.e., universal mental health promotion, selective prevention, and indicated early intervention), can help address these barriers and support a growing trend toward integrated care.

School principals indicate that mental health is one of the most challenging unmet needs among their students.[1] Across the nation, there is a high incidence of children and adolescents who have mental health concerns that are not identified and/or addressed with appropriate supports. National prevalence rates indicate that approximately 20% of children meet criteria for a mental health disorder, which equates to approximately five students in a classroom of twenty-five. It is estimated that from 25% to 79% of school-age youth in need of mental health services are not receiving them; therefore, their mental health needs are not being met.[2] These unaddressed

concerns reduce students' on-task behavior, negatively impact classroom functioning, and are linked to increased school failure/dropout, incidents of exclusionary discipline (e.g., suspensions, expulsions, arrests), and inappropriate referrals to Special Education services. Exposure to adverse experiences and potentially traumatic events also significantly contributes to children's mental health concerns and increases risk for academic difficulties.[3] It is estimated that at least 50% of American youth have experienced a potentially traumatic event,[4] with rates of exposure being even higher in urban communities.[5,6] Despite this level of need, many students are unable to access effective care in their schools or communities.

Among families that do access outpatient care in traditional community-based settings, treatment completion rates are low. Approximately 40–60% of children, adolescents, and families who begin mental health treatment drop out prematurely.[7,8] This lack of engagement in treatment is related to the many obstacles that families must navigate in order to receive mental health services in traditional outpatient and specialty clinic settings, including structural barriers (e.g., lack of availability of providers, language barriers, insurance challenges, transportation difficulties, inconvenient appointment times, long wait lists) and concerns about the mental health system (e.g., limited trust of providers, privacy concerns, lack of cultural competency, stigma).[9,10] Providing preventive and early intervention services directly in schools may help communities address the limitations of accessing care in traditional community settings and is also cost-effective.[11,12,13]

This IMPACT report describes the core components of a comprehensive school mental health framework, including its benefits to schools and students, with examples of national best practices and consideration of relevant challenges. The report also provides recommendations and a plan for the strategic advancement of a comprehensive school mental health framework in Connecticut, building on existing effective approaches as well as statewide collaborative partnerships within and across the behavioral health, education, and juvenile justice systems. This framework can also be used to assist other states or counties in developing a plan for addressing student mental health that is tailored to local needs. The framework was developed by the Center for School Mental Health at the University of Maryland in partnership with the Child Health and Development Institute (CHDI).

Addressing Student Mental Health In Schools Improves Outcomes

Integrating mental health services in school settings offers tremendous promise for addressing gaps in mental health care as well as a mechanism for improving academic success. In addition to enhancing access to care, providing mental health services and supports in schools offers a host of potential benefits, including:

- greater follow-through with care for students and families;
- ability for school-based providers to see students in a natural and less stigmatized environment;
- ability to engage family members and natural supports in care planning through a family-school-community approach;
- opportunities for mental health screening and early identification, and;
- cost-effective opportunities to offer a continuum of mental health interventions and supports.

The extent to which mental health supports are well integrated into the curriculum and the school setting has been shown to predict positive social-emotional outcomes for students.[14] In fact, some of the interventions with the most compelling evidence of effectiveness are best implemented in schools. For example, daily progress reports, contingency contracting, and teacher-implemented positive behavior programs (e.g., PAX Good Behavior Game) have demonstrated positive short- and long-term impact on students' psychosocial and academic outcomes as well as evidence of cost effectiveness.[12,13]

Schools Offer Familiar and Less Stigmatizing Settings for Students

Stigma around mental illness is one of the barriers to children and families accessing and benefiting from mental health services. Stigma can directly affect help-seeking behaviors and openness to mental health treatment for the parent and the child. Schools generally offer a more familiar, less stigmatizing, and potentially less threatening environment than standalone mental health clinics. Several studies have documented the positive therapeutic alliance between school-based providers and students and families.[14,15] Further, schools can help to reduce stigma and normalize mental illness and treatment by providing training and support to teachers and parents about mental health literacy and help-seeking.

Comfort and stigma may be an even greater concern for racial and ethnic minority youth and families seeking mental health care,[16] particularly among children of undocumented immigrants, newly arrived immigrants or refugees, and unaccompanied minors.[17] Individuals from minority populations and other marginalized groups may be less likely to pursue mental health services, may struggle to find care that is culturally and linguistically competent, and may not feel that they are understood by their provider.[18] For families connected to the school setting, linkage to school-based programs, school-based health centers, or referrals to community-based services may be facilitated by school support staff to assist in coordination of appropriate care.

Early Identification and Intervention Promotes Better Care and Results in Cost Savings

School staff are often the first to identify children with a potential mental health concern and often are the treatment providers as well.[19] In fact, one study suggests that more than 70% of youth who receive mental health services do so in education settings.[11] As Weist (1997) explains, "By placing services in [schools], we are reaching youth 'where they are,' eliminating many of the barriers that exist for traditional child mental health services."[20] Beyond initial access, students are more likely to follow through with and complete mental health services in schools as compared to the community, where high no-show rates are common.[21]

When mental health providers are placed in schools, this creates an ideal opportunity for screening and early identification of mental

health needs. Periodic universal mental health and trauma screening using validated measures allows schools and community partners to identify needs among their student population, identify students who may benefit from further assessment and intervention efforts, and monitor changes in these needs over time.[22,23] These data can inform resource allocation, utilization, and prioritization of programming. As noted in one article, "School-based mental health professionals can shift their focus away from solely providing indicated services to providing more population-based, ultimately preventive, services,"[24] which are also generally more cost efficient. Teachers play an important role in surveillance, as they view a large sample of same-aged children and are well-positioned to nominate for further assessment students who are atypical in their development and behavior.

Identifying mental health problems early leads to better long-term outcomes, as the length of time a child's mental health problems go unidentified is correlated with maladaptive trajectories.[25] Given that treatment of youth mental illness costs the United States billions of dollars annually, efforts to reduce the incidence of mental illness through screening and early intervention could serve to not only improve quality of life, but also to significantly reduce fiscal burden by reducing the need for more intensive and costly outplacement services.[26,27]

Schools Offer Opportunities for a Continuum of Services

Schools offer an excellent venue for providing a continuum of physical and mental health services and supports by offering direct school-based services, access to co-located school-based health centers, and by providing school-linked access to community-based care. The public health model focuses on preventing problems before they occur by implementing policies and interventions that promote health, prevent problem behaviors, and address risk factors for various health problems. Public health frameworks typically call for primary (Tier 1; universal), secondary (Tier 2; for selected at-risk students) and tertiary (Tier 3; for students in need of targeted services) interventions.[28] School systems are well-suited to adopt this continuum of service delivery, often referred to as multi-tiered systems of support (MTSS), given their access to a large population of students with and without mental health difficulties. Schools already operate from a preventive, multi-tiered framework with respect to academic performance using the Response to Intervention (RTI) approach, known in Connecticut as Scientific Research-Based Intervention (SRBI). Their use of universal screening, early identification, and intervention to "catch problems early" and prevent academic decline aligns well with the implementation of MTSS for addressing the mental health needs of students.

Mental health promotion and prevention programs involve promoting social and emotional competence among all students, teaching core positive behaviors and relationship skills, and improving mental health literacy.

Mental health promotion and prevention programs involve promoting social and emotional competence among all students, teaching core positive behaviors and relationship skills, and improving mental health literacy. Similarly, frameworks such as Positive Behavioral Interventions and Supports (PBIS) provide an array of evidence-based strategies to support classroom management by all teachers and positive behaviors among all students in a school building.[29] Evidence suggests that this investment in whole school approaches to mental health affects population-level student outcomes such as improved reading scores and decreased suspensions[30] and may also lead to a reduction in referrals to specialty mental health and special education services.[31] Additionally, school-based health centers, which provide access to physical and mental health promotion and intervention services within the school setting, are a cost-effective model for advancing a continuum of services to promote positive outcomes for students.[32]

School-Based Services Promote Youth, Family, Educator, and Peer Engagement

Children's health outcomes are better when parents are involved in their children's mental health care,[33] just as their educational outcomes are better when parents are engaged in their schooling.[34,35] Addressing student mental health in schools allows the mental health system to better engage youth and those directly involved in their daily lives, including parents/caregivers, educators, and peers. Typical barriers to family participation and engagement in community-based care include transportation, limited hours, and communication difficulties. Providing mental health promotion activities and intervention services in the school allows youth to engage at many points throughout their day in mental health programming, including opportunities to shape and evaluate the school mental health system. Parents and peers may also be more available as supports in schools than in traditional community-based settings, as schools may be more familiar, less stigmatizing, and more accessible. Schools also offer the unique opportunity to engage prosocial and influential peers in supporting student mental health by engaging them as peer mentors, advocates, and therapy group members. Finally, educator engagement is critical to the success of school mental health. School mental health providers can partner with educators to keep abreast of student functioning, monitor and adjust treatment strategies, and respond to questions. Teachers who receive training and coaching in student mental health demonstrate increased capacity to respond appropriately to students experiencing psychological distress, report better teacher-student rapport, and report less peer victimization in their classrooms.[36,37]

A multi-tiered system of supports provides an array of health promotion/ prevention, early intervention, and treatment services to meet the needs of all students.

CSMHS Improve Psychosocial and Academic Outcomes

There is a growing body of evidence suggesting that Comprehensive School Mental Health Systems (CSMHS) are effective at improving student outcomes, including: improved academic performance,[38,39] fewer special education referrals and lower need for restrictive placements,[40] decreased disciplinary actions,[41] greater engagement and feeling of connectedness to school,[42] and higher graduation rates.[43] Academic outcomes have been increasingly linked to CSMHS approaches that include skills-based Social and Emotional Learning (SEL) components such as self and social awareness, decision-making, and relationship skills.[44] For example, students in SEL programs, on average, score ten or more percentile points higher on achievement tests than peers who are not in an SEL program, show better attendance, display better classroom behavior, earn better grades, and are less likely to be disciplined.[45]

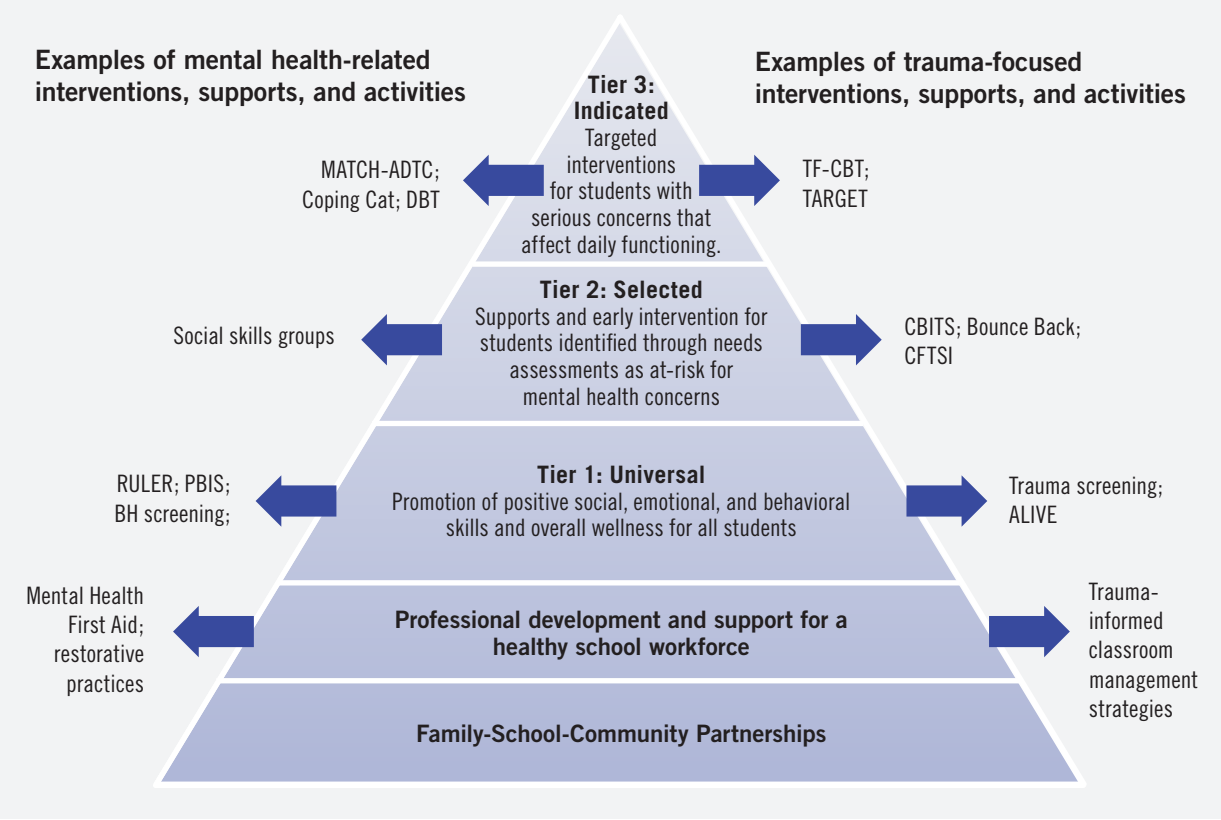
Organizing Principles Of Comprehensive School Mental Health Systems

CSMHS are structured around family-school-community partnerships and the delivery of evidence-based mental health services within a multi-tiered system of supports (MTSS), which provides an array of health promotion/prevention, early intervention, and treatment services to meet the needs of all students. A Trauma-Informed MTSS integrates services and supports for students and staff with specific attention to addressing needs related to traumatic stress, which have generally not been incorporated into school services. Figure 1 provides an integrated framework with examples of student services and supports available at each tier, including training and support for staff, built on a foundation of family-school-community partnerships. Note that the figure is for illustrative purposes and some of the sample interventions listed may be implemented across multiple tiers (e.g., PBIS, restorative practices, CBITS).

Family-School-Community Partnerships to Promote Student Mental Health

Students are affected by the many relationships and interactions within and between home, school, and community.[6] There is a growing emphasis on advancing meaningful relationships and collaborative work among families, schools, and communities to improve student outcomes,

Figure 1: Trauma-Informed Multi-Tiered System of Supports for School Mental Health



and each of these partners must be committed to working together to address the interconnected academic, social, emotional, and behavioral needs of all students. When families are involved in their students' care and when schools, families, and communities partner to develop and share resources and coordinated strategies, student outcomes improve and schools and communities benefit. Additionally, a shared vision and plan help drive sustainability of these benefits over time.

Promoting trauma-informed school mental health presupposes the involvement of multiple child-serving systems. At minimum, education and mental health are key child-serving systems, and other system partners may include public health, juvenile justice, pediatric primary care, and early care and education. Establishing a network of cross-system collaborations can result in multiple strategies and funding streams to effectively support the whole child, the family, and

the school. Benefits of this collaboration include streamlined access to services, less duplication of services, access to a broader service array, enhanced communication between agencies, and ultimately, more effective care.[46,47] To support this approach, there must be a willingness among partners to move beyond a "walled" or siloed model in which only school-based staff are part of a child's support team. Instead, this approach includes caregivers, community partners, and other meaningful individuals in a child's life as part of the care team. In forming such partnerships, it is necessary for partners to review overlapping priorities and needs, identify and address any competing priorities, and consider how a coordinated team-based approach could be beneficial to meeting the goals of each partner. For instance, it may be important for school- and community-employed staff to discuss how their responsibilities are similar and distinct, how they will collaborate to facilitate seamless referral pathways and comprehensive care, and how they will avoid "turf battles." Ideally, consideration should be given to the unique requirements/mandates and strengths/limitations of each discipline or stakeholder group and how they affect the ability to engage and work with students, families, and school staff.

This integrated team-based approach requires that schools are open to having families and community partners (e.g., community behavioral health providers, child-serving agency workers, advocates, health care providers) engage in all aspects of the CSMHS, including team meetings. Team meetings at the individual student level may include Planning and Placement Team (PPT) meetings for students with Special Education needs, meetings to support Individualized Education Programs (IEP) for students with academic or other behavioral support needs, Child and Family Team (CFT) meetings for students engaged in Wraparound care planning or Care Coordination services, and restorative conferences to support discipline interventions. A multi-tiered system of support at the school level may include three teams with one team focusing on the planning, implementation, and evaluation of universal interventions and the other teams focusing on 2nd and 3rd tier interventions. Note that some schools, depending on size and number of team members, prefer to have a universal team and a combined Tier 2 and Tier 3 team, while smaller schools may be able to have only one team to address all three tiers. While school-employed staff may take a more active role in Tier 1 and Tier 2 interventions and a smaller role in Tier 3 interventions, community partners may have a larger role in Tier 2 and 3 interventions. It is helpful to have regularly scheduled meeting times and a process for holding meetings that includes clear rules, expectations, and action planning. The process should use data to track progress towards goals and monitor the effectiveness of interventions. Figure 2, adapted from Lever et al. (2015), provides sample questions to assess and facilitate school and community provider collaboration in this process.

Figure 2: Questions to Consider During Family-School-Community Teaming[47]

- What are the outcomes valued by all team members (families, schools, community partners), and how are these outcomes measured to document impact of interventions?
- How will all team members (including community behavioral health professionals) support implementation of interventions across all three tiers (universal, selected, targeted)?
- Can school-employed and community-employed behavioral health professionals provide care to the same student simultaneously? If so, how will they ensure services are complementary?
- Who is authorized to provide services mandated within students' Individualized Education Programs?
- What factors determine whether a student with identified behavioral health problems is referred to a school- versus community-employed behavioral health professional?
- Who is responsible for conducting behavioral health screening and assessment, and how are findings conveyed to all team members?
- How do school personnel (administrators, teachers, student support staff) receive feedback about referrals, intervention implementation, and outcomes from school-based community professionals?
- How is feedback about referrals, intervention implementation, and outcomes integrated into a continuous quality improvement process?
- What strategies will be used to engage and meaningfully involve families in the teaming process?

This partnership model also requires shared funding streams for each partner, data collection, and data sharing. Community partners must have the necessary funding to support clinician time in non-billable meetings without jeopardizing fiscal sustainability. Ideally, each school or district should develop sufficient funding streams and clear roles and responsibilities of school and community partners to together meet the mental health needs of all students. A challenge for coordination of efforts can result when data are not shared across school and community providers. Issues related to data sharing (HIPAA, FERPA) should be identified early, and consideration should be given to securing consents and releases of information to allow social-emotional, behavioral, and academic data to be shared across system partners to create a more comprehensive picture of student progress. Consideration should also be given to how data will best be collected, analyzed, and shared from the inception of the partnership and should be clearly outlined in any memorandum of understanding.

Earlier access to less intensive evidence-based academic and behavioral interventions promotes better student outcomes across settings and may reduce the need for more intensive supports.

Whole School, Whole Community, Whole Child Model in Connecticut

The Collaboratory on School and Child Health (CSCH) at the University of Connecticut represents an exemplary university-community partnership that facilitates innovative and impactful connections across research, policy, and practice arenas in school and child health. CSCH connects multidisciplinary researchers around a shared goal of promoting healthy, safe, supportive, and engaging environments for all students. At its foundation is the U.S. Centers for Disease Control and Prevention's Whole School, Whole Community, Whole Child (WSCC) model.[49] The CSCH framework for multi-tiered service delivery integrates the many components in coordinated school health, including physical, social, emotional, behavioral, and academic domains of children's health and well-being. The New Haven Trauma Coalition (NHTC) at Clifford Beers Clinic implements a WSCC tiered approach to incorporate trauma training for all school staff, school-wide trauma screening, Cognitive Behavioral Intervention for Trauma in School (CBITS) and Bounce Back (the elementary school version of CBITS) for identified students, and care coordination services for students with more intensive needs. In the 2015–16 school year, NHTC screened 949 students for trauma, 114 of whom showed a need for clinical treatment.[50] Initial outcomes for students participating in CBITS or Bounce Back group treatments through NHTC demonstrated significant reductions in symptoms of post-traumatic stress disorder and chronic absenteeism.

Delivering Mental Health Services within a Multi-Tiered System of Supports

Many schools use a multi-tiered system of supports (MTSS) approach to deliver instructional or behavioral intervention to students at varying intensities. This ensures that all students in both general and special education will have at least some exposure and access to mental health programming and/or services while also addressing the academic needs of all students.[10] Integrating existing MTSS programming with CSMHS has several benefits:

- Many existing initiatives familiar to schools share the common structural elements of MTSS, and therefore, may be more readily integrated into existing efforts. Initiatives with similar tiered approaches include Problem Solving/ Response to Intervention (RtI) or Scientific Research Based Intervention (SRBI), Positive Behavioral Interventions and Supports (PBIS), Continuous Improvement Models (CIM), Lesson Study, and Differentiated Accountability.
- Consistent with an RtI/SRBI process, existing MTSSs increase the likelihood that youth will be identified, referred, and have access to and benefit from school mental health interventions.
- Earlier access to less intensive evidence-based academic and behavioral interventions promotes better student outcomes across settings and may reduce the need for more intensive supports.

- Active progress monitoring of academic and behavioral interventions ensures they are delivered with fidelity and is associated with improved student outcomes.

Social Emotional Learning (SEL): A School-Based, Universal Approach to Improving Students' Social Emotional Competencies

The Yale Center for Emotional Intelligence developed the RULER (Recognizing, Understanding, Labeling, Expressing, and Regulating) approach to help schools integrate social-emotional learning into the school environment. Practical tools such as the Mood Meter assist teachers and staff in teaching emotional intelligence. RULER has been found to reduce anxiety among students, increase academic performance, promote non-violent conflict resolution, and improve classroom climate.

The number of tiers in an MTSS can vary, though many districts employ a three-tiered model:

Universal services and supports (Tier 1) are mental health-related activities that promote positive social, emotional, and behavioral skills and overall wellness among whole populations of students. Examples include RULER, PBIS, and Mental Health First Aid. Tier 1 activities are designed to promote competencies and prevent problem behaviors among all students, regardless of whether they are at risk for mental health problems. These activities can be implemented school-wide, at the grade level, and/or at the classroom level. Universal screening may be implemented to identify student needs and the prevalence of needs within a school, and the interventions that can be put into place to address mental health concerns and/or traumatic stress. Sometimes these approaches are referred to as primary prevention.

Selective services and supports (Tier 2) address mental health concerns among groups of students who have been identified through screening and school teaming processes as being at risk for a behavioral health concern. Examples include social skills groups, CBITS, and Bounce Back. When problems are identified early and supports are put into place, risk factors are addressed, problems are reduced or eliminated, and healthy development is promoted. Sometimes these approaches are referred to as secondary prevention services.

Indicated services and supports (Tier 3) address mental health concerns and are individualized to meet the unique needs of students who are already displaying a mental health concern and significant functional impairment. Examples include MATCH-ADTC (Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Sometimes these are referred to as mental health interventions or tertiary prevention. Schools are often not well-equipped to deliver Tier 3 interventions, and instead refer youth with this level of need to community-based mental health organizations for further assessment and treatment.

A Trauma-Informed MTSS also allows for the installation of practices to specifically support youth who have been exposed to trauma (see Figure 1). For example, trauma-informed school models are increasingly adopting MTSS as a foundational framework for installing interventions across the continuum of mental health supports. The principles of a trauma-informed school include four tenets referred to as the 4 Rs, which were developed by the Substance Abuse and Mental Health Services Administration (SAMHSA):[48]

1. Realizes the prevalence and impact of trauma
2. Recognizes trauma symptoms and the need for educational supports
3. Responds to trauma in a developmentally appropriate manner
4. Resists re-traumatizing students and staff by integrating trauma-informed care and self-care at the classroom and school levels.

Screening for mental health concerns and trauma exposure and symptoms addresses tenets 1 and 2, delivering trauma-focused evidence-based practices such as Cognitive Behavioral Intervention for Trauma in Schools (CBITS) or Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) meets tenet 3, and addressing staff wellness and integrating trauma-informed classroom behavior management strategies in classrooms are efforts that meet tenet 4.

Best Practice Strategies for Schools and Districts to Advance Quality and Sustain School Mental Health Systems

The Center for School Mental Health at the University of Maryland has developed a set of quality and sustainability performance standards to guide districts and schools as they work to advance student mental health.[51] These standards reflect best practice strategies for systematically developing, improving, and sustaining multi-tiered, evidence-based mental health supports and services in schools. Performance standard domains and indicators are synthesized in Tables 1 and 2, followed by more detail on how to work toward achieving the standards. The National Quality Initiative is funded by the Health Resources and Services Administration, and is a joint effort by the Center for School Mental Health at the University of Maryland and the School Based Health Alliance to advance a culture of accountability and quality improvement. This partnership resulted in the development of the SHAPE System (www.theshapesystem.com), a free, user-friendly, online portal intended to document CSMHS performance.

To complement the measurement system, the Center for School Mental Health partnered with the National Child Traumatic Stress Network to develop the Trauma-Responsive Schools Implementation Assessment (TRS-IA). The TRS-IA offers school and district teams using the SHAPE System the opportunity to assess their trauma responsiveness along a number of domains, including school-wide and classroom approaches to trauma, evidence-based practices for trauma treatment, and staff self-care.

Table 1: Center for School Mental Health's School Mental Health Quality Assessment Performance Indicators[51]

Teaming
- Have multidisciplinary team
- Avoid duplication and promote efficiency
- Use best practices for meeting structure and process
- Promote data sharing among school mental health team members
- Connect to community resources when need cannot be fully addressed in school

Needs Assessement/Resource Mapping
- Conduct comprehensive student mental health needs assessment
- Use needs assessment to inform school mental health planning and implementation
- Conduct resource mapping to identify school and community services and supports
- Use resource mapping to inform school mental health services and implementation

Screening
- Screen for mental health concerns to identify and refer students for additional supports

Evidence-Based Services and Supports
- Reach of Tier 1, 2, and 3 services and supports, respectively
- Extent Tier 1, 2, and 3 services and supports are evidence-based, respectively

Evidence-Based Implementation
- Have system to determine whether a service or support was evidence based
- Extent to which evidence-based supports and services fit with strengths, needs, cultural considerations
- Use best practices to support training and implementation of evidence-based services/supports

Student Outcomes and Data Systems
Have system that shows:
- Improvement in academic functioning for Tier 1, 2, and 3 services, respectively
- Improvement in psychosocial functioning for Tier 1, 2, and 3 services, respectively
- Referrals to and follow-through with school-based and community services
- Number of students placed outside of district because of mental health
- Number of student inpatient psychiatric hospitalizations
- Use district data to determine selection of mental health interventions for students
- Have a system to monitor individual student progress across tiers
- Aggregate student mental health data
- Disaggregate student mental health data
- Monitor fidelity of intervention implementation

Table 2: Center for School Mental Health's School Mental Health Sustainability Assessment Performance Indicators[51]

Funding and Resources
- Use multiple and diverse funding and resources to support a full continuum of services
- Maximize leveraging of funding and resources to attract an array of funders
- Have adequate funding to support services and supports at each tier
- Use best practice strategies to retain staff

Resource Utilization
- Maximize the expertise and resources of stakeholders to support professional development
- Maintain or have access to a regular updated mapping or listing of school/community resources
- Monitor policy at local, state, and federal levels that has an impact on school mental health funding
- Utilize third party fee-for-service mechanisms to support services

System Quality
- Use evidence-based services and supports
- Use best practices to inform ongoing district data-based decision-making
- Meaningfully involve youth and families with school and community partners in CSMHS

Documentation and Reporting of Impact
- Document impact of CSMHS on educational/academic outcomes
- Document impact of CSMHS on emotional/behavioral outcomes
- Document impact of CSMHS on sustainability factors
- Report overall impact of CSMHS

System Marketing and Promotion
- Disseminate findings to community
- Broadly market CSMHS to school district leadership
- Broadly market CSMHS to non-education community partners

School mental health systems are not "one size fits all" and should be tailored to address the needs and strengthen assets unique to each district's students, families, schools, and communities.

Needs Assessment and Resource Mapping

School mental health systems are not "one size fits all" and should be tailored to address the needs and strengthen assets unique to each district's students, families, schools, and communities. A needs assessment can be used to gather information related to the most pressing concerns, strengths, challenges, and gaps in the system. This knowledge can help prioritize activities and services and can help ensure that service provision is responsive to school or school system needs.

Conducting a needs assessment may include the following activities by the school behavioral health team, in partnership with educators, youth, and families:

- Determine appropriate data (e.g., school records, survey data, informal inquiries with teachers and parents, review of office referrals, provider feedback on caseload characteristics, etc.) and identify priority areas of focus based on student needs.
- Assess common risk and stress factors faced by students (e.g., exposure to crime, violence, substance abuse) and the extent to which universal screening for behavioral health and trauma concerns is implemented.
- Evaluate whether the school behavioral health team has staffing capacity and services in place to help students contend with common risk and stress factors and identify service gaps where applicable.

Needs Assessment in Stamford Guided the Development of a Trauma-Informed School Mental Health System

Stamford Public Schools (SPS) serves as a local model for improving outcomes by adopting a trauma-informed approach to school mental health. CHDI began working with SPS in 2014 to conduct a review of the district's mental health system and to develop a plan to enhance trauma-informed mental health services district-wide. SPS implemented the SHAPE system as a needs assessment process to inform program implementation that eventually resulted in significant progress in four priority areas: 1) expanding clinical staff capacity; 2) professional development in mental health competencies; 3) engagement in mental health planning and oversight; and 4) data collection and evaluation. The district successfully expanded implementation of evidence-based trauma-informed practices, including CBITS, Bounce Back, and Dialectical Behavior Therapy (DBT); hired trauma specialists across the district to provide clinical services and supports for identified students; and expanded their data collection to develop an early warning system to prompt early interventions for students showing mental health symptoms, excessive absences, or behavioral referrals. Lessons learned in Stamford are being used to engage other Connecticut districts to complete the SHAPE system measures, integrate school and community-based mental health services, and promote quality and sustainability of these enhancements.[52]

- Assess the frequency, quality, and content of professional development for school staff specific to adolescent development, behavioral health, and trauma concerns among youth.
- Evaluate whether the school behavioral health team provides services that match the presenting needs and strengths of student/families.
- Evaluate whether community-based services and resources are available to meet the identified student and family needs.
- Assess school efforts to refer students to community-based behavioral health services and track access to and utilization of these services.
- Evaluate whether existing programs and services are achieving the desired outcomes.

Resource mapping is a component of a comprehensive needs assessment that helps schools and districts identify the array of community-based partnerships and resources available to complement the educational supports for students and families.

The SHAPE System

The School Health Assessment and Performance Evaluation (SHAPE) System addresses each of the quality and sustainability indicators for CSMHS (see Tables 1 and 2) and can be used by CSMHSs at the state, district, and school level to:

1) Conduct needs assessment and resource mapping to document school and community-based service array of multi-tiered services and supports;
2) Advance a data-driven, quality improvement and mental health team planning process to support school mental health;
3) View, print, share, and review free customized reports that document strengths and gaps of the CSMHS; and
4) Access action-oriented and targeted resources to help advance school mental health quality and sustainability at the school and district levels.

An online performance system and action-oriented resources have been tested and improved through a series of Collaborative Improvement and Innovation Network (COIIN) initiatives with 25 school districts throughout the country, including Stamford, Connecticut. CHDI, in collaboration with the Department of Children and Families, the State Department of Education, and the Injury Prevention Center at Connecticut Children's Medical Center, received a technical assistance grant from the Center for School Mental Health to support up to 20 Connecticut school districts to implement the SHAPE assessment in the 2017–2018 school year. Efforts are underway to expand implementation of SHAPE statewide to support schools and districts in adopting best practice strategies for assessing and sustaining quality mental health services and supports.

Identification of resources in the school and community can minimize duplication of services, better match service needs with available resources, and support coordinated care. In many cases, the knowledge of resources may reside with one or two individuals, which can limit effectiveness and sustainability when those people are not available or leave the district. Further, schools often implement new programs in response to compelling presentations by program purveyors and/or a time-limited grant, but without the benefit of being able to select sustainable programs that fill the biggest needs based on a comprehensive map of the service array.

A structured resource mapping process serves to increase understanding of program requirements to access services (e.g., insurance, hours of operation, eligibility) and increase awareness of underutilized partnerships. Mapping may also promote opportunities for cross-system and interdisciplinary training, facilitate streamlined referral and transition processes across systems and programs, and ultimately inform strategic planning. School districts can leverage federal funds from the Every Student Succeeds Act (ESSA) to support needs assessments of academic performance as well as the "root causes" affecting achievement, such as unmet basic needs and behavioral health challenges.[53]

Resource mapping must be considered an on-going and data-informed process. District- and school-level teams should work together with community partners to develop memoranda of understanding that specify partnership roles and responsibilities, referral processes, feedback loops, data systems and decision-making rules, and regularly scheduled meetings. As described above, the SHAPE System provides a comprehensive tool for districts and schools to assess and document their needs, strengths, staffing, and services within a multi-tiered system of supports.

As part of the mapping process, it is important that school-community teams document not only the existence of programs and resources, but also the impact of such programs and resources on expected and actual outcomes. Discontinuing programs that are no longer meeting their desired outcomes allows resources to be re-allocated to more effective approaches. By restricting behavioral health resources to only those with demonstrated impact on desired outcomes, schools and school systems can be more prudent in their selection process, thereby increasing efficiency and likelihood of student success.

Universal Screening Identifies Students' Mental Health Needs

Mental health screening is a process of determining whether students may be at risk for or have a mental health or traumatic stress concern, and is typically undertaken to identify youth who are in need of services. Universal screening of all students using empirically supported

Identification of resources in the school and community can minimize duplication of services, better match service needs with available resources, and support coordinated care.

measures has been identified as a best practice and has been shown to effectively identify youth with mental health concerns; however, screening limited to at-risk populations is also commonly employed in schools. Schools can take the following action steps to implement a screening process:

1) Assemble a team of key family, student, school, and community stakeholders to plan and implement a screening process for a specific school or district, including deciding on the target population for screening (e.g., all students or at-risk students only).
2) Provide education to stakeholders, including students and families, on the benefits of mental health screening, and discuss their views and concerns about how it should be conducted in the school(s) and how the data will be used and shared.
3) Address legal and ethical considerations such as parent/guardian consent, student privacy, and a plan to screen students in a timely manner.
4) Select screening tool(s) that are evidence-based, brief, easy to use, and provide valuable information. Other factors to consider when selecting a screening tool include the availability of training and technical assistance, whether it measures the desired content (e.g. type of mental health concern, trauma, age range), whether it is developmentally and culturally/linguistically sensitive, staff perceptions about its utility and feasibility, compatibility with other measures used in the school or community, cost, and data collection/reporting procedures. The SHAPE System includes resources to help schools select

A formalized professional development plan should be in place for all staff, including educators, administrators, paraprofessionals, school-based health and clinical staff, and community-based child-serving system partners.

free or low-cost behavioral health screening measures appropriate for use in school settings. For a review of trauma screening measures that are appropriate for schools, see Eklund et al. (2018).[54]

5) Establish a tracking, triage, and referral system to monitor screening results and referral of students with positive screens to services.

6) Identify team(s) that will use screening data to inform student mental health decisions regarding treatment and referral.

7) Develop a data collection process and a plan for data entry, analysis, and reporting.

8) Establish a clear and consistent process for referring students to school and community mental health services before collecting screening data, so that identified students may be referred to appropriate services, including a process for immediate intervention among youth at high risk.

Universal School Mental Health Screening

As part of the CSMH National Quality Initiative learning community, Methuen Public Schools, a suburban school district north of Boston, Massachusetts, used quality improvement processes to incrementally establish a universal mental health screening process in the district. Initial steps included identifying which students to screen, choosing screeners that matched population needs, determining a process for obtaining consent, and working with students to inform and refine the screening process. Within one school year, the district moved toward full implementation of two large-scale online screenings at the high school level that integrated consent and opt-out processes, and has since expanded screenings to elementary and middle schools. Follow-up data analysis revealed that 100% of students who required follow-up received it within seven days of the screening, with urgent concerns being addressed immediately upon identification.

Professional Development Ensures a Continuum of Support for Students

A formalized professional development plan should be in place for all staff, including educators, administrators, paraprofessionals, school-based health and clinical staff, and community-based child-serving system partners. Professional development opportunities should be tailored to the required competencies associated with various roles within the school and community. For example, teachers may require professional development in basic mental health literacy, including the impact of trauma and mental health conditions on learning and classroom behavior, whereas school-based clinicians may not require training in basic mental health literacy but will require specific training on the implementation of evidence-based practices. Administrators may require specific training on mental health literacy, strategies for streamlining identification and referral processes between the school and community, and the seamless integration of mental health professionals within the school context. Other training modules include the prevalence of mental health challenges and their impact on learning, school-based intervention strategies that can be used in the classroom and other school settings, best practices in engaging families, and identification and referral processes for students in need of more intensive services.

Free Trauma and School Mental Health Trainings for Clinicians and School Staff

Free trainings through the University of Maryland's Center for School Mental Health's online training platform, www.mdbehavioralhealth.com, are available for clinicians and other school-based staff to enhance knowledge and skills needed to provide effective care to children and adolescents in school and community settings, including:

- Community Partnered School Behavioral Health
- Mental Health to Support Student Learning: Training Modules for Educators and School-based Staff
- Youth Co-Occurring Disorders Training for Behavioral Health Providers
- Mental Health Training Interventions for Health Providers in Schools
- Interprofessional Training Program for Military Connected Families

Free training resources and toolkits related to identifying and addressing traumatic stress in schools can be found on the websites for the National Child Traumatic Stress Network (NCTSN; www.nctsn.org) and the NCTSN Treatment Services and Adaptation Center for Resilience, Hope, and Wellness in Schools (https://traumaawareschools.org).

Professional development for school staff should focus on internalizing (e.g., depression, trauma, anxiety) and externalizing (e.g., ADHD, disruptive behaviors) concerns, should be relevant to students across the developmental continuum, and should provide developmentally and culturally/linguistically appropriate strategies for addressing behavioral and mental health concerns. Cross-training opportunities for school-based community partners, including school resources officers and local law enforcement, are critical for promoting understanding of school language and culture, special education, school discipline policies and procedures, their role as a guest in the school building and partner to promote student academic and social-emotional-behavioral success, and strategies for effectively providing support or mental health consultation to school staff to improve individual, classroom, and school-wide functioning.

Staff Wellness Supports Healthy Students

In addition to professional development to build information and awareness of trauma-informed school-based mental health, school staff members also require support to promote and enhance their own wellness and self-care as they care for students who may have intensive needs. Teachers, administrators, and support staff who respond to students experiencing trauma may be negatively affected and experience secondary traumatic stress and/or compassion fatigue, whereby the perceived demands resulting from experiencing others' trauma leads to feelings of exhaustion or stress.[56] Some staff even experience trauma exposure directly when violence or other disturbing events occur within schools. Administrators have a responsibility to support staff wellness, including monitoring staff for signs of secondary traumatic

SBDI Helps Schools Reduce Exclusionary Discipline and Address Mental Health Needs

The Connecticut School-Based Diversion Initiative (SBDI) is a school-level intervention designed to prevent youth from entering the juvenile justice system by building schools' capacity to: 1) Reduce the use of in-school arrests, out-of-school suspensions, and expulsions 2) Build knowledge and skills among school personnel and police to recognize and manage behavioral health challenges in school, and 3) Link youth at risk of arrest to appropriate school- and community-based services and supports. Key activities include customized professional development in adolescent development, child trauma, and classroom behavior management; linkage to community-based services such as mobile crisis and other supports; and school discipline policy consultation to integrate diversion principles and restorative practices. SBDI has been implemented in 43 schools in 15 districts in Connecticut and has been adapted in other states. SBDI is provided at no cost to schools through funding provided by the CT State Board of Education, the Judicial Branch Court Support Services Division, and the Department of Mental Health and Addiction Services. The Department of Children and Families also provides oversight to SBDI and CHDI serves as the Coordinating Center. A free SBDI Toolkit is available for schools to download to guide implementation.[55]

stress and offering appropriate policies, peer support, and on-campus resources to prevent burnout and to develop a supportive workplace environment.[56] A healthy and supported school workforce is critical for supporting healthy, high achieving students.

Evidence-Based Practices Improve Outcomes

Evidence-based practices (EBPs) are programs, services, and supports that research has shown to be effective for improving the outcomes they are intended to achieve (e.g., symptom reduction and/or improved functioning) with a particular population (e.g., elementary school aged children) in a specific setting (e.g., schools). EBPs are considered an important part of CSMHS, and the selection of programs (and assessment of existing programs) should be driven in large part by the evidence of effectiveness for the target population. The requirements for a program to be considered an EBP are not universally defined or agreed upon and the required level of scientific evidence varies significantly for many programs that are promoted as "evidence-based." Thus, it is important to consider the strength of evidence, even for programs considered to be EBPs, as well as other factors such as cost, availability of implementation support, local needs, and capacity for sustainability.

Several resources exist for identifying and selecting EBPs, including an online module from the National Resource Center for Mental Health Promotion and Youth Violence Prevention (https://healthysafechildren.org), which provides step-by-step recommendations for selecting and implementing EBPs in school settings. The Hexagon Tool, developed by the National Implementation Research Network (NIRN), based on work by Kiser and colleagues (2007),[57] can assist schools and districts in evaluating EBPs across tiers with respect to six factors, including: needs, fit, resource availability, evidence, readiness for replication, and capacity to implement. There are also several national registries that can aid in identifying and comparing EBPs. SAMHSA's Evidence-Based Practices Resource Center was launched in April 2018 as the National Registry of Evidence-Based Programs and Practices (NREPP), which had been in place since 1997, was phased out.[58] Other online registries include the Blueprints for Healthy Youth Development,[59] and the Institute of Education Sciences What Works Clearinghouse.[60]

It is often difficult for school staff, providers, and families to know where EBPs are available locally, as the array of services changes frequently. Connecticut's Evidence-Based Practice Tracker,[61] funded by the Department of Children and Families (DCF) and managed by CHDI, is one online resource that can be accessed by the public to identify EBP providers across the state. The EBP Tracker public directory is searchable by zip code and shows where several EBPs are available, including: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Cognitive Behavioral Intervention for Children in Schools (CBITS), and Bounce Back.

Collecting and analyzing data in real time to monitor student needs, access to care, service quality, fidelity to evidence-based models, and student outcomes facilitates system-wide transformation and sustainability of EBPs.

Implementation Science Ensures Effective Delivery of Care

Despite the rapidly increasing number of EBPs being developed, most services provided in schools and communities are not evidence-based. In a phenomenon referred to as the "research to practice gap," much of the research establishing evidence for treatment models is not applied to real-world settings and there is often a significant delay from the publication of research to the implementation of research findings in practice. For example, it takes an average of 17 years for just 14% of research to benefit families.[62] The relatively new field of implementation science emerged to improve methods for ensuring research and EBPs are fully implemented into routine practice, with the goal of more rapidly improving the quality and outcomes of services that families receive.[63]

Selecting models and initial training on an EBP is only the beginning step for successful implementation. Implementation science literature confirms that a one-time training will not result in sustainable changes, and that effective implementation requires ongoing supervision and coaching, leadership, and organizational support, and capacity for data and quality improvement to fully implement and sustain EBPs with the desired outcomes. For example, in addition to providing training to ensure that teachers have knowledge about mental health, it is important to provide ongoing coaching and monitoring to ensure that knowledge is translated into behavior change (e.g., promoting positive mental health in the classroom, managing behavioral concerns, increasing identification and referral).

The National Implementation Research Network describes core implementation drivers, which include staff recruitment and selection, preservice and in-service training, ongoing coaching and consultation, staff performance assessment, decision support data systems, facilitative administration, and systems intervention.[64] A tool developed by Blasé, van Dyke, and Fixsen (2013)[65] can help teams conduct a stages of implementation analysis to identify how they can improve their success with implementing an EBP. In Connecticut, DCF and CHDI have successfully used Learning Collaboratives, adapted from the National Child Traumatic Stress Network (NCTSN)[66] and based on the Institute for Healthcare Improvement's Breakthrough Series Collaborative,[67] to disseminate multiple EBPs across the state. The model supports shared learning, ongoing implementation support, and use of data for quality improvement to ensure effective and sustained implementation.

Comprehensive Data Systems Guide Quality Improvement

Data analysis, reporting, and quality improvement are critical components of CSMHS. Collecting and analyzing data in real time to monitor student needs, access to care, service quality, fidelity to evidence-based models, and student outcomes

facilitates system-wide transformation and sustainability of EBPs. Schools generally have access to a range of existing data that can be used to inform planning and delivery of school-based mental health services and supports, and may also have standard data reporting systems such as an Early Warning System, PowerSchool, or School-Wide Information System (SWIS) for those implementing Positive Behavioral Interventions and Supports.[68] While the quality and availability of data and information systems varies widely across schools and districts, data sources generally include: daily attendance and activity sign-in sheets, academic records, discipline referrals, demographic records, and school climate surveys.

Results of universal screening and outcomes associated with academic and behavioral interventions may also be available. Additional information about EBPs can be used to support implementation and to ensure that services are effective. The EBP Tracker system is available in Connecticut at no cost to community- and school-based clinicians and agencies implementing a range of EBPs through CHDI. The system includes the ability to monitor and report fidelity and outcome data on children receiving a range of EBPs, including standardized assessments, clinical components/fidelity, progress, and outcomes.

Creative Financing Models Advance and Sustain School Mental Health

Creating feasible and sustainable funding models for Comprehensive School Mental Health Systems (CSMHS) is a challenging but critical priority for local, state, and national entities interested in advancing school mental health. Estimates suggest that the annual cost of behavioral health services delivered in all settings exceeds $11.68 billion or $172 per child.[33] Funding streams typically come from public sources (i.e., federal, state, and local government), insurance companies, managed care companies, charitable groups, and foundations. The availability of state and local data and an understanding of CSMHS financing can help inform needed policy and funding modifications to support a continuum of mental health supports. Table 3 displays a few examples of states that have creatively addressed policy and funding challenges to implement CSMHS.

Table 3: Innovative Funding Approaches to Support CSMHS

State	Innovative Funding Examples
California	The "Mental Health Services Act" (MHSA) funded CSMHS through additional tax, while supporting local ownership and development of CSMHS programs to fit their needs.
Florida	In Jacksonville, Florida, the Duval County Public Schools Full Service Schools PLUS Model implemented a blended funding approach that combines funding from five diverse funding sources including the Duval County Public Schools System as the lead agency in partnership with a local behavioral health organization and other community, private foundation, and agency partners.
Michigan	IDEA Medicaid was revised to include Tier 2 and 3 mental health counseling sessions provided by school professionals.
Minnesota	In 2013, the Minnesota legislature increased funding for school-based behavioral health services from $4.7 million per year to $45 million over five years. The resulting state grant program administered by the Minnesota Department of Human Services issued grants to 38 mental health agencies serving more than 800 schools.
South Carolina	The Department of Education developed a Psychosocial Behavioral Health Rehab Medicaid Standard to support Tiers 2 and 3 counseling. The state's Department of Mental Health also provides legislatively authorized funds on a recurring basis to support rural CSMHS.

To sustain the delivery of CSMHS, programs most frequently braid or blend funding from multiple distinct sources and maximize funding within each source to achieve a fiscally viable funding model. Categorical funding from public and private sources can supplement limited local school budgets to allow for the expansion of behavioral health services and supports for students; however, these funding approaches tend to support service delivery that is relatively restrictive in scope and short-term in duration. Reallocating portions of general funds or special education funding to support Tier 1 or 2 prevention and early intervention services can help maximize limited resources, particularly to support programs and services that can demonstrate direct linkages between behavioral health needs and academic outcomes. The sustainment of school mental health systems requires the cross-stakeholder development of a compelling state vision and shared agenda—one that can inspire local action—and a strategic action plan and infrastructure to carry out the agenda. As demonstrated in Table 3, creativity is also a key ingredient in driving funding to support this shared vision and plan with sustainable resources. Several states and communities have established School Mental Health "Communities of Practice" or Steering Committees to advance shared goals that support student mental health and have often drawn from local events or political factors.

Public and private resources have grown considerably over the past two decades to create school-based outposts for behavioral health services. Federal, state, and local support for school-based health services reached

Center for School Mental Health's Best Practices for Funding[47]

- Create multiple and diverse funding and resources to support a full continuum of services
- Maximize leveraging and sharing of funding and resources to attract an array of funders
- Increase reliance on more permanent versus short-term funding
- Have adequate funding to support services and supports at each tier
- Use best practice strategies to retain staff
- Utilize third party fee-for-service mechanisms to support services
- De-implement programs that are not achieving desired outcomes and reallocate resources to evidence-based and effective programs
- Evaluate and document outcomes, including the impact on academic and classroom functioning
- Use outcome findings to inform school, district, and state-level policy impacting funding and resource allocation

unprecedented levels following the traumatic events in Newtown, Connecticut in 2012 and subsequent school shootings. Through several federal projects (e.g., Project AWARE, Promoting Student Resilience, School Climate Transformation, Project Prevent) federal dollars were allocated to support Mental Health First Aid training and improved screening and referral of students with mental health needs to improve their access to trauma-informed care, conflict resolution, and violence prevention. Similarly, the Affordable Care Act authorized federal support totaling $200 million between 2010–2013, which allowed more than 500 communities to build and expand school-based health programming.[69] Table 4 was adapted from a 2015 report by the Center for School Mental Health to include examples of common funding streams for funding school mental health services, and examples of how those funding sources are being used in Connecticut.

Several resources have been developed to guide local schools, districts, and states in securing and sustaining school-based health services and supports as broadly defined and have implications for supporting Comprehensive School Mental Health Systems.[70] For example, a 2016 toolkit from the U.S. Departments of Education and Health and Human Services[71] provides guidance for maximizing Medicaid enrollment of eligible students, expanding services and supports covered by Medicaid such as case management and peer support, and expanding partnerships with hospitals and other community providers.

As schools and districts in Connecticut work towards developing capacity to expand and sustain a system of high-quality services and supports to promote the healthy development of students, it is critical to maintain a wide array of funding streams to fully support a statewide model for Comprehensive School Mental Health Systems.

Table 4. Overview of Common Funding Opportunities[47]

Funding Stream	Description	Connecticut Examples
Federal Grants	Several federal grants have been created in which a portion of funds can be allocated for CSMHS. These include the *Healthy School, Healthy Communities* program (Bureau of Primary Health Care); *Safe Schools/Healthy Students Initiative* (Departments of Education, Justice, and Health and Human Services); *Title XX Social Services* block grant; Preventive Health and Health Services block grant; and the *Maternal and Child Health* block grant.	Safe Schools/ Healthy Students (U.S. Department of Health and Human Services, SAMHSA) School Climate Transformation (U.S. Department of Education)
State or County Funding	Some states have begun to include school-based health and behavioral health services in their state or county budgets. For example, services can be financed partially by state allocations that can be used to support multiple activities (e.g., budget line item/s) or by implementing specific programs (e.g., Safe and Drug Free Schools) that also come with budgets to supplement general money for school behavioral health programs. State health initiatives and state and local taxes (e.g., tobacco tax, property tax) may also offer some support for school behavioral health services. For example, Boone County, Missouri implemented a ¼ cent sales tax (one penny for every $4 spent) towards mental health and used that revenue to provide grant support for school-based mental health staff.	Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Connecticut Department of Children and Families); New Haven Trauma Coalition
Fee-for-Service	Third-party payers including state Children's Health Insurance Programs, Medicaid, and commercial insurance provide support for school behavioral health through fee-for-service reimbursements. Though there are disadvantages to this line of funding, including the large bureaucratic and administrative load required to recover funds, the necessity of diagnosing students to receive reimbursement, and the lack of reimbursement for many activities included in CSMHS (e.g., consultations with parents and teachers, classroom observations, and case management), fee-for-service revenue is an integral part of long-term financial success for school behavioral health services.	Commercial insurance, Medicaid
Outpatient Behavioral Health Funding	Partnering with an existing outpatient behavioral health center is an excellent way of facilitating service delivery, since outpatient clinics have the infrastructure, processes, and credentialing required to bill a broad array of public and private insurance programs for services.	Community-partnered school mental health
Solicited Funds	Many CSMHS obtain at least some of their funding from private donors and private foundations. This source of funding can comprise a portion of a general budget for school mental health or funds may be solicited to support specific initiatives.	Connecticut Health Foundation; Hartford Foundation for Public Giving
Pooled, Blended, or Braided Funds	Relying on multiple funding streams through a pooling, blending, or braiding of sources in an important component of successfully funding school behavioral health. This is a key component to ensure that the services continue even if one of the funding sources should end. An additional advantage of this approach is that services tend to be more comprehensive since funding sources often differ on which services, providers, and clientele are covered.	School-based health centers

Recommendations

The following set of recommendations and next steps is designed to offer a blueprint for Connecticut to advance a comprehensive statewide system of school mental health that would support positive behavioral health outcomes for all children. Other states and jurisdictions seeking to develop or expand Comprehensive School Mental Health Systems are encouraged to use these recommendations as a guide to adapt their own action steps for advancing this work.

State Level Next Steps to Support Comprehensive School Mental Health Services

1) Develop a shared school mental health vision and action plan to enhance school mental health services.

- The vision and action plan will draw on existing behavioral health system development policy and infrastructure and will clearly describe the financial, legislative, and service delivery components required for enhancing school mental health services.
- This vision and plan will be developed by soliciting and respectfully incorporating the perspectives of multiple partners, including youth and families. A unified vision jointly held by key state agency and policy stakeholders is essential for providing clarity and consensus around core aspects of school mental health and should involve leaders representing behavioral health, public health, education, juvenile justice, social services, family members, youth, and family advocates—all of whom have vested interests in the same outcomes: healthy, safe, and successful students. Connecticut's existing PA 13-178 and PA 15-27 legislation and the Children's Behavioral Health Plan Implementation Advisory Board provide a solid framework for planning, reviewing, and implementing school mental health policy and practice enhancements. Continued support for the integration of mental health services and supports across settings through the activities of the Trauma-Informed School Mental Health Task Force of the Behavioral Health Plan Implementation Advisory Committee is recommended. In addition, coordination with the statewide CONNECTing Children and Families to Care (statewide SOC grant) initiative can also serve as a vehicle for advancing these efforts statewide.

2) Establish a centralized organizational infrastructure and accountability mechanisms to ensure implementation of the vision and action plan.

- Organizational infrastructure and accountability mechanisms are essential for developing effective and sustainable school mental health programs and services. This is particularly important when a "champion" leaves, when grant funded programs end, and when there is a lack of shared investment in school mental health efforts. While the ownership of a school mental health action plan must be shared among stakeholders and agencies, one entity must ultimately be accountable for the planning, implementation, and evaluation of statewide programs and services. States can benefit

from a central entity that has recognition, authority, accountability, and the capacity for statewide dissemination of school mental health efforts, optimally in partnership with all invested state agencies.

3) Develop multiple and diverse funding mechanisms to sustain school mental health services across a multi-tiered system of supports.

- Funding should be identified to advance a continuum of school mental health services and supports across each tier. Medicaid and fee-for-service mechanisms should be optimized, leveraged, and integrated with other funding mechanisms as part of a larger and diverse school mental health funding profile. The state should consider examining the current Medicaid state plan and associated regulations and resolve any barriers that disincentivize schools and community-based organizations from collaborating on behavioral health service delivery.
- The state should aggressively pursue federal and philanthropic grants that are focused on enhancing school mental health services.
- The state should provide support and technical assistance to schools to build their capacity to bill Medicaid, commercial insurance, and other payers to support service delivery and establish diverse revenue streams.
- Federal funds from the *Every Student Succeeds Act* should be leveraged to provide support for school-based needs assessments of health and academic functioning and schoolwide improvements using the SHAPE system.
- Opportunities to more fully support social-emotional promotion, prevention, and early intervention services, which are highly cost-effective over the long term, should be identified and prioritized.

4) Establish a uniform data system that connects academic and psychosocial data and allows for data sharing between school-employed and school-based community partners.

- The data system must respect concerns about student privacy, while allowing for systematic tracking of screening tools, service delivery, and outcomes.
- School mental health services will be significantly bolstered if evaluation efforts integrate academic and behavioral health outcomes. Participation in this data system should be an expectation of all mental health provider organizations working in schools. School level data (e.g., grades, attendance, discipline referrals) should be an integral part of mental health service evaluation and should be accessible, with appropriate releases, to mental health providers. The Data Innovations Committee of the Connecticut Safe Schools Healthy Students effort identified exemplar data system models and practices throughout the state, and has technical assistance tools to support implementation.

Next Steps for Districts and Schools to Support Comprehensive School Mental Health Services

5) Establish family-school-community partnerships to support school mental health, including on-site Tier 2 and 3 services with students at risk for or experiencing mental health concerns.

- The State Department of Education, the Department of Children and Families, and the Department of Public Health, which oversees school-based health centers, in collaboration with other state agency partners, should create and oversee technical assistance and implementation support to promote and build capacity for family-school-community mental health. Technical assistance may include sharing local examples of school-community mental health partnerships, providing templates for memoranda of understanding between schools and community behavioral health providers, offering education on how to fund community-partnered school behavioral health, and guidance on how to conduct effective teaming between school- and community-employed school mental health staff. For example, the Hexagon Tool[57] developed by the National Implementation Research Network can assist schools and districts in evaluating EBPs across tiers with respect to six factors, including: needs, fit, resource availability, evidence, readiness for replication, and capacity to implement.

6) Conduct school- and district-level school mental health needs assessment and resource mapping using the SHAPE system as a foundational tool.

- All Connecticut school districts should be required or strongly encouraged to complete the SHAPE system as an introductory step in identifying assets and gaps in their behavioral health infrastructure and services. The assessment should incorporate data on school climate, student mental health needs, and resource mapping that identifies available resources in schools and communities. To support SHAPE completion, schools should receive support and technical assistance, perhaps through the CONNECTing Children and Families to Care Initiative.

7) Integrate mental health services and programming within a Multi-Tiered System of Support by leveraging existing infrastructure, training, and technical assistance support mechanisms across all tiers to address academic as well as social-emotional-behavioral health concerns.

- Implement systems for early identification of students with mental health concerns to promote referral to prevention and treatment. In addition to the results of validated screening measures, early identification systems often draw on data points that include peer and teacher nomination, low attendance or chronic absenteeism, and office referrals for disciplinary problems. The SHAPE system offers a repository of free and low-cost validated measures that are the most effective for specific age groups and for identifying particular mental health concerns.
- Incorporate universal (Tier 1) mental health promotion, including social emotional learning at the district and school level. Social-

emotional-behavioral expectations for students should be defined and taught to students with rewards to students for displaying such behaviors (see www.CASEL.org for a review of model programs). Families should be aware of academic, social, emotional, and mental health expectations within the school and how they can help support student success by encouraging these behaviors at school and at home.

- Build capacity for a trauma-informed approach for implementation of MTSS. Use national best practices for trauma-informed schools (see *Helping Traumatized Children Learn and SAMHSA 4 Rs*), and promote the installation of evidence-based trauma interventions (e.g., Bounce Back, CBITS, TF-CBT) at each tier of support.

8) Provide ongoing professional development for all school-based staff (administrators, educators, discipline teams, mental health and health providers) on the strategies and skills needed to promote positive academic, social, emotional, and mental health.

- Professional development for administrators and educators should include information related to normative adolescent development and prevalence of behavioral health concerns, identification and referral processes, and school- and classroom-based intervention strategies to address mental health needs. Educator training should also include information on the direct impact of student mental health and trauma on learning and academic success and what strategies can be implemented to lessen that impact.

- Professional development for mental health professionals and partner agencies should address evidence-based mental health practices and programs across promotion, prevention, and intervention levels.
- Professional development should include plans for ongoing implementation support, coaching, and performance feedback, to ensure that acquired knowledge related to mental health is translated into behavior change (e.g., promoting positive behavioral health in the classroom, increasing identification and referral, using evidence-based practices and programs).
- To build a skilled workforce, pre-service training (in education and behavioral health) should incorporate evidence-based strategies on promoting student mental health in schools. The state should examine ways to partner with local universities to infuse school mental health into undergraduate and graduate level teacher preparation curricula, and consider adjustments to state policy and/or legislation to require mental health training for educators.
- Incorporate staff wellness and secondary trauma into training and support for school staff and behavioral health providers. The focus of these efforts should include monitoring, peer support, and resources for secondary traumatic stress and compassion fatigue to maintain a healthy and supported education and school behavioral health workforce.

Conclusion

Integration of mental health services into the education system has the potential to offer our nation's youth a comprehensive array of mental health supports and to remedy many of the shortcomings of our traditional, siloed approaches to youth mental health and education. Such an approach also has the potential to save significant resources by providing prevention and intervention services earlier, more efficiently, and more effectively. Federal, state, and local investments in school mental health reflect an acknowledgement of this potential, with multi-tiered systems of support becoming a regular part of the dialogue among educators. A systematic and streamlined partnership between families, schools, and communities to support a continuum of mental health supports in schools can lead to better behavioral health for all students, as well as increased access, earlier identification and intervention, and ultimately better outcomes for students with mental health challenges. This vision reflects a greater reliance on the natural supports that exist for students, including families and educators, and less reliance on an already scarce specialty mental health system.

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