Thriving in School: School-Based Mental Health for Children and Youth with Special Health Care Needs (CYSHCN)

Environmental Scan Report

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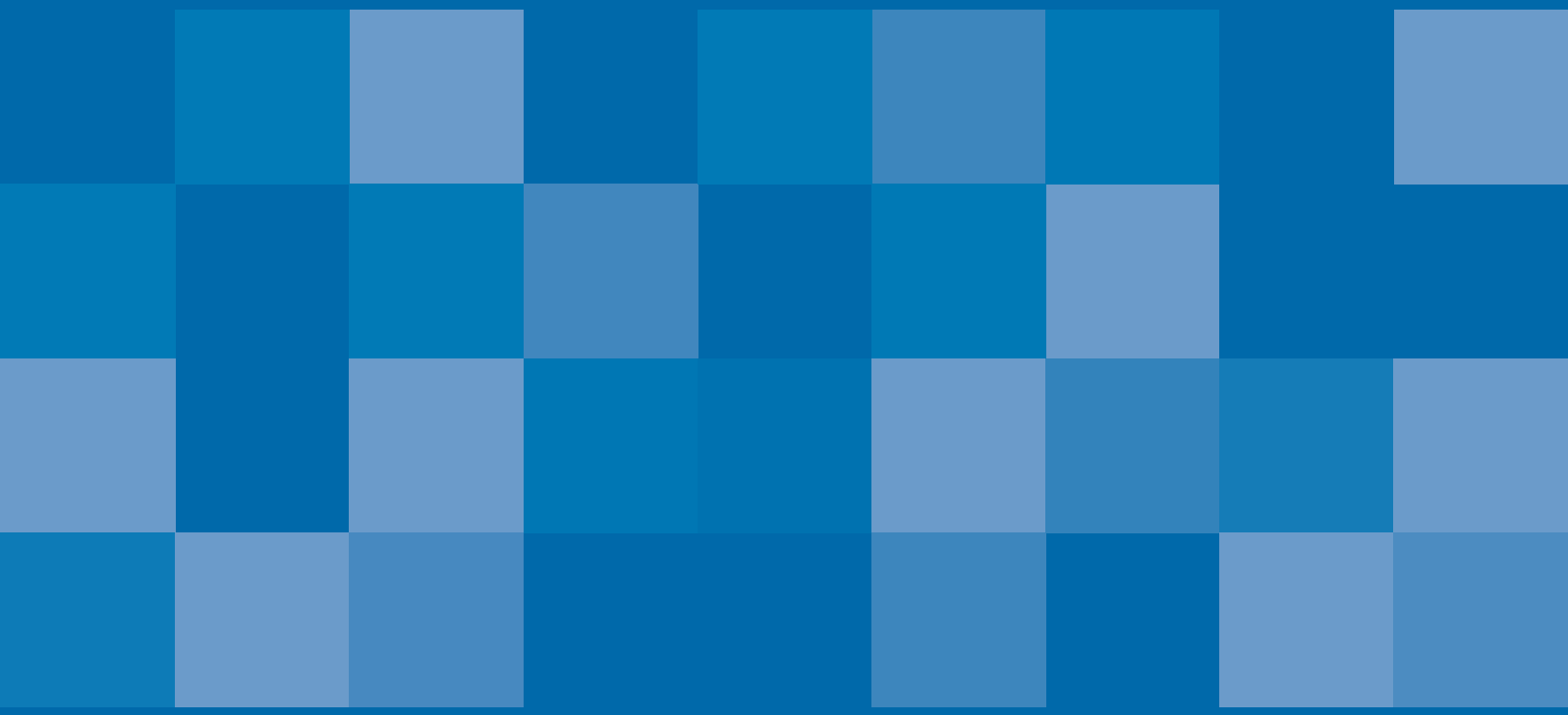

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Contributions

The project team would like to thank the key informants who contributed their time, knowledge, and lived experiences to this environmental scan. The project team also thanks the Steering Committee members who contributed their expertise.

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Table of Contents

1. Background

Children and youth with special health care needs (CYSHCN) face significant challenges that often lead to poor health and education outcomes. Approximately 19 percent of children in the United States (U.S.), nearly 14 million, are identified as having special health care needs. These children frequently experience chronic conditions that interfere with daily functioning and academic achievement, leading to higher absenteeism rates and lower graduation rates when compared to their peers.[1] Eight of the top ten conditions experienced by CYSHCN are developmental, mental, or behavioral conditions, referred to in this project specifically as CYSHCN with emotional and behavioral disorder (E/BD).[2]

CYSHCN with E/BD are often at risk of being from families experiencing poverty,[3] being exposed to adverse childhood experiences (ACE),[4] and having comorbidities.[5] CYSHCN with E/BD often encounter significant challenges in school environments, affecting their educational trajectory. As with the broader CYSHCN population, absenteeism is a major concern for students with E/BD as they are more likely than their peers to experience absenteeism, often as an avoidance mechanism, leading to substantial learning disruptions and disengagement from school activities.[6] Students with E/BD may also experience lower academic performance due to missed school or disengagement from school. Additionally, students with E/BD are at an elevated risk for substance use, with studies indicating that these students are significantly more likely to experiment with substances at an earlier age compared to their peers.[7] This increased vulnerability is often attributed to difficulties in emotional regulation and impulsive behavior typically associated with E/BD. Students with E/BD are also prone to exhibit violence or aggressive behavior and are more likely to self-harm.[8,9] Consequently, CYSHCN with E/BD are also disproportionally affected by suspensions and expulsions.[10] These challenges contribute to the school-to-prison pipeline, particularly for non-white students.[8]

Societal influences can have an impact on children and youth's health and well-being, particularly for CYSHCN with E/BD. For example, COVID-19 was detrimental to CYSCHN with E/BD receiving SBMH services as many children stayed home from school and certain services were not offered virtually or are most effective when delivered in-person.[4] More broadly, while adolescence can be a challenging time for any youth as they navigate identity formation, sexuality, gender identity, and relationships within societal ideals and norms, similar to other youth with certain disabilities, CYSHCN with E/BD may be specifically challenged during this time without having the emotional skills to cope.[11] However, not all CYSHCN with E/BD have the same experiences. It was clear from informants with lived experience that CYSHCN with E/BD have distinct manifestations of their symptoms that can vary not only by individual but also depending on the day. Some students with E/BD are high-performers and may internalize their symptoms, discussed in more depth below.

School-based Mental Health (SBMH) services have been shown to effectively improve behavioral and academic outcomes.[12] Studies indicate that students receiving these interventions exhibit an increase in academic achievement and significant reductions in disciplinary issues. Furthermore, payment models continue to progress to cover CYSHCN needs with almost half of CYSHCN covered by Medicaid or Medicaid and private insurance, and nearly 90 percent of school-based mental health centers (SBHCs) billing Medicaid.[13] Still, additional evidence generation focused on scalable and adaptable interventions is crucial to tailoring services that meet the diverse needs of CYSHCN with E/BD.

To galvanize the field for filling pressing gaps in school-based mental health programs serving CYSHCN with E/BD, the project team—composed of AcademyHealth, Econometrica, and Family Voices—conducted an environmental scan to serve as the basis for a shared research agenda.

2. Methods

A multi-step approach was used to gather input from a range of interest holders with lived experience and expertise in behavioral pediatrics, child- and family-serving systems, CYSHCN family advocacy, Medicaid and Title V policy, school-based health policy and practice, and SBMH services. Namely, a literature scan was conducted in response to the research questions paired with key informant interviews (KIIs) and a survey administered to state Medicaid policymakers that was then supplemented by a listening session.

2.1 Literature Scan

The non-systematic literature scan was guided by two main research questions: (1) What, if any, evidence gaps exist related to school-based mental health services for CYSHCN with E/BD, and (2) What, if any, best or emerging/promising practices have been identified for implementing school-based mental health services for CYSCHN with E/BD?

The scan drew from relevant literature and evidence reviews (peer-reviewed and grey literature), adjacent research agendas, systematic and scoping reviews, and resources shared by Steering Committee members. Literature was accessed using PubMed, Google, and Google Scholar search engines. Articles were deemed eligible if they: (1) were published in the last ten years; (2) were in English; and (3) were focused on the U.S. health care system/education system. Items deemed ineligible included: (1) books or book chapters; (2) school focus was outside of the public school system or was focused on pre-school or post-high school education; and (3) articles focused on assessment or evaluation of a singular intervention. The Steering Committee reviewed search string terms and strategy. Our search yielded 43 peer-reviewed articles on CYSHCN and mental health and 203 peer-reviewed articles and dissertations and three conference proceedings on E/BD, mental health, and schools. After a title and abstract review, 23 peer-reviewed articles on CYSHCN

and mental health and 35 on E/BD, mental health, and schools were coded. Additional hand searches yielded relevant websites and practice guides that informed our understanding.

Data from peer-reviewed and grey literature were extracted using a standardized MS Excel extraction tool. A thematic analysis was conducted to identify common themes across the literature. This approach allowed for the organization of information into distinct domains, highlighting recurring patterns and key concepts. Results from a preliminary search were used to build KII guides to interrogate and validate findings. Secondary searches with additional search terms were conducted after the conclusion of the KIIs to expand the knowledge base to key points that were identified during the interviews.

2.2 Key Informant Interviews

The project team conducted a series of qualitative interviews to validate preliminary findings from the literature and provide insight into the most pressing gaps across CYSHCN family, researcher, educator, and practitioner perspectives. Categories of interest holder perspectives were identified a priori by the project team and reviewed by the Steering Committee. Purposive and snowball sampling was used to identify interviewee candidates. Informants were identified by soliciting recommendations from the Steering Committee and through the literature as authors of seminal publications. Informant candidates for family partners were recruited by Family Voices, including but not limited to sourcing recommendations from their network of Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB)-funded Family-to-Family Health Information Centers (F2Fs). Family partners were provided $125 each to compensate for their time. In total, nine key informant interviews (n=9) were conducted in April and May of 2025. A summary of key informant perspectives is provided in **Table 2.1.**

Semi-structured discussion guides were developed and tailored for each perspective type and were reviewed by the Steering Committee. Informants were invited to participate via email and provided the discussion guide in advance of the interview. The interviews lasted approximately 60 minutes in duration and were conducted virtually via Zoom. A primary and a secondary interviewer were present for eight of the nine interviews, with one interview having a single interviewer. A notetaker participated in all interviews. During interviews, informants were encouraged to draw out areas of specificity for CYSHSN with E/BD in their responses where possible, beyond commenting on SBMH services as a whole. A description of this population of focus was provided to informants beforehand and reviewed during the interview. Audio was recorded with the consent of participants and transcripts were produced to supplement the detailed notes used to synthesize themes and key takeaways within and across the KIIs.

Table 2.1. Key Informants by Perspective Type

Perspective	Number Participated
Educators	2
Family Partners	2
Practitioners	2
Researchers	1
Associations for School-Based Providers	2
Total	**9**

To help illustrate the current landscape and fill information gaps that had emerged from the literature, discussion topics included questions related to:

- Current state of SBMH services for CYSHCN who have E/BD
- Ideal state of SBMH services for CYSHCN who have E/BD
- Gaps that need to be closed in order to move from the current state to the ideal state
- Knowledge gaps that need closing and the related barriers and facilitators to closing them

Thematic analysis was performed in part during team debriefing sessions with at least one facilitator and the notetaker to identify themes and discordance. Interview notes were also re-read by the notetaker and at least one facilitator to identify themes and central concepts. Insights garnered prompted additional searches of the literature to broaden understanding and find a literature base for several key concepts.

2.3 State Medicaid Agency Survey & Listening Session

The project team leveraged AcademyHealth's position as the professional home of the Medicaid Medical Directors Network (MMDN) to administer a survey and hold a listening session to gain preliminary insight into the gaps most relevant and impactful to Medicaid policymaker priorities. The MMDN brings together senior clinical leaders in Medicaid across the 50 U.S. states and six territories to discuss their most pressing needs and share best practices.[14] As part of the environmental scan, permission was obtained from MMDN leadership to administer the survey to MMDN membership. In addition, deidentified results from the survey and takeaways were shared with the MMDN during a listening session to qualitatively couch survey findings.

2.3.1 Medicaid Medical Directors Survey

The survey was fielded to a targeted group of Medicaid Medical Directors (MMD) who represented 19 geographically diverse states, five of which completed the survey. While small, the sample retained diverse representation from states in the northwest, midwest, northeast, and southern regions in the continental US. These states were prioritized for outreach due to geographic variation, strong engagement with the MMDN to increase the likelihood that they would respond, and

several states were included based on literature findings and intel from a key informant. The Steering Committee provided real-time input on the survey topics during the first Steering Committee meeting and gave asynchronous input on the survey questions afterwards. An additional subject matter expert (SME) provided further input on the questions. The survey contained questions related to:

- Current scope of school-based services covered
- Future/planned scope of school-based services covered
- Evidence gaps interfering with policy decisions and/or readiness

The survey was administered via SurveyMonkey in April 2025. A Word document version of the questions was provided to respondents for review prior to completing the online survey. MMDs were encouraged to work collaboratively with appropriate members of their state agency to answer the questions accurately. Thus, the survey was primarily completed by designated colleagues who were more closely involved in the respective state's school-based mental health policy.

2.3.2 Listening Session

To supplement findings from the survey, a listening session was held in May 2025 with members of the MMDN representing 15 states that similarly spanned the northwest, midwest, northeast, and southern regions. The listening session lasted approximately 60 minutes and was held virtually via Zoom. Questions from the survey were repurposed for open-ended responses to seed discussion during the listening session. Key takeaways from the listening session were then synthesized and paired with findings from the survey to assist in understanding the current landscape of school-based services.

3. Results

Findings from the environmental scan are presented below. To provide greater context for later results, this section begins with a discussion on defining the subpopulation of CYSHCN with E/BD. Next, we present findings from the literature with key takeaways from informant interviews woven throughout and concluding each section with findings from the MMD survey.

3.1 Defining CYSHCN with E/BD

This section presents findings related to defining the subpopulation of CYSHCN with E/BD. Results from the literature scan and informant interviews are presented first, followed by findings from the MMD survey.

3.1.1 Literature Scan & KII Findings

Much has been written in the literature about the definitions of CYSHCN and E/BD, though not often as an amalgam. For the purposes of this scan, we include the term E/BD to pinpoint a more specific subpopulation of CYSHCN that could be identified in the education field and corresponding literature. CYSHCN has been defined multiple ways, with definitions that most often focus on chronicity of a medical or developmental condition, including in the most commonly referred to definition by the Health Resources and Services Administration (HRSA).[15] The overarching category of E/BD includes a broad range of mental health disorders in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5) and Emotional Disturbance (ED) is utilized in the Individuals with Disabilities Education Act (IDEA) to identify school-children eligible for services (**Table 3.1**). The literature findings on the IDEA definition acknowledge it as incomplete and imprecise,[16] which complicates the identification of children and youth who may need mental health care. The majority (72 percent) of State Education Agencies (SEA) feature definitions similar to the federal IDEA definition on their websites, whereas some states differ in their use, with some preference for the term "emotional" over "behavioral."[16]

Informants quickly affirmed and expanded upon the complexity of defining CYSHCN with E/BD, with many informants commenting on the expansive range of children and youth even within this narrowed subpopulation. There is literature to suggest that E/BD may be better defined by developmental periods and de-segmented into mood, anxiety, and behavior disorders.[17,18] Defining CYSHCN with E/BD is further complicated given that many CYSHCN experience a range of physical and emotional/behavioral health conditions and limitations. Nearly 40 percent of CYSHCN have four or more conditions.[13]

Focusing on CYSCHN, who also have E/BD, hones in on some of the most vulnerable students within the U.S. public school setting. To better operationalize a working definition for *CYSHCN with E/BD,* five key components were identified to help ground future research targeted towards this population, which were:

- Age range of the children and youth
- Physical conditions
- Emotional/behavioral conditions
- Care and service needs
- Mental health care use

Each of these components is summarized in **Table 3.2.** below.

3.1.2 State Medicaid Findings

State Medicaid programs do not themselves identify CYSHCN with E/BD for specific management, but survey respondents reported deciphering eligibility primarily using the child or youth's current Medicaid status to determine coverage for SBMH services. Two states obtained the data needed to verify the eligibility of CYSHCN with E/BD through reviewing submitted or processed claims (diagnostic codes) and/or through medical/behavioral health provider attestation of status. Unique family reporting mechanisms and having a plan of care required for the services were less commonly used among participating state Medicaid agencies to determine benefit coverage. The survey did not solicit in-depth information on whether state Medicaid agencies identi-

Table 3.1. Definitions of CYSHCN and E/BD

Children and youth with special health care needs (CYSHCN)	Emotional Disturbance (E/D)
CYSHCN have or are at increased risk for having chronic physical, developmental, behavioral, or emotional conditions. They have conditions such as asthma, sickle cell disease, epilepsy, anxiety, autism, and learning disorders. They may require more specialized health and educational services to thrive, even though each child's needs may vary.[19]	ED is defined in the Individuals with Disabilities Education Act (IDEA) as: • an inability to learn that cannot be explained by intellectual, sensory, or health factors; • an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; • inappropriate types of behavior or feelings under normal circumstances; • general pervasive mood of unhappiness or depression; • tendency to develop physical symptoms or fears associated with personal or school problems.[20]

Table 3.2. Summary of CYSHCN with E/BD Definition Components

Definition Component	Summary
Age Range (6-17 years old)	The age range of CYSHCN can vary slightly but most commonly encompasses children and youth ages 0-17 years, particularly given the availability of information for this population from sources such as the National Survey of Children's Health (NSCH). This survey contains the Children with Special Health Care Needs (CSHCN) Screener to collect data on the prevalence and impact of special health care needs among children in this age bracket.[21] Some statewide survey[22] and local program outreach[23] have extended the age range up to 21 years though it is less common. In addition, IDEA mandates the provision of a free, appropriate public education for eligible students with disabilities ages 3-21. This project focuses on CYSHCN with E/BD ages 6-17 years to capture those who are typically within school settings (K-12) and are thus more likely to receive SBMH services.
Physical Conditions	CYSHCN have or are at increased risk for having chronic physical conditions such as asthma, sickle cell disease, and epilepsy. CYSHCN with E/BD could include a 14-year-old with a significant history of school absenteeism and diagnosis of social anxiety disorder; a 17-year-old with diabetes, adjustment disorder, and substance use disorder; and a 10-year-old with prematurity, cerebral palsy, language delay, hyperactivity, and aggression. This component of the definition is key given that children and youth with mental health needs disproportionately also have medical needs.
Emotional/Behavioral Conditions	Inappropriate behaviors for the setting/stimuli can be internalized (e.g., anxiety, depression) or externalized (e.g., hyperactivity, impulsivity). In the school environment, externalized behaviors may cause classroom disruptions that impact the teacher and other students in the class, as well as a student's academic performance. These behaviors or mental state are chronic and can negatively impact interpersonal relationships. Diagnosis may be the result of either a primary medical diagnosis or due to secondary identification of behaviors that would qualify a student for an Individualized Education Plan (IEP).
Care and Service Needs	Care and service needs of CYSHCN with E/BD encompass needs related to both physical conditions and emotional/behavioral conditions (described above). The NSCH identifies CYSHCN using the validated 5-item CSHCN Screener which asks parents/caregivers if their child has any of the following service needs or limitations due to a health condition that has or is expected to last 12 months or longer: (1) use or need of prescription medication(s); (2) above average use or need of medical care, mental health, or educational services; (3) functional limitation(s) that limit daily activity, compared with others of the same age; (4) use or need of specialized therapies (e.g., occupational, physical, and/or speech therapy); and (5) treatment or counseling for emotional, behavioral, or developmental problems.[1]
Mental Health Care Use	Mental health care use includes the use of services such as individual-based interventions (e.g., counseling or therapy), case management or coordinating mental health services, and referrals for care outside of the school.[24] Mental health care utilization encompasses different tiers of services and support based on the student's needs from individual or group counseling to crisis intervention. Mental health care involves coordinating between different systems and legal structures that can span medical (e.g., HIPAA), education (e.g., FERPA), and other child-serving systems such as juvenile justice and/or child welfare. CYSHCN with E/BD may access mental health care through school-based health centers (SBHCs).

fied CYSHCN for case management, population management, medical homes, and/or alternative payment models.

3.2 Current State of School-Based Mental Health Services

These findings describe the current state of SBMH services as summarized in the literature, based on the learned expertise and lived experience of informants, and from the snapshot into state Medicaid agencies obtained through the survey and listening session. In particular, understanding the current state of SBMH services illuminates where pain points and evidence gaps remain related to SBMH services for CYSHCN with E/BD, including how best these services can be adapted across schools and implemented to serve the needs of students.

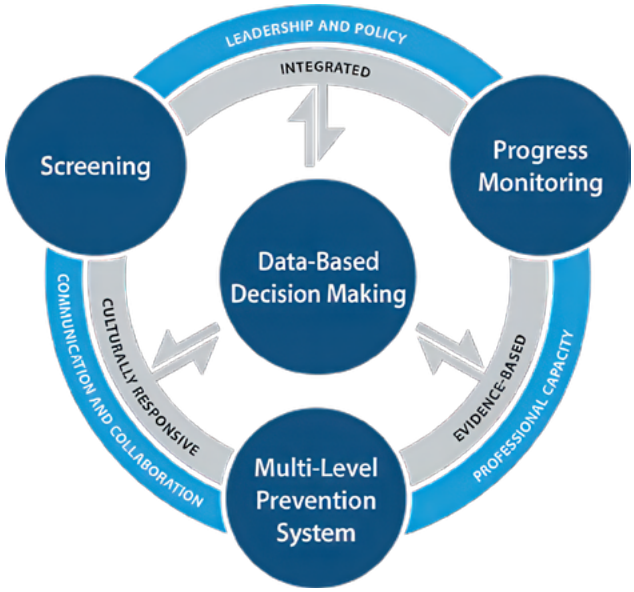
As an effective framework for addressing system-level approaches to school-based mental health, the findings in this scan are mapped to the Multi-tiered System of Support (MTSS).[25] While multiple versions of MTSS exist, this scan utilizes the American Institutes for Research (AIR) Center on Multi-Tiered System of Supports depiction of the framework which shows the complex and interrelated ways that system components interact in practice (**Figure 1**).[26] This MTSS framework includes essential components for SBMH, inclusive of screening, data-based decision making, progress monitoring, and multi-level prevention system. Providing the infrastructure for these components are functional parts of the support framework, inclusive of leadership and policy, professional capacity, and communication and collaboration. Included as underlying values or optimal approaches in this model, are that practices would be integrated, evidence-based, and culturally responsive to student needs. Taken together with a high level of functioning, the MTSS framework provides a model for SBMH. As noted by an informant, the frameworks are only as valuable as the functionality of the components from which they are comprised.

The results below describe in detail subcomponents underlying the model in terms of what is known broadly about the current state of SBMH services for CYSHCN with E/BD. The named approaches that practice be integrated, evidence-based, and culturally responsive, are woven throughout the components. Within the subcomponents, known barriers to operationalization are included and therein lies opportunity for further inquiry towards improved SBMH services.

3.2.1 Essential Components

There are four essential components to the MTSS: (1) screening, (2) data-based decision making, (3) progress monitoring, and (4) multi-level prevention systems, which refers to three tiers of support that increase in intensity depending on a child/youth's need. These components provide the basic makeup of activities for what SBMH looks like in practice. The components, as described in the literature and expanded on by informants, are detailed below. Results from the state Medicaid survey are included where applicable to the components.

Figure 1. Multi-Tiered System of Supports Framework



Screening

Screening refers to a systematic process for identifying students who might be at risk for poor mental health or academic outcomes and may need additional intervention supports.

Literature Scan and KII Findings

The identification of children who receive special education services under the category of EB/D is less than one percent, where it is estimated that 13-20 percent experience a mental, emotional, or behavioral disorder each year with approximately one third experiencing internalizing mental health symptoms and about 68 percent experiencing behavioral issues.[27] Furthermore, only 10-40 percent of children with any experiences related to E/BD receive treatment, with disparities within that population where those in foster care and poverty are less likely to get care. Students most likely to receive an E/BD diagnosis are male (80 percent), students of color, particularly Black students, as well as students from families experiencing poverty.[8]

Progress Monitoring

Progress Monitoring in SBMH is an essential practice that involves the ongoing assessment of all students' emotional and behavioral well-being, particularly for CYSHCN with E/BD.

Literature Scan and KII Findings

This approach uses tools such as standardized assessments to measure the effectiveness of interventions, instructions, and supports. Informants also noted that more informal monitoring is also common and can possibly be life-saving, if school staff know the usual affect of a child or youth and notice any changes that warrant concern.

State Medicaid Findings

State responses pertaining to assessment methods for the quality of services and monitoring outcomes demonstrated more variability

Table 3.3. Screening Subcomponents

Screening Subcomponent	Description	Barriers to Operationalization
Identification	The identification of students who would benefit from receiving SBMH services and assessment of what those services would entail.	It is well documented that CYSHCN with E/BD are underdiagnosed in part due to the lack of universal screening, which few schools have.[28] While nearly one fourth of CYSHCN have a mental health need, to date, there has been little documentation of screening specifically for mental health needs of the CYSHCN population within the school-setting, though they are at risk for E/BD.[29] Students exhibiting internalizing behaviors are less likely to be screened and diagnosed with E/BD because their symptoms are less outwardly noticeable and disruptive. Students with internalizing behaviors also tend to perform academically and therefore are often less of a concern within the school setting for mental health support.[10] Several informants noted that the stereotype that a child or youth with E/BD is struggling academically can contribute to a misleading notion that high-achieving students are not struggling with emotional and behavioral challenges, including but not limited to suicidality. Further, students may respond to questions with respondent bias so as not to appear in need of mental health services.
Assessment and Diagnosis	A thorough evaluation of screening information to determine the specific nature and extent of a student's mental health needs, guiding the development of targeted intervention plans.	High-performing students may actively seek to distance themselves from a label or diagnosis until symptoms prevent them from doing so. From an equity standpoint, students who are undiagnosed, but have indicators of E/BD, may face barriers to securing a diagnosis, which may be partially covered or not covered at all by insurance. Further, testing may be conducted outside of the school setting, presenting another set of barriers. Students without a diagnosis have been found in the literature to receive significantly fewer school-based services.[10]
Responsiveness and Readiness	The ability of a school to respond to screening with high-quality SBMH services in a timely and appropriate approach to CYSHCN with E/BD.	Limitations of school resources may hinder timely and appropriate follow-up and sufficient response to support all CYSHCN who may be diagnosed with or exhibit symptoms of E/BD. Further, formal supports may not exist to appropriately address the wide range of needs of CYSHCN with E/BD. It can also be particularly challenging for students with internalized mental health symptoms or older students, who have often gone unscreened or experienced a trauma, to obtain an Individualized Education Plan (IEP) or Section 504 Plan. Students of color who exhibit E/BD behaviors, particularly externalizing behaviors, are more likely to be disciplined than provided with mental health services.[28]

Table 3.4. Progress Monitoring Subcomponents

Progress Monitoring Subcomponent	Description	Barriers to Operationalization
Data Sources	Data may be stored in medical records or academic records, protected by separate regulations, Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) respectively.	Disparate data sources create challenges to understanding the needs of the CYSHCN with E/BD at the population-level, where data are not able to be matched across data sets. Further, data originating within schools, is not always accessible or able to be shared in a streamlined manner with districts or the state, thus creating a vacuum.
Data Collection	Data may be collected on both process and outcome measures. Data may be both quantitative and qualitative and used at both the individual and population levels. Data may be formally collected or shared informally between school staff and/or other child-serving systems, such as law enforcement or child services. Frequency of collection, timeliness, and quality of the data are important factors for consideration.	School staff are limited in their time to track and input data. Further reporting structures limit the authority to which staff must comply with data collection. For example, a superintendent cannot mandate certain data be collected by SBHC staff, unless they are directly employed by the school.[30] Data collection of outcome measures are less common than process measures, particularly given the longitudinal nature.

Table 3.5. Data-Based Decision Making Subcomponents

Data-Based Decision Making Subcomponent	Description	Barriers to Operationalization
Outcome Indicators	Decision making based on outcome indicators are used to assess the effectiveness and impact of interventions, providing insight into whether desired changes in a student's emotional, behavioral, or academic performance have been achieved.	School systems and community partners may have different, and potentially opposing, ideas on what constitutes appropriate outcomes. For example, outcomes can range from access to a larger quantity of services with variation in quality or access to fewer but high-quality services that have an impact on outcomes such as symptom reduction. Informants noted that an expectation to look at academic outcomes for every mental health intervention can risk setting up the field for failure. For instance, academic outcomes such as attendance, grades, or standardized test scores might be distal outcomes that are not targeted by a brief intervention for anxiety.
Communication of Findings	Communicating findings involves clearly and effectively sharing results and insights gained from data analysis with relevant interest holders to inform decision-making and support strategies.	Challenges arise in engaging families and youth in decision-making on SBMH services for CYSHCN with E/BD, particularly in sharing back information and data. Often, the onus is put on the family to understand how a child's needs and the supports available might align.

Table 3.6. Multi-Level Prevention System Subcomponents

Multi-Level Prevention System Subcomponent	Description	Barriers to Operationalization
Interventions	Evidence-based tiered interventions within an MTSS offer support that are designed to be responsive to varying types, intensities, and frequencies of student needs across the three tiers. Interventions for CYSHCN with E/BD often fall into tiers two and three, however the population can also benefit from tier one.	While there are SBMH interventions, fewer focus on interventions for students with E/BD specifically.[31] Informants also noted that there is not enough validation for evidence-based interventions (EBIs) for CYSHCN with E/BD. In particular, there is a paucity of brief interventions that can also be used by non-mental health professionals and interventions that could utilize technology.
Implementation	The execution of plans or policies of SBMH services, ensuring that resources are effectively utilized and objectives are met in practice. Services are often delivered through school staff, school-based health center (SBHC) staff, or community supports within the school.	There is high variability across schools, districts, and states with respect to the provision of evidence-based mental health services within the school setting.[16] The current state is largely characterized by disjointed integration of physical health, mental health, and education support. For SBHCs, where mental health visits comprise 30 percent of all visits, this significant variability also persists.[32] Depending on the state, defined guidelines may exist, such as having both somatic and mental health healthcare providers within the SBHC to coordinate care. The localization of education, including locally driven funding, impacts the extent to which interventions are offered on-site in schools or in partnership with community providers such that it largely depends on the administrative and school board priorities. Emergent in the literature is the use of implementation science to begin to address how SBMH interventions are implemented, using criteria such as importance, feasibility, fidelity, and outcomes, as well as sustainment, however lack of consistent and longitudinal measures create limitations.[33,34]
School Setting	The school setting is comprised of when and where mental health interventions occur and how they are initiated.	Finding the appropriate time to engage with students during the school day's schedule can be challenging due to several reasons, including but not limited to: (1) balancing mental health needs with classroom instruction, (2) navigating potential stigma around removing a student from class and/or having them interact with a mental health provider in common spaces, (3) the disruption to the flow of the school day can be challenging for CYSHCN with E/BD who are high-performing students, or a student who does well overall with a routine, and (4) re-integrating a student back into the classroom after a brief intervention or after a more prolonged absence.

within the sample, with no answer representing all five respondents. The quality of SBMH services for CYSHCN with E/BD was assessed primarily through the measurement of access to care. Half of the respondents used interim reporting of locally developed process measures. Assessment methods such as family/child experience surveys, site visits, and Healthcare Effectiveness Data and Information Set (HEDIS) metrics were used less often. The outcomes of these mental health services were often monitored using school records and access to services. Family/child experience surveys, national performances measure, locally developed measures, and cost avoidance analysis saw limited use as methods of assessment.

Data-Based Decision Making

Data-Based Decision Making uses data to make decisions about services for CYSHCN with E/BD, such as the type of appropriate instruction or intervention, as well as staffing, funding, and other resource allocation decisions.

Literature Scan and KII Findings

Collaboration among teachers, counselors, and parents is vital to share insights and refine strategies, ensuring a comprehensive support system for CYSCHN with E/BD. One informant noted that school districts are not always integrated into planning for changes, especially when the SEA is less involved. For instance, when the program is not working well, the SEA is only aware that the program is happening while the state Medicaid agency sets the rules and policies, because ultimately the program lives in Medicaid. This can pose a challenge as Medicaid and school districts typically do not speak the same language.

State Medicaid Findings

All five state survey respondents used designated points of contact between the state Medicaid agency and the state Department of Education to promote data sharing and communication. Four states flagged intermittent or ad hoc data linkage whereas three of the five indicated there was infrastructure for ongoing data sharing and communication structures or processes to promote knowledge sharing of individual agency data. Training was less commonly used by states to promote data sharing and communication, regardless of whether the training was regular or intermittent.

Multi-Level Prevention Systems

Multi-Level Prevention Systems are structured frameworks designed to address and support students through varying levels of intervention. These systems often include three tiers: universal prevention aimed at all students to foster a positive school climate and prevent issues; targeted interventions for at-risk students who need additional support; and intensive, individualized interventions for students with significant challenges or diagnosed disorders.

Literature Scan and KII Findings

This tiered approach ensures that resources and strategies are effectively allocated, allowing schools to address problems proactively and efficiently. While these systems are often ideally oriented towards prevention, treatment or response interventions may also be incorporated.

Connecting Components

There are three connecting components to the MTSS: leadership and policy, professional capacity, and communication and collaboration. These components provide the basic scaffolding for how the essential components are operationalized, such as how they are financed, staffed, and coordinated.

Leadership & Policy

Leadership and Policy refers to the impact of school and district leadership along with the laws, statutes, and regulations that impact SBMH services. Medicaid is particularly important within this component because the majority of school-based services are billed to Medicaid and CYSHCN with E/BD are most likely to have Medicaid as their health care payor.[13] The findings in this section draw directly from the survey and listening session conducted with state Medicaid agencies.

State Medicaid Findings

Medicaid can play a critical role in improving SBMH services, particularly through opportunities to finance the delivery of services and provide coverage to CYSHCN with E/BD. Schools can receive funding from Medicaid in several ways, including but not limited to Medicaid reimbursement for medically necessary services that are part of a student's IEP.[24] The five states surveyed provided information on current practices around eligibility for services, entities, and providers. Overall, respondents exhibited similarities regarding the mental health services, entities, and providers that are eligible for reimbursement by Medicaid in a school-based setting for CYSHCN with E/BD. However, significant variation exists between and within states such as in urban areas compared to rural areas. The survey additionally indicated that the identification of CYSHCN remains an area in need of further discussion.

- *Mental health services*. Eligible services included psychological assessment/evaluation, individual and group psychology and counseling, and medical providers with a mental health care claim. Substance use prevention and/or screening along with suicide prevention and/or screening were less commonly reimbursable. Further, all five responding states indicated that a service must be deemed medically necessary to qualify for Medicaid reimbursement; the service being listed in the state plan emerged as another common criterion for eligibility. Half of the states required an IEP or Individualized Family Service Plan (IFSP) as additional criteria whereas an Individualized Health Plan (IHP) or Behavioral Intervention Plan (BIP) was required less often.
- *Entities*. LEAs were eligible to bill for mental health services in four of the five states. Three states also reported that Federally Qualified Health Centers (FQHC) providing school-based healthcare services as well as provider organization providing school-

Table 3.7. Leadership and Policy Subcomponents

Leadership and Policy Subcomponent	Description	Barriers to Operationalization
Medicaid Eligibility	Eligibility to receive Medicaid reimbursement for medically necessary mental health services, school health providers, and entities. "Medically necessary" services for children under age 21 are defined under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.[38]	The availability of eligible services and providers might be further jeopardized by cuts to Medicaid at the federal level, which can leave states determining how to fill gaps with less funding at the state level. State cuts could result in fewer available Medicaid-eligible providers, the reduction and/or elimination of programs and services, and/or fewer students enrolled in Medicaid, which would then affect the overall ability of schools to respond and address students' diverse mental health needs. Survey data collected by the Healthy Schools Campaign highlighted the risk of job losses and reductions in vital services for students as a consequence of Medicaid cuts.[39] Further, as shown in the state Medicaid survey results, variation in how states define eligibility of students may leave some CYSHCN with E/BD ineligible to receive services if they do not have IEPs and IFSPs.
Medicaid Reimbursement	Reimbursement for Medicaid-covered services provided to some or all Medicaid-enrolled students. The breadth of covered students, services, and types of providers varies by state and whether they have expanded their school Medicaid program.	Consistent federal underfunding of IDEA increases school districts' dependence on Medicaid reimbursement to provide students with disabilities the supports and services that they need. While the outcomes will vary state-to-state, reduction in federal funding can significantly impact school Medicaid programs and lead to school district budget gaps.[39]
School-based Medicaid Expansion	A Medicaid policy shift from 2014 provides states with the option to expand their school Medicaid program to reimburse services delivered to all Medicaid-enrolled students.[36] Expansion occurs when a state submits a state plan amendment (SPA) to CMS for approval to cover services beyond an IEP. This may include billing Medicaid for screening, diagnosis, and treatment services to all students enrolled in Medicaid.	Many states codified the original 1988 policy, known as the "free care" rule, into their state Medicaid plan. Some states additionally codified the policy into state law, which can present barriers to implementing the revised CMS policy.[40] The original policy prohibited Medicaid reimbursement for school health services if those services were freely provided to the general student population, with exceptions given to services outlined in a student's IEP or IFSP.[40] While states can submit SPAs to expand their school Medicaid program on the policy end, informants emphasized that there must be dedicated and sustained resources to support implementation across school districts. Administrative complexity still poses a challenge for implementation. Further, one informant posited that having strong coverage policies to enroll and keep students enrolled may help to alleviate churn, which can otherwise cause disruptions for both families and the school Medicaid program.
Other Funding	States may pursue non-Medicaid funding for SBMH services, often adhering to specific program goals, reporting requirements, and evidence-based practices. This topic includes how state legislators could/should be engaged to enact bills that would require all payors to support services for this population, so as to include non-Medicaid eligible families and sufficient coverage from private payors.	States and school districts often face budget challenges and are increasingly facing heightened pressure and uncertainty with respect to securing funding for programs, including but not limited to SBMH services for CYSHCN with E/BD. The lack of adequate funding infrastructure to support MTSS could leave schools with difficult decisions related to resource allocation for mental health programming. This includes changes to policy and funding at the federal and state levels, as well as shifts in philanthropic funding.[41] Depending on the funding source, schools and districts might be subject to the regulatory practices from the independent authority that local geographies have in billing.

Table 3.8. Professional Capacity Subcomponents

Professional Capacity Subcomponent	Description	Barriers to Operationalization
Adequate Staffing	The number of staff needed within a school, district, and/or community to support the mental health care needs of CYSHCN with E/BD. While inclusive of mental health care staff, teachers and other school staff may be included (e.g., administrators, classroom aides, school bus drivers, etc.).	There is a shortage of SBMH providers to serve the number of children in school, particularly in rural areas. Further, the fluctuation of education budgets can create larger class sizes and fewer adults per student, which can impact the attention and interventions received by CYSHCN with E/BD.
Appropriate Staffing	Provision of services by the appropriate licensed mental health professional for the needs of the situation exhibited by CYSCHN with E/BD both within the school and coordinate community supports. This may also include provision of interventions by non-mental health professionals within the school setting, who feel comfortable and equipped to interact with CYSHCN with E/BD.	Based on the shortage of SBMH staff, providers must step in as needed, often working below the skillset of their licensure, and thus not able to provide the support to other children and youth, in particular high need CYSCHN with E/BD. This further creates provider burnout, leading providers to leave the field.
Workforce Training	Training is inclusive of both graduate-level, pre-professional training, continuing education, and in-service trainings. Specific topics refer to mental health literacy training, as well as training in trauma, identifying emotional and behavioral disorder symptoms related to CYSHCN with E/BD, and appropriate evidence-based interventions for CYSHCN with E/BD.	While the CYSHCN with E/BD population within the general education population has increased, training for school staff to adequately handle the population's needs has not.[44,45] Further, pre-professional training does not necessarily prepare professionals for the real-world encounters that they may experience within a school-setting with CYSHCN with E/BD. Additionally, not all school staff bring the same lens to work based on their personal beliefs, and therefore staff may have their own internal biases that hinder their willingness, interest, or level of motivation to learn about mental health.

based health care service and individual providers enrolled in Medicaid were eligible. To a lesser extent, managed care providers and the State Department of Education were deemed eligible.

- *Providers*. Psychologists, psychiatrists, physicians, counselors, and social workers emerged as the most common types of providers eligible for reimbursement of mental health provision in the school setting for CYSHCN with E/BD. Nurse behavioral analysts and family therapists were the next common types, followed by paraprofessionals and psychological evaluators.

Payment & Funding for SBMH Services. Survey respondents shared that payments for SBMH services were commonly made via the submission of individually coded claims to the state (e.g., fee-for-service payments). With respect to managed care, three states indicated that managed care paid providers for services coded individually, and in two states, managed care paid for SBMH services as part of a contract expectation. Furthermore, for two respondents, the state paid another entity such as a community-based services (HCBS) provider, mental health non-profit organization, or FQHC. Although they saw limited use amongst survey respondents, other means of payment included SBMH services, that were not coded individually, being submitted by providers to the state (e.g., capitated payments, random moment time studies), the state paying managed care, and managed care paying the provider for global services.

States further described the ways they received Medicaid funding during the listening session. For some, they received funding through school-based care services programs for students with IEPs and IFSPs. School districts may also have the option to become a licensed behavioral health agency (BHA) through a Medicaid Service Provider model.[35] As for random moment time studies, states might reimburse school staff for administrative activities such as referrals, care coordination, and helping families apply for Medicaid.

School-based Medicaid Expansion. The landscape of school Medicaid funding has expanded over the last five years. According to the Healthy Students, Promising Futures (HSPF) Learning Collaborative, 25 states have opted to change their state policy to reimburse services beyond IEPs, representing tremendous progress.[36] More states have expanded their billing and have greater awareness of the potential of Medicaid as a funding stream, not only to support students with IEPs and students with disabilities, but to support mental and behavioral health services in school. In 2024, the Centers for Medicare and Medicaid Services (CMS) awarded school-based services grants to 18 states for the implementation, enhancement, and expansion of Medicaid and the Children's Health Insurance Program (CHIP) school-based services.[37]

Table 3.9. Communication and Collaboration Subcomponents

Communication and Collaboration Subcomponent	Description	Barriers to Operationalization
School Climate	School climate is the overall quality and character of school life. It includes the experiences of students, staff, and parents.[46] This area was expanded to also look at the school district, especially in terms of how the system is run, the environment it creates, and the strength and effectiveness of leadership.	Schools with poorer climate tend to have higher rates of discipline, social, emotional, and behavioral problems, and staff dissatisfaction.[46,47] Students with E/BD report significantly lower perceptions of school climate and higher rates of peer victimization than their peers without E/BD.[47] The overall ethos and values of a school can predicate buy-in for SBMH services, which is also in part an extension of the appetite of the district to support programming and allocation of resources. The level of stigma within the school climate around mental health, particularly for emotional and behavioral challenges, was noted by informants as an impeding factor for progress in better serving CYSHCN with E/BD.
Family Engagement	Active partnerships between the school and parents/caregivers to support and enhance mental health and the educational experience for CYSHCN with E/BD, fostering an open line of communication and collaboration to improve student outcomes.	Stigma can discourage help-seeking behaviors from students and families because of feelings of embarrassment, shame, or fear. Even the perception of stigma from other parents or other children and youth can cause families and CYSHCN with E/BD to self-isolate.[48] Furthermore, both students and families may be marginalized by their peers or bullied. Parents may withdraw or disengage from the school, which can be perceived as uncollaborative or uninterested in their child's situation, but may stem from their own struggle to cope. Further, families may not be informed as to how systems integrate, which can create barriers from a lack of communication. One informant noted families are not educated on the integration of the education and payor systems, leading families to be wary to bill for mental health services in school in fear or marginalization of their child if the school knows their mental health condition.[49]
Community Partners	Collaboration between the school and local supporting providers and organizations, as well as other child-serving systems (e.g., child services, law enforcement) to enhance the educational experience and well-being of CYSHCN with E/BD.	Education, medical, and community entities are not typically established for community integration to support SBMH. There are few examples of successfully enshrining school and community integration at scale. Further, while the state education department may make recommendations to LEAs or schools, localized entities have substantial autonomy. SBMH services provided within the school are most often focused on academic outcomes. Therefore, there are barriers to integrating supports, particularly in accordance with a more comprehensive care plan leading to services provided within the school context to be incomplete in supporting CYSHCN with E/BD. Related to collaboration with non-school based entities, mandated reporting has come under more debate for perpetuating racism and generational trauma.[50]

Professional Capacity

Professional Capacity refers to workforce factors that impact school staff and community providers to support the mental health of CYSHCN.

Literature Scan and KII Findings

Multiple components contribute to capacity, including the number of professionals, both SBMH professionals and education professionals, and training for non-mental health staff. Moreover, protecting the time of SBMH providers with specialized skill-sets is imperative to ending the burnout cycle. As one informant noted, that on top of her full case load, she was the one providing in-service training to school staff, only increasing her workload. Investing time and resources to strengthen training for teachers and school staff would alleviate some of the burden on school-based mental health professionals to address student needs and would also serve to empower teachers with a broader array of options in response to unwanted or unprovoked behavior. Without proper training, teachers often resort to discipline as their only option in response to a child or youth's behavior, even though the behavior may stem from an underlying mental health issue.[42]

Challenges with the workforce can take many different forms, from shortages to duplicative roles to insufficient training. First, challenges may arise from SBHCs being located within a health professional shortage area (HPSA). According to HRSA, 122 million people nationally are in HPSAs for mental health with over 6,000 practitioners needed to remove the HPSA designation.[43] In such areas where schools have a shortage of providers, professionals trained as adult psychiatrists may serve children and youth. Second, staffing complexities may also arise from overlapping and/or duplicative roles. Third, more people must be trained in school mental health to meet students' needs. The field lacks a clear definition of the necessary skills and knowledge, and this is exacerbated by lower enrollment in graduate programs.

Communication & Collaboration

Communication and Collaboration is essential for the successful operation and sustainability of MTSS, as it involves the coordinated efforts of educators, administrators, specialists, and families.

Literature Scan and KII Findings

Effective communication ensures that all interest holders are informed about each student's progress, interventions, and any adjustments needed for support. Regular meetings and transparent information sharing foster a shared understanding of goals and responsibilities, enabling a cohesive approach to addressing the needs of CYSHCN with E/BD. Collaboration allows for diverse perspectives and expertise to be integrated into the decision-making process, leading to well-rounded strategies that benefit learning and the well-being of CYSHCN with E/BD. This collective effort not only enhances the effectiveness of interventions but also builds a supportive community focused on creating optimal educational and mental health outcomes for all students.

The current quantity and quality to which interest holders communicate and collaborate is related to supporting CYSHCN with E/BD ranges widely. For example, some state Medicaid agencies involve families and youth to gather input on coverage decisions; however, the extent and focus of this engagement can vary, with feedback not always directly addressing SBMH services. One informant noted that they sometimes hesitated to refer a child for services outside the school setting if they knew the family could not afford it or if it was unlikely that the child would attend the appointment. Additionally, informants with lived experience shared a spectrum of emotions regarding interactions with law enforcement and child services, often characterized by fear and anxiety, given the historical role these entities have played in family dynamics. These interactions can be especially overwhelming for caregivers who may already be experiencing burnout while managing multiple demands and can lead to less productive forms of collaboration than possibly intended.

State Medicaid Findings

States reported engagement with a range of interest holders using varied approaches in the process of defining, planning, and/or implementing Medicaid policy for school-based mental health care for CYSHCN with E/BD. All five states held ad hoc committee meetings with their respective Department of Education, four held ad hoc committee meetings with their key partners systems (e.g., courts, tribes, community service providers), and three met with schools and LEAs. Four of the five states indicated engaging families and youth in some capacity, often through one or more of the following methods: formal focus groups, qualitative interviewers, and/or surveys. Additionally, one state had ad hoc committee meetings with families and another included families in standing state committees with appointments made by leadership. In the listening session, participants raised that while some states may have relevant advisory committees—such as for children with medical complexity (CMC)—they may lack a mechanism to address SBMH services for the population of CYSHCN with E/BD more specifically.

One state in attendance of the listening session described extensive engagement that included meeting with school-based services and health care services, staff counselors, LEAs, tribes, children and youth behavioral health workgroups, and other state agencies. These efforts enabled the identification of opportunities to expand services and help schools bill Medicaid.

4. Discussion

This environmental scan describes the current state of knowledge related to SBMH services for CYSHCN with E/BD, calling attention to pressing issues of operationalization, where barriers and evidence gaps exist that could be addressed through future research. This work surfaced a number of key considerations and gaps in knowledge and/or consensus that must be addressed to better support SBMH for CYSHCN with E/BD. These considerations are provided in the sections below. Our findings outlined above combined with these considerations lay the foundation for future research on this topic.

4.1 Refine the population definition

Creating a comprehensive, universal, inclusive definition of the children and youth who would benefit from SBMH services for emotional and behavioral needs remains vital to creating systems and policies that enable high quality service provision. Clarifying this population in a manner that is both intelligible and actionable across diverse interest holders and programs enables the field to gain a better understanding of the issues at hand and how to then allocate resources accordingly. To do so, decision-making interest holders must be able to identify the children and youth that they are serving both within and across programs as to not duplicate or misalign services. Grounding the population more concretely, whether via diagnoses or based on the impact that a student's emotional and behavioral needs have on their life and educational journey, informs the type of data that is collected via screening and assessment, and ultimately how services are delivered. Furthermore, clearly identifying the population informs the infrastructure needed to deliver high quality services and shapes considerations around feasibility, reliability, and validity.

Some of the complications that accompany articulation of a population definition are the tradeoffs present in determining a level of specificity that enables effective, targeted distribution of resources while still retaining a broad enough conceptualization that minimizes the risk of excluding children and youth who would benefit from SBMH services but do not fall within the drawn lines. Both CYSHCN and E/BD are umbrella terms that imperfectly attempt to navigate a complex web of medical, psychological, and educational considerations. CYSHCN with E/BD include wide variance in conditions, from asthma and diabetes to autism and cerebral palsy, which are associated in particular with E/BD, as well as diagnoses such as anxiety disorders, depression, conduct disorder, and oppositional defiant disorder.[8] Complications further arise because psychological issue identification diagnoses rely on behavioral assessments and psychiatric evaluations, which can be subjective and influenced by factors such as cultural and environmental context. The variability in symptoms and their severity further complicate the diagnostic process.

Moreover, the impact of these conditions on a child's daily life and the level of care required can vary significantly, adding another layer of complexity in defining and categorizing these needs. Informants reiterated that children and youth show up as themselves, both inside and outside of the school setting, thus demanding a definition that addresses the needs of a child and youth wholistically and includes medical treatment, therapy, and often educational and social support.

The intersection of health care and educational systems adds a distal layer of complexity in defining and addressing the needs of CYSHCN with E/BD. Additionally, the broader definitions must factor in socioeconomic variables such as access to quality healthcare and education, which can impact diagnosis and the level of care that children and youth receive. Consequently, achieving a clear and unified definition requires collaboration across fields to ensure that the specific needs of these children and youth are adequately met, emphasizing the importance of tailored approaches over broad categorizations.[51]

4.2 Center youth and family engagement

The significance of centering youth and families in SBMH services for CYSHCN with E/BD emerges as a pivotal theme in the discourse on effective mental health interventions. One of the limitations of the MTSS is that the focus of the system is not inherently centered on students and families but on the functioning of the system of services. Involving these primary interest holders in both design and implementation processes ensures that the services provided are not only relevant, but also culturally engaged and contextually appropriate. Evidence from diverse educational contexts suggests that interventions tailored to the specific needs and experiences of students are more likely to engage them effectively. This engagement is crucial for students with E/BD, who may often feel marginalized within traditional educational settings.[25,52]

By integrating the voices and perspectives of students and their families, schools can mitigate the common disconnect between available services and the actual needs of students, contributing to improved outcomes. Ideally, schools would not only invite, but actively incorporate, these perspectives into the decision-making processes. Despite recognizing this need, significant barriers persist, primarily due to the complexities inherent within school bureaucracies and a lack of accessible pathways for interaction for non-professional interest holders. However, promising opportunities lie in leveraging existing structures, such as parent-teacher associations and community organizations, which possess established networks. By focusing on capacity-building initiatives, such as workshops and informational sessions, schools can equip families with the necessary tools to navigate and influence these structures effectively. Continued exploration and documentation of successful participatory initiatives will be pivotal in advancing this critical aspect of school-based mental health strategies.

Further, when students and their families are active participants and partners in decision-making regarding mental health services, there is an increased sense of ownership, empowerment, and increased wellbeing. Such participation enhances motivation among students to engage actively with service providers and interventions, which is particularly pertinent for CYSHCN with E/BD, who may have previous experiences of exclusion or misunderstanding. Engaging families as partners in this process fundamentally strengthens the student's natural support network at school, at home, and within the community they live in, fostering an environment conducive to positive mental health outcomes both at school and at home.

This participatory approach also addresses practical considerations by bridging the gap between school-based resources and the home environment. Families provide critical insights into home dynamics and external influences on a student's mental health, enabling a more comprehensive understanding of the factors at play.[53] This knowledge allows for the development of interventions that consider the student's entire ecosystem, thereby facilitating continuity of care across settings. The evidence suggests that when school strategies are aligned with support processes at home, there is a notable improvement in the consistency and effectiveness of mental health interventions.

Finally, the adaptability and relevance of school-based mental health services are maintained through continuous engagement with CYSHCN with E/BD and families. Regular feedback mechanisms enable schools to refine and adjust services to keep pace with the evolving needs and circumstances of students. This dynamic approach is critical as it prevents the potential stagnation of mental health programs and ensures their ongoing efficacy. As educational and societal contexts continue to evolve, maintaining open channels of communication with families and students ensures that interventions remain aligned with current realities, ultimately fostering resilience and long-term positive outcomes for students with E/BD.

4.3 Build on existing best and promising practices

Building on existing best and promising practices for SBMH services for CYSCHN with E/BD involves refining evidence-based frameworks, such as the MTSS, and scaling promising practices to better address the diverse needs of this population. Several informants pointed out that the field has gained a deeper knowledge base over the past several decades and it is important to build from that foundation.[54] For example, Child Study Teams (CST) in which the child meets with school staff such as the school nurse/nurse practitioner from the SBHC, the guidance counselor, assistant principle, and/or additional staff as needed, are a promising practice for providing collaborative services. Regular meetings of the CST enable school staff to bridge the divide between physical health, mental health, and the school environment (e.g., the classroom), allowing for a more holistic approach in understanding the student and their behaviors.[55] Successful models also typically feature a champion for children within the school, be it the classroom teacher or classroom aide, the school nurse, the guidance counselor, and/or a coach. Many practical guides have been created for implementation of SBMH services and it is important to continue to use, refine, and study approaches to further identify best practices.[56-61]

Additionally, schools can leverage technology-driven promising approaches to expand access to mental health resources, ensuring that all students receive the appropriate level of care and support. Expanding on the use of technology and digital platforms offers significant potential for enhancing school-based mental health services. Introducing online resources, telehealth services, and digital self-help tools can provide CYSHCN with E/BD greater access to mental health support, particularly in underserved or rural areas where in-person services might be limited. Leveraging technology also facilitates greater personalization, allowing interventions to be tailored to the specific needs and preferences of students. Human centered design has been cited as a promising way to engage students in development of these types of interventions. However, it is essential to ensure that these technological solutions are implemented with careful consideration of data privacy and accessibility issues, providing equitable access to all students.

Implementation science has been used more recently to identify best practices in SBMH services by providing a structured approach to evaluating and improving how interventions are applied in real-world settings. Through its emphasis on bridging the gap between research and practice, implementation science examines the various factors that influence the effective delivery of mental health services within schools, such as organizational culture, staff training, and resource allocation.[5] By using evidence-based frameworks and methodologies, this field has helped identify which strategies work best in different school environments and why, leading to the development of more robust and contextually relevant mental health services. Further, through continuous monitoring and feedback mechanisms, implementation science approaches facilitate the adaptation of these interventions to meet the evolving needs of students, ensuring that practices remain dynamic and grounded in empirical evidence. This iterative process of assessment and refinement underscores the importance of implementation science in establishing and maintaining high-quality, effective mental health supports in educational settings that are appropriate for CYSHCN with E/BD.

In building upon existing best and promising practices, it is important to avoid creating additional silos in addressing mental health needs for CYSHCN with E/BD. This entails avoiding the duplication of services or adding services that are counter to what has been planned for the child or youth. The model of the medical care home is a promising illustration of delivering family-centered, comprehensive, coordinated, and culturally effective care, integrating various services. Placing the family at the center of the care team empowers parents and caregivers to participate actively in decision-making and care planning, which can lead to more effective care management. Ideally, providers and supports, including pediatricians, as part of the medical care home are attuned to an individual child's needs, as well as the federal, state, and local policies that could align those needs with services, such as access to IEP or 504 plans.[62,63] Integration of school-based services in the medical home model is important, while recognizing that not all CYSHCN will have a medical home with which to coordinate.

4.4 Explore funding opportunities within and beyond Medicaid

As the Medicaid funding landscape continues to undergo significant changes, careful consideration of additional funding sources to support the provision and sustainment of SBMH services for CYSHCN with E/BD is needed.[39] A survey conducted by the Healthy Schools Campaign and its partners in 2025 highlighted the many ways in which school districts use Medicaid funds, such as (1) supporting salaries for school health staff and personnel (e.g., school nurses, school psychologists, etc.), (2) for mental and behavioral health contracted services, (3) for assistive technology and specialized equipment for students with disabilities, (4) for care coordination and referral services, (5) for Medicaid outreach and enrollment services, and (6) for telehealth.[39] Consequently, Medicaid cuts can have a notable impact on a school district's budget and lead to the reduction of school mental and behavioral health services and school staff and personnel. This includes the reduction of preventative care and early intervention services such as screenings.

The increased resource scarcity is also being felt within education, raising the alarm on devasting effects for public school students with disabilities and students with mental or behavioral health needs. At the time of this writing, dismantling the Department of Education disrupts the department's ability to enforce critical civil rights laws including IDEA and Section 504 as well as disrupting congressionally mandated IDEA funding to states.[41] Although state and local governments provide the majority of funding for K-12 schools, federal funding is important in supporting schools' abilities to provide special education under IDEA and Section 504. Additionally, acknowledging that students in this population are already underserved by services covered by an IEP or 504 plan, and therefore creative solutions are needed to address the needs of CYSHCN with E/BD. The road ahead for improving SBHM services for CYSHCN is difficult, but not impossible, and there are opportunities to be found among the challenges. For instance, the shifting funding landscape encourages interest holders to strengthen existing partnerships and seek out new relationships with other sources of funding for SBMH services and staffing. Navigating the path forward will require building trust, alongside sources of funding.

Even in a time of resource scarcity, further identifying the needs of CYSHCN with E/BD can prompt alternative paths for funding, particularly by couching these needs as part of chronic issue management, prevention, or administrative unburdening. One way this scan uniquely builds on the literature is with information collected with Medicaid agencies. Survey respondents and listening session attendees were asked what, if any, additional SBMH services their state Medicaid agency might like to provide CYSHCN with E/BD that are not currently eligible for Medicaid reimbursement. Three of the states surveyed expressed interest in expanding the types of licensures covered. States further indicated interest in expanding the types of services that are eligible, and two states indicated interest in more comprehensive care coordination and case management services between health and education professionals as well as among health professionals. In addition, listening session participants raised goals around simplifying the reimbursement process and reducing administrative burden for schools trying to access Medicaid funding. For example, having multiple ways for schools to receive Medicaid reimbursement can prove a confusing and difficult process to navigate, such as in the case of LEAs contracting with potentially multiple managed care plans. Identifying underlying needs allows for the possibility of sourcing previously untapped funding and leans away from assumptions that needs will be covered by more traditional funding sources, thus allowing for a reframing of priorities in care.

States, districts, and schools will need to be ever more exact with utilizing braided funding to finance their services and staffing. Informants highlighted several funding mechanisms, including: (1) expanding State Plan Amendments to allow for drawing down more funds for SBMH services, (2) expanding state Medicaid plans to include a broader array of providers to support reimbursing school psychologists and counselors for mental health work in schools, (3) requiring commercial insurers to pay for SBMH services, and (4) investing in mental health promotion and prevention supports in schools.

Additionally, there are examples of steps that states have already taken to support school-based services that utilize funding in unique ways. For instance, states such as New Mexico have joint positions between their Medicaid agency and education agency, with strong commitment and dedicated resources in both entities. School districts are brought in regularly to discuss the Medicaid School-Based Services (MSBS) program and policies, providing real-time and direct insight into the implementation process. In addition to funding mechanisms, considering the recipients in a whole-child model also highlights alternative opportunities to improve school-based mental health services. More funding and support for culturally based interventions would help shift away from psychopathology-driven models towards leveraging assets of the community (e.g., positive use development), which can be especially significant for students and families from historically marginalized communities.

5. Next Steps

This environmental scan provided background for the Thriving in School project's Consensus Convening, a half-day virtual event that brought together a wide range of interest holders spanning CYSHCN families, researchers, school-based providers, educators, and state policymakers. The synthesis and summary of findings from data collection supported the development of an action-oriented, CYSHCN-driven agenda by defining preliminary key areas of research. Next steps include the creation of a prioritized research agenda which will reference findings from this environmental scan but primarily focus on the methods and findings of the Consensus Convening and prioritization process. The resulting agenda will provide a national roadmap to address CER gaps in school-based mental health services for CYSHCN with E/BD.

6. Appendix

Table 6.1. Literature Search Research Questions

Guiding Questions
1. What, if any, evidence gaps exist related to school-based mental health services for CYSHCN?
2. What, if any, best or emerging/promising practices have been identified for implementing school-based mental health services for CYSCHN?

Table 6.2. Literature Search Key Search Terms for PubMed

Search Terms for PubMed Search	
"children with medical complexity" AND "mental health"	*"serious emotional disturbance" AND "school" AND "mental health"*
AND	AND
"conduct disorder" AND "school" AND "mental health"	*"children with disability" AND "school" AND "mental health"*

Table 6.3. Literature Search Key Search Terms for Google Scholar

Search Terms for Google Scholar Search	
"emotional and behavioral disorder" and "school" and "mental health"	*"serious emotional disorders" and "school" and "mental health"*
AND	AND
"emotional and behavioral disorder" and "school" and "mental health" and "equity"	*"school-based mental health" and "emotional and behavioral disorder" and "trauma"*

Table 6.4. Literature Search Inclusion/Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Was published/developed in the last ten (10) years: 2015 – 2025 • Systematic Reviews • White papers, grey literature, practical guides	• Is not published in English • Books and book chapters • Does not include US-based health care or education systems • Does not include public school-based mental health care (i.e. home-schooling or alternative schooling) • Pre-school or post-high school education levels

Table 6.5. Forms of Engagement Used by Survey Respondents

Interest Holder	Standing State committee with appointments made by leadership	Ad hoc committee meetings	Formal focus group	Surveys	Qualitative interviews	Not engaged
Families	X	X	X	X	X	X
Youth			X	X	X	X
Providers	X	X		X	X	X
Schools/LEAs*	X	X	X	X		
Department of Education	X	X	X	X		
Key partner systems**	X	X	X	X	X	X

*Local education agencies
**For example, courts, tribes, community service providers.

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