Thriving in School: A Patient-Centered Comparative Effectiveness Research Agenda on School-Based Mental Health for Children and Youth with Special Health Care Needs (CYSHCN)

Research Agenda Report

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Prepared By:
Jaime Adler, MS, MPH; Sarah Weinberg; Taylor Dunlap; Jean O'Connor, JD, MPH, DrPH; Steph Lomangino, LMSW; Oneyda Arellano, PMP, CHES; Elizabeth Cope, PhD, MPH

Contributions from:
Thriving in School Project Steering Committee

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About Family Voices

Family Voices is a national family-led organization and grassroots network that transforms systems of care to work better for all children and youth, especially those with special health care needs or disabilities. Family Voices promotes partnership with families, including those of cultural, linguistic, and geographic diversity. By putting families at the forefront and centering their leadership and lived expertise, we build a culture that includes everyone and fosters equitable outcomes.

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Introduction

Children and youth with special health care needs (CYSHCN) face significant challenges that can lead to poor health and education outcomes. According to 2019-2020 data from the National Survey of Children's Health (NSCH), CYSHCN are more likely than non-CYSHCN to have unmet health care needs across all types of care including medical, dental, vision, and hearing.[1] Notably, mental health care had the widest gap in terms of unmet needs. Although research increasingly indicates that school-based mental health (SBMH) services are an effective way to improve access to mental health care,[2] more evidence is needed on how best to coordinate and adapt SBMH services to meet the needs of CYSHCN.

AcademyHealth, in partnership with Econometrica and Family Voices, launched a 12-month project in November 2024 to unite lived and learned expertise through a national agenda-setting exercise. The resulting research agenda encompasses CYSHCN with emotional and behavioral needs alone or in combination with physical and developmental needs. The project aimed to re-focus the field and build the evidence needed via three main project objectives:

1. Identify key patient-centered comparative effectiveness research (CER) gaps, which impact decision-makers, in SBMH programs serving CYSHCN.
2. Build capacity to enhance the evidence base through interest holder relationship building and a participatory patient-centered CER topic generation/prioritization process.
3. Co-develop with interest holders, and promote the conduct of, a national, coordinated research agenda designed to address identified patient-centered CER gaps in SBMH programs serving CYSHCN.

This report presents a prioritized research agenda to address the most pressing evidence gaps regarding SBMH for CYSHCN with emotional and behavioral needs. It supports efforts to navigate high variability of SBMH services to better identify what strategies and interventions are most effective for these students.

Background

The Health Resources and Services Administration (HRSA) defines CYSHCN as those who have or are at increased risk for having chronic physical, developmental, behavioral, or emotional conditions.[3] This diverse population has distinct needs, unique challenges to accessing well-functioning systems of care, and may require specialized health and educational services to thrive. CYSHCN comprise approximately one-fifth of children and youth in the United States,[4] though the prevalence is likely higher given that not all children and youth with diagnosed conditions and functional difficulties are identified by the five-item screener used in the NSCH.[5] Eight of the top ten conditions experienced by CYSHCN are categorized as developmental, mental, or behavioral conditions.[4]

This project focused on *CYSHCN with emotional and behavioral needs*, a group which has significant overlap with students who may have one or more of the following educational designations: a Special Education student; a student with an Individualized Education Program (IEP); a student with an Individualized Family Service Plan (IFSP); or a student with a Section 504 Plan (504 plan). Students do not need to have one of these educational designations for inclusion in this population to account for those who may not have yet received a designation. Given that there is no standardized definition for this subpopulation, this project proposed five components of a *CYSHCN with emotional and behavioral needs* to help ground future research related to SBMH, including:

- **Age range of children and youth:** The population spans school-aged children and youth (typically 6-17 years of age for students in Kindergarten through 12th grade) to capture those who are typically within public school settings and thus be more likely to receive SBMH services.
- **Physical conditions:** Children and youth with mental health needs disproportionately also have physical medical needs. Examples of physical health conditions include asthma, sickle cell disease, and epilepsy.
- **Emotional/behavioral conditions:** Chronic emotional/behavioral conditions can be internalized (e.g., anxiety, depression) or externalized (e.g., hyperactivity, impulsivity) and may negatively impact a student's academic performance, interpersonal relationships, and/or cause disruptions in the classroom.
- **Care and service needs:** Children and youth with mental health needs have elevated need for, but potentially insufficient access to, care and service. For example, the child or youth may use or have need of prescription medication and/or specialized therapies due to a chronic health condition.
- **Mental health care use:** The children and youth in this population have above average and/or ongoing utilization of mental health services. 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. Similar to care and service needs, a student may have need for mental health services but face barriers preventing them from accessing these services to meet those needs.

The priority subpopulation of CYSHCN with emotional and behavioral needs was selected after extensive conversation due to the elevated risk of these children and youth falling through service gaps. More broadly, this target subpopulation emerged due to current events of increased school violence, increased self-harm or suicidality, lower graduation rates, under-diagnosis due to stigma or fear by the family, challenges posed to educators, and the substantial potential impact of filling current evidence gaps.[6,7] Supporting researchers in defining their cohort in a manner that is meaningful and actionable in both school and clinic settings can assist in better aligning program and policy with this subpopulation's needs.

Examples of this subpopulation include:

- A 14-year-old student with a significant history of school absenteeism and diagnoses of social anxiety disorder and attention deficit hyperactivity disorder;
- A 17-year-old with diabetes, adjustment disorder, and substance use disorder;
- A 10-year-old with prematurity, cerebral palsy, hyperactivity, and aggression; and
- A 6-year-old with Autism Spectrum Disorder and language delay.

Approach

This project followed a three-phased process: (1) scoping and framing, (2) ideating and validating, and lastly, (3) activating and sustaining (**Figure 1**). An iterative, participatory approach was used to guide engagement and development of research questions that are responsive to patient needs, relevant to school-based implementation, and amenable for downstream uptake in Medicaid policy. At each step of the process, participants included a diverse composition of interest holders including CYSHCN families or caregivers, researchers, school-based providers, educators, and state policymakers.

I. Scope & Frame

The project team first established a Steering Committee comprised of 11 experts to provide strategic oversight and methodological guidance throughout the project (see **Appendix I** for the full roster). The project team then conducted an environmental scan to scope and frame the project, mapping out gaps in the current landscape of SBMH services for CYSHCN to guide the agenda-setting process.

Steering Committee. The group met virtually four times over the course of the project; the first meeting was split into two sessions to accommodate scheduling. Steering Committee members also provided asynchronous review of materials in-between meetings. They brought lived experience and expertise in behavioral pediatrics; child and adolescent psychiatry; child- and family-serving systems; CYSHCN family advocacy, policy, and practice; implementation science; Medicaid; Maternal and Child Health Title V policy; school mental health services; school-based health practice and policy; service system design; and sustainable financing. Overall, Steering Committee members represented a range of perspectives with attention given towards gender, racial, and ethnic diversity as well as geographic diversity.

Environmental Scan. To gather existing information on SBMH services for CYSHCN with emotional and behavioral needs, a multi-step approach was used. First, AcademyHealth conducted a literature scan of peer-reviewed, grey literature, and adjacent research agendas. Key informant interviews were then held with individuals who brought lived experience and expertise in behavioral pediatrics, CYSHCN family advocacy, Medicaid policy, and SBMH policy and practice. Lastly, AcademyHealth administered a survey to geographically diverse state Medicaid policymakers and then supplemented responses with qualitative data collection via a listening session. A thematic analysis was conducted to identify common themes across findings, allowing for the organization of information into draft research domains that would inform materials for the Consensus Convening (described below).

The environmental scan further served to (1) map the current state of SBMH for CYSHCN to essential and connecting components of the Multi-Tiered System of Supports (MTSS) framework, (2) outline known barriers to operationalization and opportunities for further inquiry to improve services, and lastly, (3) raise key considerations and gaps in knowledge and/or consensus that must be addressed to better support this population. The full environmental scan, *Thriving in School: Environmental Scan of School-Based Mental Health for CYSHCN*, is available on AcademyHealth's website.

Figure 1. Three-Phased Project Approach

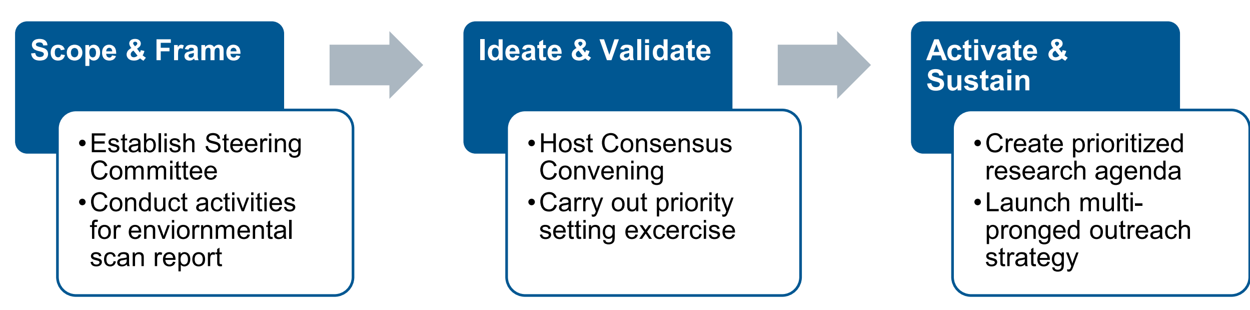


Exhibit 1. Project Engagement Overview (January—August 2025)

	Steering Committee	Key Informant Interviews	Survey & Listening Session	Consensus Convening	Codigital Ideation & Prioritization
Date	January, February, May & September	April	April & May	July	July–August
Purpose	Guide the overall project with lived and learned expertise	Confirm preliminary findings from literature scan and illustrate the most important gaps as seen by families, researchers, and practitioners	Provide insight into gaps that are most impactful/ relevant to state-based Medicaid policymaker priorities	Define key research domains and identify driving and restraining factors for successful adoption and implementation of the research agenda	Generate, refine, and prioritize research questions for the research agenda
Participants	11 Members	9 Interviews	18 States*	33 Participants	27 Participants

*Survey respondents (n=5 states) and listening session participants (n=15 states) with two states participating in both.

II. Ideate and Validate

The second phase of the project centered on defining and then refining research domains. The domains were then used to structure the generation and prioritization of research questions.

Consensus Convening. In July 2025, approximately 30 interest holders gathered for a virtual, three-hour convening to support (1) the development of an action-oriented agenda by defining key areas of research and (2) the sustainability of the agenda by identifying driving and restraining factors related to advancing the agenda. The project team facilitated breakout groups wherein participants focused on a respective draft research domain, allowing these small groups to collaboratively workshop the domain description and begin ideating on potential topics for research questions. Afterwards, participants shared and reacted to proposed revisions to the domain descriptions as a full group. The full group also collectively identified driving and restraining forces for implementing the research agenda (available in **Appendix III**). Steering Committee members, along with 25 newly invited participants, represented a range of interest holders spanning CYSHCN youth and family advocates, researchers, school-based providers, educators, and state-based policymakers. Following the convening, the project team further refined the description of the target population and revised the research domains based on the feedback received.[i] Two new research domains, Equity and Youth/Family Engagement, were added to the original five.

i The population was initially narrowed to focus on CYSHCN in K-12 public schools who have emotional and behavioral disorders or disturbance (E/BD) as defined in the Individuals with Disabilities Education Act (IDEA). This framing was broadened to *emotional and behavioral needs* following the July Consensus Convening wherein participants reflected that E/BD terminology is often tied to Special Education and might not adequately capture the breadth of CYSHCN who could benefit from SBMH services.

Codigital Prioritization. Between July-August 2025, all Steering Committee members and Consensus Convening participants were invited to participate in an asynchronous ideation and prioritization process using an online platform, Codigital. Additional youth and family advocate perspectives were invited to strengthen representation of that interest holder group. The Codigital platform enabled a multi-sector audience to iteratively and collaboratively generate research questions for each of the seven domains. Over 150 questions were generated by 22 participants in the first round, which ran for eight business days. The project team then curated, streamlined, and de-duplicated the research questions, resulting in 24 participants ranking 120 questions in the second round across six business days. Participants were asked to prioritize research questions based on the following criteria:

- **Relevance:** The evidence generated will be readily usable by CYSHCN families, school-based practitioners, and policymakers to better serve CYSHCN with emotional and behavioral needs.
- **Responsiveness:** The evidence generated will be directly responsive to needs/gaps identified by interest holders (e.g., youth and family advocates, researchers, practitioners, etc.).
- **Feasibility:** Valuable evidence will be generated given effort, infrastructure, time, and resource requirements.
- **Impact:** The evidence generated will lead to measurable improvements in SBMH services, systems, and outcomes for CYSHCN with emotional and behavioral needs.

Ranking based on these criteria positioned the agenda to emphasize feasibility and impact to establish a clear roadmap appropriate for research, practice, policy, and advocacy. Participants ranked questions through a series of randomized pairwise comparisons within each domain. They were prompted to select which question was

more important to address, leading to the questions either rising or declining in the ranking. The process was cumulative across participants, reflecting the group's collective input.

Once the prioritization process concluded, the project team re-reviewed the research questions to ensure that they were framed to support patient-centered CER. Questions were additionally re-shared with the Steering Committee for input. The project team then compiled the final prioritized research questions.

III. Activate and Sustain

In the third and final phase, results were analyzed and synthesized to create the research agenda. The project team, in collaboration with the Steering Committee, additionally created and executed a multi-pronged dissemination strategy to reach key audiences and support the actionable use of the agenda.

Final Agenda. This research agenda serves as a strategic blueprint guiding the direction and priorities of patient-centered scholarly inquiry. The domains and questions created throughout the Ideate and Validate phase are meant not only to focus the efforts of researchers, but also foster collaboration and alignment among interest holders, funding bodies, and policymakers. Furthermore, this research agenda is meant to enhance the impact of research by ensuring that investigations are relevant and timely, thus contributing to informed decision-making and innovation in SBMH services for CYSHCN with emotional and behavioral needs. By providing a clear sense of purpose and direction, this research agenda is a tool to focus resources, including time, talent, and funding, ultimately advancing the collective understanding and progress of SBMH services for this population.

Outreach Strategy. Disseminating a research agenda is a critical step that involves sharing the strategic priorities and directions of research with a broader audience to foster understanding, collaboration, and support. By actively promoting the research agenda, researchers can attract interest, secure funding, and build networks, thus enhancing the agenda's influence and impact. Additionally, widespread dissemination helps align diverse research efforts under common goals, streamlining efforts toward innovative solutions and advancing knowledge in the field. Key considerations for dissemination and uptake of the agenda were discussed during the Consensus Convening and a summary can be found in the Force Field Analysis in **Appendix III**.

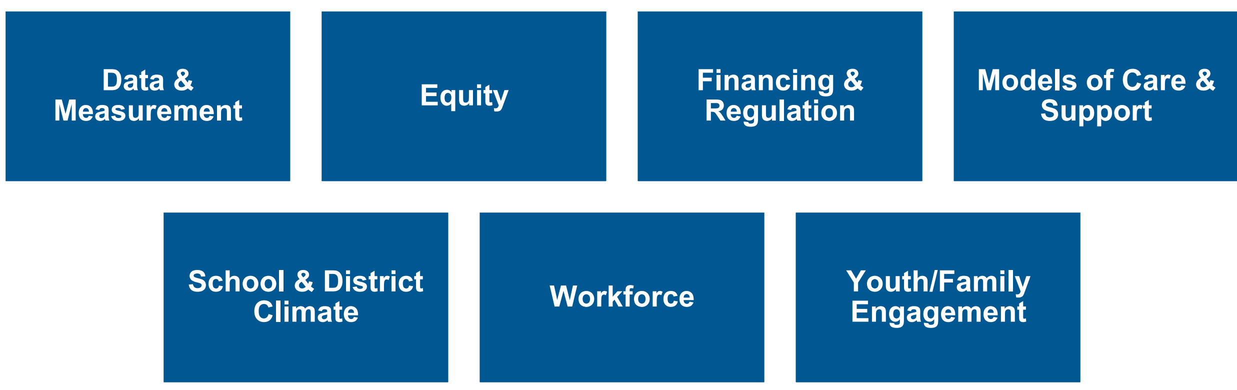
A publicly available dissemination toolkit is available on the program page to support ongoing dissemination of this research agenda.

Results

Seven research domains emerged from this participatory agenda-setting process, including: (1) Data and Measurement; (2) Equity; (3) Financing and Regulation; (4) Models of Care and Support; (5) School and District Climate; (6) Workforce; and (7) Youth/Family Engagement (**Figure 2**). The prioritized research agenda features the top five ranked research questions for each domain (n=35 research questions), with the full list of 120 prioritized questions available in **Appendix II**.

For each domain, we present key themes and prioritized research questions identified through a consensus-driven process that centered the voices and needs of children, youth, families/caregivers, and communities. This curated set of prioritized questions serves to both highlight knowledge areas of importance as decided upon by participants as well as provide a digestible number of questions that can offer enough specificity to address knowledge gaps for that research area.

Figure 2. Research Domains



Data & Measurement

This domain explores how interest holders involved with SBMH services might collect, share, analyze, and use individual- and population-level data. Data collected within the school and shared between the school, district, and state levels can help address gaps in mental health care, support better SBMH services, and improve clinical and academic outcomes for CYSHCN with emotional and behavioral needs with the proper infrastructure.

Participants prioritized areas of evidence generation that highlighted the need for comprehensive data infrastructure that ensure effective data management and utilization to improve SBMH services for CYSHCN with emotional and behavioral needs. The prioritized questions further emphasized context-specific considerations in evaluating access, quality, and outcome measures across school settings.

Table 1. Key Themes from the Data & Measurement Research Questions

Key Theme	Description
Data Collection, Measurement, and Monitoring	• Defining, measuring, and tracking mental health status and school-based mental health (SBMH) service gaps for children and youth with special health care needs (CYSHCN) with emotional and behavioral needs.
Data Infrastructure, Interoperability, and Sharing	• Building systems that capture and integrate educational, health, and behavioral data for CYSHCN with emotional and behavioral needs. • Enabling secure exchange between schools, CYSHCN families, mental health agencies, and service providers.
Governance, Ethics, and Trust	• Addressing privacy, consent, and data-ownership concerns unique to CYSHCN with emotional and behavioral needs in schools (e.g., when multiple caregivers, care teams, and educational settings are involved). • Building trust with CYSHCN and their families/caregivers to support data collection.
Barriers, Facilitators, and Resource Needs	• Understanding the policy, technical, and workforce factors that either support or hinder the use of integrated data for SBMH efforts for CYSHCN.
Application of Data for Equity, Intervention, and Outcomes	• Using collected data sets to track disparities, guide culturally and linguistically appropriate interventions, and evaluate outcomes such as academic engagement, mental health status, and care coordination for CYSHCN.

Table 2. Prioritized Research Questions for Data & Measurement

Top 5 Research Questions for Data & Measurement
1. What infrastructure and resources (e.g., financing, staffing, technology, policies for gaining consent) are most effective in supporting the collection and use of secure, high-quality data across school systems for CYSHCN with emotional and behavioral needs?
2. What measures of access, quality, intermediate outcomes (e.g., school attendance), and/or long-term outcomes (e.g., high school graduation) are most critical for evaluating SBMH services, and under what circumstances do they best inform service improvement?
3. What are the most valid, reliable, and feasible instruments that can be used to collect mental health data from the school and school system for the purpose of sharing with relevant interest holders and policymakers?
4. What measures and instruments should be used to identify CYSHCN who could benefit from SBMH services and support their needs, monitor change over time, and assess intervention outcomes at each tier of the MTSS framework?
5. What barriers and facilitators influence the effective collection and use of high-quality data within schools and across service systems (including financial, cultural, and social factors)?

Equity

This domain focuses on the fair delivery of SBMH services for CYSHCN with emotional and behavioral needs and the prioritization of equitable education and mental health outcomes to promote the health and wellbeing of all children. Drivers of equitable and inequitable access, quality, and outcomes are all included, along with effective strategies for achieving equity.

Prior to the Consensus Convening, equity was positioned as a cross-cutting theme among the domains. It emerged as its own distinct research area due to the importance of working towards fair and just delivery of SBMH health for CYSHCN with emotional and behavioral needs. Furthermore, positioning equity as its own domain allowed participants to generate focused research questions to unearth greater nuance on how best to serve a subpopulation of students that encompasses a diverse and complex range of needs and experiences. This includes, but is not limited to, understanding how CYSHCN—especially those from racially, linguistically, and/or economically marginalized groups and immigration statuses—experience gaps in referral, service availability, and treatment effectiveness within SBMH systems.

Table 3. Key Themes from the Equity Research Questions

Key Theme	Description
Equity in Access, Quality, and Outcomes	• Understanding how CYSHCN—especially those from racially, linguistically, or economically marginalized groups—experience gaps in referral, service availability, and treatment effectiveness within SBMH systems.
Cultural Responsiveness and Reducing Stigma	• Designing and evaluating interventions and systems that reflect CYSHCN students' cultural, linguistic, and community contexts.
Student, Family/Caregiver, and Community Voice	• Incorporating the lived experiences of CYSHCN, families/caregivers, and historically excluded communities into research design, policy development, and service delivery.
Evidence-Based Interventions and Early Identification	• Determining which screening tools and interventions work best for identifying and supporting CYSHCN's emotional and behavioral needs—particularly those in under-resourced schools or marginalized populations. • Ensuring timely, coordinated care that is provided by a trusted workforce.
Systems, Implementation, and Sustainability	• Building durable SBMH infrastructures that integrate medical, behavioral, and educational supports for CYSHCN with emotional and behavioral needs. • Adapting to shifting policy, reimbursement, and funding constraints.

Table 4. Prioritized Research Questions for Equity

Top 5 Research Questions for Equity
1. What implementation strategies are most effective in ensuring equitable SBMH support for CYSHCN with emotional and behavioral needs (e.g., equity audits, disaggregated data reviews)?
2. What training and professional development approaches most effectively prepare SBMH providers to deliver timely, equitable, and culturally responsive care to CYSHCN with emotional and behavioral needs?
3. How do school funding and resource allocation affect the equitable availability of SBMH support for CYSHCN with emotional and behavioral needs?
4. What existing strategies or mechanisms have schools used to successfully support SBMH services despite school funding disparities?
5. Which available SBMH interventions are the most effective at improving health outcomes among marginalized CYSHCN with emotional and behavioral health needs?

Financing & Regulation

Financing and costs for SBMH services for CYSHCN with emotional and behavioral needs includes consideration of federal, state, local, and private funds including Medicaid reimbursements and other sources. *Regulation* of SBMH services for this population that are consistent with community values require adherence to policies and reporting structures dependent on the financing source, in addition to the medical and legal responsibility of team-based care. No implementation of finance and regulation activities were completed during this project's engagement award term. Rather, this represents another research domain and the collectively developed and prioritized research questions.

Participants prioritized areas of evidence generation related to optimizing funding strategies, school-community partnerships, and billing processes to improve SBMH service delivery for CYSHCN with emotional and behavioral needs. More specifically, they honed in on research questions about strategies for blending and braiding funding to improve the comprehensiveness and sustainability of services, the impact of variation in funding streams on SBMH service availability and quality, and practical and financial supports needed for schools to bill Medicaid and commercial insurance. Participants also expressed interest in more evidence around the cost-effectiveness of implementing SBMH services for CYSHCN within MTSS across each tier level (universal, targeted, and intensive).

Table 5. Key Themes from the Financing & Regulation Research Questions

Key Theme	Description
Funding Sources and Financing Models	• Investigating how funding streams (e.g., Medicaid, federal, state, local, private) support SBMH services for CYSHCN with emotional and behavioral needs, how financing structures vary, and the effects of these variations on service availability and quality.
Equity, Access, and Sustainability	• Examining how variations in reimbursement rates and state/local funding mechanisms affect equitable access to SBMH services for CYSHCN with emotional and behavioral needs across schools and districts. • Identifying strategies to ensure sustainability despite policy or funding shifts.
Return on Investment and Cost-Effectiveness	• Evaluating short- and long-term economic impacts of providing SBMH services for CYSHCN with emotional and behavioral needs (e.g., reduced emergency visits, improved attendance, and family caregiver wellbeing). • Comparing short- and long-term returns on investment, cost savings, and the comparative cost-effectiveness of different delivery models such as the Multi-Tiered System of Supports (MTSS) framework.
Barriers, Facilitators, and Implementation Strategies	• Identifying regulatory and operational hurdles schools face in leveraging funding (e.g., complex Medicaid billing requirements, meeting compliance standards), building school–community partnerships, and identifying policy supports needed to provide timely, coordinated care to CYSHCN.
Impact on School Climate, Staff, and Families/Caregivers	• Exploring how funding stability and service availability influence school climate, staff workload, retention, and CYSHCN students' and their families'/caregivers' emotional safety, trust, and access to care.

Table 6. Prioritized Research Questions for Financing & Regulation

Top 5 Research Questions for Financing & Regulation

1. How do variations in funding streams (e.g., Medicaid vs. local education budgets) affect the availability and quality of SBMH services for CYSHCN? How do these funding differences influence staff and student perceptions of school climate?
2. What are the most effective strategies for combining federal, state, local, and private funding to improve the accessibility, comprehensiveness, quality, and sustainability of SBMH services for CYSHCN with emotional and behavioral needs?
3. What approaches within school–community partnerships most effectively structure financing and shared responsibility for delivering SBMH to CYSHCN with emotional and behavioral needs?
4. What is the cost-effectiveness of implementing SBMH services for CYSHCN within tiered models of support across each tier (universal, targeted, intensive)?
5. What supports do schools need to effectively bill Medicaid and commercial insurance for SBMH services? What are the biggest facilitators and barriers for billing Medicaid for SBMH services for CYSHCN with emotional and behavioral needs?

Models of Care & Support

This domain targets the design and evaluation of support/service delivery frameworks and collaborative care models that involve educators, mental health professionals, policymakers, and families/caregivers working together to support the academic, social, developmental, and emotional needs of CYSHCN. Central to this domain is the investigation into evidence-based interventions and approaches that aim to improve the accessibility, effectiveness, and sustainability of comprehensive mental health services within schools, fostering an environment conducive to the well-being and academic success of the affected students.

Participants prioritized areas of evidence generation related to identifying and comparing models of care and interventions to most effectively support CYSHCN within diverse school environments. This entails prioritizing research questions that examine what types or combinations of models are most effective in supporting the academic, social, and mental health needs for CYSHCN across age groups and cognitive and developmental abilities. The higher ranked questions also focused on identifying which components of evidence-based models of care are essential and which are adaptable to fit a school's local context, along with measuring the relative impact of comprehensive teams working together to serve CYSHCN.

Table 7. Key Themes from the Models of Care & Support Research Questions

Key Theme	Description
Evidence-Based Models of Care and Adaptation	• Identifying which elements of evidence-based SBMH approaches (e.g., MTSS, wraparound, integrated behavioral health) must be delivered with high fidelity for CYSHCN, and which can be adapted to local contexts when scaling across diverse school settings without reducing effectiveness.
Effectiveness of Models Across Populations and Contexts	• Examining how different SBMH approaches are most effective for CYSHCN across age groups, cognitive or physical abilities, cultural or linguistic backgrounds, with attention to differences in urban and rural school settings.
Collaboration, Transitions, and Continuity of Care	• Identifying best practices for coordinating care for CYSHCN with emotional and behavioral needs among schools, community mental health providers, families/caregivers, and clinical settings, especially during key transitions (e.g., hospital discharge, grade-level changes, aging out of pediatric services) to ensure seamless support.
Implementation Challenges and Scaling Strategies	• Identifying drivers, barriers, and promising practices for implementing comprehensive, trauma-informed, and culturally responsive SBMH models for CYSHCN with emotional and behavioral needs in diverse school contexts. • Addressing factors for sustainable scale-up (e.g., staff capacity, reliable funding, trauma-informed care integration, culturally responsive frameworks, cross-agency agreements).
Measuring Impact on Outcomes and School Climate	• Assessing how different SBMH models affect CYSHCN's mental health symptoms, academic engagement, exclusionary discipline, and family engagement. • Examining the role of school climate and staff collaboration in sustaining these models over time.

Table 8. Prioritized Research Questions for Models of Care & Support

Top 5 Research Questions for Models of Care & Support

1. What types or combinations of school-based models (e.g., multi-tiered system of supports, school-community partnerships, wraparound, peer support) are most effective in supporting the academic, social, and mental health needs of CYSHCN with diverse demographic and clinical characteristics?
2. Which SBMH models of care (e.g., school-based health centers), are most effective for CYSHCN across age groups, cognitive abilities, and developmental abilities?
3. Among evidence-based models of care, what components are essential, requiring fidelity, and what components can be adapted to fit local context when scaling across school settings?
4. What are the most effective strategies for measuring the relative impact of having comprehensive teams (including SBMH teams and community providers) work together to serve CYSHCN with emotional and behavioral needs?
5. What models best incorporate youth, family, and community voices into care planning and service delivery in school-based settings?

School & District Climate

This domain encompasses five main components that make up the overall quality and character of school life: (1) Safety, (2) Teaching and Learning, (3) Interpersonal Relationships, (4), Institutional Environment, and (5) Leadership and Efficacy.[ii] This includes the impact of relationship- building on the decision-making process and overall experiences of students, staff, and parents. 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 how strong and effective the leadership is. School and district climate further encompasses the identification of support necessary for faculty and staff, families/caregivers, and students as well as fostering staff buy-in to promote a supportive learning environment that prevents bullying/trauma and resists re-traumatization.

Participants prioritized areas of evidence generation related to identifying school system-level indicators that predict successful coordination of mental health services for CYSHCN with emotional and behavioral needs. They further prioritized questions exploring how schools and districts could improve climate and leadership strategies to enhance mental health service delivery and integration within schools.

Table 9. Key Themes from the School & District Climate Research Questions

Key Theme	Description
Measuring School Climate	• Identifying reliable, actionable measures to assess school and district climate for CYSHCN with emotional and behavioral needs. • Evaluate how MTSS affect academic and mental health outcomes.
Impact of Structural Factors	• Analyzing how class size, resource availability, physical space, and district-level policies shape the learning environment and influence the effectiveness of SBMH supports for CYSHCN with emotional and behavioral needs.
Leadership and Workforce Well-Being	• Exploring how supportive school and district leadership, professional development, and staff wellness initiatives can strengthen teacher and staff buy-in, reduce burnout, and enhance the consistent delivery of SBMH services for CYSHCN with emotional and behavioral needs.
Equity and Community Engagement	• Examining how inclusive policies, culturally and linguistically responsive practices, and meaningful school-family-community partnerships create a sense of belonging and equitable access to SBMH supports for CYSHCN and their families/caregivers.
Belonging and Stigma Reduction	• Investigating trauma-informed strategies to foster social connection, reduce stigma, and encourage CYSHCN engagement with SBMH services and supports that improve their academic and emotional outcomes.

Table 10. Prioritized Research Questions for School & District Climate

Top 5 Research Questions for School & District Climate
1. What are the system-level climate indicators (e.g., staff support, communication structures, role clarity) that predict successful district-wide coordination of SBMH services for CYSHCN?
2. What role does school climate (e.g., teacher-student relationships that foster trust and motivation, disciplinary practices, inclusion culture) play in the success or limitations of mental health service delivery models particularly for CYSHCN with emotional and behavioral needs?
3. What conditions at the school and district level help or hinder school personnel (e.g., teachers, staff) to develop stronger relationships with students who have special health care needs and ensure that effective trauma-informed systems are in place when a student reports a mental health concern?
4. What leadership practices at the district level are most strongly associated with equitable and timely implementation of SBMH services and improvements in both mental health and climate metrics?
5. What are effective strategies for school and/or district leaders to integrate student mental health, wellbeing, and academic support for CYSHCN with emotional and behavioral needs?

ii This research domain was adapted from the National School Climate Center's five domains of school climate.

Workforce

This domain focuses on the conditions required for a trauma-informed, well-staffed and coordinated school team that can flexibly support CYSHCN with emotional and behavioral needs. This topic explores effective strategies for aligning roles, trainings, and responsibilities across team members to foster collaboration, avoid duplication of efforts and ensure shared goals while also promoting staff well-being.

Participants identified prioritized research areas related to the licensing, recruitment, training, and retention of a SBMH professional workforce that can support a wide range of providers and services. For instance, questions investigated effectives strategies for supporting the workforce's ability to promote high-quality SBMH services, accounting for the need to mitigate staff burnout. Participants also prioritized questions that support whole-person care by examining the comparative effectiveness of training models in preparing the workforce to deliver inclusive, trauma-informed, and culturally responsive mental health care to CYSHCN with emotional and behavioral needs across school settings. Higher ranked questions also reflect interest in researching the conditions under which best or promising practices for facilitating shared goals and understanding among different roles and across sectors are most effective.

Table 11. Key Themes from the Workforce Research Questions

Key Theme	Description
Training and Capacity Building	• Identifying best and promising practices for training school-based teams across roles and sectors (e.g., teachers, counselors, nurses, social workers, paraprofessionals, and administrators) to build shared understanding, facilitate collaboration, and deliver inclusive, trauma-informed, and culturally responsive mental health care for CYSHCN.
Workforce Structure and Models	• Exploring the most effective ways to structure the SBMH workforce to meet CYSHCN's emotional and behavioral needs, including expanding roles of existing staff, hiring specialized providers (e.g., behavioral health clinicians, care coordinators), leveraging paraprofessionals and peer youth support, and partnering with community organizations or telehealth services. • Evaluating which approaches are most feasible and effective across diverse school settings.
Retention, Sustainability, and Staff Well-Being	• Understanding the strategies, supports, and incentives that most effectively promote workforce retention, reduce burnout, and improve job satisfaction among SBMH providers and those they partner with in communities and health systems to care for CYSHCN with emotional and behavioral needs in urban and rural settings.
Alignment, Collaboration, and Role Clarity	• Examining how clearly defined roles, interprofessional collaboration, and alignment between staff perceptions of school climate and workforce responsibilities influence the coordination and quality of SBMH services for CYSHCN with emotional and behavioral needs.

Table 12. Prioritized Research Questions for Workforce

Top 5 Research Questions for Workforce

1. How can the SBMH professional workforce be effectively structured to adequately fund and host a variety of providers and services (e.g. school-based health clinics, community-based organizations)? What workforce structuring is more feasible and efficient across different geographic locations and school settings (e.g., urban, rural)?
2. What training models most effectively prepare teachers and other school staff to provide inclusive, trauma-informed, and culturally responsive care for CYSHCN with emotional and behavioral needs within and beyond the classroom environment?
3. What are best or promising practices for training the school team (e.g., social workers, nurses, counselors, psychologists, teachers, community health partners, etc.) to facilitate shared understanding and goals among different roles and across sectors to support CYSHCN with emotional and behavioral needs? Under which conditions are these practices most effective?
4. What supports are needed to promote effectiveness and sustainability of the workforce, including but not limited to identifying and addressing staff burnout? What are the best or promising strategies for school mental health staff retention to support this workforce's ability to promote high-quality SBMH services for CYSHCN with emotional and behavioral needs?
5. What barriers exist within and across states in licensing and recruiting SBMH professionals? What are the best or promising strategies for school mental health staff retention, and how do the effectiveness of these strategies vary by geographic location and/or school setting?

Youth/Family Engagement

This domain seeks to identify effective strategies for involving families or caregivers and young people as active participants in the planning, implementation, and evaluation of SBMH programs and policies targeting CYSHCN with emotional and behavioral needs. Emphasizing partnership and communication, this work aims to empower families/caregivers and youth, ensuring that their perspectives and needs shape supportive, responsive, and culturally sensitive mental health services in educational settings.

Participants prioritized areas of evidence generation related to having and sustaining youth- and family-centered approaches in the planning, delivery, and evaluation of SBMH services for CYSCHN who have emotional and behavioral needs. In the top five ranked questions, this included a focus on evidence to better understand school climate conditions that are predictive of sustained family engagement. These questions help cultivate a stronger understanding of supportive conditions at the school, district, and/or community level for engaging CYSHCN and their families/caregivers to improve SBMH services. Research questions also reflected participants' desire to align SBMH services with the goals of both the students and their family, demonstrated in part by a higher ranked question that examined the role of peer support and youth advocacy/empowerment in improving mental health outcomes for this population.

Table 13. Key Themes from the Youth/Family Engagement Research Questions

Key Theme	Description
Youth Empowerment and Peer Support	• Identifying the most effective practices for integrating peer support, youth leadership, and self-advocacy strategies to build CYSHCN student engagement, autonomy, and positive mental health outcomes.
Family Engagement and Cultural Responsiveness	• Understanding how cultural values, socioeconomic context, language, and caregiving demands influence CYSHCN family participation in SBMH services. • Tailoring interventions to improve shared decision-making, communication, and trust across diverse contexts.
Building Strong Family-School Partnerships	• Exploring policies, co-design methods, and leadership practices that strengthen collaboration between families/caregivers, schools, and districts so that SBMH services for CYSHCN are aligned with youth and family goals.
Creating Safe, Inclusive, and Responsive Environments	• Examining conditions—such as confidentiality protections, psychologically safe spaces, and youth-centered approaches—that enable CYSHCN and their families/caregivers to openly express needs, participate in planning, and provide feedback on mental health supports.
Leveraging Technology and Real-Time Feedback	• Assessing promising technology-based approaches (e.g., secure apps, text-based surveys, virtual forums) for collecting timely input from CYSHCN and their families/caregivers and comparing effectiveness across diverse school settings. • Identifying models that successfully translate feedback into service improvements.

Table 14. Prioritized Research Questions for Youth/Family Engagement

Top 5 Research Questions for Youth/Family Engagement

1. What school climate conditions are most predictive of sustained family engagement in the co-design, continued participation, and evaluation of SBMH programs for CYSHCN with emotional and behavioral needs?
2. What role do youth peer support and youth advocacy/empowerment play in enhancing engagement and outcomes in mental health care for CYSHCN with emotional and behavioral needs?
3. What are the best or promising practices to ensure schools provide mental health services that are aligned with both a youth and their family and/or caregiver's goals?
4. How do schools operationalize youth- and family-centered approaches in planning, delivering, and evaluating SBMH services for CYSHCN with emotional and behavioral needs? In what types of school settings are these approaches more effective?
5. What are exemplar programs that engage CYSHCN and their families in providing real-time feedback and participating in formal processes of assessment, planning, and implementation of SBMH services? What conditions at the school, district, and/or community level make these programs more or less successful in engaging youth and family to improve services?

Discussion & Implications

The research questions presented in this agenda offer a more focused view into a large and complex ecosystem involving multiple fields and child- and youth-serving systems that each play a role in caring for CYSHCN with emotional and behavioral needs. Structuring the research agenda into seven domains with prioritized questions helps provide a roadmap for family-partnered research teams to conduct CER of the highest importance to CYSHCN families and policymakers. In addition, the domains and questions surface larger implications for SBMH, particularly with respect to this target population.

Ongoing Challenges in Defining the Population

This research agenda sits at the nexus of health care and education, two enormous fields of study and implementation with their own vocabulary, mental models, frameworks, and approaches. The challenges with providing whole-person care are well known within health systems and intersecting child- and youth-serving systems given that these systems operate by addressing needs via disparate categorization of experiences, inevitably leaving some children and youth with complex needs to fall through the gaps.[8] Operationalizing policy necessitates defining boundaries around which children and youth are included or excluded, but these imperfect parameters place those existing on the boundary at risk of inadequate support if not outright harm. This is particularly true for CYSHCN, who may experience varying degrees of health care needs and functional limitations alone or in combination with other health care needs.[1] When categorizing needs, specifically around mental health, these needs might not fit neatly within a defined scope and thus risk going unaddressed. Further, disparity between the health and education systems' definitions impacts future research fidelity, emphasizing the need for concrete, implementable parameters for research teams.

The multiple fields, such as clinical, education, and payers, that have a role in caring for CYSHCN with emotional and behavioral needs require a consistent way to operationally define and identify these children and youth across systems and account for different legal structures (e.g., the Health Insurance Portability and Accountability Act [HIPAA] and the Family Educational Rights and Privacy Act [FERPA]) so that services and benefits can work synergistically and ensure these students are not excluded from services. Future CER focused on school-based interventions for CYSHCN with emotional and behavioral needs must employ standardized, cross-sector functional criteria rather than relying on broad legal or diagnostic labels alone. For example, researchers might define their cohort using common, observable behaviors and service utilization markers that are meaningful in both school and clinic settings. This could entail using measures such as the Children's Functional Assessment Rating Scale[9] or specific metrics of chronic absenteeism and disciplinary actions to define the target population. Creating a measurable, translatable cohort definition can then improve the generalizability of future findings.

As part of this agenda's goal to center the needs and voices of CYSHCN and their families/caregivers, it is important to acknowledge which children and youth are currently captured in the evidence base and which are often left out as to inform next steps for addressing pressing evidence gaps. With respect to the literature, students who experience medical complexity to an extent that prevents them from attending school might not be strongly captured within the literature on SBMH. Remaining cognizant of the needs of CYSHCN and the likelihood of their chronic absenteeism, homeschooling, or enrollment in independent learning programs is encouraged. The risk of excluding these children in the evidence and in lines of further inquiry opens the possibility that the resources they need most are not identified. Further, leaving the SBMH needs of this population unaddressed perpetuates turning away from child wellbeing and leaving students and families/caregivers with a lack of options in finding mental health support. Unaddressed gaps can lead to inappropriate actions such as punitive measures in place of mental health care,[10] where CYSHCN may receive disciplinary action in response to disruptive behaviors instead of needed care. While this agenda seeks to aid in bridging the gap across sectors by incorporating a range of interest holders in its development process, limitations persist in how information is presented without a shared language and understanding of the population.

Implications for Evidence Generation

Addressing identified patient-centered CER gaps in SBMH programs that serve CYSHCN is important for strengthening the evidence base to inform improvements in access, quality, adaptability, and scalability of services. This, in turn, can support improved health, academic, and service utilization outcomes. Notably, *how* evidence is generated is as important as the evidence itself. Achieving a better system of care and support for this target population, and children and youth more broadly, necessitates careful consideration of methodologies and approaches for generating relevant, responsive, feasible, and high impact evidence in a manner that minimizes the risk of harm to those the evidence seeks to serve.

To that end, the research questions surfaced several cross-cutting themes that intersect domains and transcend individual research silos, offering a broader perspective in order to address the complex challenges inherent to improving SBMH services for CYSHCN with emotional and behavioral needs: (1) human-centered and trauma-informed approaches to research; (2) relevance and rigor of the proposed research areas; and (3) research that focuses on implementation of integrated solutions.

1. The integration of human-centered and trauma-informed approaches in research is paramount, as it underscores the importance of prioritizing the needs, goals, experiences, and well-being of these individuals and decreasing the likelihood of (re)traumatizing CYSHCN students and their families. This can be especially relevant for CYSHCN given that over one in three children with multiple adverse childhood experiences had a special health care need in 2019-2020.[1] In addition, accounting for the needs of families/caregivers, school support staff, teachers, and mental and somatic health staff is necessary to attend to the physical, emotional, and psychological health of those who support this student population on the ground. The School Pulse Panel, conducted by the National Center for Education Statistics and the U.S. Census Bureau, found that in the 2024-25 academic year, 36 percent of staff reported seeing an increase in staff expressing concerns about themselves or their colleagues showing signs of depression, anxiety, emotional dysregulation or trauma since the prior school year.[11] Fortunately, CER can help build the evidence on which approaches work best for different interest holders, taking individual needs to scale. Emphasizing human-centered methods can craft solutions that not only support this target population, but also the collective health of the educational ecosystem.
2. In the pursuit of gathering evidence, there is a tension between focusing on measurable indicators of effectiveness and outcomes, and meaningful concepts that are impactful and informative, but may be harder to measure. Balancing evidence generation that creates concrete findings and proposed measurable impact, along with more intangible aspects such as quality of life or sense of belonging, is a necessary line to walk to address the current gaps in SBMH services for CYSHCN with emotional and behavioral needs. Only focusing on impactful but intangible concepts may squander precious resources for research in this area and the ability to make meaningful improvements, while only focusing on the readily measurable can potentially diminish innovation and create suboptimal interventions that do not address the needs of those with lived experience.
3. Creating additive SBMH interventions is not a sustainable solution, nor does it address the issue of unclear communication between schools and community as to what services are available and what is still needed. Existing evidence-based models of practice for SBMH services, such as the MTSS framework, school-based health centers (SBHCs), and contracted services, should be acknowledged and leveraged. Although there are national quality guides for needs assessment and resource mapping for schools and districts,[12] challenges remain in helping schools and communities identify the status of available mental health services to help braid these services together more effectively and eliminate potential duplication. Including both education interest holders (e.g., educators, administrators, social workers, and clinic-level staff) and health-system leaders (e.g., hospital or SBHC administrators) can capture real-world school priorities and clarify the diverse funding and operational models of SBHCs.

Assessing the Policy Landscape

The policy landscape encompassing SBMH has changed significantly during 2025,[13] resulting in heightened challenges for those in the health care and education fields and further elevating the need for coordinated, collaborative, and innovative thinking to chart the path forward for supporting CYSHCN with emotional and behavioral needs. Broadly, a reduction of vital SBMH services could increase instances of school violence, reduce graduation rates, and lessen the job readiness of American students.

While the future of federally funded programs and systems to promote access to mental health services is uncertain at the time of writing, the trajectory of declining federal support further strains schools' abilities to meet the mental health needs of their students, including CYSHCN. In 2022, Congress enacted the Bipartisan Safer Communities Act which expanded mental health services in communities and schools and provided pathways for sustainable, long-term funding of school-based services through billing for Medicaid.[14] In 2024, CMS awarded school-based services grants to 18 states for the implementation, enhancement, and expansion of Medicaid and the Children's Health Insurance Program school-based services.[15] As one example of the shifting policy landscape, the Medicaid School-Based Services (SBS) Technical Assistance Center (TAC)—a joint effort between CMS and the U.S. Department of Education[16]—received notice of an intended substantial funding reduction from CMS in 2025 and has been unable to publicly release completed materials since March of 2025. The Medicaid SBS TAC represented an effort to support and expand school-based health services, reduce school violence, and reduce the administrative burden of federal policies. The contraction of its activities illustrates the shift in priorities at the federal level. This de-prioritization disrupts actions taken by a bipartisan Congressional mandate to help schools deliver mental health services,[17] such as establishing the Medicaid SBS TAC.

In the wake of Medicaid cuts, SBMH services and the students served by them are at risk of experiencing ongoing harm due to behavioral health concerns. A nationwide survey conducted by the Healthy Schools Campaign in March 2025 highlighted that Medicaid cuts would lead to job losses and reduction in services particularly for students with disabilities and mental and behavioral health needs.[18] Medicaid plays a key role in helping school districts provide services in compliance with the Individuals with Disabilities Education Act (IDEA)—described below—and as a result, these funding cuts will impact schools' abilities to meet the educational, physical, and mental health needs of students with disabilities. Almost half of CYSHCN are covered by Medicaid or Medicaid and private insurance, and nearly 90 percent of SBHCs report billing Medicaid.[19] Reducing SBMH services can be particularly devasting for CYSHCN and their families/caregivers who do not always have the means to cover the cost of services outside of the school setting, and/or accessibility to such services.

Additionally, cuts to the Office of Special Education Programs within the Department of Education disrupt the agency's ability to oversee Special Education enforcement, including the implementation of IDEA.[20] Enacted in 1990, IDEA requires that eligible children and youth with disabilities receive free, appropriate public education (FAPE) in the least restrictive environment. Under IDEA Part B, children and youth aged three through 21 can receive Special Education and related services through an IEP.[21] The overlap between the CYSHCN population and students with educational designations such as IEPs is noteworthy, as is the acknowledgement that interest holders within Special Education may understand and identify CYSHCN with emotional and behavioral needs through the IDEA language of Emotional Disturbance (ED). Despite the incomplete and imprecise definition of ED,[22-24] as well as a paucity of research into how precisely this category intersects with CYSHCN, the definition is utilized in IDEA to identify school children eligible for services. The provision of FAPE underscores the need for SBMH services as these services are needed to ensure equity in access. Consequently, disruptions in enforcing IDEA add another level of complexity in working towards addressing the fragmentation and gaps across systems to better serve CYSHCN with emotional and behavioral needs.

No policy briefs or policy activities were completed during the award term. Bipartisan concern regarding the youth mental health crisis presents opportunities to explore shared priorities to champion and advance the wellbeing of students, recognizing both the challenges ahead and chances for cross-sector collaboration. Recommended next steps are described in the Future Directions section.

Limitations

Many perspectives across sectors and lived experiences must intersect to inform a holistic picture and effective systems of support for SBMH for CYSHCN with emotional and behavioral needs. Though the project team worked to include several relevant perspectives throughout the agenda-setting process, this agenda is limited by the relatively small pool of engaged interest holders (n=73). This smaller sample of key informants, convening attendees, and prioritization participants impacts the generalizability of results. Furthermore, while this agenda puts forth areas of inquiry most likely to generate evidence related to CYSHCN with emotional and behavioral needs, it is not inclusive of all questions for this target population. Additional work in this area, inclusive of a larger number of perspectives, would allow added nuance within the research questions, bolster generalizability, and encourage cross-sector collaboration. The limitations presented here serve to both contextualize this work and inform future strategic action.

Limitations regarding participation rates also included a low response rate and level of engagement of Medicaid perspectives, particularly with the MMD survey and involvement in crafting research questions. The lower survey response rate might suggest limitations as to how well this agenda speaks to issues of relevance to those in influential positions related to financing SBMH services for CYSHCN with emotional and behavioral needs. Given the limited engagement of research funders and policymakers who have a funding scope of influence, the research agenda does not reflect robust input from those with the ability to make research funding available. As such, there are opportunities to involve these perspectives more meaningfully in future work to explore the most effective and sustainable funding strategies.

The level of attainable engagement was impacted by internal and external factors such as resources and time constraints, policy and funding changes within health care and education fields during key data collection activities, and some attrition of Consensus Convening participants during the Codigital prioritization exercise. Particularly, Spring and Summer 2025 saw landslide proposed and actualized changes within the heath care and education fields especially at the federal level. Many interest holders were consequently working with competing priorities at the time of data collection, which was most likely exhibited in the low response rate for the MMD survey. In addition, differing levels of familiarity and comfort with generating CER questions among interest holders may have contributed to lower participation in the Codigital ideation and prioritization exercise. Establishing a stronger baseline of knowledge across participants in advance of this activity, whether during the convening or in follow-up, may have encouraged stronger engagement and strengthened the initial quality of the questions.

Future Directions

This research agenda offers a unique contribution to the fields of health care and education by focusing on CYSHCN with emotional and behavioral needs in the context of providing high-quality SBMH that is adaptable to a school's local context. While much progress is still to be made and sustained, as evidenced by robust list of research questions produced for this agenda, this work builds upon existing efforts related to CYSHCN, school-based mental health, and better incorporating the voices of youth and families/caregivers into evidence-based decision-making. The agenda additionally highlights the need to clearly communicate about the relative effectiveness of SBMH service delivery models, payment and financing models, and program adaptation that is required to best serve the CYSHCN population.

Moving forward, the next iteration of this work should prioritize immediacy in holding dedicated, high-level briefings and/or events with potential funders to convert the time and effort of this participatory agenda-setting process into tangible funding. This next iteration of work must include structured, one-on-one follow-ups with Medicaid directors and federal/foundation program officers, such as those at the Agency for Healthcare Research and Quality (AHRQ). This targeted engagement will serve to directly integrate their financing needs into the research designs, ensuring that the research agenda is fiscally sustainable and relevant to policymakers' budget priorities.

Opportunities for Alignment & Actionable Uptake

This agenda presents a prioritized list of research questions for which subsequent evidence generation and implementation falls beyond the scope of this project. However, the agenda's value in serving as a blueprint for the researchers and funders who undertake this work is made stronger by positioning the research questions for actionable use and uptake. These questions largely serve to progress CER related to SBMH programs for CYSCN with emotional and behavioral needs, whether through directly being CER questions or acting to strengthen researchers' understanding of the larger ecosystem in which services are delivered. Organizing evidence gaps into more digestible categories of patient-centered inquiry can facilitate alignment and coordination of efforts across interest holders, funding bodies, and policymakers.

The involvement of multiple perspectives also allows for connections between topics to advance shared goals, such as weaving together teacher burnout and the youth mental health crisis when considering the effectiveness of SBMH interventions that not only support students, but also staff. While these questions are primarily targeted towards researchers, those who take on these questions may wish to consider what framing would best resonate with partners and intended audiences for the evidence they produce. For example, research might be framed using more applied language with school audiences to elevate the practical benefits to students, teachers, and administrators in improving outcomes relevant to them such as improved attendance. Funders are often interested in more immediate, measurable health outcomes and thus are likely to be invested in research questions that drive knowledge generation with those outcomes in mind.

To that end, the creation of a one-page, policy-friendly summary of the top three research priorities would be a valuable immediate next step to transform the agenda into a blueprint for advocacy and resource allocation. The effectiveness of a summary, particularly one targeted directly at AHRQ, CMS, and the Department of Education, can be strengthened by including a clear, measurable goal that demonstrates significant real-world impact of research, such as reducing punitive disciplinary measures for CYSHCN with emotional and behavioral needs by a certain percentage within a set timeframe (e.g., three years). Regarding uptake opportunities for practitioners, grant funding addressing this agenda should include a mandatory knowledge translation deliverable—such as a two-minute video or a workflow checklist for SBMH staff—to ensure that the evidence is immediately accessible on the ground. This approach acknowledges the limited time school personnel have for reading lengthy reports.

Notably, many of the research questions can be pursued using existing validated measures and tools. The Family Engagement in Assessment Systems Tools[25] are one such option for those using the research agenda to plan, assess, and improve family engagement. Researchers interested in the School and District Climate domain might leverage tools such as the National School Climate Center's Comprehensive School Climate Inventory, which is a survey with disaggregated reporting that can track metrics on inclusion, safety, and well-being over time for students, staff, and families.[26] The National Center for School Mental Health also offers a variety of resources that address eight domains of school mental health quality assessment, including: foundations of school mental health, teaming, needs assessment and resource mapping, mental health screening, mental health promotion for all students (i.e., Tier 1), early intervention and treatment (i.e., Tiers 2 and 3), funding and sustainability, and impact. Several resources speak to the broader school ecosystem and address factors relevant, but not centered on, this population. As one example, guidance on assessing social influencers of health through screening or surveillance tools[27] can be impactful for CYSHCN with emotional and behavioral needs given that mental, emotional, and behavioral problems often go undetected and untreated for these students.[28] This broader guidance can also be placed in conversation with CYSHCN-driven guidance, such as that for pediatric providers to address psychosocial risk and protective factors as part of comprehensive, coordinated care with a student's medical home.[29]

Aligning with Other Agendas & Initiatives

In addition to the above examples for framing and conducting research, positioning the agenda alongside related initiatives is a necessary approach to avoid perpetuating silos and instead leverage opportunities for alignment. The non-exhaustive list of examples of related research agendas and initiatives, discussed below, share the goal of promoting the highest research priorities and impact for interest holders.

Prior to this project, multiple research agendas had been developed for CYSHCN and school mental health more broadly. The Systems and Policy Research Network for Children and Youth with Special Health Care Needs and Their Families (formerly CYSHCNnet) developed a national research agenda for CYSHCN between 2019-2021 which featured six priority areas: (1) Child Health, (2) Family Health, (3) Caregiving for CYSHCN, (4) Care Models, (5) Health Financing, and (6) Young Adult Transitions.[30] These priority areas reflect similar domains within this agenda, namely, Models of Care and Support, Financing and Regulation, and Youth/Family Engagement among others. In 2014, Ownes et al. proposed a research agenda for implementation science in school mental health that was followed by a progress update from Lyon et al. in 2024.[31,32] The latter proposed critical research questions in the following areas: (1) pragmatic implementation strategies, (2) implementation mechanisms explaining the connection between implementation strategies and outcomes, (3) strategic intervention redesign to promote implementation, and (4) de-implementation of low-value practices. Referring to such foundational findings can prove helpful when considering challenges to operationalizing the proposed research outlined in this document, such as the complexity of research and sustaining interventions within school environments.

In Summer 2025, the Innovations Institute at the University of Connecticut School of Social Work held a research summit focused on research priorities for youth and family behavioral health. It supported an overall goal to "inform and undertake a research agenda for youth and family behavioral health that can meet the needs of policy makers and tangibly improve policies, public systems, and services for youth and families."[33] While not specific to CYSHCN or SBMH, the work pairs nicely with this research agenda and offers an opportunity to crosswalk learnings and key themes. For instance, both agenda-setting processes surfaced similar research priorities around the need for more evidence on best practices to promote interagency/system collaboration, support child and youth, caregivers/families, and the workforce, and scale effective interventions. In addition, the Summit's participants—which spanned researchers, youth and family leaders, provider associations, federal and foundation funders, and state behavioral health and Medicaid decision-makers—could represent a valuable opportunity to collaborate with a greater number of interest holder perspectives, as was discussed in the Limitations section. Lastly, opportunities for synergy may arise in thinking collectively about collaborative action steps, discussed in the Summit, in conversation with the driving and restraining forces for implementing the research agenda identified during this project's Consensus Convening to chart the path forward for youth mental health.

Conclusion

There are significant and real threats to the foundational systems that support children and youth's present and future well-being. The threats to infrastructure, resources, and supports present challenges to assuring all areas of the nation meet the needs of CYSHCN. These research questions offer foundations of an opportunity to bridge the gap between generating timely, responsive, and high-impact evidence and bringing the field closer to an ideal state of SBMH services for CYSHCN with emotional and behavioral needs.

Appendix I. Steering Committee & Project Team

Steering Committee

Jill Haak Bohnenkamp, PhD
Associate Professor; Co-Director
University of Maryland School of Medicine National Center for the School Mental Health

S. Amanda Dumas, MD, MSc, FAAP
Associate Medical Director, Pediatrics
MassHealth (Medicaid)

Victoria Eckert, MSSA, LMSW
Associate Director
Youth MOVE National

Dennis Z. Kuo, MD, MHS
Purcell Family Distinguished Professor; Chief of Developmental and Behavioral Pediatrics
University of Rochester Medical Center/Golisano Children's Hospital

Terri D. McFadden, MD, MPH, FAAP
General Pediatrician; Professor
Emory University School of Medicine

Cecilia Oregón, MPP, MPH
Executive Director
Kaiser Permanente's Institute for Health Policy (IHP)

Debra Waldron, MD, MPH, FAAP
Senior Vice President
Healthy and Resilient Children, Youth, and Families at the American Academy of Pediatrics

Allysa N. Ware, PhD, MSW
Executive Director
Family Voices

Michelle Zabel, MSS
Executive Director
Innovations Institute at UConn SSW

Project Team

Jaime Adler, MS, MPH
Senior Manager
AcademyHealth

Oneyda Arellano, PMP, CHES
Manager, Health Group
Econometrica

Elizabeth Cope, PhD, MPH
Chief Programs & Science Officer
AcademyHealth

Taylor Dunlap
Research Associate
AcademyHealth

Steph Lomangino, LMSW*
Program Strategy Manager
Family Voices

Jean O'Connor, JD, MPH, DrPH*
Director, Health Group
Econometrica

Sarah Weinberg
Research Associate
AcademyHealth

**Also members of the Steering Committee.*

Appendix II. List of Prioritized Research Questions

The full list of prioritized research questions is included below.

Data & Measurement: This domain explores how interest holders involved with school-based mental health (SBMH) services might collect, share, analyze, and use individual- and population-level data. Data collected within the school and shared between the school, district, and state levels can help address gaps in mental health care, support better SBMH services, and improve clinical and academic outcomes for CYSHCN with emotional and behavioral needs with the proper infrastructure.

Prioritized Research Questions:

1. What infrastructure and resources (e.g., financing, staffing, technology, policies for gaining consent) are most effective in supporting the collection and use of secure, high-quality data across school systems for CYSHCN with emotional and behavioral needs?
2. What measures of access, quality, intermediate outcomes (e.g., school attendance), and/or long-term outcomes (e.g., high school graduation) are most critical for evaluating school-based mental health services, and under what circumstances do they best inform service improvement?
3. What are the most valid, reliable, and feasible instruments that can be used to collect mental health data from the school and school system for the purpose of sharing with relevant interest holders and policymakers?
4. What measures and instruments should be used to identify CYSHCN who could benefit from school-based mental health services and support their needs, monitor change over time, and assess intervention outcomes at each tier of the multi-tiered system of supports (MTSS) framework?
5. What barriers and facilitators influence the effective collection and use of high-quality data within schools and across service systems (including financial, cultural, and social factors)?
6. What mental health measures are sensitive to change over time and are best suited for progress monitoring in schools?
7. What are the most efficient methods of data collection and analysis that school staff can use to make timely and accurate decisions about mental health interventions for CYSHCN?
8. What is the most valid and reliable way to define the subpopulation of CYSHCN with emotional and behavioral needs using data that can be feasibly collected and/or accessed across agency, system, and state boundaries?
9. What are effective ways for schools to use near real-time data (e.g., absenteeism, missed assignment) to identify when timely adjustments in school-based mental health services are needed?
10. What are the most critical individual- and population-level data that schools should collect to inform mental health services for CYSHCN with emotional and behavioral needs? What analytic approaches best translate these data into actionable insights for improving access, equitable care, and mental health and academic outcomes?
11. What valid, reliable, and feasible tools can be used to measure the impact of school-based mental health services on the families of CYSHCN (e.g., parents, siblings) and how can these tools inform improvements in service delivery and family well-being?
12. What types of data are most critical for understanding how schools and school systems engage families, and what approaches are most effective for collecting these data across diverse contexts?
13. What role does real-time school climate data play in guiding tiered interventions for CYSHCN with emotional and behavioral needs?
14. How does the perceived trustworthiness of climate survey processes affect student and staff willingness to report mental health needs or concerns?
15. What data should be collected across settings to enable measures of effective care coordination for CYSHCN with emotional and behavioral needs? What are appropriate process and outcome measures within and across disciplines (mental health, nursing, education)?
16. Which models of successful, interoperable data sharing across education, health care, and community systems exist, and how can these models be scaled and adapted more widely to strengthen coordinated school-based mental health support for CYSHCN?

17. What are best or promising practices for schools to use longitudinal climate data alongside school-based mental health screening instruments to identify trends in emotional wellbeing across different student populations, including CYSHCN with emotional and behavioral needs?
18. How do data governance policies (e.g., FERPA, HIPAA) enable or restrict the sharing of school-based mental health data in school-community partnerships, and what strategies can optimize data exchange to improve outcomes for CYSHCN with emotional and behavioral needs?
19. How do patterns in school climate survey responses correlate with student-level referrals for school-based mental health services, and what predictive insights can be drawn from these associations?
20. What types of data infrastructure most effectively enable school-based mental health services to match students with appropriate supports, monitor needs in real-time, and adjust interventions when needed? How much local heterogeneity in data infrastructure can be tolerated without compromising the fidelity, quality, and equity of services being provided?
21. What approaches for data collection, sharing, and reporting best support both system learning and accountability?
22. How does the integration of school climate indicators in district-level dashboards affect administrative decisions about mental health staffing and resource allocation?
23. How does the collection and disaggregation of climate and mental health data inform the identification and reduction of disparities in access to school-based mental health services between CYSHCN and non-CYSHCN students? To what extent should schools disaggregate data to systemically monitor gaps in service delivery and student wellbeing?

Equity: This domain focuses on the fair delivery of school-based mental health services for CYSHCN with emotional and behavioral needs and the prioritization of equitable education and mental health outcomes to promote the health and wellbeing of all children. Drivers of equitable and inequitable access, quality, and outcomes are all included, along with effective strategies for achieving equity.

Prioritized Research Questions:

1. What implementation strategies are most effective in ensuring equitable school-based mental health support for CYSHCN with emotional and behavioral needs (e.g., equity audits, disaggregated data reviews)?
2. What training and professional development approaches most effectively prepare school-based mental health providers to deliver timely, equitable, and culturally responsive care to CYSHCN with emotional and behavioral needs?
3. How do school funding and resource allocation affect the equitable availability of school-based mental health support for CYSHCN with emotional and behavioral needs?
4. What existing strategies or mechanisms have schools used to successfully support school-based mental health services despite school funding disparities?
5. Which available school-based mental health interventions are the most effective at improving health outcomes among marginalized CYSHCN with emotional and behavioral health needs?
6. What are the most effective strategies for sustaining school-based mental health services for CYSHCN with emotional and behavioral needs at the state level given a volatile and uncertain state policy landscape?
7. What screening approaches are most effective for identifying at-risk children early, including those impacted by social determinants of health and wellbeing such as economic insecurity and family dysfunction?
8. What are the primary drivers of equitable and timely access to high-quality, effective school-based mental health services for CYSHCN with emotional and behavioral needs?
9. How does cultural responsiveness affect school-based mental health interventions for CYSHCN with diverse backgrounds and needs, and what strategies are most effective in increasing access to culturally and linguistically appropriate school-based services for historically marginalized student populations?

10. How do schools serving historically marginalized communities involve CYSHCN and their families in designing culturally responsive school-based mental health supports, and how does this participation affect perceptions of school climate?

11. To what extent do differences in perceived school climate—particularly regarding safety, belonging, and respect—contribute to inequities in access to school-based mental health services across CYSHCN subgroups defined by racial identity, language, and disability? Can a positive school climate reduce disparities in mental health referrals and outcomes for CYSHCN from underserved populations?

12. How do the types of school-based mental health services provided to CYSHCN with emotional and behavioral needs vary by demographic characteristics?

13. How does negative cultural stigma surrounding mental health care prevent CYSHCN with emotional and behavioral needs from seeking or receiving help?

14. What are the most effective and feasible approaches to delivering risk factor-tailored school-based mental health services?

15. How do staff perceptions of equity and inclusion within the school climate influence their referral decisions and support for CYSHCN with emotional and behavioral needs?

16. How does implicit bias affect the diagnosis, referral, and treatment of emotional and behavioral conditions among CYSHCN? How often are CYSHCN with mental health needs overlooked in school or misidentified by the system due to implicit bias?

Financing & Regulation: Financing and costs for school-based mental health (SBMH) services for CYSHCN with emotional and behavioral needs includes consideration of federal, state, local, and private funds including Medicaid reimbursements and other sources. Regulation of SBMH services for CYSHCN with emotional and behavioral needs that are consistent with community values require adherence to policies and reporting structures dependent on the financing source, in addition to the medical and legal responsibility of team-based care.

Prioritized Research Questions:

1. How do variations in funding streams (e.g., Medicaid vs. local education budgets) affect the availability and quality of school-based mental health services for CYSHCN? How do these funding differences influence staff and student perceptions of school climate?

2. What are the most effective strategies for combining federal, state, local, and private funding to improve the accessibility, comprehensiveness, quality, and sustainability of school-based mental health services for CYSHCN with emotional and behavioral needs?

3. What approaches within school–community partnerships most effectively structure financing and shared responsibility for delivering school-based mental health to CYSHCN with emotional and behavioral needs?

4. What is the cost-effectiveness of implementing school-based mental health services for CYSHCN within tiered models of support across each tier (universal, targeted, intensive)?

5. What supports do schools need to effectively bill Medicaid and commercial insurance for school-based mental health services? What are the biggest facilitators and barriers for billing Medicaid for school-based mental health services for CYSHCN with emotional and behavioral needs?

6. What funding sources support the delivery of mental health services for CYSHCN with emotional and behavioral needs in public and private pre-Kindergarten through 12th grade schools?

7. What are the most innovative and effective strategies for sustaining school-based mental health services for CYSHCN when financing streams change?

8. How do financing structures and regulations affect collaboration and care coordination between school-based mental health service providers and other health or social service providers?

9. How does the affordability of school-based mental health services influence their use among CYSHCN with emotional and behavioral needs? What is the financial impact on families when school-based mental health services are limited or eliminated?

10. What are the short- and long-term returns on investment (ROI) from school-based mental health services, including both direct and indirect costs avoided? How does the ROI vary by funding source, particularly Medicaid?

11. What funding strategies outside of the Individualized Education Plan (IEP) process are most effective for sustaining school-based mental health services, and under what conditions are they most effective at maintaining consistent access to services for CYSHCN?

12. How does dedicated funding for mental health infrastructure affect students' and families' perceptions of emotional safety and inclusiveness in schools? Do schools with more stable and diversified funding for school-based mental health demonstrate stronger climates of care, trust, and adult-student relationships than schools with inconsistent funding?

13. What policy, funding, and implementation strategies are most effective in ensuring school-based mental health services for CYSHCN with emotional and behavioral needs are delivered consistently across school districts with differing financial resources?

14. How do variations in school district funding, such as local property taxes versus state funds, impact access to mental health services for CYSHCN with emotional and behavioral needs?

15. How do financing and reimbursement models influence equitable access to school-based mental health services for CYSHCN with emotional and behavioral needs? Does the relationship between financing, reimbursement, and equitable access vary by geographic location or school setting?

16. How do school staff, mental health providers, and parents perceive the availability, use, and impact of different funding streams for school-based mental health services for CYSHCN?

17. What mechanisms do states use to fund their share of school-based mental health services (e.g., charging the state share to school districts) and how do these mechanisms support or limit access to services for CYSHCN?

18. How have states or large school districts scaled school-based mental health supports and what effects has this had on access, quality, and outcomes?

19. How do regulatory compliance requirements for school-based mental health services impact staff workload, access to professional support, and perceptions of wellbeing, and how do these effects vary across schools' state and local contexts?

20. What barriers and facilitators influence the capacity of schools and districts to effectively use available funding for school-based mental health services? How does the source of funding affect the quality of mental health services provided?

Models of Care & Support: This domain targets the design and evaluation of support/ service delivery frameworks and collaborative care models that involve educators, mental health professionals, policymakers, and families working together to support the academic, social, developmental, and emotional needs of students. Central to this domain is the investigation into evidence-based interventions and approaches that aim to improve the accessibility, effectiveness, and sustainability of comprehensive mental health services within schools, fostering an environment conducive to the well-being and academic success of the affected students.

Prioritized Research Questions:

1. What types or combinations of school-based models (e.g., multi-tiered system of supports, school-community partnerships, wraparound, peer support) are most effective in supporting the academic, social, and mental health needs of CYSHCN with diverse demographic and clinical characteristics?

2. Which models of care are most effective for CYSHCN across age groups, cognitive abilities, and developmental abilities?

3. Among evidence-based models of care, what components are essential, requiring fidelity, and what components can be adapted to fit local context when scaling across school settings?

4. What are the most effective strategies for measuring the relative impact of having comprehensive teams (including school-based mental health teams and community providers) work together to serve CYSHCN with emotional and behavioral needs?

5. What models best incorporate youth, family, and community voices into care planning and service delivery in school-based settings?

6. What are the best practices for fostering effective collaboration and communication between school staff, families, mental health professionals, and community agencies in support of CYSHCN with emotional and behavioral needs?

7. What are the implementation drivers and barriers to scaling comprehensive mental health models in diverse school settings at the school, district, and/or state level?

8. What are best or promising practices for providing support to CYSHCN with emotional and behavioral needs and their families when transitioning between community support programs, such as inpatient and outpatient care, and the school setting?

9. How does the implementation of trauma-informed care models in schools reshape staff perceptions of school climate, particularly in terms of professional collaboration and emotional safety?

10. What evidence-based mental health guidance can programs use to provide effective mental health guidance that is supportive rather than punitive, while implementing models of care that are patient-centered and promote student autonomy?

11. What is the impact of integrated models of care that embed mental health professionals within school teams on students' perceptions of adult support and connectedness—a key component of school climate?

12. What are effective strategies for identifying and addressing knowledge gaps between interest holders (e.g., community-based organizations, substance use providers, health plans, school mental health professionals) to avoid duplicating services for CYSHCN with emotional and behavioral needs?

13. What elements of multi-tiered systems of support (MTSS) are most effective at improving student engagement for CYSHCN and reducing exclusionary discipline, and how do these elements reflect broader improvements in school climate?

14. What models for integrating school-based services in health homes are most effective for CYSHCN with emotional and behavioral needs and under what circumstances are they most effective?

15. What are promising school-based mental health models for ensuring that the academic wellbeing of high-achieving CYSHCN is preserved or enhanced while they receive intensive emotional and behavioral support?

16. What role does school climate play in sustaining collaborative care models over time, particularly in schools with high staff turnover or limited capacity to provide mental health care?

School & District Climate: This domain encompasses five main components that make up the overall quality and character of school life: (1) Safety, (2) Teaching and Learning, (3) Interpersonal Relationships, (4), Institutional Environment, and (5) Leadership and Efficacy.[iii] This includes the impact of relationship-building on the decision-making process and overall experiences of students, staff, and parents. 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 how strong and effective the leadership is. School and district climate further encompasses the identification of support necessary for faculty and staff, families, and students as well as fostering staff buy-in to promote a supportive learning environment that prevents bullying/trauma and resists re-traumatization.

Prioritized Research Questions:

1. What are the system-level climate indicators (e.g., staff support, communication structures, role clarity) that predict successful district-wide coordination of school-based mental health services?

2. What role does school climate (e.g., teacher-student relationships that foster trust and motivation, disciplinary practices, inclusion culture) play in the success or limitations of mental health service delivery models particularly for CYSHCN with emotional and behavioral needs?

3. What conditions at the school and district level help or hinder school personnel (e.g., teachers, staff) to develop stronger relationships with students and ensure that effective trauma-informed systems are in place when a student reports a mental health concern?

4. What leadership practices at the district level are most strongly associated with equitable and timely implementation of school-based mental health services and improvements in both mental health and climate metrics?

5. What are effective strategies for school and/or district leaders to integrate student mental health, wellbeing, and academic support for CYSHCN with emotional and behavioral needs?

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iii This research domain was adapted from the National School Climate Center's five domains of school climate.

6. How does a positive school climate influence staff willingness to engage in and sustain school-based mental health initiatives, particularly for CYSHCN with emotional and behavioral needs? What is the relationship between staff climate perceptions (e.g., feeling heard, respected, supported) and their responsiveness to students exhibiting signs of emotional or behavioral distress?
7. What are the most effective approaches for school- and district-level leadership to promote workforce well-being, buy-in, and professional efficacy related to school-based mental health services? How can services and mental/behavioral support be improved for teachers/staff?
8. What impact do structural factors such as class size, resource availability, and/or a school's physical space have on perceptions of school climate for CYSHCN with emotional and behavioral needs?
9. What measurable impact does the perception of belonging and psychological safety among CYSHCN with emotional and behavioral needs have on their willingness to engage with school-based mental health services and their comfort with advocating for their mental health needs?
10. What school and/or district factors impact changes in the school climate associated with cultural and political factors currently in the forefront (e.g., DEI or LGBTQ+ policy changes, a student and/or their family's immigration status(es)) and the associated mental health risks?
11. Under what conditions does the quality and nature of the relationship between schools and their surrounding communities help or hinder the implementation of school-based mental health services for CYSHCN with emotional and behavioral needs? How are school-based mental health services prioritized and/or adapted according to the social and emotional needs of the surrounding community?
12. What are the most valid, reliable, actionable, and feasible ways to measure the effectiveness of multi-tiered systems of support (MTSS) in improving school and district climate?
13. What strategies are most effective in reducing stigma toward CYSHCN, particularly those receiving emotional and behavioral support within the school setting? To what extent does a climate of safety and trust among students and staff reduce stigma around accessing mental health services?
14. What are effective approaches for school-based mental health providers and teachers to support CYSHCN returning from inpatient mental health treatment in having a smooth transition to school to ensure academic success without compromising their emotional recovery?
15. What impact does culturally responsive engagement of CYSHCN and their families in school-based mental health services have on how historically underserved communities perceive school climate?

Workforce: This domain focuses on the conditions required for a trauma-informed, well-staffed and coordinated school team that can flexibly support CYSHCN with emotional and behavioral needs. This topic explores effective strategies for aligning roles, trainings, and responsibilities across team members to foster collaboration, avoid duplication of efforts and ensure shared goals while also promoting staff well-being.

Prioritized Research Questions:

1. How can the school-based mental health professional workforce be effectively structured to adequately fund and host a variety of providers and services (e.g., school-based health clinics, community-based organizations)? What workforce structuring is more feasible and efficient across different geographic locations and school settings (e.g., urban, rural)?
2. What training models most effectively prepare teachers and other school staff to provide inclusive, trauma-informed, and culturally responsive care for CYSHCN with emotional and behavioral needs within and beyond the classroom environment?
3. What are best or promising practices for training the school team (e.g., social workers, nurses, counselors, psychologists, teachers, community health partners, etc.) to facilitate shared understanding and goals among different roles and across sectors to support CYSHCN with emotional and behavioral needs? Under which conditions are these practices most effective?

4. What supports are needed to promote effectiveness and sustainability of the workforce, including but not limited to identifying and addressing staff burnout? What are the best or promising strategies for school-based mental health workforce retention to support this workforce's ability to promote high-quality school-based mental health services for CYSHCN with emotional and behavioral needs?

5. What barriers exist within and across states in licensing and recruiting school-based mental health professionals? What are the best or promising strategies for school-based mental health workforce retention, and how do the effectiveness of these strategies vary by geographic location and/or school setting?

6. What are the strengths and weaknesses of training existing staff (e.g., nurses and teachers), hiring additional school mental health professionals, and/or contracting for professionals with outside professional organizations (including telehealth)? Under what conditions and local contexts is one model, or a combination, for the school-based mental health workforce more effective than others?

7. What impact does trauma-informed training and collaborative professional cultures have on staff perceptions of the efficacy of school-based mental health services and reducing staff burnout in schools serving high-need populations such as CYSHCN with emotional and behavioral needs?

8. What domains of school climate most affect retention and job satisfaction among mental health professionals and support staff working with CYSHCN in school settings (i.e., safety, teaching and learning, interpersonal relationships, institutional environmental, and leadership and efficacy)?

9. What practical and financial supports are most effective for integrating peer support professionals into the school-based mental health workforce?

10. What are best or promising peer support practices that can effectively identify and assist CYSHCN who are at risk for significant mental health issues? What factors make these practices more or less successful in the school environment?

11. What are effective approaches for using professional development opportunities to train staff in data collection and management to support the effective collection and use of data?

12. What incentives and supports for school-based staff, such as teachers, are most effective in helping them to promote high-quality school-based mental health services for CYSHCN with emotional and behavioral needs amid other demands?

13. Among school personnel providing mental health services to CYSHCN, how does the performance of certified, specially trained staff (e.g., specially trained teachers, school nurses, mental health staff with training specific to the school setting and CYSHCN) compare to non-certified workers?

14. What practical and financial supports are most effective for integrating peer support professionals into the school-based mental health workforce?

15. How does alignment (or misalignment) between staff's perceptions of school climate and workforce roles facilitate or hinder the coordination and delivery of school-based mental health services for CYSHCN with emotional and behavioral needs?

Youth/Family Engagement: This domain seeks to identify effective strategies for involving families or caregivers and young people as active participants in the planning, implementation, and evaluation of SBMH programs and policies targeting CYSHCN with emotional and behavioral needs. Emphasizing partnership and communication, this work aims to empower families/caregivers and youth, ensuring that their perspectives and needs shape supportive, responsive, and culturally sensitive mental health services in educational settings.

Prioritized Research Questions:

1. What school climate conditions are most predictive of sustained family engagement in the co-design, continued participation, and evaluation of school-based mental health programs for CYSHCN with emotional and behavioral needs?

2. What role do peer support and youth advocacy/empowerment play in enhancing engagement and outcomes in mental health care for CYSHCN with emotional and behavioral needs?

3. What are the best or promising practices to ensure schools provide mental health services that are aligned with both a youth and their family's goals?

4. How do schools operationalize youth- and family-centered approaches in planning, delivering, and evaluating school-based mental health services for CYSHCN with emotional and behavioral needs? In what types of school settings are these approaches more effective?

5. What are exemplar programs that engage CYSHCN and their families in providing real-time feedback and participating in formal processes of assessment, planning, and implementation of school-based mental health services? What conditions at the school, district, and/or community level make these programs more or less successful in engaging youth and family to improve services?

6. What are the most effective practices for creating psychologically safe and confidential environments for CYSHCN with emotional and behavioral needs to encourage their honesty about their own mental health needs and participation in school-based mental health programs?

7. What school, district, and/or community factors (e.g., culture, policies, structure, climate) support or hinder shared decision-making with youth and families when receiving school-based mental health services? What mechanisms and strategies are most effective in facilitating communication and engagement of CYSHCN and their parents/caregivers in school-based mental health services?

8. What communication and leadership styles at the school and district level are most effective in cultivating partnerships between families of CYSHCN and schools to support the delivery of school-based mental health services? Under what conditions are these family-school partnerships most successful in achieving desired mental health and academic outcomes for the student?

9. What impact do cultural, socioeconomic, and linguistic factors have on CYSHCN family engagement in school-based mental health services (e.g., bidirectional communication, shared decision-making)? What interventions can be tailored to address these factors and under what conditions are tailoring these interventions most successful in supporting family engagement?

10. What school- and district-level approaches to structuring school-based mental health services enable schools to better meet the needs of CYSHCN and their families (e.g., offering services outside of school hours)?

11. What practices and environmental conditions within school settings support children's and youth's autonomy and decision-making with respect to school-based mental health care for CYSHCN with emotional and behavioral needs?

12. What impact does the presence or absence of collaborative family-school partnerships have on fostering or hindering a school climate of care and responsiveness for CYSHCN with emotional and behavioral needs?

13. What are the legal and policy differences within and among states in requiring parental consent for services, and how do these differences impact access to and participation in school-based mental health services? What legal and policy differences most impact the ability of CYSHCN with emotional and behavioral needs to obtain mental health care with and/or without parental permission?

14. What existing or promising technology-based approaches are effective in collecting stories of youth and families' lived experiences as qualitative data to inform decision-making on school-based mental health programs for CYSHCN with emotional and behavioral needs? How does the effectiveness of technology-based approaches compare across schools' geographic settings (e.g., urban, rural)?

15. What are best or promising practices for ensuring that CYSHCN families and youth are appropriately financially compensated for their time and expertise when participating in formal processes to assess, plan, and implement school-based mental health services?

Appendix III. Force Field Analysis

Table A.3. Restraining and Driving Forces for the Adoption and Implementation of the Research Agenda

Restraining Forces	Goal	Driving Forces
• Pushback and bureaucracy at the federal, state, and local levels can hinder momentum and undermine essential health infrastructure (e.g., damaging basic health services for students such as vaccinations). • National de-emphasis on the influence of factors that are essential in understanding the etiology of emotional distress (e.g., racial identity, gender identity, sexual orientation, culture, socioeconomic status, etc.). • Heightened privacy, safety, and funding concerns over how data collection and data sharing could harm a student's wellbeing and the ability to receive funding due to collecting certain types of data (e.g., gender identity). • Funding landscape has financial constraints with new limitations on Medicaid, which covers almost half of the CYSHCN population. • Competing priorities in school districts stretch time and resources in addition to the workforce shortages, limited staff capacity, expertise, and the infrastructure needed to collect data. • Voices of families and educational decision makers often are not included in discussions, and they may be wary of "research" on their children/students. Parents can face unrealistic expectations from other interest holders to know and do everything with little resources. • Silos within and across research, policy, and practice can perpetuate assumptions over responsibilities and language disconnects. • Need for a greater shared understanding of implementation science and more recognition of the complexity of research, and sustaining interventions, within the school environment. • Less standardization of education (including moves toward charter schools, private schools, and home schooling) make implementation of standardized approaches within and across states more challenging. • Bias and, in some cases, active pushback from parents towards SBMH services (e.g., political controversy due to a perception that school therapists may influence students' sexual orientation or gender identity).	*Adoption and implementation of the research agenda*	• Bipartisan concern about the youth mental health crisis presents opportunities to pursue shared priorities (e.g., emphasis on chronic disease in MAHA platform, opportunities for special education in the HHS re-organization). • Greater transparency with students and families about how data is used could help combat potential distrust of systems via fostering greater trustworthiness of systems. • Solidarity across interest holders who bring their lived experience, expertise, passion, and resources to work towards positive change. Involvement of youth, family, and community research leaders/partners in research design can strengthen research and increase buy-in. • Build upon the (1) increased awareness and discussion of mental health among youth, and (2) initiatives, foundations, and organizations similarly concerned with students' mental health to leverage the research agenda to facilitate buy-in and participation in research. • Existing state-allocated funding to children and youth's mental health due to the impact of the COVID-19 pandemic along with opportunities to develop relationships with new sources of research funding (e.g., private organizations). • The current regulatory environment may allow privacy restrictions to be more simplified. • Advances in technology (e.g., informatics) expand capacity and are more widely used. Additionally, there has been movement on standardized bidirectional data sharing between schools and community providers. • Connect high teacher burnout to the youth mental health crisis to garner support from teachers; resource scarcity/exhaustion can create willingness and desire for collaboration. • Address more immediate, measurable health outcomes that are prioritized by funders (rather than downstream outcomes). • Use applied language with school audiences (e.g., evaluation, effectiveness studies, etc.) to elevate the delivery of services and practical benefits to students, teachers, administrators, and improve outcomes relevant to them.

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