IMPROVING YOUTH BEHAVIORAL HEALTH THROUGH **SCHOOL-BASED STRATEGIES**

APRIL 2022

01 INTRODUCTION

The COVID-19 pandemic has impacted the mental and emotional health and well-being of youth. In 2021, 15% of youth in the United States had a major depressive episode and 4% had a substance use disorder with the highest rate among youth of color, according to a **Mental Health America report**. Critically, Mental Health America also found that over half of LGBTQ+ youth screened for suicide risk experienced thoughts of suicide or self-harm.

Despite increased need for youth behavioral health prevention and treatment, states are reporting decreased access and availability of services. Kaiser Family Foundation **reported** that outpatient mental health services declined by 58% for Medicaid and Children's Health Insurance Program beneficiaries from January-May 2020. School-based behavioral health services have played a pivotal role in addressing the needs of students during the COVID-19 pandemic and beyond.

Methods

ASTHO, in partnership with CDC Healthy Schools Branch, convened a School Behavioral Health Advisory Committee to identify policy gaps and strategies for delivering behavioral health services in schools. The findings detailed in this report were discussed in two convenings held in April and May of 2021. Through qualitative analysis of discussions among advisory committee members, challenges and strategies were categorized into four overarching themes to advance school behavioral health:

01 **Develop shared communication and vision.**

02 **Enhance state-cross sector partnerships.**

03 **Use data driven action.**

04 **Implement innovative policies to improve access to services.**

01 INTRODUCTION

Themes, strategies, and state examples discussed in the remainder of the report were informed by the School Behavioral Health Advisory Committee comprised of the following organizations. The findings shared here are that of the authors and don't necessarily reflect that of the participating organizations.

- Association of State and Territorial Health Officials
- Centers for Disease Control & Prevention
- Child Trends
- Colorado Department of Health Care Policy & Financing
- Council of Chief State School Officers
- Healthy Schools Campaign
- Maine Center for Disease Control & Prevention
- Mental Health America
- Michigan Department of Health & Human Services
- Oklahoma State Department of Education
- South Carolina Department of Mental Health
- Substance Abuse and Mental Health Services Administration
- Tennessee Department of Health
- Washington Office of Superintendent of Public Instruction
- University of Maryland National Center for School Mental Health

02 SHARED COMMUNICATION AND VISION

Creating shared and inclusive language is critical to the formation of cross-sector collaborations that advance school behavioral health. By aligning definitions of **frequently used terms** in the school setting, behavioral health partners may begin conversations from a place of shared understanding. Communication in school behavioral health could be facilitated by developing shared language to be used by participating state agencies, school districts, and community-based partners when discussing policies and projects.

STRATEGY 1:

Collaborate with the Department of Education on a comprehensive mental health framework to guide student well-being, such as the Multi-Tiered System of Supports framework.

Multi-Tiered System of Supports

The School Behavioral Health Advisory Committee provided input on common language to be used for the purpose of the committee and this report. The committee defined school behavioral health as "the continuum of health services delivered by schools to address the behavioral health needs of students." The definition is based on the National Association of School Psychologists multi-tiered system of supports (MTSS) framework. The American Institute for Research MTSS Center defines MTSS as "a proactive and preventative framework that integrates data and instruction to maximize student achievement and support students social, emotional, and behavioral needs from a strengths-based perspective."

MTSS has been shown to be effective at reducing symptoms of depression for students, with a systematic review of 119 studies finding that over 75% of studies showed positive outcomes for depression symptoms.

The following graphic includes services National Association of School Psychologists listed and services the advisory committee identified. Medicaid, education, and public health agencies have a role to play in delivering the services across each tier. Services may be fluid between the tiers based on student needs.

TIER 1
Universal Services

- Social-emotional learning
- Safe and supportive environments
- School-wide curricullum lessons or grade-level classroom presentations for all students

TIER 2
Targeted Services

- Counseling
- Behavior intervention plans
- Early intervention services and support, such as small-group interventions, individualized interventions, mentoring, and low-intensity classroom-based supports
- Needs assessments, screenings, and referrals

TIER 3
Intensive Services

- School-based health centers
- Trauma-informed care
- Treatment services and supports, such as individual, group, or family therapy

02 SHARED COMMUNICATION AND VISION

STRATEGY 2:

Utilize shared and inclusive language when communicating work around school behavioral health.

Another strategy for improving communication in school behavioral health is to utilize inclusive language, such as person-first language, that incorporates the lived experiences and voices of youth and families. This can be achieved by creating youth and family networks to inform all the stages of program implementation. The MTSS framework requires the school system to continuously collaborate with families and communities, use a data driven approach to make decisions, and incorporate equity as the basis for all programming. The Council of Chief State School Officers (CCSSO) and the Collaborative for Academic, Social, and Emotional Learning **indicate** that an equity-focused MTSS incorporates measures of school climate and students' lived experience in decision making.

Oklahoma's MTSS Framework to Support Students' Mental Health

In response to high rates of ACEs, the Oklahoma State Department of Education (OSDE) has focused on trauma-informed education and has embraced an MTSS framework for programming. OSDE receives the U.S. Department of Education's **School Climate Transformation Grant**, which supports Tier 1 programming across the state. The state also receives the Substance Abuse and Mental Health Administration **AWARE Grant** that supports Tier 2 and Tier 3 services.

OSDE, in collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services, is developing an online platform for students and families as an asset resource map of all school-based mental health and social emotional learning programming available to schools. In response to COVID-19, OSDE also developed **Ready Together Oklahoma**, an action plan for prioritizing the health and well-being of students. As part of the plan, OSDE is using $35 million of its emergency coronavirus relief funding to invest in the Oklahoma School Counselor Corps, adding approximately 300 new counselors and mental health professionals to schools around the state.

03 DATA DRIVEN ACTION

STRATEGY 3:

Use a strength-based approach when collecting, analyzing, and disseminating data highlighting the role of student connectedness and resiliency.

Cross-sector agencies can develop an asset-based data framework to understand the complete picture of behavioral health needs in schools. An asset-based data framework values students' cultural diversity and incorporates the voices of families and students in decision making. Strength-based measures such as school and peer connections, school climate, and positive family relationships can be incorporated into data collection efforts. The National Collaborative for State and Supportive Environments have compiled **data on youth behavioral health** outcomes including positive asset-based measures. Child Trends has compiled a list of **positive development indicators** that allows practitioners and data analysts to see validated asset and strength-based measures.

STRATEGY 4:

Harmonize data sources between cross-sector agencies to understand a complete picture of youth behavioral health.

States could explore ways to harmonize and integrate data sources from public health, Medicaid, and education agencies to develop a comprehensive picture of behavioral health. State cross-sector collaborations should consider the data sources critical for each sector and how to frame behavioral health in terms that resonate with each sector.

Education

The education sector engages with **95% of U.S. children**, providing a safe, supportive, and inclusive environment for learning, social interaction, and health promotion. Because of this regular engagement, the education sector can serve a unique and important role in assessing student health and implementing interventions to address student needs and promote overall wellbeing.

- As required by the Every Student Succeeds Act (ESSA), **needs assessments** provide the education sector with an opportunity to better identify and address health conditions that contribute to poor educational outcomes. The **School Health Index Self-Assessment and Planning Guide** is another useful resource for identifying youth risk behaviors and designing policies and programs to promote health.
- By collaborating with the education sector, state health agencies can consider the link between behavioral health, **education accountability**, and school improvement data. For example, understanding students' attendance data, including **chronic absenteeism** data, can help identify students at risk of behavioral health issues. The **Learning Policy Institute Map** shows which accountability data states are using, including chronic absence, school climate, and suspension rates.

Public Health

As explained in the **10 essential public health services**, the public health sector has a vested interest in primary prevention of health issues by assessing population health, strengthening partnerships, building a diverse and skilled workforce, and enabling equitable access to health services. Public health can assist in assessing student needs, convening stakeholders, designing interventions, and ensuring access to high-quality health services.

- The **Whole School, Whole Community, Whole Child** outlines how the education and public health sectors can align their efforts across 10 domains to achieve the shared goal of promoting a population of healthy, educated students.
- States can utilize student data to inform the creation of their **State Health Improvement Plan** priorities to have the greatest impact in meeting the specific, identified health needs.
- CDC's Healthy Schools Branch and Division of Adolescent and School Health spearhead two sets of data collection in support of state public health and education agencies:
  - The **Youth Risk Behavior Surveillance System (YRBSS)** is a natural collaborative opportunity for the health and education sectors, with 31 state departments of education and 19 state public health departments funded to conduct school-based surveillance on youth risk behavior including suicidal ideation and substance use disorders. YRBS monitors health-risk behaviors among adolescents and young adults at the national, state, territorial, tribal, and local levels. YRBSS includes national, state, territorial and freely associated state, tribal government, and local school-based surveys of representative samples of 9-12th grade students. Many localities and states conduct their own versions of YRBSS with opportunities to expand culturally appropriate and asset-based measures.
  - **School Health Profiles** is a system of surveys assessing school health policies and practices in states, large urban school districts, and territories. Surveys are conducted biennially by education and health agencies among middle and high school principals and lead health education teachers.

Maine Integrated Youth Health Survey

The Maine Center for Disease Control and Prevention (state public health agency) and Maine Department of Education have been collaborating since 2009 to administer a state level survey to assess the health of Maine youth (Kindergarten-12th grade). The **Maine Integrated Youth Health Survey** replaces the state YRBS and incorporates additional data from several national and state surveys into one comprehensive school administered survey. The survey includes traditional behavioral health measures like substance use, bullying and violence, suicide, and depression.

The survey also includes asset-based measures like whether students have caring school environment, receive support from older adults, have positive family relationships, and whether students feel like they matter in their communities. Maine CDC is using the data to inform state resiliency programs with partners like the **Maine Resilience Building Network** and **Maine Youth Action Network**. For example, through the **Youth Mattering Initiative** the data is being used to educate local and state cross-sector partners about the role of resiliency.

Maine is also working collaboratively on a universal early childhood data system that would include information about the continuum of prevention and services children are receiving. The system will focus on early intervention and ensuring children are entering educational settings emotionally and mentally healthy.

Medicaid

37.5%

Children ages 0–18 covered by Medicaid in 2019.

After employer-sponsored insurance, Medicaid is the **second largest insurer** of U.S. children ages 0–18, providing health insurance coverage for 28,216,000 children (37.5%) in 2019. Medicaid plays an important role in ensuring students have access to high-quality, affordable healthcare. Medicaid has critical data on understanding provider access, healthcare utilization, and behaviors of youth experiencing mental health conditions or substance use.

- Medicaid's **quality of care performance measures** help strengthen the quality of health services Medicaid-enrolled students receive.
- State Medicaid programs collect data on **school-based services** including **school-based administrative claiming**. Being specific about which variables in a claim or provider are most helpful—such as specificity in type of providers and services essential to the population of interest—will make it easier for states to analyze data. Analyzing this data can lead to addressing gaps in access to healthcare and creating a continuum of care for youth.
- Some state Medicaid programs are also leveraging electronic health records to maintain real-time data on students and evaluate school-based programs.

School-Based Services Covered by Medicaid

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Audiology
- Nursing
- Psychological Services
- Personal Care Services
- Transportation

National partners are also assisting states at improving their evaluation of school behavioral health programs. For example, state and school districts cross-sector teams can collaborate using the **School Health Assessment and Performance Evaluation System (SHAPE)** developed by the National Center for School Mental Health (NCSMH) at the University of Maryland School of Medicine. SHAPE allows school district and state teams to assess their implementation of comprehensive school mental health systems relative to national performance standards and to engage in continuous quality improvement.

04 CROSS-SECTOR PARTNERSHIPS

STRATEGY 5:

Assemble a cross-sector team with representation across all relevant sectors and levels of implementation.

A strong partnership between education, Medicaid, behavioral health, and public health is essential for addressing youth behavioral health needs. Aligning sectors' resources and actions around the shared goal of improving student mental health and substance use outcomes can help overcome the challenges of limited funding, siloed efforts, and duplication of work.

Each sector plays an important role in ensuring students have access to behavioral health programs. Education creates a common point of contact that empowers behavioral and public health professionals to serve children in need. At the same time, Medicaid plays an essential role in ensuring students have access to high-quality, affordable healthcare. When these sectors work in tandem, states can more effectively reduce behavioral healthcare gaps and strengthen the school behavioral workforce.

States can build on existing infrastructure and collaboration to ensure teams with representation from both the state and local levels. Strong cross-sector and multi-level coordination ensure communication between state-level policy and local-level implementation. Stakeholder mapping can help identify potential new partners by increasing understanding of a given group and their interest in school behavioral health services. Additionally, seeking out opportunities to involve youth in behavioral health efforts will help tailor interventions to the key population's needs and communicate the importance of addressing youth behavioral health and wellbeing.

Key Stakeholders

- State education agency
- State Medicaid agency
- State health agency
- State behavioral health agency
- State Title V maternal and child health agency
- State Title X family planning agency
- Associations for school health providers
- Behavioral health providers
- Safety net providers
- State Nursing Associations
- Health insurance providers
- Youth advocacy organizations
- Family advocacy organizations
- Teachers' unions
- Faith-based organizations

04 CROSS-SECTOR PARTNERSHIPS

Conducting a community assessment can help identify gaps in access to school behavioral health services. Once needs are identified, team members' activities, resources, and expertise can be matched to community needs in a joint workplan around the shared goal of advancing access to school behavioral health services. Staff and leadership from different sectors should participate in the process of identifying and coordinating funding sources to help support the shared workplan.

Tennessee's Adverse Childhood Experiences (ACEs) Collaboration

The **Building Strong Brains Tennessee (BSBTN)** initiative strives to address ACEs through public and private partnerships that involve the three branches of state government and are driven to create community-specific solutions. Examples of state executive agencies represented in the public steering committee include the Department of Health, Department of Education, and Department of Human Services. Using the "three-branch, two-science approach," BSBTN aims to translate science and evidence into policy, training, and action to prevent ACEs and address their impact.

In addition, the **Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) School-Based Behavioral Health Liaisons** provides ACEs prevention services to students in elementary, middle, and high schools. The liaisons also provide face-to-face consultation with classroom teachers of students who are at risk for emotional or behavioral health challenges. TDMHSAS receives state funding to provide a behavioral health liaison in all 95 counties in partnership with community mental health provider agencies.

STRATEGY 6:

Improve the capacity of the traditional and non-traditional school workforce to address behavioral health.

School Behavioral Health Workforce

The **school workforce** lays the foundation for behavioral health services provided in the school environment. Schools traditionally rely on a behavioral workforce comprised of a diverse group of professionals such as school counselors, social workers, school psychologists, school nurses, and occupational therapists. While the traditional behavioral workforce is essential to school-based behavioral health services, many schools and school districts lack the funds and resources to adequately staff these professionals. The challenges of sufficiently staffing a traditional clinical behavioral workforce in the school environment highlights the need for schools and school districts to implement innovative and considerate workforce development policies. School behavioral workforce policy areas include cross-disciplinary training, mental health education, and broadening school-based provider types.

04 CROSS-SECTOR PARTNERSHIPS

Policies that address the school workforce's training offer a unique ability to leverage the existing school workforce to build the capacity of school-based behavioral health services. Examples include policies that **train non-clinical school staff** on screening, identifying, and interacting with students in need of behavioral health services. Educators and school staff have a high level of interaction with students daily, placing educators and school staff in the best position to identify and respond to students showing signs of mental unwellness and other behavioral or mental health concerns. Training educators and school staff on how to identify and respond to the mental health needs of students could allow schools to streamline behavioral service requests and improve students' access to needed behavioral and mental health resources.

Schools and school districts can also enact policies that educate faculty, administrators, and students about behavioral and mental health to normalize and destigmatize mental disorders. Destigmatizing mental health within the school environment can increase the likelihood of a student feeling safe and supported to access school-based behavioral healthcare, thus increasing schools' capacity to provide behavioral health services. Policies designed to train and educate the school workforce can improve school-based services and enhance the capacity of schools to address the needs of their student body.

Schools can also serve as providers of high-quality, low-cost healthcare services, especially for children whose families encounter challenges in accessing and utilizing healthcare. Over 2,000 school-based health centers **operate** across the country, providing students with on-site access to mental and behavioral health and other healthcare services. Additionally, schools may provide services through school health providers, such as **school nurses** and **school mental health providers**.

Another option to increase a school's behavioral health workforce is to expand which provider types may work in the school environment. Licensure requirements for behavioral health providers can be varied and inconsistent across the school, state, and federal levels. These varying guidelines make it challenging to reimburse and support behavioral health services within schools. Leveraging policy to align requirements across jurisdiction levels and expanding the types of behavioral and mental health providers who can practice in schools would increase the school's capacity to provide mental and behavioral health service. Developing policies that train the non-clinical workforce and expand the possible clinical workforce states can develop and improve schools' ability to provide mental and behavioral health services.

Washington State's Children's Regional Behavioral Health Pilot

In July 2017, Washington state launched the **Children's Regional Behavioral Health Pilot** in response to a report that identified unmet student behavioral health needs. In the pilot, a behavioral health system navigator would network with regional healthcare partners and school districts to communicate the role of the education sector in providing school behavioral health services, improve Medicaid claiming, foster community partnerships, and strengthen collaboration between state and local partners.

Washington's **participation** in the Healthy Students, Promising Futures Learning Collaborative since 2016 provided this pilot with a strong foundation of partnerships between the Health Care Authority; Office of Superintendent of Public Instruction; Department of Health; Department of Children, Youth, and Families; and Washington School-Based Health Alliance. In July 2020, the Behavioral Health System Navigator positions were funded by the state legislature in all nine of the regional Educational Service Districts.

STRATEGY 7:

Expand Medicaid reimbursement in school settings, by removing state restrictions on school health services, to align with national Free Care Reversal Guidance.

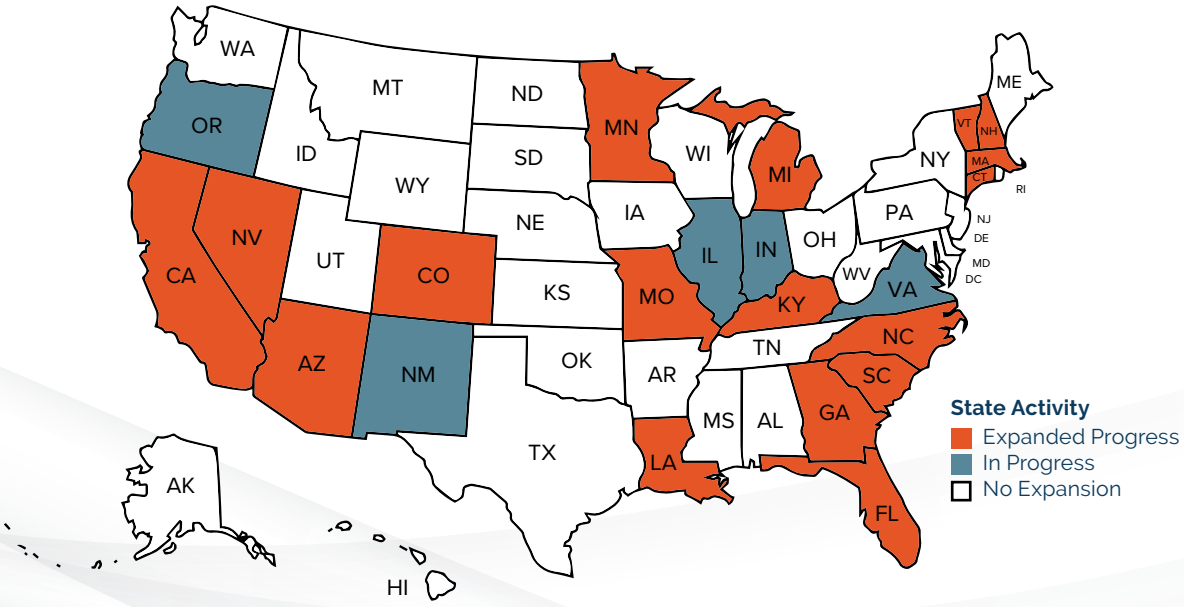
Medicaid School-Based Services

Prior to 2014, states faced significant barriers to receiving federal Medicaid funding for school-based health services. The "free care rule" prevented Medicaid reimbursement for services that were provided to everyone without charge, limiting funding to services included in students' Individualized Education Programs (IEPs) or Individualized Family Service Plan. In December 2014, CMS issued **guidance** effectively reversing the free care rule clarifying that school districts can receive reimbursement for any eligible service a Medicaid enrolled student receives. The purpose of the updated guidance was to improve access to healthcare services and ensure Medicaid reimbursement is available for covered services regardless of whether services would have been provided at no cost to students.

With this free care policy reversal, school districts have **expanded their school-based health programs**, provided more services to students, and have sustainable funding for schools. Generally, states submit a plan amendment (SPA) to CMS to implement this policy change. Despite this guidance, many states have not leveraged this opportunity to expand their school Medicaid program. As of December 2021, **16 states** have expanded the use of Medicaid to pay for school health services for all Medicaid-eligible students through a SPA or regulation, while four states are in the process of submitting a SPA for approval.

Several state agencies were involved in implementing the free care reversal policy.

States that expanded medicaid coverage in schools and states in the process of expanding Medicaid coverage in schools



Colorado Free Care Reversal

School-based healthcare providers in Colorado participate in random moment time studies (RMTS) to receive interim Medicaid reimbursement through a cost-settlement model instead of the traditional fee-for-service. Colorado received approval for the state plan amendment to **expand school-based services** to all students in Medicaid in February 2020. Prior to approval, Colorado conducted an analysis over three separate phases to better understand the financial impact of the free care rule policy. This analysis spurred cross-agency communication bringing together various stakeholders like the Department of Education to share data and research. For phase one, the Colorado Department of Health Care Policy and Financing studied the cost impact of the policy and if it would financially benefit the state.
Phase two involved on-site visits to better understand how the policy would be implemented in schools. During the implementation, Colorado convened a stakeholder group that consisted of representatives from Local Education Agencies, (LEAs), Education officials, Health personnel, and Medicaid officers. The Medicaid office led the implementation and provided technical assistance through webinars and trainings. In phase three, the Colorado Department of Health Care Policy and Financing received guidance from CMS that separating IEP services and non-IEP services on the annual cost report was a valid approach to claiming Medicaid reimbursement.

Michigan Caring for Students Expansion

Michigan's SPA **expanded** Medicaid reimbursement to include services delivered to all Medicaid-enrolled students, not just students enrolled in an IEP. Michigan created workgroups bringing together the Department of Education and Department of Public Health staff. The Medicaid agency led the policy implementation, while the public health staff were responsible for providing information to schools and healthcare professionals. The state used a contractor to facilitate trainings, regional meetings, and an annual conference to share the information around expanding their school Medicaid program.

The expansion is known as **Caring for Students** and builds on existing school-based services to increase federal funding to the state for behavioral health and nursing services for students on Medicaid. Michigan's SPA also expanded the type of providers that could bill Medicaid including physician assistants, nurse specialists, school psychologists, and school social workers.

Using separate Medicaid eligibility ratios for the general population and the special education population, Michigan increased overall reimbursement. The implementation of the state plan amendment allowed Michigan to expand services. Prior to implementation schools were servicing 108,000 students and can now serve 980,000 students. They were also able to increase behavioral health providers from 1,700 to 3,000 in three months.

Remaining Challenges in Implementation

Systemic issues such as limited funding, lack of resources, and low staffing prevent strong collaboration between Medicaid, education, and public health. To expand Medicaid school-based services, states must revise existing policies and programs to expand coverage and implement innovative policies for school-based services. LEAs are **required** to complete cost reports outlining administrative costs, clinical administrative costs, clinical costs, and non-reimbursable costs.

Advisory committee members relayed that states often need to balance the changes to covered services made possible under the free care policy reversal with other ongoing challenges, such as decreasing the amount of time providers had to respond to RMTS requests. In a nutshell, if a state uses a cost-settlement model, simply increasing the number of services covered does not always increase funding for the overall program.

Fee-for-Service

- Reimbursement is based on number of services provided in a school setting.
- School districts must submit fee-for-service claims to CMS for all Medicaid allowable school health services.

Cost-Settlement

- Cost-settlement models involve a series of calculations, including a cost report, a RMTS, Cost Reconciliation, and Cost Settlement.
- To determine reimbursement, the RMTS are quarterly reports that outlines the amount of time school staff spend on providing services to Medicaid-eligible students.

STRATEGY 8:

Expand school telehealth service provision.

School Telehealth

The COVID-19 pandemic expanded the use of telehealth for several services. Prior to the pandemic, **24 states had policies** that allowed reimbursement of telehealth services in schools. During the pandemic, 31 states expanded Medicaid reimbursement for school-based telehealth services. About half of states reimburses all Individualized Education Program and Early and Periodic Screening, Diagnostic, and Treatment services via telehealth.

The most commonly provided telehealth services in schools are audiology and speech-language. However, behavioral health services were the most common types of services provided during the pandemic with 22 states now allowing Medicaid reimbursement for behavioral health services. There are **opportunities** to better understand how telehealth can be used for students as schools reopen, especially when school is not in session. States should consider Medicaid reimbursement policies as well as pay equity between telehealth and physical health services.

South Carolina Telehealth Expansion

In 2016, South Carolina's governor signed **S.B. 1035** into law to increase access to telehealth, including in schools. As part of the Health Schools Campaign's Learning Collaborative, South Carolina has **expanded access** to school health services through telehealth. The telehealth program started in just one school but has grown to more than 80 schools in the state, especially in areas with high health disparities. Students in schools are linked to a nurse and local provider with HIPAA-compliant equipment. Treatment is provided for acute conditions such as ear infections as well as some chronic care management for asthma and ADHD. The program has increased both access to services for students and funding to schools.

STRATEGY 9:

Leverage recent federal school health funding to support school behavioral health services.

Methods of Financing Behavioral Health in Schools

Although Medicaid reimbursement is the primary mechanism for funding services for eligible students, states can use federal funding to supplement services. The **American Rescue Plan** (ARP) includes **$122 billion** for the Elementary and Secondary School Emergency Relief (ARP ESSER) Fund. In March 2020, Congress passed the Coronavirus Aid Relief, and Economic Security Act (CARES Act), which established the Education Stabilization Fund (ESF), allocating $30 billion to the U.S. Department of Education. The ESF included three types of emergency relief funding opportunities: Governor's Emergency Education Relief Fund, ESSER, and the Higher Education Emergency Relief Fund.

The Department of Education has a **portal** that outlines the funds awarded by program and total money spent by each state. Funds have already been allocated to state educational agencies and school districts for reopening and to ensure sustainable funding. Information on the total allocation per state can be found **here**. Healthy Schools Campaign, CCSSO, and National Center for School Mental Health have also released **guidance** on how the ESSER funds can be used to support student well-being including through tiered levels of support.

In 2015, Congress passed the **Every Student Succeeds Act (ESSA)** reauthorizing the 50-year-old Elementary and Secondary Education Act. ESSA authorized funds to help states, LEAs, schools, and communities provide students with a well-rounded education. States were required to submit a consolidated plan to apply for ESSA funding. The template for the application can be found **here**.

STRATEGY 10:

Braid/layer funding to support a shared risk and protective factors approach to youth behavioral health.

To address limited funding, states have braided or layered their funding streams to leverage existing resources to maximize their efforts to address the shared risk and protective factors associated with behavioral health. Braiding funding means that funds are allocated from multiple sources to support one contract or project, while layering funding means that funds are coordinated from multiple sources for a common set of initiatives. For example, by adopting a primary prevention approach, the **Maine Department of Health** leveraged tobacco grant dollars and overdose prevention grant dollars to support their school-based health centers. More information for state agencies considering braiding and layering to address funding can be found **here**.

06 CONCLUSION

The COVID-19 pandemic deepened existing inequities and increased exposure to variety of risk factors that may negatively impact the health and education of youth. However, changes in state and federal policies both before and during the pandemic have created opportunities for improving health equity and increasing behavioral health service access for youth. States can leverage cross-sector collaboration between education, Medicaid, health agencies, and community partners to address the behavioral health needs of youth.

In summary, the following are high-level strategies discussed by the advisory committee and outlined in this report, which may be implemented to advance work in school behavioral health:

01 **Collaborate with the Department of Education on a comprehensive mental health framework to guide student well-being, such as the Multi-Tiered System of Supports framework**

02 **Utilize shared and inclusive language when communicating work around school behavioral health.**

03 **Use a strength-based approach when collecting, analyzing, and disseminating data highlighting the role of student connectedness and resiliency.**

04 **Harmonize data sources between cross-sector agencies to understand a complete picture of youth behavioral health.**

05 **Assemble a cross-sector team with representation across all relevant sectors and levels of implementation.**

06 **Improve the capacity of the traditional and non-traditional school workforce to address behavioral health.**

07 **Expand Medicaid reimbursement in school settings, by removing state restrictions on school health services, to align with national Free Care Reversal Guidance.**

08 **Expand school telehealth service provision.**

09 **Leverage recent federal school health funding to support school behavioral health services.**

10 **Braid/layer funding to support a shared risk and protective factors approach to youth behavioral health.**

06 APPENDIX: RESOURCES

Comprehensive School Mental Health Frameworks

- **Whole School, Whole Community, Whole Child (WSCC) by CDC:** https://www.cdc.gov/healthyschools/wscc/
- **"Using Policy to Create Healthy Schools: Resources to Support Policymakers and Advocates" by Child Trends:** https://www.childtrends.org/publications/using-policy-to-create-healthy-schools
- **WSCC State Policy Database by National Association of State Boards of Education:** https://statepolicies.nasbe.org/
- **Advancing Comprehensive School Mental Health Systems: Guidance from the Field by National Center for School Mental Health:** https://www.schoolmentalhealth.org/Resources/Foundations-of-School-Mental-Health/Advancing-Comprehensive-School-Mental-Health-Systems--Guidance-from-the-Field/
- **"Essential Components of MTSS" by Center on MTSS:** https://mtss4success.org/essential-components
- **"Integrating Social and Emotional Learning Within a Multi-Tiered System of Supports to Advance Equity" by CCSSO, CASEL, and AIR:** https://753a0706.flowpaper.com/CCSSOSELMTSSToolkit/#page=1

Data Driven Action

- **"Interactive Map: Making ESSA's Equity Promise Real" by Learning Policy Institute:** https://learningpolicyinstitute.org/product/essa-equity-promise-interactive
- **Positive Indicators Project by Child Trends:** https://www.childtrends.org/research/research-by-topic/positive-indicators-project
- **Youth Risk Behavior Surveillance System Overview by CDC:** https://www.cdc.gov/healthyyouth/data/yrbs/overview.htm
- **"Using Needs Assessments to Connect Learning + Health: Opportunities in the Every Student Succeeds Act" by Healthy Schools Campaign:** https://healthyschoolscampaign.org/resources/single/using-needs-assessments-to-connect-learning-health-opportunities-in-the-every-student-succeeds-act-essa/
- **"School Health Index" by Centers for Disease Control and Prevention:** https://www.cdc.gov/healthyschools/shi/index.htm
- **"Data on Prevalence of Common Behavioral Health Issues by National Center on Safe Supportive Learning Environments:** https://safesupportivelearning.ed.gov/data-prevalence-common-behavioral-health-issues
- **"Data Driven Primary Prevention Strategies for Adverse Childhood Experiences" by ASTHO:** https://www.astho.org/topic/report/data-driven-primary-prevention-strategies-for-aces/
- **"Data Sharing Across Child-Serving Sectors: Key Lessons and Resources" by Nemours and Mental Health America:** https://www.movinghealthcareupstream.org/wp-content/uploads/2020/01/data-sharing-brief.pdf
- **"Data-Sharing Tool Kit for Communities: How to leverage community relationships while protecting student privacy" by the United States Department of Education:** https://www2.ed.gov/programs/promiseneighborhoods/datasharingtool.pdf

06 APPENDIX: RESOURCES

Cross Sector Partnerships and Workforce

- **"Effective School-Community Partnerships to Support Student Mental Health:" by National Center for School Mental Health and National Association of School Psychologists:** http://www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Resources/Effective-School-Comm-Partnerships-to-support-SMH-Final.pdf
- **"Recruitment and Retention of School Mental Health Providers" by Mental Health Technology Transfer Center Network:** https://mhttcnetwork.org/sites/default/files/2021-08/SMHWorkforceReport_2021_final_updated_05AUG21.pdf
- **Diverse Workforce Self-Assessment" by Mental Health Technology Transfer Center Network:** https://mhttcnetwork.org/centers/pacific-southwest-mhttc/product/assessing-workforce-diversity-tool-mental-health

School Based Medicaid Services

- **"How States Can Leverage Medicaid Funds to Expand School-Based Health Services" by Healthy Schools Campaign:** https://healthyschoolscampaign.org/dev/wp-content/uploads/2020/02/Policy-Brief-1-28-20.pdf
- **Map indicating states that have expanded Medicaid services reimbursement by Healthy Schools Campaign:** https://healthystudentspromisingfutures.org/map-school-medicaid-programs/
- **"Early Evidence of Medicaid's Important Role in School-based Health Services" by Child Trends:** https://www.childtrends.org/publications/early-evidence-medicaid-role-school-based-heath-services

School Behavioral Health Telehealth

- **Telehealth Policy Resources and Reports by Center for Connected Health Policy:** https://www.cchpca.org/resources/ | https://www.nashp.org/wp-content/uploads/2021/05/telehealth-report.pdf
- **Telehealth Resources by National Consortium of Telehealth Resource Centers:** https://telehealthresourcecenter.org/
- **"States Expand Medicaid Reimbursement of School-Based Telehealth Services" by National Academy of State Health Policy:** https://www.nashp.org/wp-content/uploads/2021/05/telehealth-report.pdf
- **"State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth" by the Center for Medicare & Medicaid Services:** https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf

06 APPENDIX: RESOURCES

Financing School Behavioral Health

- **"Restart & Recovery: Leveraging Federal COVID Relief Funding & Medicaid to Support Student & Staff Wellbeing & Connection":** https://learning.ccsso.org/restart-recovery-leveraging-federal-covid-relief-funding-medicaid-to-support-student-staff-wellbeing-connection
- **"Education Stabilization Fund" by U.S. Department of Education:** https://covid-relief-data.ed.gov/?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=
- **Template for ESSA application by U.S. Department of Education:** https://www2.ed.gov/admins/lead/account/stateplan17/revisedessastateplanguidance.docx
- **"Blended and Braided Funding: A Guide for Policy Makers and Practitioners" by Association of Government Accountants:** https://www.agacgfm.org/Intergov/More-Tools/Blended-and-Braided-Funding-A-Guide-for-Policy-Ma.aspx
- **"Blending, Braiding, and Block-Granting Funds for Public Health and Prevention: Implications for States" by ASTHO, deBeaumont Foundation, and NASHP:** https://debeaumont.org/news/2017/blending-braiding-and-block-granting-funds-for-public-health-and-prevention-implications-for-states/
- **"Braiding and Layering Funding for Adverse Childhood Experiences" by ASTHO:** https://www.astho.org/ASTHOReports/Braiding-and-Layering-Funding-for-ACEs-Prevention/08-05-21/
- **"School Mental Health Quality Guide: Funding and Sustainability" by the National Center for school Mental Health:** https://www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Quality-Guides/Funding-and-Sustainability-1.27.20.pdf
- **"State Funding for Student Mental Health" by Education Commission of the States:** https://www.ecs.org/state-funding-for-student-mental-health/

This publication was made possible by Grant Number 5 NU38OT000290-04-00 from Department of Health and Human Services Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.