Community-Partnered School Behavioral Health
State of the Field in Maryland

2015
Acknowledgements

Since 2013, the School Behavioral Health Coalition (led by the Mental Health Association of Maryland) has been meeting to advance support and understanding of Maryland’s Community-Partnered School Behavioral Health (CP-SBH) programming. Participants in this group represent a broad array of stakeholders from agencies, organizations and programs interested in advancing CP-SBH, including the Maryland State Department of Education (MSDE) and the Department of Health and Mental Hygiene (DHMH)’s Behavioral Health Administration. This group helped to inform Maryland House Bill 639, Task Force on Community-Partnered School-Based Mental Health\(^1\). As a result of this bill, the Maryland State Legislature requested that DHMH study and make recommendations to advance school behavioral health in the State.

This report is in response to HB639, and represents a collaborative effort between the School Behavioral Health Coalition, MSDE, DHMH, and the Center for School Mental Health at the University of Maryland. The aim of this report is to identify the state of and recommendations for the future of Community-Partnered School Behavioral Health in Maryland.

Special thanks to the following for assistance with informing this report:

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  - Johns Hopkins Bayview Medical Center
  - Maryland Addictions Directors Council
- Maryland Association of Resources for Families and Youth
- Maryland Coalition of Families for Children’s Mental Health
  - Maryland Disability Law Center
- Maryland State Department of Education (MSDE)
  - Mental Health Association of Maryland
  - Mountain Manor Treatment Center
  - National Alliance on Mental Illness, Maryland
- National Council on Alcoholism and Drug Dependence, Maryland
  - North Star Academy
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- Programs that are showcased in this report:

  - **Maryland**: Anne Arundel County Expanded School Based Mental Health Services Initiative, Baltimore City Expanded School Mental Health Network, Johns Hopkins Bayview Medical Center Baltimore Student Assistance Program, Linkages to Learning, Maryland Treatment Center’s Discovery Center, Talbot County Public Schools.

  - **National**: D.C. School Mental Health Program, Hennepin County’s Children’s Mental Health Collaborative, Syracuse Promise Zone, Vanderbilt School-Based Program.

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Executive Summary: Community-Partnered School Behavioral Health

In 2014, in response to Maryland House Bill 639, Task Force on Community-Partnered School Behavioral Health\(^1\), the legislature requested that the Department of Health and Mental Hygiene (DHMH) study and make recommendations to advance school behavioral health in the State. To address this request, DHMH worked with the Maryland School Behavioral Health Coalition to develop a report on the current state of Community-Partnered School Behavioral Health (CP-SBH) to include the following components:

- Prevalence of CP-SBH programs in the State of Maryland
- Effectiveness of CP-SBH programs across the State and the nation
- Fiscally sustainable models of CP-SBH, including maximization of third-party billing for mental health services and supplemental funding for ancillary services; and
- Practical and empirically-supported recommendations for advancing CP-SBH in Maryland

Methodology used to generate report contents included a comprehensive literature review of CP-SBH best practices and programs, a statewide survey of Maryland school systems (completed by Student Service Directors, Core Service Agency Leads, and Alcohol and Drug Coordinators), and stakeholder interviews and feedback.

**Behavioral Health and Community-Partnered School Behavioral Health Defined:**

**Behavioral Health** encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for substance abuse, addiction, and substance use disorders, mental illness, and/or mental disorders\(^2\).

**Community-Partnered School Behavioral Health** involves community behavioral health providers as partners with schools and families to augment existing school supports and services to provide a more comprehensive and broader array of behavioral health care within schools to students and their families.

**Background**

Mental health and substance use disorders are among the top conditions that cause disability, resulting in significant costs to families, employers, and publicly funded health systems. In fact, the Substance Abuse Administration and Mental Health Administration estimates that by the year 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability\(^3\). Approximately one in four youth in the United States have diagnosable behavioral health disorders\(^4\). This translates to over 337,000 of Maryland’s under-18 population experiencing behavioral health disorders that negatively impact their ability to function in school, at home, and in the community\(^5\). Youth with these behavioral health concerns are at significantly increased risk for negative outcomes such as school dropout, juvenile justice involvement, and substance abuse. Interventions that prevent disorders before
they even develop offer the best protection for our youth. In addition, providing interventions early and in accessible settings (such as schools) greatly reduces negative outcomes, and supports positive outcomes associated with productive citizenry⁶.

**Preventing and addressing child and adolescent behavioral health concerns early are fiscally responsible strategies.** According to a July 2014 report by the Robert Wood Johnson Foundation, investing in funds for prevention and early intervention programs and services not only saves direct costs but indirect costs, as well. These indirect costs can be thought of as “healthy years of life,” and reflect both premature death, and years lived with a disability, both of which incur significant societal cost burden. These costs also include parent/caregiver loss of productivity because of an increased need to care for their children and the loss of future productivity for the affected children⁷. It is estimated that for every dollar spent on child behavioral health services, at least $2, and up to $10, is saved⁹ (in later, more intensive services - Juvenile Justice, Social Services, education, and health - and lost productivity⁸.)

**Providing services directly to students in schools is a logical and effective strategy to address mental health needs of children and adolescents.** Of youth who access treatment, 70-80% of them receive these services in schools⁹,¹⁰,¹¹. For many students, if not for school-based services, they would not have been identified as having a behavioral health concern and would not have accessed and received treatment services. Schools are a critical and natural setting to teach and promote positive social, emotional, and behavioral skills, identify and assist youth at risk for experiencing more serious behavioral health concerns, and provide behavioral health treatment to youth already displaying more serious behavioral health concerns.

**Providing behavioral health services in schools, in partnership with community mental health and substance use providers, has proven effective¹².** CP-SBH promotes:

- Increased academic achievement
- Improved behaviors in the school and decreased disciplinary actions
- Less school violence and reduced dropout
- Increased academic engagement and motivation
- Improved school climate

**Maryland is well-positioned to achieve the societal and fiscal benefits of providing school behavioral health statewide.** This report describes the need for, prevalence of and models for high quality, sustainable CP-SBH services, and provides specific recommendations for Maryland to advance CP-SBH to promote children’s mental health.
Key Findings and Recommendations

Three overarching recommendations related to CP-SBH are suggested:

1) Create and share a common set of statewide guidance documents that can be utilized across jurisdictions to establish, disseminate, and foster high quality CP-SBH programs across Maryland.

2) Develop statewide standardized reporting, collection, and outcome measurement mechanisms, policies, and procedures. This reporting should include a census of CP-SBH programs throughout the state to clarify prevalence of CP-SBH programs across Maryland and to promote awareness of and access to the services. 

_PASSAGE OF SUCH STANDARDIZATION WOULD ALLOW FOR:_

✓ Greater access of CP-SBH programs to best practices in service provision and program policy and procedures
✓ Increased accountability across providers and agencies, and
✓ Enhanced access to information regarding the prevalence, funding, and outcomes of CP-SBH across the state to inform return on investment.

3) Expand access to and funding for CP-SBH in schools (K – 12) in Maryland in an effort to address barriers to learning for all students.

PREVALENCE

Key findings

• Prevalence of CP-SBH services varies widely across the State (ranging from no schools to all schools in a given jurisdiction.
• No system is in place in Maryland that identifies and documents CP-SBH existence, service array, and extent of weekly staffing coverage
• A limited number of CP-SBH programs effectively integrate substance-use prevention and intervention services within their daily practice
• A majority of CP-SBH programs provide treatment services for students already identified with concerns, yet few provide behavioral health promotion and/or prevention services.

Long-Term Goals

• Expand CP-SBH programs across the State to reduce variability across school systems, and ensure that all student needs are effectively met.
• Develop a common census across the state to measure the prevalence and availability of CP-SBH programs
• Ensure that all students at all schools in Maryland have access to a full continuum of behavioral health services through CP-SBH
• Systematically collect and disseminate to schools, families, and community partners CP-SBH availability, access, and service array by school and school system...
• Expand access to and funding for substance-use prevention services across the K – 12 curricula, and for substance-use intervention services for middle- and high-school aged students.
QUALITY

Key findings

- There is wide variability in the extent to which programs are implementing best practices and using evidence-based programs to maximize high quality of care.
- CP-SBH providers would benefit from additional training related to providing effective behavioral health services in schools, and may need access to additional training in order to provide empirically-supported services across a multi-tiered system of support.
- CP-SBH programs are not consistently collecting, analyzing and reporting student- and school-level data to document impact of service provision.

Long-Term Goals

- Develop a single, comprehensive system to support common CP-SBH data collection and program evaluation across jurisdictions to streamline and inform decision-making.
- Encourage and appropriately reimburse/incentivize providers to utilize empirically-supported treatments and best practices tailored to suit the needs of youth, families, schools, communities, and jurisdictions.
- Offer readily accessible and no cost/low cost training on implementing evidence-based programs and best practices in schools related to mental health, substance use, and co-occurring disorders across a multi-tiered system of support.
- Provide training to CP-SBH providers on school policy, teaming, and unique aspects of school-based service provision

SUSTAINABILITY

Key Findings

- Sustainable models of CP-SBH programming braid together diverse funding streams, including fee-for-service and local/state funding sources.
- Although jurisdictions reported using a variety of funding sources, there is a predominant reliance on fee-for-service revenue, which results in a primary focus on treatment services as compared to a multi-tiered system of support (that include prevention and promotion supports as well as treatment).
- Substance use services are heavily reliant upon grant dollars which have significantly reduced in recent years. Financing substance use services in schools has been particularly challenging related to recent decreases in prevention funding.

Long-Term Goals

- Ensure that meaningful partnerships and integrated funding strategies among schools, behavioral health programs, family organizations, and community organizations are pursued and leveraged to promote sustainability of CP-SBH programs.
- Work across child-serving agencies (including behavioral health, education, juvenile justice and child welfare) to identify and leverage funding opportunities that support school behavioral health within the larger system of care.
- Improve availability of and funding for school mental health and substance use services, particularly, prevention services.
Background

This report marks the latest in a continuing effort to improve and expand school behavioral health services throughout Maryland. These efforts date back to 2003, when the Maryland Mental Hygiene Administration (MHA), with assistance from a broad and diverse group of stakeholders, created the Blueprint for Children’s Mental Health, which endorsed a bold vision and policy framework for improving mental health services for children and adolescents. A primary strategy embraced in that report was mental health promotion, including the expansion of school mental health.

Since that time, leadership at the Behavioral Health Administration (BHA; the result of the state merging the Mental Hygiene Administration and the Alcohol and Drug Abuse Administration), the Maryland State Department of Education (MSDE), the Maryland Coalition of Families for Children’s Mental Health (MCF), and the University of Maryland Center for School Mental Health (CSMH), and numerous youth-serving behavioral health agencies and staff from across the state, have been working to implement and build from the recommendations in that initial Blueprint document. These collaborations have resulted in a number of subsequent reports, including the Maryland School Mental Health Survey, a 2009 report of the Maryland Blueprint Committee-School Mental Health Group¹³. While there is increased awareness of the value of school-based mental health services and pockets of excellence in the State, there is much work to be done to understand and ensure high quality CP-SBH provision throughout Maryland.

Recognizing the imperative of taking the next step, and cognizant of the increasing body of evidence supporting the impact of CP-SBH, the School Behavioral Health Coalition, a small coalition of individuals representing programs and advocacy organizations with interest in advancing CP-SBH, worked with the Maryland General Assembly in 2014 to develop and introduce House Bill 639. House Bill 639 would have established a task force to study and make recommendations to expand and improve the quality of CP-SBH service delivery throughout the state. While the Bill did not pass, the imperative of CP-SBH was recognized and next steps were requested. More specifically, the Chairman of the House Health and Government Operations Committee requested that the Department of Health and Mental Hygiene examine the issues raised in the legislation during the interim between sessions.

While the efforts regarding mental health services for children have been tremendous, there has been no similar effort regarding substance use disorder services for children in Maryland. As the public mental health and substance use disorder systems have been financed separately and differently, there are many fewer substance use disorder services in schools in the state for a variety of reasons. As the state has recently begun an effort to integrate these services, the state’s leadership on mental health issues for children has been working to include substance use issues and shifted the state’s focus to address behavioral health services more broadly.
Dr. Sharfstein, Secretary of Health in Maryland, in turn requested that BHA help to guide and oversee the development of a report on CP-SBH. Related to expertise on the topic, the BHA asked the Center for School Mental Health with guidance from the Behavioral Health Coalition to lead the development of a comprehensive report with the following purpose:

- Study the prevalence of existing community–partnered school–based behavioral health (CP-SBH) programs in the State
- Collect and evaluate data on the efficacy of community–partnered school–based behavioral health programs across the State and the nation
- Identify fiscally sustainable models of providing community–partnered school–based behavioral health, including maximization of third–party billing for mental health services and supplemental funding for ancillary services; and
- Make practical and empirically supported recommendations

What is Behavioral Health?

Within this report, the term “behavioral health” is defined by using the definition provided by the Substance Abuse and Mental Health Services Administration. Behavioral health encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders.

In July 2014, the State of Maryland merged its Mental Hygiene Administration and its Alcohol and Drug Abuse Administration Agencies into one agency, the Behavioral Health Administration (BHA). BHA leadership have been working to develop an integrated system of care to address the interconnected and frequently co-occurring mental health and substance use challenges of Maryland youth.

The Prevalence of Behavioral Health Concerns in Youth

High rates of under-identification, limited access to treatment, and low quality of behavioral health services for children and adolescents in the United States prompted the U.S. Surgeon General to declare a national public health crisis. Between 20% to 38% of youth in the United States have diagnosable behavioral health disorders, while 9% to 13% have serious disturbances that impact daily functioning. By conservative estimates, one in five children will experience behavioral health concerns that could benefit from early identification and intervention. However, less than half of these youth will access treatment services related to a variety of challenges (e.g., transportation, insurance, finances, child care, stigma, scheduling), with some research indicating that 75% of children with emotional and behavioral disorders do not receive mental health services.
The mental health needs of students across the developmental spectrum, from pre-school through university graduation, are significant and have been well established in recent years. Although there are challenges in applying diagnostic criteria to children, between 14-20% of school-aged children and adolescents experience an emotional or behavioral disorder each year\textsuperscript{17}. The most common mental health disorders for school-aged children are anxiety, disruptive behavior, depression, and attention-deficit/hyperactivity disorders. During high school, suicide becomes a significant problem that increases among young adults aged 20-24 years\textsuperscript{17}. With regard to substance use, according to the National Survey on Drug Use and Health\textsuperscript{18}, 22.6 million youth aged 12 and older reported illicit drug use during the month preceding the survey and, an estimated 51.8% reported current alcohol usage. Of those youth who reported either drug use or alcohol use, 7.3% (1.8 million) were classified as substance abusive or dependent, with only 7.6% (138,000) receiving treatment at a specialty facility\textsuperscript{18}.

The Youth Risk Behavior Surveillance System (YRBSS) monitors six types of health-risk behaviors that contribute to the leading causes of death and disability in youth and adults\textsuperscript{19}. The YRBSS includes a national school-based survey conducted by state, territorial and local education and health agencies and tribal governments. Since the YRBSS is given nationally and in the State of Maryland, there is an opportunity to compare Maryland needs to the larger nation and to consider areas of high priority needs within Maryland. The following two charts highlight trend data for high risk behaviors for Maryland students in the ninth through twelfth grades during 2013; the first chart depicts alcohol and drug use whereas the second chart depicts other risk factors as well as mental health indicators. These data highlight the need for both substance use and mental health prevention and intervention services in Maryland and nationwide, and clearly demonstrates the high level of behavioral health needs of Maryland students. Maryland students show significantly greater lifetime hard drug use (e.g., inhalants, heroine, ecstasy) in six of nine categories when compared to national samples and were significantly more likely to have been offered, sold, or given an illegal drug on school property in the past year. Further, Maryland students indicated that they were significantly more likely to engage in a physical fight and to be injured with a weapon at school and were more likely not to attend school because they felt unsafe. As a whole, the data indicate that like many of their national peers, a fairly large percentage of youth are contending with behavioral health concerns that could impact school functioning\textsuperscript{19}.
Table 1. Alcohol/Drug Use in Youth in Maryland and Nationally

<table>
<thead>
<tr>
<th>High School Youth Risk Behavior Survey, 2013 Grades 9 – 12</th>
<th>% of Maryland Students</th>
<th>% National Students</th>
<th>Significant Difference?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Alcohol Use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least one drink of alcohol</td>
<td>60.9%</td>
<td>66.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Drank alcohol before age 13 years</td>
<td>19.3%</td>
<td>18.6%</td>
<td>No</td>
</tr>
<tr>
<td>Currently drink alcohol</td>
<td>31.2%</td>
<td>34.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Had five or more drinks of alcohol in a row</td>
<td>17.0%</td>
<td>20.8%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Tobacco Use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used any type of tobacco past 30 days</td>
<td>16.9%</td>
<td>22.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>Smoked cigarettes past 30 days</td>
<td>11.9%</td>
<td>15.7%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Lifetime Marijuana Use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever used marijuana</td>
<td>35.9%</td>
<td>40.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Tried marijuana before age 13 years</td>
<td>8.8%</td>
<td>8.6%</td>
<td>No</td>
</tr>
<tr>
<td>Currently used marijuana</td>
<td>19.8%</td>
<td>23.4%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Lifetime Hard Drug Use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td>6.5%</td>
<td>5.5%</td>
<td>No</td>
</tr>
<tr>
<td>Hallucinogenic drugs</td>
<td>-</td>
<td>7.1%</td>
<td>-</td>
</tr>
<tr>
<td>Inhalants</td>
<td>10.4%</td>
<td>8.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>8.3%</td>
<td>6.6%</td>
<td>Yes</td>
</tr>
<tr>
<td>Heroin</td>
<td>4.9%</td>
<td>2.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Methamphetamines</td>
<td>5.0%</td>
<td>3.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Steroids without a doctor's prescription</td>
<td>5.1%</td>
<td>3.2%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prescription drugs without a doctor's prescription</td>
<td>15.2%</td>
<td>17.8%</td>
<td>Yes</td>
</tr>
<tr>
<td>Injected illegal drug</td>
<td>3.9%</td>
<td>1.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Offered, sold, or given an illegal drug on school property in the past year?</td>
<td>29.1%</td>
<td>22.1%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Bolded number indicates significantly greater use*
Table 2. Other Risk Factors and Mental Health Indicators in Maryland and Nationally

<table>
<thead>
<tr>
<th>High School Youth Risk Behavior Survey, 2013 Grades 9 – 12</th>
<th>% of Maryland Students</th>
<th>% National Students</th>
<th>Significant Difference?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual Behavior</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever had sexual intercourse</td>
<td>39.1%</td>
<td>46.8%*</td>
<td>Yes</td>
</tr>
<tr>
<td>Had sexual intercourse before age 13</td>
<td>6.6%</td>
<td>5.6%</td>
<td>Yes</td>
</tr>
<tr>
<td>Drank alcohol or used drugs before sexual intercourse</td>
<td>24.0%</td>
<td>22.4%</td>
<td>No</td>
</tr>
<tr>
<td>Had sexual intercourse with 4+ people during lifetime</td>
<td>12.3%</td>
<td>15.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Used no method of birth control</td>
<td>14.3%</td>
<td>13.7%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Injury and Violence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drove a car after drinking alcohol in the past 30 days</td>
<td>8.8%</td>
<td>10.0%</td>
<td>No</td>
</tr>
<tr>
<td>Rode in a car driven by someone who had been drinking alcohol in the past 30 days</td>
<td>20.7%</td>
<td>21.9%</td>
<td>No</td>
</tr>
<tr>
<td>Had a physical fight on school property</td>
<td>14.3%</td>
<td>8.1%</td>
<td>Yes</td>
</tr>
<tr>
<td>Carried a weapon on school property</td>
<td>4.8%</td>
<td>5.2%</td>
<td>No</td>
</tr>
<tr>
<td>Threatened or injured with a weapon on school property</td>
<td>9.4%</td>
<td>6.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Experienced physical dating violence</td>
<td>11.1%</td>
<td>10.3%</td>
<td>No</td>
</tr>
<tr>
<td>Experienced sexual dating violence</td>
<td>11.7%</td>
<td>10.4%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Suicide Risk</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt sad and hopeless</td>
<td>27.0%</td>
<td>29.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Seriously considered attempting suicide</td>
<td>16.0%</td>
<td>17%</td>
<td>No</td>
</tr>
<tr>
<td>Made a suicide plan</td>
<td>12.5%</td>
<td>13.6%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Bullying and Harassment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were bullied on school property</td>
<td>19.6%</td>
<td>19.6%</td>
<td>No</td>
</tr>
<tr>
<td>Were bullied electronically</td>
<td>14.0%</td>
<td>14.8%</td>
<td>No</td>
</tr>
<tr>
<td>Did not attend school because they felt unsafe in the last 30 days</td>
<td>8.8%</td>
<td>7.1%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Bolded number indicates significantly greater use

Substance use is related to other high risk behaviors. Alcohol and/or other drug use may influence youth to engage in other high risk behaviors like driving a car under the influence, and having unprotected sexual intercourse. In fact, 8.8% of youth reported that they had driven a car after drinking (in the last 30 days), and one in four (25%) of youth who had ever had sexual intercourse reported having drank alcohol or used drugs before sexual intercourse. In Maryland, over a four year period (2007-2011), 87 deaths and 9,546 injuries occurred in accidents involving drivers aged 16-20. Engaging in high risk behaviors can result in “adverse health outcomes such as sexually transmitted infections, unintended pregnancy and negative effects on social and psychological development”\(^{19}\). Other risky behaviors highlighted in the report include bullying on school property (19.6%), and electronically (14.0%). Survey highlights also focus on violence, including students engaging in physical fighting on school property.
(14.3%), carrying weapons (15.8%), carrying weapons on school property (4.8%), and having been physically hurt by a boyfriend/girlfriend (among students who dated or went out with someone – 11.1%).

Substance use and abuse among children and adolescents, and its comorbidity with mental illness, is a serious and wide-spread concern, in Maryland and nationwide. A **co-occurring disorder (COD)** means that the child has at least one mental health disorder and at least one alcohol or drug use disorder. Youth with CODs demand more attention and services compared with youth with one type of disorder. As compared to youth with only a mental health or substance use disorder, youth with CODs:

- Have greater impairment in functioning
- Have more history of engagement in illegal activities
- Are less responsive to treatment

**The co-occurrence of mental health and substance use disorders is a major concern.** Among the treatment seeking population, as many as 75% of adolescents with substance use disorders have co-occurring psychiatric conditions. Findings from research studies estimate that up to 90% of adolescents who receive treatment for substance use have at least one COD\textsuperscript{20}. Similarly, another study estimates that 43% of adolescents receiving mental health treatment have a co-occurring substance use disorder\textsuperscript{21}. **Many youth with CODs do not receive effective treatment to address both their mental health and substance use concerns**\textsuperscript{20}. This shortcoming is related to several factors, including poor communication and interaction between mental health and substance use systems, limited number of providers trained to provide youth COD treatment, and licensing and fee-for-service restrictions.

**The Role of Schools in Addressing Student Behavioral Health**

Each day in the United States, millions of children and adolescents go to school with significant behavioral health concerns that can negatively impact their school performance. Within the child and adolescent behavioral health field, the crisis of poor access and follow-through with services, along with significant workforce development challenges have compelled researchers, clinicians, and policymakers to view schools as a logical first-line of addressing youth well-being. Schools offer a natural setting to teach and promote positive social, emotional, and behavioral skills, identify and assist youth at risk for experiencing more serious behavioral health concerns, and provide behavioral health treatment to youth already displaying more serious behavioral health concerns. While less than half of youth with behavioral health needs access services, when youth do access treatment, 70-80% of them receive the services in schools\textsuperscript{22, 23, 24}.

\textbf{1 in 5 children will experience behavioral health concerns but less than half will access treatment. When youth do access treatment, 70-80% receive school-based services.}
What is Community-Partnered School Behavioral Health?

Community-Partnered School Behavioral Health (CP-SBH) is a framework for supporting student behavioral health along the full prevention-intervention continuum. This framework involves community behavioral health providers as partners with schools and families to augment existing school supports and services to provide a more comprehensive and broader array of care. CP-SBH services are provided by community-employed and school-employed behavioral health staff in partnership with educators and families. These providers partner to support a broader array of behavioral health care that together offer greater frequency, intensity, and specialized services (e.g., trauma informed care, medication management, substance use prevention) within the school building. This framework provides the opportunity for schools to expand their behavioral health capacity through enhanced staffing, resources, skills, and knowledge through these community partnerships.

Importantly, “Community-Partnered” mean that student behavioral health is a shared responsibility. For instance, schools often need support from the community in order to be able to more fully address all students’ behavioral health needs, just as the community can better understand, support and address youth needs when they partner with schools. A ‘Community-Partnered’ approach to SBH implies that families, schools, and communities each have shared responsibility in students’ behavioral health and well-being and need to partner with one another to provide the most comprehensive and effective care to each student.

Effective CP-SBH programs work together with families, schools, and community partners to:

- Promote the social, emotional, and behavioral health of all students;
- Identify social, emotional, behavioral problems and provide early intervention services; and
- Treat or refer for students identified with existing social, emotional, behavioral health problems.

For the purposes of this report, CP-SBH involves formal partnerships between schools and community behavioral health providers that involve at a minimum weekly school-based service provision in a school by the community behavioral health provider. Several school systems in Maryland had arrangements with community providers that did not fit under the definition of CP-SBH. For instance, simply seeing a student in the school would not meet the criteria of CP-SBH unless there is close collaboration/consultation with families and school staff related to student behavioral success (e.g. participating on school teams, consulting on a behavioral concern, developing treatment plans in collaboration with school staff). For some Maryland jurisdictions, service provision was set up to be provided in the school “if needed” as compared to having a regular presence in the school. Often these arrangements were set up more to meet an individual child’s need instead of as a way to address more comprehensive school behavioral health needs for the student body.
Comprehensive service provision through CP-SBH can include universal mental health promotion activities for all students, selective prevention for students identified at-risk for behavioral health problems, and indicated intervention services such as clinical assessment and treatment. While ideally CP-SBH programs would be involved across the multi-tiered systems of support within a school building, most programs are only providing services in 1 or 2 tiers, with treatment services for youth already displaying behavioral concerns being the most common.

A description of a three tiered approach for CP-SBH is highlighted in Figure 1.

**Figure 1. A Multi-Tiered System of Support model for Community-Partnered School Behavioral Health**

![Three Tiered System of Support Diagram]

**Service Provision Framework**

While each CP-SBH program may look different from school to school and from jurisdiction to jurisdiction, they share several best practice policies and procedures for program set-up and daily structure. Most CP-SBH programs have a signed Memorandum of Understanding (MOU) between the school system and the provider. Typically this MOU would delineate the type of service provision (e.g., individual, family, group) and by what type of provider (e.g., licensed social worker, psychologist, psychiatrist, counselor, advanced graduate trainee). Days and hours of service provision expectations are also provided. Some programs may highlight the process of consent and the referral process, as well as agreements to participate in school team meetings, share data and outcomes, and to provide and participate in professional development training. In exchange, schools often agree to provide the community program with a confidential space, a locked file cabinet, phone and computer access, and inclusion on school teams and access to education staff. While most CP-SBH programs are free-standing...
and not affiliated with a larger health entity within the school building, another framework for providing services within a school can be through a school-based health center.

**School-Based Health Centers (SBHCs)**

School-based health centers are a natural partnership for many CP-SBH programs. SBHCs are health centers, located in a school or on a school campus, which provide onsite comprehensive preventive and primary health services. For example, SBHCs can provide immunizations, physicals, acute care, student, staff, and family education, dental care, mental health services and more. There is a growing consensus that SBHCs play a critical role in the prevention, detection, and early intervention of troubling physical and behavioral health problems:

**Many CP-SBH programs are offered in collaboration with SBHCs.** There are currently an estimated 2,000 school-based health centers providing primary healthcare to approximately two million children and adolescents. The majority of these clinics are located in underserved, high needs areas, with large populations of vulnerable and often underserved youth. Mental health providers are located in 75% of school based health centers (SBHCs)\(^26\), and mental health care is one of the top reasons for student visits to SBHCs\(^27\). **Where SBHC programs and CP-SBH programs co-exist, it is recommended that they collaborate and operate as an integrated team.** It is important to note that even when SBHCs are not present, CP-SBH programs should collaborate with other health providers in the school such as school nurses in order to provide comprehensive, integrated care.

**Why Provide Community-Partnered School Behavioral Health?**

Providing services directly to students in the school setting has many advantages. CP-SBH offers numerous opportunities to provide high quality behavioral health services and programs to students, while addressing interconnected academic and behavioral health needs and challenges. When families, schools, and communities can partner around student behavioral health, students do better. The list below highlights some of the advantages of providing CP-SBH:

- Improved access to behavioral health care
- Ability to provide broad wellness promotion and behavioral health prevention programming and services
- Greater potential to impact the learning environment and educational outcomes
- Greater generalizability of treatment to child’s daily environment
- Assistance to overcome logistical barriers to care and decrease the stigma of help seeking
- Enhanced capacity for delivering a full continuum of care including prevention, behavioral health promotion, early identification and intervention
• Less time lost from school related to outside appointments
• Increase in clinical efficiency and productivity
• Cost effectiveness

Data suggest that addressing behavioral health concerns is an imperative for our nation’s education system. When behavioral health concerns are addressed, students have higher academic achievement, improved attendance, fewer disciplinary encounters, among other positive outcomes. High rates of under-identification, limited access to treatment and low quality of behavioral health services for children and adolescents in the United States has implications for behavioral health challenges that will be displayed in the classroom. At a federal level, CP-SBH has been recognized as critical to early identification and referral, violence prevention efforts and overall community safety28 and has been central to several recent federal grants (e.g., Project Prevent, Project Aware, Safe Schools Healthy Students).

When students have their social-emotional-behavioral needs addressed through wellness, prevention, and intervention, there are fewer barriers to learning and more time for productive classroom instruction.

CP-SBH programs have significantly greater access to children and adolescents relative to providers delivering care within a hospital or community center setting and have opportunities to address concerns in a real world setting. The high rates of CP-SBH service provision as compared to show-rates in traditional community settings has led some to suggest that schools have become the “defacto” location for mental and behavioral health service delivery for children and adolescents29.

Schools also promote early identification and intervention. When addressed early, child and adolescent problems may be less likely to result in a negative trajectory that can continue into adulthood. Emerging neuroscience suggests that untreated behavioral health disorders can also harm brain development during critical periods of learning, emotional growth, and socialization. If we fail to appropriately screen and treat childhood behavioral and emotional disorders early, problems may persist and lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood.

Fiscal Responsibility of addressing Child and Adolescent Behavioral Health Problems

According to the American Academy of Child and Adolescent Psychiatry, preventing and addressing child and adolescent behavioral health concerns early are fiscally responsible strategies30. Mental, emotional, and behavioral health disorders among children and adolescents are estimated to cost United States taxpayers approximately $247 billion annually in mental health and health services, lost productivity, and crime. In 2012, state mental health agencies spent $37.5 billion dollars on mental health services. California spent the most, at $5.7 billion, while Idaho spent the least, at $57.4 million31.
Poor social and emotional skills in young children are predictors of early school failure, leading to continuing school problems and possible involvement in the high-cost child welfare, mental health, and juvenile justice systems. Within the juvenile justice system itself, 70.4% of youth have been diagnosed with at least one mental health disorder. In turn, this costs society an estimated $1.2 to 2 million each in rehabilitation, incarceration, and costs to victims. According to a July 2014 report by the Robert Wood Johnson Foundation, investing in funds for prevention and early intervention programs and services not only saves direct costs but indirect costs, as well. These indirect costs can be thought of as “healthy years of life,” and reflect both premature death, and years lived with a disability, both of which incur significant societal cost burden. These costs also include parent or caregiver loss of productivity because of an increased need to care for their children and the loss of future productivity for the affected children.

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**Early intervention benefits are often efficient, effective and offer benefits greater than their costs.**
- The National Research Council and the Institute of Medicine of National Academies

For every dollar spent on child behavioral health services, approximately $2-$10 is saved in later, more intensive services such as Juvenile Justice, Social Services, education, health, and lost productivity. In 2009, the National Research Council and the Institute of Medicine of the National Academies concluded that 10 out of 12 substance use prevention programs for youth were highly cost-effective, with benefit to cost ratios ranging from 3:1 to 1000:35. The Substance Abuse and Mental Health Services Administration reports particularly high levels of cost-effectiveness among community mental health services delivered through systems of care, which requires collaboration among multiple public systems (e.g., schools and hospitals).

- The average reduction in per-child hospital days from initial entry into services through 12 months resulted in an average savings of $2,776.85 per child.
- From entry into community systems of care through 18 months, the number of children who utilized inpatient facilities decreased by 54%.
- The percentage of youth who purposefully harmed themselves or attempted suicide decreased 32% after 12 months in systems of care.

The implementation of prevention programs in public schools has also shown positive economic effects. The Seattle Social Development Project, an intervention implemented across 18 elementary schools in diverse, high-crime neighborhoods, reported 11% fewer mental health disorders and higher overall educational and economic attainment in young adults in a fifteen year follow-up. Fast Track targets individual children at high risk for antisocial behavior, and has a significant impact in preventing the
diagnosis of conduct disorder among the youth at highest risk\textsuperscript{37}. In turn, the National Research Council and the Institute of Medicine concluded \textbf{that early intervention benefits are often efficient, effective and offer benefits greater than their costs}\textsuperscript{38}.

\section*{Evidence of Effectiveness of CP-SBH}

The CP-SBH field has shown notable growth over the past 20 years. Beyond just students with diagnosable disorders, research indicates that all youth in schools can benefit from school behavioral health policies and programs that successfully promote social, emotional, and behavioral health, build positive school climate, and prevent school violence and dropout\textsuperscript{39,40}. Importantly school behavioral health programs have been successful in overcoming logistical barriers to care and decreasing the stigma of help seeking, which has resulted in dramatic improvements in access to care\textsuperscript{40\textsuperscript{41}}. Furthermore, integrating behavioral health services within schools promotes an ecologically grounded, comprehensive approach to helping children and families by addressing their educational and concomitant emotional, behavioral and developmental needs\textsuperscript{42}. CP-SBH programs also promote the generalization and maintenance of treatment gains\textsuperscript{43}, enhance capacity for prevention and mental health promotion\textsuperscript{44}, and foster clinical efficiency and productivity\textsuperscript{45}. There is also evidence that these programs have an impact across a variety of emotional and behavioral problems in children and adolescents\textsuperscript{46}; \textbf{Decades of research in CP-SBH has demonstrated outstanding outcomes associated with CP-SBH} including:

- Increased academic achievement,
- Improved behaviors in the school and decreased disciplinary actions,
- Less school violence and reduced dropout,
- Increased academic engagement, motivation, and confidence,
- Improved school climate,
- Cost savings.

\begin{itemize}
  \item When barriers to learning are addressed through a coordinated and comprehensive education and behavioral health approach, children have better outcomes such as improved grades and attendance, better performance on state assessments, reduced suspensions and expulsions, and fewer discipline referrals.
\end{itemize}
What are Some Best Practices of High Quality CP-SBH Programs?

Like any other setting that delivers child and adolescent mental health services, school behavioral health programs are able to achieve better student, family, and school outcomes when interventions utilized are based on evidence-based practices and programs. In addition, using best practices is critical for CP-SBH sustainability because high quality behavioral health programs are more likely to achieve and be able to document service impact and better able to sustain adequate funding for services.

According to the national literature in the field, essential empirically supported practices and foundational principles for CP-SBH include:

- **Development of a “shared agenda”** based on strong partnerships among families, schools, and community behavioral health partners and other child-serving agencies. This involves ensuring all perspectives on goals and vision of services, including youth and family voice, are solicited and respectfully incorporated as often as possible. This speaks to Best Practice #1 below, Establishing and Maintaining Effective Partnerships.
- **Treatment is delivered within a multi-tiered model (Figure 1).** Tier 1 represents universal prevention efforts geared towards all children; Tier II targets prevention efforts towards youth at risk for behavioral health disorders; Tier III provides individualized support for those already diagnosed with behavioral health problems and who need more specialized intervention.
- **Programs and services are available to all students** (and their families) in special and general education, with close collaboration between behavioral health and education at the school level. Best Practice #2 emphasizes the importance of the multi-tiered model in CP-SBH which should be provided for all students regardless of special education status.
- **At all phases of service provision, emphasis is on data-based decision making and on the implementation of evidence-based promotion and intervention.**
- **Intervention is matched to student needs and strengths,** and seeks to ensure that resources reach the appropriate students at the appropriate level of frequency, intensity, and quality of service provision. Ideally this matching process will occur via data-based decision making, noted above, and as discussed further in Best Practices #3 and #4 in the selection of evidence-based practices and the utilization of data-based decision making.

**Best Practice #1: Establishing and Maintaining Effective Partnerships**

**The Role of Family & Youth Partners**

Successful CP-SBH programs make every effort to include family members. Families and youth make up the largest stakeholder group in CP-SBH, and are the primary consumers, beneficiaries, and advocates
for behavioral health programs and services. Parents and other family members are the experts on their own children, and should be encouraged and supported to participate actively. Unless families and youth are involved in prevention, intervention, treatment, and dissemination of CP-SBH programs, attempts to deliver effective CP-SBH services will be severely compromised and less likely to meet the needs of the student population.

**Potential benefits of family partnerships include**⁴⁸:

- Reductions in stigma related to behavioral health
- Greater access to needed services and supports
- Fewer barriers to care
- Interventions and recommendations better tailored to family needs
- Enhanced parenting skills, school involvement, and communication between home and school
- Improved social, emotional, and educational outcomes for students

**Tips for Fostering Meaningful Family Partnerships**

**Tip #1: The definition of ‘family’ should be broadly defined.** A family may consist of youth and their parents, primary caregivers, and others legally, formally, or informally bound to one another. Family members may be biological parents, but can also refer to grandparents, adult siblings, foster parents, adoptive parents, or other relatives or friends who assume a parental, custodial, or supportive role.

**Tip #2: Consider designating a “Family Liaison” position.** Formally involving family members in program development, decision-making, implementation, and evaluation can be particularly effective. Family leaders may have the trust and support of other families, are valuable and insightful contributors when important decisions related to service provision need to be made. They can also play an important role in teaching practitioners about how to make their systems and services more family-friendly.

**Tip #3: Involve family organizations.** Family organizations bring knowledge and passion based on practical, real-life experiences. Such organizations are often experts in navigating varied systems and can provide critical feedback on accessibility and effectiveness of services. The Maryland Coalition of Families for Children’s Mental Health (www.mdcoalition.org) is one example within Maryland of a family advocacy organization which provides education, advocacy training, leadership development and peer support for families of children with emotional and behavioral difficulties. CP-SBH programs in Maryland are encouraged to connect with the Maryland Coalition and/or other family organizations to assist schools and community partners with establishing meaningful family partnerships in all aspects of their school-based work.

**Tip #4: Solicit youth and family voices and opinions.** Parents and families understand their children’s strengths and difficulties in coping with the stresses of their community and home. Families can provide CP-SBH programs critical feedback on the accessibility and effectiveness of services, and can bring
passion and knowledge based on practical, real-life experience. Soliciting youth voices and opinions about CP-SBH programming can further understanding of barriers that may impede CP-SBH use for students, and help problem-solve effective solutions to these impediments. Youth can also speak to the ease of using particular CP-SBH resources, and can provide critical feedback regarding the efficacy and utility of these programs. Research on family partnership indicates that family’s perceptual barriers such as stigma regarding behavioral health services and illness, perceived irrelevance of treatment, and prior negative experience are just as salient as pragmatic barriers (e.g., lack of transportation, time off or child care). In addition, recent work has been conducted to understand the most common family engagement strategies used among the highest performing treatments in randomized controlled trials. These findings indicate that the three top practice elements in family engagement are:

1. **Assessment** – Measuring a student and their family’s strengths and needs through a variety of methods, during which a trusting relationship can become developed
2. **Accessibility promotion** - Strategies designed to make behavioral health services more convenient and accessible to increase family participation (which may include service provision directly in schools)
3. **Psychoeducation about services** – Providing the family with information of the content and structure of services provided, including roles of the student, family, and all program staff

*The Role of School Partners*

Education staff and school leadership are a vital component of school behavioral health. Without the support of school administration and the collaboration of educational staff, school behavioral health cannot be effective. **Advancing collaborative relationships among educators and administrators with school-employed health and behavioral health providers is essential.** Primary partners in school-behavioral health (in addition to youth and families—see above) are listed below:

- **Educators** are key partners in referral, consultation, and support. Teachers and classroom staff are on the frontline of being able to identify student strengths and challenges in the classroom, and are often the first to notice emergent behavioral health concerns and key adults in treatment, particularly as it relates to implementing treatment strategies within the classroom.

- **School-employed health and behavioral health providers** (e.g., school psychologists, school social workers, school counselors, occupational therapists, school nurses) support students’ social, emotional, and behavioral health needs and can address non-academic barriers to learning to promote student success.

- **School and school system administrators** provide needed institutional, administrative, and physical resources and the access to students and educators that is needed for effective integration into the larger school team.

*The Role of Community Partners*
It has long been understood that children are influenced by the many relationships and interactions with
and between home, school, and the community settings. Consistent with this perspective, there is a
growing emphasis on advancing collaborative relationships with community partners, parents, and
youth as a way to establish and sustain CP-SBH programming. Forging relationships with these
partners is a key component of CP-SBH. **Community behavioral health providers**, working in close
 collaboration with schools, can enhance the breadth and depth of services and supports that are
available to students within the school setting.

Schools also benefit when they meaningfully partner with **multiple agencies and programs to provide
more integrated and coordinated care**. Establishing a network of cross-system collaborations provides
multi-level strategies to effectively support the whole child, the family, and the school. Benefits of this
collaboration includes streamlined access to services, less duplication of services, access to a broader
array of services, and enhanced communication between agencies, and ultimately, more effective care.

As with any collaboration, infrastructure that supports communication, planning, implementation and
evaluation is essential. A number of best practices support this infrastructure. These include:

- Time to develop shared goals and visions, values and principles
- Planning and implementation of cross system policies and procedures
- Cross disciplinary training and ongoing implementation support;
- Continuous quality improvement and evaluation
- Outreach and advocacy

Multisystemic collaborations are also essential for **transition-aged youth**. Typically between the ages of
18 – 21, transition-aged youth with behavioral health needs often find it difficult to find or maintain
services they need to successfully transition to adulthood. Unfortunately, no coordinated system
currently exists to guide young people with and without behavioral health needs through the
challenging task of entering adulthood including transitioning from high school to college and/or career.
Developing collaborations that support students in transitions between school levels (e.g., elementary,
middle, high, college), educational placements (e.g., levels of restrictiveness such as residential versus
self-contained versus mainstreamed general education) and from hospital/juvenile services/foster care
and other transitions that may occur for a youth increases the likelihood of more positive academic,
social, emotional, and behavioral outcomes for students.

**Best Practice #2: Integrate CP-SBH into multi-tiered systems of support**

Schools have been increasingly invested in building multi-tiered systems of support to address the
academic needs of the larger student body and not just students with identified disabilities. To address
this need, many schools utilize a Multi-Tiered System of Support (MTSS) model to deliver instructional or
behavioral intervention to students in varying intensities (multiple tiers). Prevention is an underlying
principle at all three tiers, with Tier I focused on preventing occurrences of problems, Tier II preventing
risk factors or early-onset problems from progressing, and Tier III individually intervening to address more serious concerns that impact student daily functioning.

**Systems that support MTSS models are ideal for also supporting a range of CP-SBH interventions for universal or individualized implementation.** Matching the range of academic, behavioral, and social needs within a school involves layering of interventions from a universal curriculum to targeted group programming and, for some students, adding on highly individualized interventions that are linked to the lower-tiered structures, instruction, and preventative measures. Integrating existing MTSS programming with CP-SBH has several benefits:

- Many existing initiatives share the common elements of MTSS, such as Problem Solving/Response to Intervention [RtI], Positive Behavior Support [PBS], Continuous Improvement Models [CIM], Lesson Study, and Differentiated Accountability.
- Consistent with an RtI process, existing multi-tiered systems of support increase the likelihood that youth will be identified, referred, and have access to and benefit from CP-SBH interventions.
- Earlier access to less intensive evidence-based academic and behavioral interventions promotes better student outcomes across school settings and may reduce the need for more intensive supports.
- Active progress monitoring of both academic and behavioral interventions establishes greater likelihood they are delivered with fidelity, effectiveness and sustainability and is associated with improved student outcomes.

The MTSS approach ensures that all students are included in the service array, including general and special education students and that all students will have at least some exposure and access to behavioral health programming and/or services.
Best Practice #3: Needs Assessment and Resource Mapping

At a local school system or school level, CP-SBH programs should not be a “one-size fits all model.” CP-SBH should be implemented to address the needs and strengthen assets unique to its students, families, schools, and communities. Therefore, in conjunction with other best practices noted in this report (e.g., by leveraging partnerships and teaming to plan for how to provide evidence-based supports within a multi-tiered system for students), a needs assessment is often very informative and provides clear guidance related to the most pressing concerns, strengths, challenges, and gaps in care. This knowledge can inform the prioritization of activities and services and can help ensure that service provision will match and be responsive to school/school system needs.

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

- Determine appropriate data collection methods (e.g., forms of data collection could be school records, informal inquiries with teachers and parents, review of office referrals, etc.) and identify priority areas of focus based on needs of student body and collect data accordingly.
- Conducts assessment on common risk and stress factors faced by students (e.g., exposure to crime, violence, substance abuse) and/or universal screening for any variety of behavioral health concerns for which there is need.
- Evaluate whether the school behavioral health team has services in place to help students contend with common risk and stress factors and identify service gaps where applicable
- Evaluate whether the school behavioral health team matches provided services to the presenting needs and strengths of student/families after the initial assessment

Most schools and school systems have developed at least some partnerships with and regularly make referrals to an array of organizations and programs that can complement educational supports. Yet, often schools and school systems do not strategically map and identify the comprehensive array of school-based and community supports available within the school and larger community. In many cases the knowledge of resources may reside with one or two individuals and this can be problematic when they are not available. Tracking of available supports and resources, services provided, and eligibility requirements can be time efficient and lead to improved access to the most effective services.

Resource mapping offers a strategy to help schools/school systems to consider the array of supports and resources available to students and families, and provides a visual picture of how services and programs are related and information on who can and how to access the supports and resources. Ideally, availability of resources is mapped across a multi-tiered system of support reflecting a more comprehensive system of care. Family-School-Community teams can utilize mapping tools to identify student and family resources that promote student behavioral health across the continuum of support, from promotion and prevention to tertiary intervention. Identification of resources across both the school and community can minimize duplication of services and support coordinated care. Mapping may also promote opportunities for cross-system and interdisciplinary training, and facilitate streamlined referral and transition processes across systems and programs. An example of a school-community resource map, across three tiers of student support is provided below:

Figure 3. Community-Partnered SBH Resource Map
As part of the mapping process, it is important that school-community teams document not only the existence of programs and resources, but also the impact of such programs and resources on expected and actual outcomes. By restricting behavioral health resources to only those with demonstrated impact on desired outcomes, schools and school systems can be more prudent in their selection process, thereby increasing efficiency and likelihood of student success.

Resource mapping must be considered an on-going and data-informed process. School system and building teams should work together with community partners to develop MOUs that specify partnership roles and responsibilities, referral processes, feedback loops, data systems and decision-making rules, and regular scheduled meetings. Table 3 highlights the objectives of school and school system sb behavioral health resource mapping.

**Table 3. Objectives of Multi-tiered Resource Mapping**

<table>
<thead>
<tr>
<th>School and district resource mapping offers a systematic process to:</th>
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<tbody>
<tr>
<td>• Identify all available resources/programs in the school and surrounding community</td>
</tr>
<tr>
<td>• Recognize gaps in services/resources that can inform strategic planning and outreach</td>
</tr>
<tr>
<td>• Better understand program requirements to access services (e.g., insurance, hours of operation, eligibility)</td>
</tr>
<tr>
<td>• Avoid duplication of services and valuable resources</td>
</tr>
<tr>
<td>• Better match service needs with available resources/programs</td>
</tr>
<tr>
<td>• Increase awareness of underutilized partnerships/resources</td>
</tr>
<tr>
<td>• Cultivate relationships with new programs/resources that can address gaps in care</td>
</tr>
</tbody>
</table>

**Best Practice #4: Utilize Empirically Supported Treatments**

Best practices highlight the importance of using interventions that have research support for their effectiveness. Relying on empirically-supported interventions helps ensure that the interventions children receive in CP-SBH programs are as effective as they can be. Many national organizations concerned with children’s behavioral health have reviewed the research pertaining to interventions and have developed lists of approaches that they consider to be effective for various disorders. The following is a list of the major national dissemination initiatives (i.e., a “list of the lists”) for both prevention and treatment approaches:
SAMHSA’s National Registry of Evidence-Based Programs and Practices (NREPP)
http://www.nrepp.samhsa.gov/Index.aspx

NREPP is a searchable online registry of more than 330 substance abuse and mental health interventions. NREPP was developed to help the public learn more about evidence-based interventions that are available for implementation.

IES’s What Works Clearinghouse (WWC)

The Institute for Education Sciences at the U.S. Department of Education established the What Works Clearinghouse (WWC) in 2002 to provide educators, policymakers, researchers, and the public with a central and trusted source of scientific evidence about "what works" in education. Through systematic reviews to identify rigorous research, the WWC provides educators with credible and reliable evidence that they can use to make informed decisions.

Blueprints for Healthy Youth Development
http://www.blueprintsprograms.com/

Blueprints for Healthy Youth Development is a registry of evidence-based positive youth development programs focused on improving child and adolescent well-being. Blueprint programs are family, school and community-based and are specifically relevant for CP-SBH and its multi-tiered focus, with programs targeting from broad prevention to more individualized intervention. Selection is based on the program’s evaluation outcomes and a review by and recommendations from an Advisory Board with expertise in positive youth development.

High quality, CP-SBH programs integrate evidence-based programs at multiple levels of student support. The sections below describe each level of support and offer some examples of evidence-based programs and practices that have been successfully implemented in the context of CP-SBH.
Figure 4: Evidence-based programs provided at multiple levels of student support

- **Intervention/Indicated:**
  - Cognitive Behavioral Intervention for Trauma in Schools, Coping Cat, Trauma Focused CBT, Interpersonal Therapy for Adolescents (IPT-A)

- **Prevention/Selected:**
  - Coping Power, FRIENDS for Youth/Teens, The Incredible Years, Second Step, SEFEL and DECA Strategies and Tools, Botvin’s Life Skills

- **Promotion/Universal:**
  - Good Behavior Game, PATHS to PAX, Positive Behavior Interventions and Support, Social and Emotional Foundations of Early Learning (SEFEL), Toward No Tobacco Use
Universal Promotion & Prevention

Universal prevention programs are designed for the overall population. Universal prevention programs commonly target many of the risk and protective factors identified by the National Institute of Mental Health\(^5\) and the National Institute of Drug Abuse\(^7\) in the prevention of mental and behavioral health disorders. These programs commonly teach personal and social skills, self-esteem, anxiety management, effective communication, relationship development, assertiveness, drug resistance skills, and ways to effectively resistance peer pressure\(^6,7,8,9\). Within a school, universal programs could target all students in the school or specific group such as 6\(^{th}\) graders. For example, a substance use prevention curricula targeted at drug and alcohol use may include curricula that teach behavioral and social skills described above, as well as normative education components designed to correct the misperception that many students are abusing drugs. Table 4 provides a list of universal prevention programs that have successfully been implemented in collaboration with CP-SBH.

Table 4. Empirically-supported Universal Prevention programs\(^60\)

<table>
<thead>
<tr>
<th>Prevention/Intervention</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Behavior Game(^61)</td>
<td>Classroom intervention with a set of evidence-based strategies and a classroom game to increase self-regulation and cooperation and decrease unwanted behaviors.</td>
</tr>
<tr>
<td>Life Skills Training(^59)</td>
<td>Group or classroom intervention to promote general social skills, self-management, drug resistance, and violence prevention</td>
</tr>
<tr>
<td>Project ACHIEVE(^62)</td>
<td>Group or classroom intervention to improve resilience, protective factors, and effective self-management skills</td>
</tr>
<tr>
<td>Project ALERT(^63)</td>
<td>Group or classroom intervention to prevent alcohol, tobacco, and marijuana use and violence</td>
</tr>
<tr>
<td>Second Step(^64)</td>
<td>Classroom curriculum that teaches socio-emotional skills to decrease impulsive and aggressive behavior and increase social competence</td>
</tr>
</tbody>
</table>

Secondary Selected Prevention

Secondary prevention programs target groups of students that are at risk for an identified undesirable outcome. Examples of groups at risk for behavioral health disorders can include individuals with high rates of truancy or poor academic performance, youth who have experienced or witnessed traumatic events, those who struggle with learning or impulsivity problems, or youth with a parent who abuses substances\(^5,7\). Secondary prevention programs are often tailored towards specific risk-factors, and often include a parent component to promote the generalization of the skills obtained at school in the home environment. Table 5 highlights some of the secondary prevention programs that have been successfully implemented through CP-SBH.

Table 5. Empirically-supported Secondary Prevention programs (CSMH 2001):
Prevention/Intervention | Goal
--- | ---
Check and Connect\(^65\) | Individualized intervention designed for students who shows warning signs of disengagement with school and who are at risk of dropping out. The program relies on close monitoring of school performance, as well as mentoring, case management, and other supports.

Coping Power\(^66\) | Group intervention targeted towards children at-risk for aggressive behaviors, drug-use, and delinquency. Uses cognitive-behavioral techniques to teach children how to identify and cope with anger and anxiety, decrease impulsivity, and develop and improve social, academic, and problem-solving skills.

The Strengthening Families Program (SFP)\(^67\) | Family skills training program designed to increase resilience and reduce risk factors (specifically, to improve social competencies & school performance, and reduce problem behaviors, delinquency, and alcohol and drug abuse in high-risk children).

**Individualized & Targeted Support**

Indicated prevention programs identify individuals who are already exhibiting clinically significant behavioral health behaviors and/or signs of substance use. Youth receiving services at this level of care often are already exhibiting anxiety, depression, or suicidality, have severe behavior problems in the classroom, are failing school, and/or are experimenting with drugs or alcohol. Many of the treatments that have demonstrated efficacy with child emotional and behavioral health have involved cognitive-behavioral therapy (CBT). These individualized programs often include a parent component to promote skills in the home environment and to teach parents to help children use cognitive-behavioral skills. Examples of programs that have been implemented in collaboration with CP-SBH at the indicated level are listed in Table 6.

Table 6. Empirically-supported Individualized Support programs (CSMH 2001):

<table>
<thead>
<tr>
<th>Prevention/Intervention</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression Replacement Training(^68)</td>
<td>CBT-based intervention to help children and adolescents improve social skill competence and moral reasoning, better manage anger, and reduce aggressive behavior.</td>
</tr>
<tr>
<td>Cognitive Behavioral Intervention for Trauma in Schools (CBITS)(^69)</td>
<td>CBT-based group intervention to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems; improve peer and parent support; and enhance coping skills among students exposed to traumatic life events.</td>
</tr>
<tr>
<td>Coping Cat(^70)</td>
<td>CBT-based intervention that helps children recognize and clarify anxious thoughts and feelings, develop plans for effective coping, and self-evaluate and reinforce positive coping skills.</td>
</tr>
<tr>
<td>Interpersonal Psychotherapy for Depressed Adolescents (IPT-A)(^71)</td>
<td>Adapted from adult version IPT, a short-term manualized intervention that focuses on developmental and interpersonal needs of adolescents (12-18 years old) with mild to moderate depression severity. Intervention builds communication and social problem solving skills.</td>
</tr>
</tbody>
</table>
Stark School-Based Intervention for Depression\(^7\) is a CBT-based intervention for children with depression that teaches self-control techniques, social skills, assertiveness, & relaxation training, imagery, and cognitive restructuring.

Trauma-Focused CBT (TF-CBT)\(^7\) is a CBT-based intervention to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents.

## Specialized Support for Substance Use and Abuse Problems

Several CP-SBH programs also provide specialized prevention and intervention support for children and adolescents who are at-risk for alcohol or substance use/abuse\(^5\). Youth receiving services at this level of prevention often are already experimenting with drugs, failing school, and exhibit mental health problems such as anxiety, depression, or suicidal behaviors. Examples of evidence-based substance use prevention programs used in CP-SBH Programs can be found in Table 7.

### Table 7. CP-SBH Evidence-based Substance Use Related Interventions

<table>
<thead>
<tr>
<th>Prevention/Intervention</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Community Reinforcement Approach (A-CRA)(^4)</td>
<td>Used to treat youth and young adults between the ages of 12 and 24 with substance use disorders. Addresses topics such as problem-solving skills to cope with stressors, communication skills, and active participation in positive activities (social and recreational) to improve life satisfaction and eliminate alcohol and substance use problems.</td>
</tr>
<tr>
<td>Adolescents Training and Learning to Avoid Steroids (ATLAS)(^5)</td>
<td>ATLAS is a multicomponent selective program for male high school athletes, designed to reduce risk factors for use of anabolic steroids and other drugs, while providing healthy sports nutrition and strength-training alternatives to illicit use of athletic-enhancing substances.</td>
</tr>
<tr>
<td>Focus on Families (FOF)(^6)</td>
<td>A selective program for parents receiving methadone treatment and their children, FOF seeks to reduce parents’ use of illegal drugs by teaching them skills for relapse prevention and coping. Parents are also taught how to better manage their families to reduce their children’s risk for future drug abuse.</td>
</tr>
<tr>
<td>Motivational Enhancement Therapy &amp; Cognitive Behavioral Therapy (MET-CBT)(^7)</td>
<td>Brief outpatient treatment for adolescents for substance use disorders. MET-CBT has two broad treatment goals: (1) to teach adolescents how to use a broad spectrum of coping activities to help deal with problems, interpersonal conflicts, and negative mood states and (2) to teach adolescents how to anticipate and challenge the thoughts, cravings, and urges that impel substance use as a means to maintaining abstinence. The ultimate goal of MET-CBT is abstinence.</td>
</tr>
<tr>
<td>Project Towards No Drug Abuse(^8)</td>
<td>Focuses on students who have failed to succeed in school and are engaged in drug abuse and other problem behaviors. Rebuilds students’ interest in school and their future, corrects misperceptions about drug abuse, and strengthens protective factors, including positive decision-making and commitment.</td>
</tr>
</tbody>
</table>

### Integrated treatment

**Integrated treatment** is a means of actively combining interventions intended to address co-occurring
substance use and mental disorders in order to treat both related problems, and the whole person more effectively. Under this model, treatment interventions for co-occurring disorders are integrated within the context of a primary treatment relationship or service setting. Mental and substance use disorders are treated by the same clinician or a small team of clinicians, who are trained in psychopathology, assessment, and treatment strategies for both disorders.

The National Institute on Drug Abuse has identified several key components that CP-SBH can incorporate to address student substance use and abuse.

- **Elementary School**: CP-SBH programs should aim to improve academic and social-emotional skills to reduce the risk of substance use. Primary objectives include self-control, emotional awareness, communication, problem solving, and academic support.
- **Middle- & High School**: CP-SBH programs should focus on increasing students’ social competence by helping improve communication skills, healthy peer relationships, self-efficacy, self-competence, and drug resistance skills, while also reinforcing anti-drug attitudes.

**Best Practice #5: Family-School-Community Teaming**

To promote student mental health, schools and community partners, including families, must be committed to working together to build or enhance a multi-tiered, systemic approach that addresses the interconnected academic, social, emotional, and behavioral needs of *all* students. It is critical to integrate behavioral health and education teams into unified teams that consider the “whole child,” addressing academic as well as social-emotional-behavioral considerations. To be successful, this integration requires that school partners are open to having community partners (e.g., community behavioral health providers, child-serving agency workers, advocates, health care providers) and families engage in all aspects of the interconnected system including team meetings. It also requires that community partners have the necessary funding to be able to support clinician time in non-billable meetings without jeopardizing fiscal sustainability.

Readiness requires a willingness to move beyond a “walled” model in which only school-based staff is part of a child’s support team to one that embraces true cross-stakeholder and cross-system partnership. In forming such partnerships, it is necessary for school, family, and community partners to be willing to have a discussion about overlapping priorities and needs and to consider how a partnership could be beneficial to meeting the goals of each partner group. For instance, it may be important for school- and community-employed staff to discuss how their roles and responsibilities are distinct, how they will collaborate to facilitate seamless referral pathways and comprehensive care, and how they will avoid “turf battles.” Ideally, these discussions will reflect a recognition of the unique requirements/mandates and strengths/limitations of each discipline or stakeholder group. Some questions to consider during the teaming process are included in Table 8.
Table 8. Questions to Consider During Family-School-Community Teaming

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

A multi-tiered system of support at the school level often has three teams with one team focusing on the planning, implementation, and evaluation of universal interventions and the other teams focusing on 2nd and 3rd tier interventions (some schools depending on size and number of team members prefer to have a only a universal team and a combined tier 2 and tier 3 team, and smaller schools may only be able to have one team to address all three tiers). It is helpful to have a regularly scheduled time and frequency for meeting and a process for holding meetings that includes clear rules, expectations, and action planning that is informed by and uses data throughout to track progress towards action items and to monitor success of interventions. Data can be used in many different ways including helping to identify students who could most benefit from services and/or interventions and can help demonstrate the impact of services. For example, some teams are using measures such as the Child and Adolescent Needs and Strengths Screening\textsuperscript{79}, and the Global Appraisal of Individual Needs\textsuperscript{80} scale to screen for or
identify children who may be in need of behavioral health supports. Data are also used to track progress of students who have received services to determine if the services are impacting outcomes important to the team (e.g., academic, social, emotional, and behavioral indicators).

A challenge for coordination of efforts can result when data are not shared across school and community providers. Identifying issues related to data sharing (HIPAA, FERPA) should be done up front and consideration should be given to securing consents and release of information to allow sharing of data across system partners in an effort to have a more comprehensive picture of student progress across educational and social-emotional-behavioral domains. Consideration should also be given to how data will best be collected, analyzed, and shared from the inception of the partnership and should be clearly outlined in any Memoranda of Understanding (MOU).

**Best Practice #6: Collect, Analyze, and Utilize Data**

Data-based decision making should drive many processes within a CP-SBH program. For instance, at the individual student level, outcome data (behavioral and academic) should be collected on a regular basis to monitor progress and to modify treatment if indicated. At the school level, data should be utilized to make decisions about matching students to the appropriate tier of service and monitoring their response to intervention received. Therefore, if a student’s functioning or level of needs change, data can inform whether they need a more or less intensive level of supports at school. At the CP-SBH program level, data should be aggregated to analyze programmatic outcomes. Program outcome data serve both internal purposes for understanding the effectiveness of the CP-SBH service array and delivery system, but also for external purposes such as demonstrating program services and outcomes to funders and other stakeholders.

Optimally, CP-SBH will have a system in place to collect student outcome data and program cost data, which when linked can demonstrate the return on investment of the CP-SBH program. This activity is critical for programs that are in the position of seeking and advocating for continued funding for services. CP-SBH programs are likely to be developing their data collection and reporting systems at various levels of sophistication. It is critical that at a minimum, programs are collecting some basic data and have a vision and associated action steps for advancing their data collection and reporting capabilities. The following continuum of program evaluation data shows various levels of data development:

**Level 1:** Collecting Standard Operating Procedure data from behavioral health agency and/or school system (e.g., To answer questions such as: How many students served? How long are sessions/services on average? What services are provided? By whom? How often?)

**Level 2:** Describing characteristics of students served (demographics, diagnoses, etc.)
Level 3: Analyzing behavioral health data/outcome data on individual students
Level 4: Comparing to “comparison” or control group of students not receiving CP-SBH services

Types and sources of data can vary widely, with some examples as follows:

Types of CP-SBH data:  CP-SBH Data sources:
- Behavioral Health Screeners  - Clinician, parent, teacher, child
- Outcome measures  - School system
- Educational data  - Behavioral health agency billing records
- Services data (billing data)

Deciding what measures to use and collecting data can be a challenge for CP-SBH. There has been a lot of work across the school behavioral health field that can inform this process and can be quite helpful to CP-SBH leadership. Examples of resources on program evaluation for non-researchers include:

Program evaluation resources relevant to CP-SBH leadership

- University of Kansas The Community Toolbox: http://ctb.ku.edu/en/evaluating-initiative

Two additional helpful resources for collecting data on program quality are discussed below.

First, assessing quality and developing an improvement plan for CP-SBH programs is critical to success and effective implementation. The Quality Assessment and Improvement (QAI) process involves identifying a problem, testing solutions, and monitoring solutions on an ongoing, system-level basis. In collaboration with the School Based Health Alliance, the Center for School Mental Health (CSMH) has developed a 5-step guide for QAI:

1. **Convene a team of at least three community partners** (e.g., school administrator, families, educators, school social worker) to assess the quality of mental health services and programming within your school.
2. **Team members independently complete an assessment of CP-SBH service provision,** considering both strengths and weaknesses
3. **As a team, review the results of the assessment and develop a consensus** around which areas to target for improvement during the school year.
4. **Develop and implement an action plan** that outlines action steps/strategies that will help your school improve around targeted areas.

5. **Evaluate progress regularly** by re-administering the assessment, analyzing patterns of change, and modifying the action plan.

**Figure 5: Five-step guide for Quality Assessment and Improvement**

As part of the evaluation process, the SBHA and the CSMH have developed the Mental Health Planning and Evaluation Template (MHPET). The **MHPET can be used in planning or evaluating new or established school behavioral health programs and can be used in a school-based health center or in any school setting.**

It is organized into the following dimensions:

- Operations
- Stakeholder involvement
- Staff and training
- Identification, referral, and assessment
- Service delivery
- School coordination and collaboration
- Community coordination and collaboration
- Quality assessment and improvement

Further details can be found: [http://www.sbh4all.org/site/c.ckLQKbOVLkK6E/b.7635259/k.BCA1/MHPET.htm](http://www.sbh4all.org/site/c.ckLQKbOVLkK6E/b.7635259/k.BCA1/MHPET.htm)
Best Practice #7: Obtain, Sustain, and Leverage Diverse Funding Streams*

Developing and sustaining funding streams to support the delivery of school behavioral health services and prevention programs is a critical challenge at local, state, and national levels. Estimates suggest that the yearly cost of behavioral health services delivered in all settings to exceed $11.68 billion or $172 per child. Funding streams are primarily supported through public sources (i.e., federal, state, and local government), insurance companies, managed care companies, charitable groups, and foundations. In order to sustain the delivery of CP-SBH services, programs most frequently braid or blend funding from multiple distinct sources. The following section highlights best practices for funding consideration in CP-SBH.

**Best Practices for Funding Considerations**

- Use Diverse Funding Sources
- Use Funding Strategies that Rely on Shared Funding and Promote Sustainability
  - Braided/Pooled/Blended Funding
  - Increase reliance on more permanent versus short-term funding
- Match Funding to Service Delivery Across Multiple Tiers
- Utilize Evidence-Based Practices and Programs
- Evaluate and Document Outcomes
- Demonstrate Connections Between Mental Health and Academic Functioning
- Cross-Training and Sharing of Professional Development Expenses

Both public and private resources have grown considerably over the past two decades to create school-based outposts for behavioral health services. Most recently, federal, state, and local support for school-based health services reached unprecedented levels following the traumatic events in Newtown, CT. This year, federal dollars were earmarked for Mental Health First Aid training and improved screening and referral of students with mental health needs to improve their access to trauma-informed care, conflict resolution, and violence prevention. Similarly, federal support totaling $200 million from the Affordable Care Act spurred more than 500 communities to build and expand school-based health.
Table 9. Overview of common funding opportunities

<table>
<thead>
<tr>
<th>Funding Stream</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal Grants</strong></td>
<td>Several <strong>federal grants</strong> have been created in recent years in which a portion of funds can be allocated for CP-SBH. These include the Healthy School, Healthy Communities program (Bureau of Primary Health Care), Safe Schools/Healthy Students Initiative (Departments of Education, Justice and Health and Human Services), Title XX Social Services block grant, Preventive Health and Health Services block grant, and the Maternal and Child Health block grant.</td>
</tr>
<tr>
<td><strong>State Funding</strong></td>
<td>Some states have begun to include school-based health and behavioral health services in their <strong>state budgets</strong>. For example, services can be financed partially by state allocations (e.g. budget line item) or by implementing specific programs (e.g. Safe and Drug Free Schools) that also come with budgets to supplement general money for school behavioral health programs. State health initiatives and state taxes (e.g. tobacco tax, property tax) may also offer some support for school behavioral health services.</td>
</tr>
<tr>
<td><strong>Fee-for-Service</strong></td>
<td>Third-party payers including State <strong>Children’s Health Insurance Programs, Medicaid</strong>, and <strong>commercial insurance</strong> provide support for school behavioral health through fee-for-service reimbursements. Though there are disadvantages to this line of funding including the large bureaucratic and administrative load required to recover funds, the necessity of diagnosing students for fee reimbursement, and the lack of reimbursement for many activities included in the CP-SBH framework (e.g. consultations with parents and teachers, classroom observations, and case management), <strong>fee-for-service revenue is seen as an integral part of long-term financial success for school behavioral health services.</strong></td>
</tr>
<tr>
<td><strong>Outpatient Behavioral Health Funding</strong></td>
<td>Partnering with an already existing outpatient behavioral health center is an excellent way of facilitating the ability to bill public and private insurance programs for services. That is, while CP-SBH programs have the staff, capability and connections to serve children in schools, the outpatient program has the structure mechanisms, and recognition needed to bill for services.</td>
</tr>
<tr>
<td><strong>Solicited Funds</strong></td>
<td>Many CP-SBH programs obtain at least some of their funding from private <strong>donors, private foundations</strong>, and <strong>federal agencies</strong>. This source of funding can comprise a portion of a general budget or they may be solicited to fund specific initiatives as part of broader school behavioral health services.</td>
</tr>
<tr>
<td><strong>Pooled, blended, or braided funds</strong></td>
<td>Relying on <strong>multiple funding streams</strong> through a pooling, blending or braiding of sources in an important component of successfully funding school behavioral health. This is a key component to <strong>ensure that the services continue even if one of the funding sources should end</strong>. An additional advantage of this approach to funding is that services tend to be more comprehensive since funding sources often differ on which services, providers and clientele are covered.</td>
</tr>
</tbody>
</table>
Models of Fiscally Sustained CP-SBH

**Baltimore, MD:** Baltimore City is recognized for its’ over 25 year history of sustaining a school mental health programs through its Expanded School Mental Health Network (ESMH; See Exemplar Section). The ESMH network is exemplary in its use of a blended funding model that has pooled and leveraged funding from multiple sources (pictured below). As can be seen in the pie chart below, approximately 50% of the funding for Baltimore City’s CP-SBH programming is generated directly from fee-for-service.

**Figure 6. FY Funding Strategy ESMH**

The City of Baltimore provides the next largest percentage of funding with 47% of funding through school system, mental health, and substance use dollars. The funders for the project have worked together as part of a leadership team to establish funding guidelines, deliverable requirements for clinicians, an online statistical reporting system, and clear expectations for principals receiving services within their schools. Services provided within this program can also be eligible for reimbursement under Medicaid.

**Washington, DC Commission:** The Washington, DC Commission was established in 1999 by a Safe Schools/Healthy Students Initiative grant to implement a comprehensive violence prevention initiative. The program has since expanded into a full-fledged school mental health program servicing 41 public and 13 charter schools, with 43 clinicians delivering comprehensive prevention, early intervention, and treatment services. This program has been supplemented and sustained by local dollars allocated by the DC Department of Mental Health. Additional funding is generated through fee-for-service provision.
This project demonstrates the value of utilizing federal grant dollars as a foundation to pilot and strategically build a program, as well as the importance of integrating local/community support to sustain CP-SBH once a grant has ended.

**Boys Town South Florida:** Boys Town South Florida offers an example of how funding has been secured for CP-SBH programming. The organization services 82 elementary schools in South Florida, and is funded primarily by local tax dollars collected by an independent taxing district that is set up as a quasi-governmental entity. Services provided also qualify for Medicaid reimbursement if a child is at-risk for abuse or neglect. The funding organization has a local board that oversees distribution of funds, monitors outcomes, and sets priorities. This program exemplifies the use of local tax resources and the benefits of community involvement.

**Unique CP-SBH Structures/Supports in Maryland**

When compared to other states, Maryland is very fortunate to have several structures/supports in place that affords exceptional opportunity to provide a foundational support and guidance to the high quality advancement of CP-SBH. These structures/supports include the Center for School Mental Health, Maryland Children’s Cabinet, Positive Behavior Intervention and Support, and the Maryland Education Leadership Community of Practice.

**Center for School Mental Health**

The University of Maryland Center for School Mental Health is the only federally-funded, national center for school mental health in the country and works closely with the State of Maryland, sharing resources and providing support through participation on behavioral health and school related committees. The mission of the Center for School Mental Health (CSMH) is to strengthen policies and programs in school mental health to improve learning and promote success for America's youth. Through participation in and development of a broad and growing National Community of Practice on School Behavioral Health, the CSMH analyzes diverse sources of information, develops and disseminates policy briefs, and promotes the utilization of knowledge and actions to advance successful and innovative mental health policies and programs in schools.

**The CSMH has two over-arching goals:**

**Goal 1:** Enhance understanding of school mental health policies and programs that are innovative, effective, and culturally and linguistically competent, across the development spectrum (from preschool through post-secondary), across three-tiers of mental health programming (promotion, problem prevention, intervention), and across levels of scale (international, national, state, local).
**Goal 2:** Enhance implementation of innovative and effective school mental health policies and programs through the dissemination and diffusion of analyses and instructive findings via a comprehensive, multi-faceted, engaging, and creative communications framework that reaches the full array of invested stakeholders in school mental health.

Currently the CSMH is funded in partnership with the School Based Health Alliance and is focusing efforts on improving the quality and sustainability of comprehensive school behavioral health programs and school-based health centers nationwide. The quality and sustainability benchmarks and data system structures developed by the CSMH and the broader school behavioral health field will be particularly relevant for and available for CP-SBH in Maryland.

**Maryland Children’s Cabinet**

The mission of the Children’s Cabinet is to promote the well-being of Maryland’s children. Led by the Executive Director of the Governor’s Office for Children (GOC), the Children’s Cabinet develops and implements coordinated State policies to improve the health and welfare of children and families. The Children’s Cabinet also works collaboratively to create an integrated, community-based service delivery system for Maryland’s children, youth and families. The Children’s Cabinet in Maryland can serve as a driving force for supporting evidence-based programs and using integrated care models, both of which are essential for CP-SBH programs.

**Evidence-Based Models Funded by the Children’s Cabinet:**

- Healthy Families America
- Home Instruction for Parents of Preschool Youngsters (HIPPY)
- Nurse Family Partnerships (NFP)
- Parents as Teachers (PAT)
- Babies Born Healthy
- Healthy Children
- School Readiness

**Positive Behavior Intervention and Support in Maryland**

PBIS *Maryland* is a collaborative effort between the Maryland State Department of Education, Sheppard Pratt Health System, the Johns Hopkins University; Center for the Prevention of Youth Violence, and 24 Local Maryland School Systems. Nationally there are over 19,000 schools in 44 states implementing universal, school-wide PBIS. PBIS Maryland celebrated 14 years of training and implementation in 2013 and has provided training in school-wide PBIS to 956 public, alternative, and non-public schools across all 24 Local School Systems in Maryland. PBIS is an important infrastructure to complement CP-SBH statewide, particularly in integrating within a multi-tiered system of support (see Best Practice #2).
PBIS Maryland includes an infrastructure that provides:

- Annual training calendar
- www.PBISMaryland.org
- Data collection capacity
- PBIS Coaching structure
- Technical assistance to Local School Systems
- Management Team
- State Leadership Team
- Social Emotional Foundations for Early Learning (SEFEL)

Maryland Education Leadership Community of Practice

The Education Behavioral Health Community of Practice (CoP) has broad representation across multiple stakeholders from a broad array of organizations and agencies who share a common interest in advancing school-based behavioral health in Maryland.

The Community of Practice has three overarching goals:

1) Improve state and regional connections in school-based behavioral health;
2) Support community outreach and education related to school-based behavioral health;
3) Support service sustainability.

The Community of Practice’s vision is grounded in the principles of school-family-community collaboration, quality and data driven decision-making, trauma-informed care, and workforce development. The CoP models for local jurisdictions interdisciplinary and cross agency collaboration and offers bi-directional linkages, resource sharing, and active problem solving between the State leadership and local jurisdictions and CP-SBH programs. The CoP is also committed to meaningfully involving youth and families and advancing workforce development for CP-SBH providers and school staff.

Federal and Other Grant Support Related to CP-SBH

Maryland is fortunate to have several federal and other large grants that can build on the foundation for CP-SBH, with key components within in each of the grants related to the advancement of school-based behavioral health. The table below highlights current grant projects related to CP-SBH within Maryland.
Table 10. Grants Awarded Related to CP-SBH in Maryland

<table>
<thead>
<tr>
<th>Grant Name</th>
<th>Funding Source</th>
<th>Awarded to</th>
<th>Region</th>
<th>Annual Amount</th>
<th>Years</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryland’s Suicide Prevention and Early Intervention Network (MD-SPIN)</td>
<td>SAMHSA</td>
<td>MD Behavioral Health Administration, Department of Health &amp; Mental Hygiene</td>
<td>Maryland</td>
<td>$735,051</td>
<td>9/30/14-9/29/19</td>
<td>Provides a continuum of suicide prevention training, resources, and technical assistance to advance the development of a comprehensive suicide prevention and early intervention service system for youth and young adults.</td>
</tr>
<tr>
<td>Project Aware – Now is the Time State Educational Agency Grant</td>
<td>SAMHSA</td>
<td>Maryland State Department of Education</td>
<td>Baltimore County, Somerset, Wicomico</td>
<td>$1,946,291</td>
<td>9/30/14-9/29/19</td>
<td>Increase awareness of mental health issues among school-aged youth, provide training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues in children and young adults, and connect children, youth, and families who may have behavioral health issues with appropriate services.</td>
</tr>
<tr>
<td>Maryland Healthy Transitions</td>
<td>SAMHSA</td>
<td>MD Behavioral Health Administration, Department of Health &amp; Mental Hygiene</td>
<td>Maryland</td>
<td>$999,918</td>
<td>9/30/14-9/29/19</td>
<td>Provides comprehensive services for transition age youth with mental health and co-occurring disorders.</td>
</tr>
<tr>
<td>Collaborative Improvement &amp; Innovation Network on School-Based Health Services</td>
<td>HRSA</td>
<td>School Based Health Alliance (Washington, DC) and Center for School Mental Health (Baltimore, MD)</td>
<td>National</td>
<td>$700,000</td>
<td>9/1/14-8/30/18</td>
<td>Improve the quality of school-based health centers (SBHCs) and comprehensive school behavioral health programs (CSMHPs); and expand the number and improve the sustainability of SBHCs and CSMHPs.</td>
</tr>
<tr>
<td>Developing Knowledge about What Works to Make Schools Safe</td>
<td>NIU</td>
<td>Baltimore County</td>
<td>Baltimore County</td>
<td>$800,000</td>
<td>1/1/15-12/31/17</td>
<td>Gauge the effectiveness of a new crisis response and prevention system in 44 Baltimore County Schools.</td>
</tr>
<tr>
<td>Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP)</td>
<td>MHA/DH, MH and MSDE</td>
<td>University of Maryland School of Medicine, Johns Hopkins University, and Salisbury University</td>
<td>Maryland</td>
<td>$900,000</td>
<td>10/1/14-6/30/15</td>
<td>Supports the efforts of primary care in assessing and managing mental health concerns in their patients from infancy through the transition to young-adulthood.</td>
</tr>
<tr>
<td>Grant Name</td>
<td>Funding Source</td>
<td>Awarded to</td>
<td>Region</td>
<td>Annual Amount</td>
<td>Years</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>---------------</td>
<td>---------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Project Launch</td>
<td>SAMHSA</td>
<td>MD Department of Health and Mental Hygiene and Maternal and Child Health Bureau</td>
<td>Maryland, Prince George’s</td>
<td>$838,778</td>
<td>9/30/12 – 9/29/17</td>
<td>Enhance the collaboration among state and local child-serving agencies; increase the use of early screenings, assessments, and mental health consultations; increase integration of behavioral health and primary care; enhance home visiting; and provide family strengthening and parent skills training.</td>
</tr>
<tr>
<td>Maryland Behavior Health Adolescent and Youth Treatment (MD-BHAY)</td>
<td>SAMHSA</td>
<td>Maryland Department of Health and Mental Hygiene, Behavioral Health Administration</td>
<td>Baltimore County and Baltimore City</td>
<td>$942,131</td>
<td>9/30/14 – 9/29/18</td>
<td>(MD-BHAY) seeks to increase access to and improve the quality of treatment for youth, ages 12-24, with substance use and co-occurring substance use and mental health disorders. MD-BHAY will reach this goal by enhancing statewide infrastructure and strategic collaborations, delivering evidence-based treatment in school and community settings, and developing sustainable funding and delivery mechanisms to support these changes.</td>
</tr>
<tr>
<td>SBIRT</td>
<td>Hilton Foundation</td>
<td>BHSB</td>
<td>Maryland</td>
<td>$333,334</td>
<td>1/1/15 – 12/31/17</td>
<td>This project involves the implementation of SBIRT (Screening, Brief Intervention &amp; Referral to Treatment) for adolescents in health centers across Maryland. The focus is on substance use prevention and early intervention for youth. SBIRT was developed primarily for adults but has shown promise for youth.</td>
</tr>
<tr>
<td>Good Behavior Game</td>
<td>NIDA</td>
<td>Johns Hopkins University and University of Maryland, Baltimore</td>
<td>Baltimore City</td>
<td>$403,456</td>
<td>6/1/13 – 5/31/15</td>
<td>This grant considers the value of using clinicans as coaches in training teachers to use the Good Behavior Game.</td>
</tr>
</tbody>
</table>
Maryland Survey Findings

Survey Methods

A key task of this report was to obtain an estimate of the prevalence of CP-SBH services within Maryland. To meet this goal, the Center for School Mental Health with support from agency leaders from MSDE and BHA developed and distributed a set of questions across three broad areas: The prevalence of CP-SBH services (e.g., “How many schools in your jurisdiction provide community-partnered SBH); type of services provided (e.g., “Of the community-partnered SBH programs within your jurisdiction, what percentage are providing...”); and source of funding streams sustaining CP-SBH (e.g., “How are community-partnered SBH programs funded in your jurisdiction? Check all that apply...”). Each area included questions regarding both mental health and substance use service provision. The survey was distributed in mid-October/November via E-mail to Directors of Student Services, Core Service Agency directors/leaders, and Alcohol and Drug Abuse Treatment Coordinators across each of Maryland’s jurisdictions. Follow-up e-mails and individual phone-calls encouraged non-responders to take the survey and helped to clarify questions related to survey responses. Overall response rate was outstanding: all jurisdictions provided data for this report. With limited time for survey completion and analysis, the CSMH team did a crosswalk of the three survey respondents for each jurisdiction to determine the extent and type of CP-SBH service provision and funding profiles. When there was discrepancy between surveys from individuals from the same jurisdiction, there were follow-up calls/emails to understand and resolve differences in reporting.

Survey Results

Prevalence of CP-SBH Programs within Maryland

Table 1 provides basic descriptive data regarding the number of schools within each school system and the number of schools that provide CP-SBH services. Of the 24 jurisdictions, 4 indicated that they did not partner with community behavioral health organizations and programs to provide CP-SBH services. While the vast majority of Maryland’s school systems provide some form of CP-SBH there is tremendous variability of number of schools served and breadth, depth and frequency of service provision. Respondents indicated that only 517 (37%) of the 1,414 schools included on this survey actually provide CP-SBH services, while only 32 (2%) provide community-partnered school-based substance-use services. Five systems report CP-SBH services in all of their schools, however, systems with full coverage only included systems in more rural communities with 25 schools or less. Systems collaborate with an average of 3 agencies to provide these services, though this ranges from 1 to 12 collaborative agencies.
## Prevalence of CP-SBH

### Table 11. Descriptive data concerning prevalence of CP-SBH and substance use programming in Maryland

<table>
<thead>
<tr>
<th>Name of School System</th>
<th>Schools in System</th>
<th>Number of Schools Providing CP-SBH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mental Health Services</td>
</tr>
<tr>
<td>Allegany County</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Anne Arundel County</td>
<td>121</td>
<td>80</td>
</tr>
<tr>
<td>Baltimore City</td>
<td>186</td>
<td>115</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>173</td>
<td>103</td>
</tr>
<tr>
<td>Calvert County</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>Caroline County</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Carroll County</td>
<td>43</td>
<td>8</td>
</tr>
<tr>
<td>Cecil County</td>
<td>29</td>
<td>28</td>
</tr>
<tr>
<td>Charles County</td>
<td>36</td>
<td>29</td>
</tr>
<tr>
<td>Dorchester County</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Frederick County</td>
<td>66</td>
<td>0</td>
</tr>
<tr>
<td>Garrett County</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Harford County</td>
<td>54</td>
<td>22</td>
</tr>
<tr>
<td>Howard County</td>
<td>76</td>
<td>1</td>
</tr>
<tr>
<td>Kent County</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>203</td>
<td>32</td>
</tr>
<tr>
<td>Prince George’s County</td>
<td>207</td>
<td>16</td>
</tr>
<tr>
<td>Queen Anne’s County</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Somerset County</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>St. Mary’s County</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>Talbot County</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Washington County</td>
<td>47</td>
<td>2</td>
</tr>
<tr>
<td>Wicomico County</td>
<td>24</td>
<td>1</td>
</tr>
<tr>
<td>Worcester County</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1414</strong></td>
<td><strong>517</strong></td>
</tr>
</tbody>
</table>

## Prevalence of Mental Health Service Provision in School-Based Health Centers

Separate from the Maryland CP-SBH survey, the Maryland State Department of Education, who provides leadership and guidance to Maryland’s School-Based Health Centers (SBHCs), collects annual data on SBHC service provision, including mental health and substance use visits in SBHCs. During the 2013-2014 school year, there were 74 SBHCs in 13 jurisdictions across the state. Within Maryland’s 74 SBHCs, 33 (45%) reported 12,228 mental health visits during the 2013-2014 school year. Substance use counseling
was not regularly provided by SBHC staff, but instead referrals were made to outside providers as needed. Providers did not have a regular schedule at the school but were available to provide school-based services on an as-needed basis.

The following jurisdictions reported mental health services within their SBHCs in 2013-2014 school year:

- Baltimore City
- Baltimore County
- Caroline County
- Dorchester County
- Howard County
- Montgomery County
- Prince Georges County
- Wicomico County

The number of mental health visits recorded across the 8 jurisdictions providing mental health services varied significantly across jurisdictions ranging from about 250 visits in one jurisdiction to over 6,000 in another jurisdiction. It is important to note that many school-based health providers such as nurses may address mental health and substance use concerns as part of a somatic visit --however the survey only counted sessions that were coded as mental health and substance use visits.

School-based Health Centers (SBHCs) and CP-SBH, though distinct service delivery models, share many common characteristics. They both:

- Provide high-quality clinical and preventive care that is developmentally-appropriate.
- Seek to improve student behavior, reduce barriers to learning, increase access to primary and behavioral health care, and improve both student attendance and academic achievement.
- Deliver services in school settings because they are trusted, familiar, and immediately available to young people.
- Target low-income and underserved communities where health disparities are more likely to exist and families have limited-to-no access to physical health and mental health services.
- Strive to reflect national standards for culturally and linguistically appropriate services by facilitating community and consumer involvement.
- Build on collaborative partnerships between school systems and community programs so that the efforts of school-employed pupil support professionals are augmented in a planned, purposeful way.
- Are sponsored by community primary care and mental health centers, hospitals, public health departments, schools, and universities to assure appropriate linkages and supports to school-based health providers and their students.

**Type of Services Provided Within CP-SBH Programs**

Figure 7 displays findings regarding the types of behavioral health services provided within Maryland systems and schools. As can be seen, nearly all systems and schools provide treatment
services within their CP-SBH programs. A smaller yet still substantial majority also provide consultation and prevention services, while approximately half provide access to psychiatry (not indicated if school-based or community-based). Fewer programs provide wellness and behavioral health promotion programming, while a minority of school systems or schools provide telepsychiatry services. Figure 7 represents complete data of 17 systems among the 20 providing CP-SBH (Some systems had missing data in their surveys). While the survey did not ask who actually receives services as a result of CP-SBH, several respondents indicated the value of service provision in their responses and the importance of increasing access through CP-SBH.

“We have successfully worked with our mental health partners for many years. They provide service to many of our students and their families. Without this service, many of our students would not receive these much needed services. These partnerships have served us well.” – CP-SBH Survey Respondent

“I do believe it is essential to provide mental health services to our students whose challenges are often ignored or attributed to poor motivation, negative attitude, apathy, or discipline concerns. Supportive services are often lacking for these students.” – CP-SBH Survey Respondent

Figure 7: Types of services provided within Maryland

![Graph showing percentage of services provided within school systems providing CP-SBH]
Source of Funding for CP-SBH Programming

Figure 8 provides data regarding common funding streams for Maryland’s CP-SBH programming in the 20 of 24 systems which provide CP-SBH. Within each of the jurisdictions, a wide variety of funding source for CP-SBH was reported. Across jurisdictions, 3 funding streams were used on average, with 7 jurisdictions reporting using four or more sources of funding, while 10 jurisdictions indicated that they rely on only one source of financial support (typically fee-for-service). The most common funding stream for CP-SBH across jurisdictions is fee-for-service, with 15 utilizing this to support CP-SBH services. This category was followed by financing provided by local and state funding sources. Less frequently used resources include federal funding (e.g., grants), school budget allocation, and private pay.

Figure 8. Types of funding streams for Maryland’s CP-SBH

<table>
<thead>
<tr>
<th>Funding Stream</th>
<th>Number of Jurisdictions Endorsing Funding Stream</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-For-Service</td>
<td>15</td>
</tr>
<tr>
<td>Local Health Department</td>
<td>8</td>
</tr>
<tr>
<td>Local Core Service</td>
<td>7</td>
</tr>
<tr>
<td>State Mental Health</td>
<td>6</td>
</tr>
<tr>
<td>Local City or County School</td>
<td>6</td>
</tr>
<tr>
<td>Federal Funding</td>
<td>6</td>
</tr>
<tr>
<td>Individual school budget</td>
<td>6</td>
</tr>
<tr>
<td>School budget</td>
<td>2</td>
</tr>
<tr>
<td>Private Pay</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>

Limitations & Next Steps

There are several limitations to this survey that are worth noting. First, results may be subject to reporter error or bias. While survey responses may provide a useful snapshot into what education and behavioral health leaders believe they are delivering within their school systems there is presently no centralized way to assess the extent to which reports are accurate or to obtain an objective assessment of CP-SBH prevalence, services, quality, or funding streams. Second, this survey was unable to capture data regarding the amount or percentage of funding available to support CP-SBH in each school system. Variations in amount of funding by funding category source
may reveal important ways to promote future access to maximize funding resources in each jurisdiction. Third, while this survey captures information regarding the type of services provided within CP-SBH programs, service directors are less often aware of the types of and quality of treatment actually provided by service providers. As empirically-supported treatments are most consistently linked to gains in behavioral health, this is an important direction for future study. Fourth, survey completion across the three survey respondents (Student Service Directors, Alcohol and Drug Coordinators, and Core Service Agency Directors) was done in isolation from each other. Ideally, the best picture of the CP-SBH provision would have been through a meeting with all three respondents to complete one survey together. In addition, there was some missing data in many of the jurisdictions related to some respondents not responding to questions because they were unaware of the answer to the question(s).

**Prevalence of Community-Partnered School Behavioral Health in Maryland**

While there is recognition of the value of CP-SBH in Maryland, the survey results indicate that there is a critical gap in service provision in Maryland, with a majority of schools in the State not having access to CP-SBH. Results from the Maryland CP-SBH survey suggests that 63% of Maryland schools do not have access to CP-SBH services. The number of schools providing school-based mental health services has not changed at all since 2009, remaining at 517 across the State.

In many instances community providers are only involved in the highest level of care versus in wellness and prevention activities, often related to funding mechanisms that are used by the CP-SBH program. In the words of one survey respondent, “Our mental health therapists operate under fee-for-service, which makes it difficult for them to attend student conferences about their clients.” In phone calls and in focus groups respondents indicated an interest in the provision of a three tiered model of service provision, but acknowledged the challenge of matching funding services to service provision when the majority of dollars available were for treatment services.

Further, in many cases the treatment services provided in schools by the CP-SBH providers may not be well integrated within the larger system of care within the school. The extent to which these programs are evidence-based, provided through a collaborative partnership of community-employed and school-employed behavioral health staff, provide both mental health and substance use services at the school, and offer the full continuum of care varies tremendously by school system and impacts the frequency, intensity, and quality of service provision.
Key Findings and Recommendations for CP-SBH in Maryland

PREVALENCE

FINDING: Prevalence of CP-SBH services varies widely across the State (ranging from no schools to all schools in a school system)

CP-SBH is available in 20 of 24 jurisdictions, with 37% of the schools providing mental health services but only 2% providing substance use services across the State. Within school-based health centers (SBHCs), mental health visits were provided in 8 jurisdictions for a total of 33 of the 74 SBHCs.

FINDING: The majority of CP-SBH programs are not providing the full continuum of comprehensive behavioral health services (behavioral health promotion, prevention and intervention).

FINDING: A majority of CP-SBH programs provide treatment services for students already identified with concerns, yet few provide behavioral health promotion and/or prevention services.

Among all programs providing comprehensive CP-SBH offered treatment services, about half offered prevention services while only 25% offered mental health promotion. It is important to note that questions related to behavioral health promotion and prevention did not inquire about frequency and intensity and may be indicative of a one-time activity versus a more strategic and comprehensive implementation plan. The survey did also not collect information on the extent to which evidence-based programs are implemented for prevention, promotion and/or treatment services.

Recommendation: Ensure that all students at all schools have access to a full continuum of behavioral health services through CP-SBH.

Recommendation: Expand CP-SBH programs across the State to reduce variability across school systems, and ensure that all student needs are effectively met.

Expansion of CP-SBH should be fostered through increased training, technical assistance and consultation in an effort to maximize funding resources and enhance opportunities for quality service provision. In addition, standardization of policy and procedures related to the establishment and ongoing operations of CP-SBH programs (e.g., MOUs, paperwork, consent, data-sharing policies, service provision) is recommended to promote the consistency of high quality service provision.

FINDING: Currently there is no system in place in Maryland or nationally that identifies and documents CP-SBH existence, service array, and extent of weekly staffing coverage.

In outreaching to each of the Maryland jurisdictions and their respective Directors of Student Services, Core Service Directors and Alcohol and Drug Abuse Coordinators, many respondents indicated that they
were unaware of the presence of CP-SBH and/or more specific details related to its provision. There was also some uncertainty related to behavioral health services actually provided and the extent of collaboration involved in CP-SBH. In addition, there was variability in responses among survey respondents within the same jurisdiction.

**Recommendation:** Develop a common census across the state to measure the prevalence and availability of CP-SBH programs.

**Recommendation:** Systematically collect and disseminate to schools, families, and community partners, CP-SBH availability, access, and service array by school and school system.

**FINDING:** A limited number of CP-SBH programs effectively integrate substance-use prevention and intervention services within their daily practice.

Substance use and abuse among children and adolescents, and its comorbidity with mental illness, is a serious and wide-spread concern, in Maryland and nationwide. However, substance use counseling is not regularly provided by Maryland’s CP-SBH staff. Instead referrals are typically made to outside providers as needed.

**Recommendation:** Expand access to and funding for substance-use prevention services across the K–12 curricula, and for substance-use intervention services for middle- and high-school aged students.

**QUALITY**

**FINDING:** Among the CP-SBH programs which exist in Maryland, there is tremendous variability in the extent to which programs are implementing best practices to maximize high quality of care.

According to follow-up phone interviews, this variability, which occurs from school to school and across jurisdictions, is related to a variety of barriers including limited funding, insufficient staffing capacity, inadequate time, competing priorities, and limited access to expertise in CP-SBH best practices.

**Recommendation:** Encourage and appropriately reimburse/incentivize providers to utilize empirically-supported treatments and best practices tailored to suit the needs of youth, families, schools, communities, and jurisdictions.

- Establish and maintain effective partnerships and team structures to maximize desired outcomes by involving families, students, education staff and school leadership, and community partners in service planning, provision and evaluation.
- Integrate CP-SBH into multi-tiered systems of support.
- Conduct needs assessments and resource mapping related to student need and available service provision.
- Collect, analyze, and utilize data to inform decision making about service provision.
- Require workforce development for educators and other professionals involved in CP-SBH on identification, referral, data-based decision making and school teaming.
**Recommendation:** Offer readily accessible and no cost/low cost training on implementing evidence-based programs and best practices in schools related to mental health, substance use, and co-occurring disorders across a multi-tiered system of support.

- CP-SBH leadership should prioritize empirically supported treatments and ensure that the necessary training and resources are provided to achieve quality implementation.
- Develop policy and fiscal structures to allow for incentives for use of evidence-based interventions.

**FINDING:** CP-SBH programs are not consistently collecting, analyzing and reporting student- and school-level data to document impact of service provision.

At the state and national levels, documenting student outcomes, including academic, behavioral, social and emotional functioning and progress, as well as linking these data to CP-SBH services provided, can be very challenging. Documenting program effectiveness, unfortunately, is inconsistent, time consuming, logistically challenging and historically an underfunded activity. While challenging to achieve, data collection, analysis and reporting is increasingly recognized and required for not only documenting provision of quality services but also for maintaining and securing continued funding.

**Recommendation:** Develop a single, comprehensive system to support CP-SBH program evaluation and collect common data across jurisdictions. This data can be utilized to streamline and inform decision-making.

- Outcome measures and data collection methods should be standardized.
- Jurisdictions should be able to enter data into a centralized system that collects and aggregates information about CP-SBH programming.
- To measure the effectiveness of CP-SBH evidence-based school mental health programs, implement consistent outcome measurement. This can help determine which programs are most effective for specific student populations.

**FINDING:** CP-SBH providers would benefit from additional training related to providing effective behavioral health services in schools, and may need access to additional training in order to provide empirically-supported services across a multi-tiered system of support.

Many CP-SBH staff may not have had formal preservice training related to effective clinical work in schools. They could benefit from tailored training to address unique programs and strategies for working across a multi-tiered framework in schools.

**Recommendation:** Provide training to CP-SBH providers on school policy, teaming, and unique aspects of school-based service provision.
SUSTAINABILITY

FINDING: Sustainable models of CP-SBH programming braid together diverse funding streams including fee-for-service and local/state funding sources.

FINDING: Although each of the jurisdictions reported using a variety of funding sources, there was a predominant reliance on fee-for-service revenue which results in a primary focus on treatment services as compared to a multi-tiered system of support (which would also include prevention and promotion supports).

Across jurisdictions, three (3) funding streams were used on average, with the most common funding stream for CP-SBH across jurisdictions is fee-for-service. Reliance on only 1 or 2 funding sources can be challenging to long-term program sustainability. Programs that had braided and leveraged funding across several funding sources had greater likelihood of sustainability. The most common funding stream for CP-SBH across jurisdictions is fee-for-service, with 15 utilizing this to support CP-SBH services. This category was followed by financing provided by local and state funding sources. Funding sources have significant impact on whether a full continuum of care is provided through CP-SBH versus only a focus on youth already identified and displaying behavioral health concerns. The reliance on fee for service revenue to support CP-SBH increases the likelihood of a focus on predominantly treatment services verses behavioral health promotion and prevention.

Recommendation: Ensure that meaningful partnerships and integrated funding strategies among schools, behavioral health programs, family organizations, and community organizations are pursued and leveraged to promote sustainability of CP-SBH programs.

Recommendation: Continued and increased funding for school behavioral health should be a priority at the school, jurisdiction and state levels.

- Establish and expand funding mechanisms for CP-SBH Services
- Promote funding strategies that match to tiered service provision
- Standardize policy and procedures related to CP-SBH programs (e.g., MOUs, paperwork, consent, data-sharing policies, service provision)
- Require workforce development for school-based staff on identification, referral, data-based decision making and school teaming
- Reimburse teacher consultation, school team meetings, and school promotion/prevention activities provided by school behavioral health staff
- Obtain, sustain, and leverage diverse funding streams
- High quality behavioral health programs are more likely to achieve and be able to document service impact and better able to sustain adequate funding for services
**FINDING:** Substance use services are heavily reliant upon grant dollars which have significantly reduced in recent years. Financing substance use services in schools has been particularly challenging related to recent decreases in prevention funding.

Based on the Maryland CP-SBH survey, approximately 2% of Maryland Public Schools offer community-partnered, school-based substance use services. Focus group data found that service provision for substance use in particular has been negatively impacted by budget cuts at the state and local levels, resulting in loss of prevention services for students in Maryland.

**Recommendation:** Work across child-serving agencies to identify and leverage funding opportunities within the larger system of care.

**Recommendation:** Improve availability of and funding for school-based substance-use service provision, particularly prevention services.

**Recommendation:** Ensure that meaningful partnerships and integrated funding strategies among schools, behavioral health programs, family organizations, and community organizations are pursued and leveraged to promote sustainability of CP-SBH programs.
Appendix: Program Spotlight from Maryland and Nationally

The following section spotlights programs in Maryland and nationally which provide CP-SBH. Note that a multi-tiered continuum of care in which communities and schools partner to provide school-based mental health and substance use prevention and intervention services, utilizing all best practices simultaneously, is a complex undertaking and in many ways aspirational. Each of the programs described below have unique strengths and were selected for their exemplar efforts and achievements with some of the best practices noted in this report.

Examples of Effective & High-Quality CP-SBH: Maryland Models

Anne Arundel County Expanded School Based Mental Health Services Initiative
Anne Arundel County, MD

The Expanded School Based Mental Health services (ESBMH) initiative in Anne Arundel County Public Schools (AACPS) developed as an organic labor of love that filled an unmet need in local schools. Services initially began in the 2003, when the Villa Maria Health System offered to place a social worker in Glendale Elementary School. In exchange for space within our school and referrals of students and families who might benefit from mental health services, the social worker would provide individual and family therapy to Medicaid eligible students and their families who might not otherwise receive care.

Expanding the model

The model was further developed over the next 8 years. Services were initially expanded into our North County cluster in 2005, and a partnership was developed with Walter Reed Army Medical Center in 2008. This ongoing partnership provides access to therapeutic services for children and families who are military dependent and assigned to Fort George G. Meade Army Base, whom attend 7 of our public schools. The School Behavioral Health Center offers all clinical services provided in other CP-SBH programs within the AACPS.

An additional service provider was added during the 2009-10 school year to meet growing need and request for services by an increasing number of schools in our system. At this point, each provider was assigned clusters of schools to facilitate services to families across grade levels and maximize travel time for service providers. Additionally, we added quarterly “partners“ meetings and bi annual meetings with

“This partnership has benefitted our students and families because service delivery became consistent and aligned to support the students’ success in the school setting.” -- AACPS
each of the Points of Contact within each school. The purpose of these meetings was to contribute to program development through open dialogue, problem solving, and the development of data collection tools for monitoring the outcomes of the service delivery model. We have recently developed a system for collecting and analyzing academic, behavioral and attendance outcomes for participating students—and expect to see change in each of these outcomes in response to treatment. Three additional providers joined us between 2012 and 2014, to complete our system-wide model for providing CP-SBH services in Anne Arundel County Public Schools. **At the conclusion of the 2013-14 school year, a total of five providers offered CP-SBH services in 105 of our 125 schools and served over 800 children and families.**

Memorandums of Understanding were created to formally identify the roles and responsibilities of each partner. These arrangements are outlined in Table 12.

**Table 12. Roles and responsibilities of each partner**

<table>
<thead>
<tr>
<th>Villa Maria Health System</th>
<th>Anne Arundel County Public Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Professional mental health clinician</td>
<td>• Office space for the mental health counselor</td>
</tr>
<tr>
<td>• Clinical &amp; administrative oversight</td>
<td>• Marketing strategies within the school &amp; among the community to inform about services available</td>
</tr>
<tr>
<td>• Liability &amp; malpractice insurance</td>
<td>• Access to phone and internet services</td>
</tr>
<tr>
<td>• Billing &amp; authorization</td>
<td></td>
</tr>
<tr>
<td>• Communication with students &amp; families</td>
<td></td>
</tr>
<tr>
<td>• Screening for more intensive, community, or psychological evaluation services</td>
<td></td>
</tr>
<tr>
<td>• Consultation with staff about referrals</td>
<td></td>
</tr>
<tr>
<td>• Individual, family, &amp; group counseling</td>
<td></td>
</tr>
<tr>
<td>• Medication monitoring, if necessary</td>
<td></td>
</tr>
</tbody>
</table>
Expanded School Mental Health Network (ESMH)
Baltimore City, MD

The Baltimore City student body is predominantly (84%) African-American, low-SES (85% meet eligibility for free and reduced lunch), and living in a highly stressed community that is exposed to elevated levels of violence and substance abuse. The ESMH network provides evidence-based intervention, prevention, consultation, assessment, and mental health promotion services to children with mental health and/or substance abuse disorders, youth exposed to trauma, or at-risk of developing future problems.

The ESMH (operated by Behavioral Health Systems Baltimore) has approached CP-SBH with an efficient model to serve 118 of the 184 (64%) schools in the system which relies on school-community partnerships, blends sustainable funding sources and has a centralized data system. Within the ESMH there are four approved regional lead agencies, University of Maryland Baltimore, Hope Health Systems, Catholic Charities and Therapeutic Living for Families. These providers applied for approval via a competitive Request for Proposals process and receive $16,000 for 2.5 days per week of coverage at a school and $32,000 for 5 days per week of coverage at a school.

This model has allowed the ESMH to standardize CP-SBH services in Baltimore City. For instance, all four approved community-based providers enter student contact data for all three tiers of support into a centralized data system. Also, there is a streamlined process for schools developing contracts with community agencies by offering common Memorandums of Agreement. Overlapping professional development opportunities are provided to both school-employed and community agency-employed behavioral health staff to maximize resources.

Provision of services in a multi-tiered fashion (e.g., including prevention and promotion services) is maintained by the contractual obligations of provider agencies to ESMH. Annual deliverable goals mandate that activities are 55% prevention/promotion and 45% fee for service. This emphasizes teacher consultation, prevention-focused classroom- and school-based programming based on blended funding from education, mental health, and substance use agencies. In particular, ESMH provides an empirically-supported prevention program, Botvin LifeSkills, as a network-wide 6th grade initiative to students at risk for substance use and other risk behaviors. This effort is funded by Baltimore Substance Abuse Systems and is a primary component of Tier 2 interventions for substance use prevention in Baltimore City. For more intensive substance use concerns, clinicians are trained to assess (using the CRAFFT and CAGE techniques) and refer students to appropriate community-based services. Currently a minimum data set is being developed to track substance use interventions such as LifeSkills.

This model relies heavily on school-community partnerships. Services involve partnerships between schools and community health/behavioral health organizations, and are guided by families and youth, and the ESMH Network partners with and builds on existing school programs, services, and strategies to augment the services available within the school setting.
Johns Hopkins Bayview Medical Center Baltimore Student Assistance Program
Baltimore, MD

The Johns Hopkins Bayview Medical Center (JHBMC) Baltimore Student Assistance Program (BSAP) offers Level One substance use disorder (SUD) services that operate in two Baltimore City High schools (Patterson/Reach). These schools have co-located Senior Mental Health Therapists from JHBMC as well. Level One SUD services primarily target harm reduction and increased education that covers a combination of prevention and intervention services. School-Based Mental Health (SBMH) services focus primarily on intervention services although each therapist sits on a minimum of one school committee and provides or arranges for two scheduled behavioral health in-services per year. Students in the BSAP also routinely participate at the Teendrop-in Center and are all registered members of the school-based health suite. The school-based services include two full time employees and are supported with block grant funding. For those schools without an additional licensed/supervised SUD counselor, each therapist has mandatory additional training and competency based evaluations related to substance use service, screening, and treatment.

Youth, families, school and community partners, and other key stakeholders are involved in program development, intervention, and prevention activities in the following ways:

- BSAP therapists routinely assess program satisfaction from youth and request ideas regarding what they see as resilience factors matching programming needs
- BSAP has a 97% agreement/consent from students for parental participation although it is not required for drug and alcohol services
- Therapists attend at every Back to School and Parent Meeting and many extra-curricular activities (e.g., games, fundraising, etc.)
- Therapists provide community response to requests for training from parent organizations, health fairs, and open clinics
- BSAP meets with principals and staff at each of the schools on a quarterly basis and also have them participate in annual evaluations of the program

Empirically-supported treatment modalities employed by BSAP include Motivational Interviewing, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy and Coping Cat. The program also uses SBIRT (Screening, Brief Intervention, and Referral to Treatment), Circle of Security, and expressive therapies (e.g., students participate with Creative Alliance, Youthworks and Herring Run Association Clean Streams).

Data collected through DRUGStat to evaluate the impact of service provision indicated the highest 90 day retention rate for the past three years. Retention markers are widely used to indicate program efficacy related to successful discharge. The highest 90 day retention benchmark throughout the City, which is based on an adult model, has been used by therapists to incentivize treatment and this has
shown some improvement in 60/90 day maintenance and family involvement. These therapists continue to think creatively about ways to engage the students and are frequently the first person students call when there are joys and disappointments.

An area of focus for the future includes developing a mechanism to utilize fee for service as a means for increasing available funding for the program. A future policy consideration to address with the school administration is allowing on-site urinalysis testing to create the potential for being compliant with a full array of services from prevention to treatment/intervention.
Linkages to Learning
Montgomery County, MD

Linkages to Learning (LTL) is a CP-SBH program founded by a collaboration of concerned civic leaders, including former Council President, Michael Subin, and current County Executive, Isiah Leggett. LTL is a program that targets families living in poverty, and offers behavioral health, social services and community education/development services. LTL provides mental health treatment and prevention services on site at every school receiving services. Substance abuse treatment is not offered on-site, but referrals are made to community partners. LTL is in 22 elementary schools (another elementary school is opening in 2015 and will have these services) and 6 middle schools in Montgomery County. The program targets students, who are economically disadvantaged, based in schools with high percentages of students who fall below the federally defined poverty line. The majority of LTL clients are members of minority groups, with a large segment of families who speak a language other than English at home. The LTL Program offers more than mental health services. It seeks to treat the whole child by providing mental health where school based health centers exist, parent education, and social services in the convenient location of the school, as well as to develop the whole school community by working with community stakeholders to bring needed resources into the school. Prevention and/or intervention for substance use include screening of every family member during intake/enrollment processes, promotion/prevention services offered on-site, and referral to community providers for those in need of treatment.

This program provides comprehensive services in a community school model, utilizes a collaborative management structure (administrative team is composed of administrators from health, education and partner agencies), and has a bilingual/bicultural capacity to serve many new residents.

Youth, Family and Community Involvement

The A 2013 study of Linkages to Learning Programs at Family Services, Inc. compared 62 children served in the CP-SBH program to 126 children treated in an outpatient community clinic. Results suggest that the outcomes in the CP-SBH program were very similar to community clinic and the overall state outcomes. The CP-SBH program demonstrated improvement in children’s emotional symptoms with moderate effect sizes, similar to the community outpatient clinic and greater than the state average. The CP-SBH program also demonstrated improvements in children’s behavioral symptoms (although smaller in effect than community outpatient and state-averages). “Linkages Site Collaborative Team” meets bi-weekly to include key school personnel (e.g., school administrator, health staff, resource teachers, school psychologists). Community needs assessments are conducted annually and include parent, school staff and student input via surveys, multi-lingual focus groups and interviews to prioritize resources and programming needed. Current strategic planning builds upon successful parent outreach and engagement strategies to formalize parent advisory groups at each site.

Evidence-Based Practices

Training and certification of providers varies from site to site, but most common empirically-supported...
treatments/interventions available include: **Brief Strategic Family therapy (BSFT), Cognitive Behavioral Therapy (CBT), Trauma Focused Cognitive Behavioral Therapy, Active Parenting, Nurturing Parent Program, Systematic Training for Effective Parenting (STEP).**

**Evaluation and Empirical Support for Linkages to Learning**
- In 1999, a United States Department of Education grant funded longitudinal study by Dr. Nathan Fox and colleagues at the University of Maryland, College Park pointed to the effectiveness of Linkages to Learning by showing that the children who participated in the program demonstrated less negative behaviors than a comparison group of at risk children who did not. Even more compelling are the findings that demonstrate particularly positive gains among children and families who received direct services through the LTL program.
- Data collected in the 2013-2014 school year reflects 70,000 client encounters, or over 2,500 per site. Parent survey feedback indicated that there was an overall satisfaction of 99% including receiving services in a timely manner, having needs understood, and being treated with respect. In addition, 74% of children exiting LTL behavioral health services maintained or improved classroom behavior, 71% of children exiting behavioral health services maintained/improved psychosocial functioning, and family self-sufficiency scores increased by 29% on average after 6 months of family case management support.
- Resource development efforts brought **in 40 cents for every public dollar invested.**

**Funding**
As a safety net service with a mission to serve un-insured or under-insured students (or those who families experience significant barriers to accessing their benefits or other community resources), 70% of behavioral health direct service costs are covered by the Montgomery County Department of Health and Human Services via contracts to nonprofits. Providers are required to bill for any billable services and cover, at minimum, the other 30% of direct service costs for school mental health. Funding for the whole initiative (includes cost of delivery of social services and community education/development) is comprised of 70% from the Montgomery County Department of Health & Human Services; 20% from donations/grants (via 200 local level partnerships across 28 sites and central office outreach/resource development); and 10% from fee collections/billable mental health services.
Maryland Treatment Center’s Discovery Center
Mountain Manor Treatment Center

*Discovery Center* is a school-based outpatient substance use disorders student assistant treatment program operating out of Achievement Academy at Harbor City High School and Augusta Fells Savage Institute of Visual Arts High School. The project provides underserved, minority youth with school-based three-tier services including screening and an early identification program, an evidence-based treatment intervention, case management, mental health services, referrals to community based resources as needed, family support services, outcomes-based evaluation of project services and training of school personnel in early identification of at-risk youth. A broad spectrum of substance use screening, treatment, prevention, education, assessment, advocacy, counseling, intervention, and referral and support services are provided in these schools that are located in communities with high rates of drug use, mental illness, school failure and drop-out, violence, poverty, and other social problems. *Discovery Center* focuses on the elimination of barriers to access to care, retention and coordination in care, and continuing longitudinal care. Discovery team members are cross trained in substance use treatment and mental health issues. Counselors utilize a peer support approach and actively solicit input from students.

**Youth, Family, School and Community involvement**
Counselors engage and build rapport with students referred for services. Relevant school and community based personnel are involved in the treatment planning process and in ongoing communication and collaboration throughout the student’s participation in the program. Parents or guardians are involved if the student signs consent and parent/counselor sessions often focus on communication skills and expanding the parents’/guardians’ capacity to identify and address behavioral health problems. Counselors complete an intake, profile, admission and enrollment for each student who enters the program as well as a disenrollment and discharge.

**Evidence-based practices include Motivational Enhancement Therapy (MET), Cognitive-Behavioral Therapy (CBT) from the Cannabis Youth Treatment (CYT) Manual series produced by the federal Center for Substance Abuse Treatment, and Elements of Recovery Oriented Systems of Care (ROSC).** The ROSC includes concepts of the person-centered approach, strengths based approach, family/friend involvement, cultural sensitivity, inclusion of the voices and experiences of recovering individuals and their families, integrated services, outcome driven treatment, and involvement of the support systems located in the home community for each patient. **Empirically supported treatment modalities include** individual counseling, twelve-step facilitation and group sessions.

**Evaluation and Continuous Quality Improvement**
*Discovery Center* counselors maintain a data system that records the number of referrals received, the number of interventions conducted, weekly groups and individual counseling sessions, the types and number of school meetings attended weekly, and school presentations to inform and train school staff. The Director of Adolescent Services audits the quality and completeness of student Discovery Center
records each year.

The program has been very successful in collecting and tracking data. Utilization of Behavioral Health System Baltimore (BHSB) Services Activities Chart has assisted counselors and leadership in making positive changes regarding referrals, program content and retention.

**Funding**
A contract with BHSB provides funding for all administrative and program costs.
Talbot County Public Schools
Talbot County, MD

Talbot County Public Schools (TCPS) program began in 1999 after receiving federal funding from the Safe Schools/Health Students (SS/HS) Grant. A single provider Eastern Shore Psychological Services (ESPS) was contracted to provide comprehensive school mental health services. The infrastructure of the program was founded on two primary principles: Decrease initial presenting symptoms and Increase school performance. In this process, a community of practice was established and community meetings assisted with the development and orchestration of rooting this program based on community resource needs. Program succession planning began in 2001, immediately after receiving the SS/HS grant. **In 2003 grant funding ended, and the program transitioned into 100% fee for service.** To assist with the identification of students, annual in-services training are provided to all school staff on the signs and symptoms of mental health disorders within the school aged population as well as for identifying depression and suicide behaviors. The TCPS School Mental Health Program offers 13 licensed clinicians full-time in nine schools with one full-time psychiatrist allocated to this program. The chief form of therapeutic intervention is CBT, with specialties in trauma and suicide evaluation.

**Patterns and Trends in Referrals**
In the process of establishing sustainability, developing outcome measures was instrumental in capturing the significant unmet health needs within this rural community. The outcome measures include basic referral demographic data, academic data related to attendance, suspensions, discipline, and provider data related to quarterly stats that also include number of participants (unduplicated), number of individual sessions, number of group visits, number of sessions provided by psychiatrist, and number of family visits. Below includes 15 consecutive years of descriptive program data (1999 – 2015).

**These data are suggestive of important referral trends:**
- October and February remain consistently the most referred months
- The most referred grades are 6th and 9th (transition grades)
- Caucasian females in the 9th grade are most commonly referred
- Programs average 219 new referrals per year

**Chief reasons for referral include:**
- Family-related problems (28%)
- Depressive symptoms (28%)
- Behavioral problems (17%)
- Anxiety symptoms (10%)
- Suicidal ideation (7%)
- Grief/loss 7%
- Other 3%

**Evaluating Efficacy**
In 2009, TCPS partnered with the University of Maryland Center for School Mental Health to evaluate outcomes. Students who accepted treatment were reviewed against those who were referred and declined services over a three-year period. **When compared to those who declined services, those who accepted treatment displayed improvement in attendance, decreased suspensions, and fewer disciplinary referrals.**
Examples of Effective & High-Quality CP-SBH: National Models

D.C. Department of Behavioral Health School Mental Health Program
Washington, DC

The D.C. Department of Behavioral Health’s School Mental Health Program (SMHP), located within the Office of Programs and Policy in the D.C. Department of Behavioral Health (DBH), provides a full continuum of services including prevention, early intervention, and treatment services to youth, families, teachers and school staff through a partnership between DC public schools and DC public charter schools. Behavioral health clinicians work to bolster and improve services already provided in schools to help create a safe and supportive school climate. By fostering resilience and reducing emotional barriers to learning, the D.C. DBH SMHP seeks to maximize the student’s potential.

In School Year 2014-2015 the program will serve 70 schools in DC. Clinicians provide universal prevention programs for students, families, and staff. Professional development is offered to school teachers and staff on several behavioral health topics, classroom management techniques, and case management. Workshops on evidence-based interventions and several classroom-based substance use and violence prevention programs are also provided for parents/guardians, school staff, and students.

Students identified at elevated risk for developing serious mental health problems may attend support groups, skills training sessions, and dropout prevention programs, with their families and teachers able to receive training and consultation on ways to best support them. Students with intense and chronic problems requiring intervention services are assigned to individual and family therapy services and therapeutic groups (i.e. loss or grief counseling). In the aftermath of a traumatic event, clinicians are on-hand to provide immediate care for both staff and students.

Evaluation results over the past 7 years have suggested that students receiving school mental health services made significant improvements:

- Students who participated in universal prevention programs demonstrated significant improvements in their knowledge of protecting themselves from abuse
- Youth and parent hopefulness significantly increased from intake to discharge
- Youth, parents, and clinicians reported that students’ everyday functioning, and behavioral and emotional symptoms significantly improved from intake to discharge
- Youth and parents endorsed high satisfaction with the treatment
- The number of students who met criteria for psychiatric disorders decreased after treatment, and demonstrated improvements in global functioning

South Capitol legislation in the District calls for behavioral health clinicians in every DC Public and Public Charter School over the next 5 years.
Hennepin County’s Children’s Mental Health Collaborative: School Mental Health Initiative
Hennepin County, Minnesota

Hennepin County’s School Mental Health Initiative (HC SMHI) includes 10 mental health agencies, working in 130 schools from 17 school districts servicing over 3000 students per year (approximately 60% of these students take part in the Free and Reduced Lunch program). Funding and evaluation continues to make this program one of the strongest school-based behavioral health centers nationally. Adherence to national, state, and local best practices have aided in the development of legislative policy to ensure funding across Hennepin County’s schools.

HC SMHI requires a licensed mental health professional to work at each school; usually this is a full time therapist at the school but sometimes a part time therapist. Through close collaboration with school employed student support staff, the therapist and school staff provide a broad continuum of services from mental health promotion to diagnosis and treatment. The therapist typically focuses on diagnosis, treatment and treatment related consultation with school staff and care coordination. Some of their time is spent supporting school employed staff in delivering Tier 1 and 2 related services and supports. Each school offers services on-site, with the option of also referring out to community-based treatment if needed. This builds upon HC SMHI’s mission to improve access and engagement in care; improve symptomology, functioning, and school outcomes; and to integrate a broad continuum of mental health services and supports. Over two years ago, the HC SMHI developed a consensus statement on a practice framework for school mental health in Hennepin County.

Evaluation and Policy Impact
The HC SMHI’s dedication to evaluation and research has helped to inform many policy changes on school-based health centers in Minnesota. The Minneapolis Public Schools School Mental Health Program (SMHP) has lead a significant amount of the evaluation and research efforts. Evaluation efforts have been ongoing since 2006 and have resulted in two peer-reviewed journal articles and numerous paper presentations at local and national conferences. Additionally, data collection efforts include literature reviews and two evaluation studies conducted by Wilder Research. Findings regarding the Minneapolis Public Schools SMHP have shown the following school outcomes:

- **Improved Access and Engagement**
  - 85% of students have been seen face to face
  - 70% of students have been seen within the last 10 days
  - 65% of students report this is their first time receiving services
  - Students average about 17 during one school year and 25 behavioral health related visits over multiple school years

- **Improved student mental health and school functioning**
  - 65% of students showed a decrease in mental health symptoms on the Strengths and Difficulties Questionnaire
- Decrease in office referrals, school suspensions, and SPED referrals
- Increase in attendance and academic achievement
- 4 year longitudinal study showed a positive impact on reading scores

Due to the evaluated success of Hennepin County, the 2013 Minnesota Legislative session increased funding for school-based behavioral health services from $4.7 million per year to $45 million over 5 years. The MN Department of Human Services received 42 proposals requesting over $70 million dollars and issued grants to 38 different mental health agencies who are serving over 800 schools in MN. The HC SMHI continues to provide leadership and work at the state level, understanding areas of improvement and program efficacy to incorporate into a practice framework for other programs at the local and state level.
Syracuse Promise Zone
Syracuse, New York

The Syracuse City School District (SCSD) is located in central New York and includes 31 schools ranging from Elementary to High School. The district services 21,000 youth with 85% of students utilizing the Free and Reduced Lunch program (the fourth highest amount in the state) and 20% of students in Special Education. The Syracuse Promise Zone seeks to match students’ emotional and behavioral needs with evidence-based interventions. Behavioral expectations and goals of each student are based on collaborative partnerships among the students’ school, family, and community in order to improve academic achievement, student engagement, and prevent school drop-out.

The overarching mission of the Syracuse Promise Zone is to increase access to mental health clinicians by providing care in school settings and advancing the use of effective interventions. Each school has a full time licensed mental health clinician on staff able to identify and intervene with youth at risk for developing serious mental health concerns. Currently, 17 schools have received training in Screening and School Based Intervention Teams-Behavior protocols. Key assessments and interventions used include 40 Developmental Youth Assets, Response to Intervention (RTI), Positive Behavior and Supports, and Trauma-Focused Cognitive Behavioral Therapy.

The SCSD Promise Zone adheres to the three tier problem-solving framework of providing universal, targeted at-risk, and individualized at-risk services, but also incorporates a fourth tier of services which target youth requiring intensive, individually designed interventions. These students are able to access high intensity, longer duration, and daily care through an Individualized Learning Plan (ILP), incorporating a function-based assessment, intensive and sustainable prosocial strategies, and a tailored behavior plan. The SCSD Promise Zone provides an array of diverse behavioral health services through the use of family case managers, outpatient mental health, counselors, SBIT teaching assistants, PBIS coaching support, data resource specialists, the PAX Good Behavior Game, chronic stress and trauma resources, and the 2X10 method.

Multi-Tiered Funding Support

The Syracuse Promise Zone has been able to secure 10.5 million dollars in funding to support its vast amount of capabilities servicing its high-need, low-income youth. Funding is received from multiple sources including Medicaid Managed Care, the local Department of Social Services, school district contracts, and state aid from the New York State Office of Mental Health and Office of Alcoholism and Substance Abuse Services (OASAS). 95% of funding is received from state authorities. Funds support services across prevention, promotion, and intervention. This blended funding profile illustrates significant investment in behavioral health at the state and local levels in order to most effectively serve the needs of students.
Vanderbilt School-Based Program
Nashville, Tennessee

Vanderbilt’s School-based Program was founded on research excellence and continues to excel as a high quality school-based mental health program serving students from socioeconomically disadvantaged backgrounds within 35 Nashville public schools. Using a multi-disciplinary team of psychiatrists, psychologists, counselors, social workers, and nurses, the program incorporates several evidence-based interventions including RECAP, TF-CBT and other CBT strategies. Clinicians are also able to provide teacher consultation, group therapy, family sessions, individual treatment, and medication management. Students are able to receive on-site medication management from a psychiatry fellow or nurse practitioner.

Vanderbilt’s School-Based program has an integrated model of teachers working alongside their mental health clinicians. School educators and principals report that clinicians are flexible, accessible, and valued members of the school team. Teachers also report that the clinicians’ role in the schools not only support management of student behavioral health concerns and but also alleviate their burden as well.

Research and Evaluation
Program leadership is knowledgeable and skilled in obtaining and utilizing data from evaluation to inform service provision. The program currently collects several forms of data for evaluation, including:

- A satisfaction survey
- The CANS
- Informal monitoring
- Performance evaluation
- Professional Advancement Ladder (PAL)

Five quality improvement committees exist to assess the efficacy of the program:

1) Research
2) Productivity
3) Evidence-based Practice
4) Morale
5) Summer Planning

Vanderbilt’s School-based Program has a strong commitment to evaluating the efficacy of its program through these committees as well as developing effective evidence-based practices for its students requiring behavioral health services.
advocates to promote social and emotional health and school readiness. National Center for Children in Poverty.


