

Building and Sustaining Programs for School-based Behavioral Health Services in K-12 Schools

Youth (i.e., children and adolescents) spend most of their time in school, offering an important opportunity to deliver mental and behavioral¹ health services that meet them where they are. In fact, prior to the COVID-19 pandemic, [35% of youth](#) who received behavioral health services did so in schools. Schools can provide prevention services aimed at supporting positive youth behavioral health, [decreasing the need](#) for higher-level care, and can also serve as a key point of access for youth to receive more targeted services, such as therapy and crisis intervention. This is particularly important for youth in under-resourced communities where there are high unmet behavioral health needs and insufficient numbers of behavioral health providers.

School-based services can also help address access and capacity constraints in the health system, and schools provide an [optimal venue](#) for identifying youth with behavioral health concerns and delivering interventions. Compared to more traditional clinical settings, behavioral health services [in schools](#) are more acceptable to families and reduce stigma associated with treatment. School-based behavioral health services have shown [positive impacts](#) on emotional outcomes and academic functioning.

Defining and meeting the needs of schools to support youth behavioral health is particularly important given the current youth behavioral health crisis. Behavioral health challenges in children were rising even prior to the COVID-19 pandemic, and youth psychological distress and unmet behavioral health need [increased further](#) during the pandemic. When combined with the [limited and inequitable](#) access to care that existed before the current crisis, the increased behavioral health challenges among youth translate to more children needing services in school. States are working to respond to this challenge and potential opportunity; between March 2020 and December 2021, states [enacted](#) more than 90 laws to support school-based behavioral health services. With this white paper, we describe several innovative strategies implemented by states and municipalities in support of comprehensive behavioral health services in schools.

Best practices for school-based behavioral health services

As communities direct more resources to school-based behavioral health services, it is important that they invest in evidence-based approaches—those that have been evaluated and have demonstrated effectiveness—for identification of and intervention for youth in need of support. School-based behavioral health services are [most effective](#) when they follow a [multi-tiered system of support](#) (MTSS) in which schools strive to meet the needs of all students through a layered continuum of supports that increase in intensity as needed.

To place students in the right level of support, schools must first identify students' behavioral health needs. One way for schools to identify unmet needs is through universal screening using validated tools. Prior to implementing this, the MTSS model serves children best when schools have a plan for how they will use the screening data, including matching students with onsite services or referring students to community providers. There are several [resources](#) to support schools and districts in implementing screening best practices.

The MTSS framework layers supports across three tiers. Tier 1 services are universal supports provided to all children in the school. They include proactive, positive behavior management practices or skill-building such as those included in [Positive Behavioral Interventions and](#)

¹ Throughout this resource, we will use the term *behavioral health*, which we view as encompassing mental health and emotional and psychological well-being.

[Supports](#) (PBIS) or Social Emotional Learning (SEL) programs (see the CASEL Guide in *Resources for Identifying Evidence-based Programs*). Tier 2 services provide targeted supports for children who would benefit from more services than Tier 1 alone. These can include small-group interventions targeting a specific area of concern such as youth with disruptive behaviors or youth at risk for depression. Tier 3 services include more intensive, individualized supports such as individual or family therapy, medication management, or multi-disciplinary team-based interventions. Across tiers, it is important to use evidence-based interventions to achieve the greatest impact on youth behavioral health (see *Resources for Identifying Evidence-based Programs*).

Resources for Identifying Evidence-based Programs

A number of resources, including those listed below, can help identify programs that meet specific evidentiary standards. In many cases, users can search these resources by features like target population, program approach and types of outcomes.

- [CASEL Guide to Effective Social and Emotional Programs](#) (Tier 1) provides descriptions of universal social-emotional learning programs that meet specific standards, including having detailed documentation, offering professional development to implementers and outlining standards of evidence.
- [What Works Clearinghouse](#) (Tiers 1 and 2) collects, reviews, and reports on studies of education interventions, including those related to behavior. The resources can support evidence-based decision-making.
- [Blueprints for Healthy Youth Development](#) (Tiers 1, 2 and 3) is a resource for identifying interventions for youth, including those to improve youth behavioral health, implemented in a range of settings such as schools.

When implementing a MTSS framework, schools and districts have flexibility in choosing evidence-based tools and interventions and determining how services are provided. Behavioral health services are often provided onsite by school personnel (e.g., school psychologists, school counselors, school social workers) or through partnerships with licensed community providers who are embedded within the school. In some cases, referral to an outside provider or a specialty clinic within a health system for a higher level of care may be the best way to support the student. However, while promising, building school and health system collaborations can be challenging, especially as it relates to the differing medical and educational privacy standards (HIPAA and FERPA). This can present a barrier to information-sharing and, by extension, make it difficult to provide coordinated care. Regardless of the approach, the MTSS framework calls for data-driven decision-making informed by ongoing monitoring of progress by all internal and community providers.

PolicyLab’s approach

Knowing the importance of schools in supporting youth behavioral health, several [PolicyLab researchers](#) have developed and evaluated school-based interventions and continue to explore how to best deliver these programs within schools and alongside educators. Furthermore, given [PolicyLab’s mission](#) to conduct research and other activities that inform practice and policy to improve child health, we are interested in advancing the discussion on how to finance, sustain and evaluate school-based behavioral health services.

To inform this discussion and our own work, this white paper explores innovative models that address some of the barriers associated with implementing, funding and sustaining comprehensive school-based behavioral health in the United States.²

Exploring innovative models

We conducted a scan of state and community models that support school-based behavioral health services to identify examples that may be replicable elsewhere and relevant to all public schools. The examples we highlight include local, state, and regional stakeholders, and payment and policy levers for service models that span Tiers 1, 2 and 3. Most importantly, schools need [additional resources](#) to provide behavioral health services to their students. For example, schools report difficulties in securing sustainable funding to provide the necessary range of services, especially preventive services. Others report barriers that include insufficient numbers of licensed providers in the workforce, lack of resources for training school staff and limited infrastructure for ongoing evaluation. While education sector [funding streams](#) are important, we focus on health-related payment levers in this paper.

Medicaid’s Role in School-based Behavioral Health Funding

State Medicaid programs and funding can be an important part of school-based behavioral health care, particularly in under-resourced settings. Nationally, more than [one-third of youth](#) were insured through Medicaid in 2019 and this number has likely [increased](#) during the pandemic. Given the nature of the program, there is higher enrollment in under-resourced communities. Thus, the degree to which Medicaid may be a funding lever for school-based behavioral health care varies a great deal and may have limited utility in districts with low student enrollment in the program.

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² In this white paper, we are specifically interested in models to sustain behavioral health interventions in the K-12 school setting, and we defined the following topics as out of scope for this resource: multi-tiered systems of supports related solely to academics, services specific to special education such as IEPs (though methods of providing the services listed above to students who also receive special education services is within scope), and school-based services specific to physical health or health education (e.g., asthma prevention, obesity prevention, sexual health services).

In 2014, the Centers for Medicare & Medicaid Services (CMS) gave states the ability to permit schools to bill Medicaid for covered services offered in the school setting for all Medicaid-enrolled students. Previously, Medicaid reimbursement was limited to Medicaid-enrolled youth with an Individual Education Program (IEP). Medicaid’s [Early and Periodic Screening, Diagnostic and Treatment \(EPSDT\)](#) benefit requires all state Medicaid agencies to reimburse for routine screening and early interventions for youth and includes behavioral health screening and treatment. However, there is a great deal of variation in state Medicaid programs that may impact access to behavioral health care in schools. [Most states](#) need to update their Medicaid plans to enable reimbursement for school-based services (view [progress by state](#)).

Another potential barrier relates to licensing requirements for providers. Several [state entities](#) (e.g., state Medicaid plans, departments of education, state licensing boards) may be involved in determining what provider types can treat youth in a school setting and if the provider is eligible for Medicaid reimbursement. In 20 states, [misalignment](#) between the Medicaid plan and education agency standards means that not all school-based behavioral health providers are eligible for Medicaid reimbursement. An example of misalignment is when a state education agency offers an expedited certification process for a school-based health professional, but the credential is not recognized by the Medicaid agency.

Fragmentation of behavioral health insurance plans from physical health insurance coverage is another potential constraint. Relevant to Medicaid’s role in school-based behavioral health is that in some [states](#), some or all behavioral health services are “carved-out” from Medicaid Managed Care Organizations’ contracts and are managed by a separate plan (fee-for-service or limited benefit). There is [variation](#) across states and [changing trends](#) in what and how services are carved in or out. Having separate behavioral health payers can add complexity for schools, which are also working with Medicaid on school-based physical health services, as they then need to navigate different payers and processes for billing and service delivery.

Leveraging Medicaid for school-based behavioral health services

Medicaid has the potential to be a sustainable funding source for school-based behavioral health services, especially in school districts with a high proportion of eligible children, and it represents a significant funding stream within many [school district budgets](#). Yet school-based services make up [less than 1%](#) of overall Medicaid program funds.

Although [17 states](#) permit Medicaid reimbursement for school-based services for all Medicaid-enrolled students, several barriers can make leveraging Medicaid reimbursement difficult even within those states. First, the administrative process associated with obtaining Medicaid reimbursement, such as providing documentation and completing time studies, can deter school districts, especially those with relatively low numbers of Medicaid enrollees. Second, there may

be misaligned licensing requirements across different state agencies that prevent reimbursement for school-based professionals. Third, the proportion of youth insured through Medicaid varies by school district, which impacts the role that Medicaid can play in funding school-based behavioral health services.

As a result of these barriers, many states and school districts have not tapped into Medicaid as a funding source, resulting in [missed revenue](#). Also, it is common that innovation starting in Medicaid prompts change among private health care payors, making it all the more important to look at how Medicaid can increase access to school-based behavioral health. In the following examples, we identify opportunities to better leverage Medicaid and private insurance along with strategies that employ a population health approach to fund school-based health services.

Centralizing Medicaid reimbursements through intermediate school units across the state: In 2019, [Michigan](#) launched the Caring 4 Students program to increase utilization of Medicaid funding for behavioral health services in schools. Michigan’s Medicaid agency partnered with the regional educational units, Intermediate School Districts, which serve almost all of the nearly 600 school districts in the state, to centralize reimbursement for services covered in Medicaid’s EPSDT benefit. This process relieves individual schools and districts of some administrative burden associated with the reimbursement process. Michigan created the program through a Medicaid [State Plan Amendment](#), which also expanded the provider types (see “Increasing Staffing in Schools” section below) that can provide behavioral health services in schools. Michigan also allocated a portion of the [state budget](#) to hire school-based behavioral health staff and build the infrastructure needed by the Intermediate School Districts. We do not have data on how these updated processes have impacted claims, but it will be important to examine trends in Medicaid claims for school-based behavioral health services over time.

Mandating cross-sector collaboration to reduce administrative burden for schools and increase utilization of Medicaid funds: In [Minnesota](#), the state Departments of Education and Human Services were [charged](#) with collaborating to develop a strategy for schools to seek reimbursement from the state’s Medicaid program for services provided through an IEP. Currently, a small proportion of the state’s more than 500 school districts receive Medicaid reimbursements, representing a missed opportunity. This missed opportunity was also [explored](#) by the [Subcommittee on Children’s Mental Health](#) for the State Advisory Council on Mental Health, which makes recommendations to the governor, legislature and state departments on behavioral health policies, programs and services. The two state agencies are examining how to reduce [administrative burden](#) for schools, which may ultimately support more schools in utilizing the Medicaid funds. The commissioners of education and human services are required to issue a report to the legislature with their strategy, and we are interested in how their recommendations might be applicable in other states.

Funding preventive school-based behavioral health services for all enrolled children, regardless of health insurance status

Schools offer an important point of connection for behavioral health promotion for all students. There is also [growing recognition](#) of the importance of mitigating behavioral health issues before they become more severe. Thus, Tier 1 and Tier 2 programs are essential components of comprehensive school-based behavioral health programming. Unfortunately, it is difficult to pay

for these schoolwide (Tier 1) and targeted prevention services (Tier 2). Without an associated diagnosis, these services are not eligible for third-party (e.g., Medicaid) reimbursement. Screening is also important as it identifies children at risk of behavioral health challenges, as well as those with a behavioral health diagnosis, offering a critical opportunity for prevention and early intervention. The examples that follow highlight innovative approaches to fund preventive school-based behavioral health services.

Braiding funding to sustain MTSS with community partners across a school district: In **Baltimore**, a community provider network [implements](#) Expanded School Behavioral Health (ESBH) and MTSS across the Baltimore City Public Schools (BCPS) with support from [Behavioral Health Services Baltimore](#) (BHSB). BCPS and BHSB coordinate the provider partnerships with [six provider agencies](#) working in 138 schools. Providers are contracted for their clinicians to deliver intensive Tier 3 individual services for about 65% of their time and to use their remaining time to support MTSS Tier 1 and 2 services through teacher consultations, group prevention activities, in-service staff development, participation in school team meetings and supporting the BCPS crisis response team. Maryland's Medicaid agency operates a public behavioral health program, managed by an administrative service organization, which allows licensed community providers to bill for school-based treatment services with an associated diagnosis. Additionally, BCPS and BHSB collaboratively [award](#) up to \$2.3 million annually to contracted providers from diverse funding sources, including a small proportion from foundation grants and the remainder split nearly equally between federal block grants and city budget allocations.¹ This funding is used to support non-billable activities, such as schoolwide and targeted prevention activities. It's worth noting that partners do not take any indirect costs from the funding sources. The provider network convenes monthly for technical assistance.

Enabling Medicaid payment for preventive behavioral health services without a diagnosis: **Massachusetts'** state Medicaid agency, MassHealth, issued [guidance](#) in 2021 that provides billing codes for providers, including school-based outpatient providers, to seek reimbursement for preventive behavioral health services for youth with a positive behavioral health screen who do not meet criteria for a diagnosis. This funding mechanism, which falls under Medicaid EPSDT benefits, will enable school-based providers to provide brief prevention services to youth before behavioral health concerns escalate. This is a relatively new mechanism so it remains unclear how this will be implemented and whether other states will also adopt this approach. Further, it will be important to see if this approach might allow for the provision of prevention services to the whole student population, not just those enrolled in Medicaid. Nonetheless, it offers promise that prevention programs might be reimbursable by Medicaid in schools, particularly when schools implement behavioral health screening. Additionally, MassHealth provides a [list of validated screening tools](#) that may be used to identify youth who would benefit from these prevention services, which may encourage schools to engage in early identification and prevention.

Supporting access to behavioral health services for uninsured and underinsured students

When children are uninsured or underinsured, they have [trouble accessing](#) health care. It is estimated that one-third of all children, including those with private and public coverage, are [underinsured](#) due to gaps in coverage of at least one month or inadequate benefits. In particular, insurance coverage of adequate behavioral health benefits (screening and treatment) has been a longstanding challenge. While there are different [federal policy protections to ensure access to behavioral health services](#), [gaps in behavioral health coverage](#) still exist. Some states have created dedicated funds to ensure schools can provide or coordinate behavioral health services for uninsured or underinsured students. Here, we highlight two examples.

State funds coupled with outreach to strengthen care protocols and Medicaid utilization: In 2020, the **Arizona** State Legislature passed [Jake's Law](#), establishing and funding the [Children's Behavioral Health Services Fund](#) with [\\$8 million](#) in general funds for the provision of behavioral health services for underinsured and uninsured children. Jake's Law also served to strengthen the care protocols for youth at risk of suicide. This law, combined with Arizona's Medicaid 2021 [State Plan Amendment](#) that enabled Medicaid reimbursement for approved school-based services for all Medicaid-enrolled students, opened up funding for school-based behavioral health services. To support uptake and participation, the state Medicaid and education agencies jointly released [resources](#) for schools and coordinated outreach strategies targeting school officials and providers. The state Medicaid agency predicts a [20% growth in claims](#) for school-based services in fiscal year 2022.

State-administered grants that leverage both state funds and federal block grant dollars to ensure access to services: In **Minnesota**, [school-linked behavioral health grants](#), established by a [state statute](#), are managed by the state's Department of Human Services. They are issued to eligible applicants through a Request for Proposal (RFP) process to licensed behavioral health providers who are embedded in or located close to the school to screen for behavioral health concerns, deliver services to students and build capacity of school personnel. Providers offer behavioral health services to all students, regardless of insurance status. The school-linked grant program [funds](#) approximately 20-30% of the total costs of comprehensive school behavioral health services in the more than 1,000 participating schools. The balance is covered by third party funding. The [grant program](#), started in 2007, received funding increases and programmatic updates informed by cross-agency review. In 2017, the grant program [reached](#) more than 60% of school districts in the state. Recent increases in the grant program [leverage](#) federal community mental health block grant funds (e.g., Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants). The grant program [increased access](#) to services: nearly half of the youth served through the grant program received behavioral health care for the first time. Additionally, a recent [publication](#) from the U.S. Department of Education highlighted Minnesota's cross-agency work to concretely link mental health and educational services and strengthen partnerships between school staff and mental health providers.

Increasing staffing in schools to support behavioral health

Behavioral health [staffing shortages](#) are prevalent, including in the school setting. A 2022 analysis of [student-to-staff ratios](#) found that very few states achieve the nationally recommended ratios for school psychologists (1:500 students) or school counselors (1:250 students), and no state meets the recommended ratio for social workers (1:250 students). These statewide data likely mask large disparities in staffing shortages within states.

As schools are being called on to attend to the increasing behavioral health needs of children, we must address these staffing shortages. One important strategy is to develop the overall pipeline of providers, including through tactics such as workforce loan repayment programs and incentives like grant programs or scholarships. Other supportive policies include those that expand the types of providers that can be reimbursed by Medicaid for providing school-based services, a current barrier to sustainable funding. In the near-term, school districts may also build partnerships with outside providers (see Baltimore and Boston examples). To ensure quality services across professional types, there should be resources to train all providers in the delivery of evidence-based practices and to support school districts' accountability through monitoring of fidelity and outcomes.

Here, we share two examples of states funding the expansion of school-based behavioral health staff.

Aligning recognized behavioral health provider types across state Medicaid and education agencies: **Michigan**, like many states, faced behavioral health staffing shortages and recognized that many different professionals can effectively provide school-based behavioral health services. To ensure that these provider types could be eligible for Medicaid reimbursement, Michigan amended its state Medicaid plan to [expand](#) the types of health care practitioners who can provide school-based behavioral health services. It now includes certified school psychologists and nurse practitioners.

Defining staffing standards and dedicating state budget to achieve these standards: In **Delaware**, [2021 legislation](#) established ratios for school behavioral health professionals in K-5 schools, including school counselors, school psychologists and social workers. Prior to this legislation, less than 15% of Delaware elementary schools employed a school social worker and most schools did not meet the recommended ratios for school psychologists and counselors. The FY22 state budget dedicated [\\$8 million](#) to hire behavioral health professionals so that school districts can come closer to achieving the recommended staffing ratios in Delaware elementary schools. Pending funding availability, the commitment extends into FY24 to help schools meet the recommended ratios. The legislation also commits to the development of a strategic plan to similarly build up middle and high school behavioral health staff to meet defined standards. With the future strategic plan, there may be an opportunity to align the increased behavioral health capacity with the existing school-based health centers that are [required](#) in all public high schools in Delaware.

Standardizing and evaluating school-based behavioral health interventions

Alongside increasing access to behavioral health services in schools, it is also critical that attention is paid to school-based behavioral health services being of high quality. Schools should conduct periodic needs assessments and continuous program evaluation. Needs assessments can be used to identify current resources and needs, inform decisions about which evidence-based interventions might be appropriate, and to plan for training and ongoing support. This is important to ensure that interventions are implemented with fidelity.

Ongoing evaluation of programs is recommended to determine the reach and [effectiveness](#) of these services and to inform continuous improvements. This evaluation should also include validated outcome measures. Leadership [commitment](#) alongside dedicated personnel and/or partners can help a school district in the assessment and evaluation. Here we highlight an example of a school district's approach to ongoing evaluation in their comprehensive behavioral health program, as well as potential partnerships districts can explore to support this work.

Using data to inform standardization and decision-making: [Boston Public Schools](#) (BPS) offers an example of standardizing practice and data-based decision-making for implementation of comprehensive behavioral health services throughout a school district. A [Comprehensive Behavioral Health Model](#) (CBHM) guides MTSS implementation in the school district. The [Boston School-Based Behavioral Health Collaborative](#) (BSBBHC), led by BPS, coordinates behavioral health partners, health care providers and government entities. To support the model, the BSBBHC established [standards of practice](#) for community partners, including 23 different agencies in 85 schools [in 2020-2021](#), and maintains an Evidence Based Practice Subcommittee to review practices and support provider training. CBHM includes [standardized tools](#) to support data-informed decision-making and routine review of program effectiveness. The BSBBHC meets monthly to coordinate, share resources, deliver trainings and review program-level data.

Several districts and states have leveraged academic partnerships to guide implementation and evaluation of school-based behavioral health services. These academic-district partnerships can be effective in addressing some of the challenges that schools may face. Academic institutions are well-positioned to support training in evidence-based interventions that can be delivered in schools, provide technical assistance to support scalability and sustainability, and guide evaluation of school-based behavioral health interventions and programs.

Leveraging academic partnerships: In **Boston**, BPS [partnered](#) with the University of Massachusetts Boston and Boston Children's Hospital to develop, implement and evaluate the CBHM. In **Missouri**, the [Boone County Schools Mental Health Coalition](#) is a partnership between the University of Missouri and six school districts to support school-based behavioral health services including identification of youth with behavioral health needs, consultation, staff training and support of service delivery. Academic institutions also help grow the evidence base for school-based behavioral health services. Many centers at academic institutions lead a portfolio of school-focused behavioral health research and/or provide technical assistance to schools, districts and/or states. A few examples include: [National Center for School Mental Health](#), [Ohio University Center](#)

[for Intervention Research in Schools](#), [School Mental Health Collaborative](#) and [SMART Center](#).

Conclusion

In our review of the examples included in this white paper, we found that innovation at the local, regional, and state levels helps to address some of the persistent challenges that schools face in providing school-based behavioral health services. The approaches described can and should inform growing efforts to build, finance, sustain and evaluate school-based behavioral health services. However, there is room for further advancement.

As school districts and state leaders seek ways to sustainably fund services and build comprehensive approaches to behavioral health in schools, Medicaid offers a promising funding source, especially in under-resourced settings. However, there are barriers to accessing this funding and the high administrative burden required of schools and providers to access reimbursements can be a deterrent. Furthermore, there are opportunities to utilize Medicaid reimbursement more consistently for school-based behavioral health services. All states should explore explicitly permitting EPSDT services in the school setting for all Medicaid-enrolled students, and further explore the opportunity to specify coverage of preventive behavioral health interventions under these benefits that might be inclusive of all children, regardless of insurance status. Additionally, state Medicaid agencies should recognize more behavioral health provider types as eligible for reimbursement. At the federal level, CMS should consider updating their school-based administrative claims [guidance](#) and resources to support states and school districts in utilizing Medicaid funding and braiding it with other relevant sources.

Medicaid funding is only one part of the solution and varies in its relevance depending on the proportion of students who are eligible for Medicaid in a district. Even in districts with high Medicaid enrollment, this funding stream will not on its own meet the need for sustainable funding for comprehensive school-based behavioral health programs for all children. In particular, Tier 1 and Tier 2 services for students without a behavioral health diagnosis are a critical part of school-based behavioral health programming, but they are often not eligible for Medicaid reimbursement.

We see in the examples highlighted in this white paper that in the absence of comprehensive funding, school districts may braid several different revenue sources, including state budget appropriations. However, securing and managing multiple funding sources, including time-limited dollars, will affect schools' and districts' capacity and ability to plan longer-term programs. It will be essential to identify and secure long-term funding sources that allow for prevention at a population level. Other current federal efforts to build capacity and resources for school-based behavioral health services are also important for changing the landscape on funding.

In many examples, partnerships and coordination between the education sector and other organizations, including health systems, community organizations, or academic institutions, help advance school behavioral health programming and unlock critical resources. At the local level, school districts and individual schools collaborate with community providers to provide direct services and support a comprehensive framework. Finally, academic institutions, where available, can be helpful partners in supporting ongoing technical assistance and evaluation.

In our review, we did not identify models of sustainable funding or partnership that assist school districts' ongoing training needs related to evidence-based interventions, fidelity monitoring

and outcome assessments. We see this as an important opportunity for future exploration and attention.

We remain hopeful that learning from the innovative strategies highlighted in this white paper and continued work in this area will pave the way for sustainable mechanisms to provide all youth with evidence-based behavioral health services and prevention strategies in schools.

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Disclaimer: This white paper reflects our best understanding of these program models. We welcome hearing about other innovative models. If we misinterpreted or misrepresented something, please let us know so that we can update our work.

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Unpublished Citations

1. Fink L, Collins A, Epps N. School Mental Health During the Pandemic: What Can We Bring Forward. Paper presented at: 2021 Annual Conference on Advancing School Mental Health: School Mental Health Moving Forward Together; October 14, 2021; virtual.