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School-Based Mental Health: Introduction and Considerations for Congress

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School-Based Mental Health: Introduction and Considerations for Congress

SUMMARY

This report describes common models of school-based mental health (SBMH) programs, summarizes research on the effectiveness of such approaches, and discusses considerations for Congress.

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Johnathan H. Duff
Specialist in Health Policy

Kyrie E. Dragoo
Analyst in Education Policy

School-based mental health activities refer to policies, initiatives, models, programs, or services in school settings that address students' emotional, behavioral, or social functioning. SBMH programming exists on a spectrum that includes the promotion of mental wellness, the prevention of mental and behavioral problems, and treatment of existing behavioral health conditions. SBMH activities are carried out by an assortment of school personnel. The availability of mental health programs or services in schools varies widely. Funding usually occurs through school budgets determined at the state and local levels, though some services may be paid for by private health insurance and state Medicaid programs. Federal support for SBMH activities can come from a variety of mandatory and discretionary funding mechanisms (see **Table A-1**).

School-Based Mental Health Models

SBMH activities often follow a *multi-tiered system of support* (MTSS) that includes universal mental health promotion activities for all students, targeted intervention services for students at higher risk for problems, and treatment for students with more intensive needs. *Tier 1* programs are used among the general student population without regard for individual risk level. *Tier 2* interventions target students with identified risk factors for certain issues, or those with emerging problems. *Tier 3* interventions offer more intensive services to students exhibiting symptoms of mental or behavioral health disorders.

SBMH programs often have theoretical bases and empirical support for their effectiveness. Studies show that when implemented properly, many SBMH programs can promote healthy development and mental well-being, and prevent or reduce an array of social, emotional, and behavioral problems. The benefits for academic achievement, however, appear less clear. Simply offering any SBMH programming does not guarantee positive results; certain program characteristics matter for achieving desired outcomes. For schools and other stakeholders, identifying appropriate programs can prove challenging. Resources to help stakeholders identify applicable evidence-based programs and practices (EBPs) include federal clearinghouses, among other resources.

School-based mental health programs can help prevent school violence and ameliorate the mental health consequences of school violence. For example, for students who have made threats of school violence, the *threat assessment* model is designed to evaluate the severity of the threat and triage students into appropriate services with mental health or criminal justice professionals.

Considerations for Congress

Determining whether and how schools should offer SBMH programs raises both logistical questions regarding the capacity of schools to deliver services and philosophical questions about the purpose of public education. Proponents of SBMH activities believe that to meet individual and societal needs, schools should include social and emotional development activities. Others assert that, for practical reasons, schools offer an ideal environment for promoting healthy emotional development and providing beneficial services. Detractors argue that conducting behavioral health-related activities in school settings is neither feasible nor consistent with the purpose of the formal education system. Many believe that any efforts to improve youth mental health necessitates some involvement of schools in the continuum of mental health care, such as collaboration between schools and community providers.

Implementing SBMH activities can be challenging. According to stakeholders, common barriers to widespread implementation of SBMH programs include time, resources, costs, and an inadequate supply of qualified behavioral health professionals. Some argue that the SBMH field should look beyond efforts to increase the number of direct clinical service providers and instead focus on prevention and collaborative service integration.

Offering SBMH programs may not be the only way to promote good mental health. Creating environments where youth can thrive or addressing the factors contributing to poor mental health can also influence mental wellness. Alternative strategies include increasing child-led free play, limiting smartphone or social media use, improving access to green spaces, providing mentoring programs, offering activities in sports and art, and connecting students to civic institutions and youth-serving organizations, among others.

The federal government supports several SBMH programs and activities. **Table A-1** identifies relevant federal school-based mental health programs and recent funding levels.

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Introduction

Mental health encompasses a range of emotional, cognitive, social, and behavioral functioning that exists along a continuum of good to poor.[1] In children and adolescents, good mental health includes timely achievement of developmental milestones, healthy social and emotional functioning, adaptive behavior, and effective regulatory and coping skills.[2] In contrast, poor mental health consists of emotional, social, or behavioral symptoms that disrupt adaptive functioning, impede healthy development, or cause impairments. Although mental health has historically been viewed through the lens of mental illness (e.g., depression, anxiety), good mental health has more recently been recognized as not simply the absence of illness, but the possession of skills necessary to thrive and cope with life's challenges.[3]

Among other factors (such as biology), the physical and social environment surrounding a child has a significant influence on healthy development and mental wellness. Therefore, schools may be a logical place to identify and address behavioral health. Nearly 50 million students in the United States are enrolled in public elementary and secondary schools that educate children from pre-kindergarten through 12th grade.[4] The Centers for Disease Control and Prevention (CDC), in its surveillance of youth mental health, estimates that one in five youth experience a mental disorder each year, and that half of all adult mental health disorders have a childhood onset.[5] In addition, federal data show positive indicators of mental health—such as resilience, curiosity, persistence, and self-control—in three-quarters of school-aged children in the United States.[6] Schools may be well-positioned to create environments, institute policies, and implement interventions designed to promote good mental health and prevent mental and behavioral problems.

Scope of This Report

This report discusses mental and behavioral health promotion and treatment in elementary and secondary (K-12) school settings in the United States.[7] School-based mental health (SBMH)

[1] Rebecca H. Bitsko, Angelika H. Claussen, Jesse Lichstein, et al., *Mental Health Surveillance Among Children—United States, 2013-2019*, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report (MMWR), vol. 71, no. 2, Atlanta, GA, February 25, 2022.

[2] Bitsko et al., *Mental Health Surveillance Among Children, 2022*.

[3] Substance Abuse and Mental Health Services Administration (SAMHSA), *Ready, Set, Go, Review: Screening for Behavioral Health Risk in Schools*, Rockville, MD, 2019.

[4] U.S. Department of Education (ED), National Center for Education Statistics, Common Core of Data (CCD), Digest of Education Statistics, "Table 105.20. Enrollment in elementary, secondary, and degree-granting postsecondary institutions, by level and control of institution, enrollment level, and attendance status and sex of student: Selected years, fall 1990 through fall 2029," Washington, DC, 2019, https://nces.ed.gov/programs/digest/d19/tables/dt19_105.20.asp?current=yes.

[5] Centers for Disease Control and Prevention, *Mental Health Surveillance Among Children - United States, 2013-2019*, Morbidity and Mortality Weekly Report (MMWR), vol. 71, no. 2, February 25, 2022. Most common include attention-deficit/hyperactivity disorder, depression, anxiety, behavioral and conduct problems, autism spectrum disorder, and substance use disorders. Ronald Kessler, Patricia Berglund, Olga Demler, et al., "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication," *Arch Gen Psychiatry*, vol. 62 (June 2005).

[6] From CDC, 2022; data from National Survey of Children's Health (2018-2019). Indicators of positive mental health for children included assessments of affection, resilience, positivity, curiosity, persistence, and self-control.

[7] The term *behavioral health* typically encompasses both mental health and substance use. For the purposes of this report, the term *mental health*, in the context of school-based mental health, includes substance use and other behaviors such as bullying or violence.

includes activities, programs, or services implemented in school settings to promote mental wellness and address mental or behavioral problems. This report describes common models of SBMH, summarizes research on the effectiveness of such approaches, and discusses considerations for Congress. This report includes several examples of SBMH interventions to illustrate the spectrum of activities. References to specific programs are not an endorsement by CRS, nor do they represent a comprehensive spectrum of SBMH activities; instead, they are intended to provide greater detail on certain program components, targeted outcomes, and populations served. The report's **Appendix** identifies relevant federal SBMH programs and recent funding levels.

School-Based Mental Health

School-based mental health activities refer to policies, initiatives, models, or services in school settings that address student mental and behavioral health.[8] SBMH includes any strategy, program, or intervention applied in a school that is specifically designed to influence students' emotional, behavioral, or social functioning.[9] Narrow definitions of SBMH limit the landscape to services delivered directly in school buildings,[10] though most contemporary SBMH approaches employ a comprehensive model in which SBMH programming can include partnerships with families and community-based providers beyond the school confines.[11] In this report, *school-based mental health* refers to policies, programs, and services provided in schools as well as school-linked services, when the school plays a significant role in the coordination of care.[12]

SBMH programs exist on a spectrum that includes the promotion of mental wellness, the prevention of mental and behavioral problems, and the treatment of emerging or existing behavioral health conditions.[13] SBMH programs may promote healthy emotional and behavioral functioning generally, address certain maladaptive behaviors for students at risk, or provide direct diagnostic or treatment services for students exhibiting symptoms. SBMH programs vary in scope, intensity, and targeted outcome.[14] As such, interventions can differ in goals (e.g., improving social functioning, reducing substance use), populations served (e.g., students, teachers, parents), location (e.g., classroom, private office), and modality (e.g., individual, small group, entire classroom).[15] Most SBMH activities occur on school grounds. However, some programs involve collaboration with community partners and could, in part, take place outside of the school. Many SBMH programs utilize classroom curricula, while others combine classroom

[8] Sharon Hoover and Jeff Bostic, "Schools As a Vital Component of the Child and Adolescent Mental Health System," *Psychiatric Services*, vol. 72 (2021).

[9] Michelle Rones and Kimberly Hoagwood, "School-Based Mental Health Services: A Research Review," *Clinical Child and Family Psychology Review*, vol. 3, no. 4 (2000). See also J. Michael Murphy, Madalaine R. Abel, Sharon Hoover, et al., "Scope, Scale, and Dose of the World's Largest School-Based Mental Health Programs," *Harvard Review of Psychiatry*, vol. 25, no. 5 (September/October 2017).

[10] J. G. Dryfoos, *Full Service Schools: A Revolution in Health and Social Services for Children, Youth, and Families* (San Francisco: Jossey-Bass, 1994).

[11] Mark T. Greenberg, Celene E. Domitrovich, Roger P. Weissberg, et al., "Social and Emotional Learning as a Public Health Approach to Education," *The Future of Children*, vol. 271 (2017), pp. 13-32.

[12] See also Beth Doll, Bonnie K. Nastasi, Laura Cornell, et al., "School-Based Mental Health Services: Definitions and Models of Effective Practice," *Journal of Applied School Psychology*, vol. 33, no. 3 (2017).

[13] Ann M. DiGirolama, Dimple Desai, Deana Farmer, et al., "Results from a Statewide School-Based Mental Health Program: Effects on School Climate," *School Psychology Review*, vol. 50, no. 1 (2021), pp. 81-98.

[14] Murphy et al., "Scope, Scale, and Dose," (2017).

[15] Rones and Hoagwood, "School-Based Mental Health Services" (2000).

components with activities involving the entire school, parents, or the community.[16] A child with a disability may have SBMH interventions included in his or her individualized education program (IEP) as a related service.[17] Generally, the SBMH programs discussed in this report are those applied to a classroom, a school, or group of children.

SBMH programs and services can include the following:

- schoolwide initiatives promoting student mental and emotional wellness and/or social-emotional development;
- schoolwide or classroom-based psychoeducation;
- classroom-based social, emotional, cognitive, or behavioral skill-building;
- screening, early identification, and diagnostic services for mental health or substance use issues;
- individual counseling or psychotherapy;
- group counseling or psychotherapy;
- crisis response services;
- comprehensive treatment planning;
- case management or referral services for community-based care, including for medication management;
- peer-led mental health awareness and support;
- behavioral health training for teachers and school personnel;
- family therapy delivered on-site at school;
- parent training, education, or consultation; and
- policies instituted across the school, school district, or state.

Implementation of school-based mental health activities varies depending on a myriad of factors. Factors affecting implementation include funding streams, staffing, geographic location, and the types of programs or services offered.[18] SBMH programs and services also vary in degree. Some schools may count a single counselor as their SBMH offerings, while other schools may employ a comprehensive spectrum of school policies, classroom-based programs, and individualized mental health services. SBMH activities are often structured around programs and interventions that have theoretical bases and empirical support for their effectiveness.

[16] Marcin Sklad, Rene Diekstra, Monique De Ritter, et al., "Effectiveness of School-Based Universal Social, Emotional, and Behavioral Programs; Do They Enhance Students' Development in the Area of Skill, Behavior, and Adjustment?," *Psychology in the Schools*, vol. 49, no. 9 (2012).

[17] For more information on IEPs, special education, and related services, see CRS Report R41833, *The Individuals with Disabilities Education Act (IDEA), Part B: Key Statutory and Regulatory Provisions*.

[18] Christina D. Kang-Yi, Aparajita Kuriyan, Grace Kinkler, et al., "Generating Actionable Evidence for School-Based Mental Health Service Delivery: Public-Academic Partnership Based Evaluations," *Community Mental Health Journal*, vol. 59 (2023).

Brief History of Federal School-Based Mental Health Efforts in the United States

In the early 20th century, more students began attending local public schools. As schools broadened course options for a larger and more diverse student body, guidance counseling emerged as a way to advise students on course plans that corresponded with their skills, abilities, and postsecondary goals.[19] In part to cultivate a competitive domestic scientific workforce after the Soviet Union launched the Sputnik satellite in 1957, Congress authorized federal funding for guidance counselors in the National Defense Education Act of 1958 (NDEA; P.L. 85-864). As a result, the number of school personnel dedicated to student advisement increased. Over time, guidance counselors broadened their focus on vocation to include issues of human growth and development.[20]

In the 1960s and 1970s, the deinstitutionalization movement in the United States—reflected in the Community Mental Health Center Construction Act of 1963 (P.L. 88-164)—shifted the locus of mental health care from state hospitals to community-based settings.[21] The advent of community mental health centers created a mechanism for a school-linked approach to mental health care. In 1975, the Education for All Handicapped Children Act (P.L. 94-142), now known as the Individuals with Disabilities Education Act (IDEA),[22] required public schools receiving federal funding to provide an individualized education program (IEP) of special education and related services (including mental health services when appropriate) to all eligible children with disabilities.

Both the IDEA and Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112) mandate that children with disabilities are entitled to a *free appropriate public education* (FAPE).[23] This requirement means all public schools must deliver mental health support and necessary educational accommodations to students with emotional and behavioral disabilities when those services are necessary for the child to receive a FAPE. These policies placed a larger responsibility on the education system to meet the mental health needs of some students and positioned schools to deliver mental health support and necessary educational accommodations when applicable.[24]

In response to reports that many youth in need of mental health services were not receiving care,[25] Congress authorized programs in the 1980s and 1990s that promoted collaboration between mental health service providers and other local public entities—including local educational agencies (LEAs)—through a *systems of care* model.[26] Federally funded programs such as the Comprehensive Mental Health Services for Children and Their Families Program supported the use of mental health clinicians in schools, school-linked services, and other comprehensive wraparound supports.[27] The proliferation of federally funded school-based health centers in the 1990s further situated schools as venues for service delivery.[28]

After the Columbine High School shooting in 1999, Congress and the executive branch increased investment in school-based mental health activities via collaborative Departments of Education and Health and Human Services programs, such as the Safe Schools/Healthy Students Initiative, and through funding for SBMH issued directly to

[19] Lois T. Flaherty and David Osher, "History of School-Based Mental Health Services in the United States," in *Handbook of School Mental Health*, ed. Mark D. Weist, Steven W. Evans, Nancy A. Lever, 1st ed. (Boston: Springer, 2003), pp. 11-22.

[20] Flaherty and Osher, "History of School-Based Mental Health," 2003.

[21] For more information, see CRS In Focus IF10870, *Psychiatric Institutionalization and Deinstitutionalization*.

[22] For more information on the IDEA, see CRS Report R41833, *The Individuals with Disabilities Education Act (IDEA), Part B: Key Statutory and Regulatory Provisions*.

[23] See CRS Report R48068, *The Rights of Students with Disabilities Under the IDEA, Section 504, and the ADA*.

[24] Krista Kutash, Albert J. Duchnowski, and Nancy Lynn, *School-Based Mental Health: An Empirical Guide for Decision-Makers*, The Research and Training Center for Children's Mental Health, Florida Mental Health Institute, University of South Florida, Tampa, FL, April 2006; Hoover and Bostic, "Schools As a Vital Component of the Child and Adolescent Mental Health System," 2021; and Flaherty and Osher, "History of School-Based Mental Health Services," 2003.

[25] Jane Knitzer and Lynn Olson, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*, Children's Defense Fund, Washington, DC, 1982, and U.S. Congress, Office of Technology Assessment, *Children's Mental Health: Problems and Services - A Background Paper*, OTA-BP-H-33, Washington, DC, December 1986.

[26] See Section 119 of P.L. 102-321 and U.S. Congress, House Appropriations Committee, *Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 1984*, report together with supplemental views to accompany H.R. 3913, 98th Cong., 1st sess., September 16, 1983, H.Rept. 98-357, p. 77.

[27] Woodruff et al., *The Role of Education in a System of Care*, 1999.

[28] See Hayley E. Love, John Schlitt, Samira Soleimanpour, et al., "Twenty Years of School-Based Health Care Growth and Expansion," *Health Affairs*, vol. 38, no. 5 (May 2019).

school communities in the aftermath of a crisis through grant programs like Project SERV.[29] Federal support for SBMH efforts continued in the wake of the Sandy Hook Elementary School shooting, through programs such as the Department of Health and Human Services' Project AWARE.[30] Congress made further investments in these programs via supplemental appropriations enacted during the COVID-19 pandemic and via the Bipartisan Safer Communities Act (P.L. 117-159), enacted after the Robb Elementary School shooting in Uvalde, TX, in 2022.[31]

School-Based Mental Health Personnel

School-based mental health programs and services are provided by an array of school personnel. SBMH programs offered schoolwide to all students may be implemented by teachers or other school staff in classroom settings, whereas screening and referral services may be administered by school social workers or nurses. School policies promoting mental well-being may also involve school administrators, school boards, and parents. More intensive treatment interventions may require a mental health professional such as a licensed mental health counselor, behavior specialist, or school psychologist.[32] For some SBMH programs, peers play a formal role in delivering components of the program, typically under the supervision of school staff or collaborative partners (see **Figure 1**).

The involvement of school personnel in the implementation of school-based mental health services often follows the roles and functions of those professionals.[33] For example, due to an increasing demand for SBMH services and an emerging focus on preventive mental health programs in schools, teachers may have an increasingly important role in the implementation of SBMH activities.[34] According to several studies, teachers appear especially effective in delivering classroom-based programs due to their professional experience instructing classrooms and their relationships with students.[35] More targeted SBMH interventions, on the other hand, may benefit

[29] U.S. Congress, *Making Appropriations for the Government of the District of Columbia and Other Activities Chargeable in Whole or in Part Against Revenues of Said District for the Fiscal Year Ending September 30, 2000, and for Other Purposes*, Conference Report to Accompany H.R. 3194, 106th Cong., 1st sess., November 18, 1999; Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Justification of Estimates for Appropriations Committees FY2001*, Rockville, MD; and HHS, SAMHSA, *The Safe Schools/Healthy Students Initiative: A Legacy of Success*, HHS Publication No. (SMA) 13-4798, 2013, https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4798.pdf. Project SERV (School Emergency Response to Violence) was created to support schools' recovery from a violent event such as a school shooting. Now Project SERV supports schools' recovery from a variety of violent and traumatic events as well as natural disasters. For more information, see CRS Report R46872, *Federal Support for School Safety and Security*.

[30] For more information, see CRS In Focus IF12478, *Project AWARE*.

[31] For more information, see CRS Report R46831, *Behavioral Health During the COVID-19 Pandemic: Overview and Issues for Congress*; CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*; and CRS Report R47310, *Bipartisan Safer Communities Act (P.L. 117-159): Section-by-Section Summary*.

[32] Licensure of health care and educational professionals is the responsibility of states. Licensing typically includes certain educational and training requirements, and an examination or registration process. Though states generally follow similar procedures for licensure, states may also have state-specific licensure requirements.

[33] Amanda L. Sanchez, Danielle Cornacchio, Bridget Poznanski, et al., "The Effectiveness of School-Based Mental Health Services for Elementary-Aged Children: A Meta-Analysis," *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 57, no. 3 (2018), pp. 153-165.

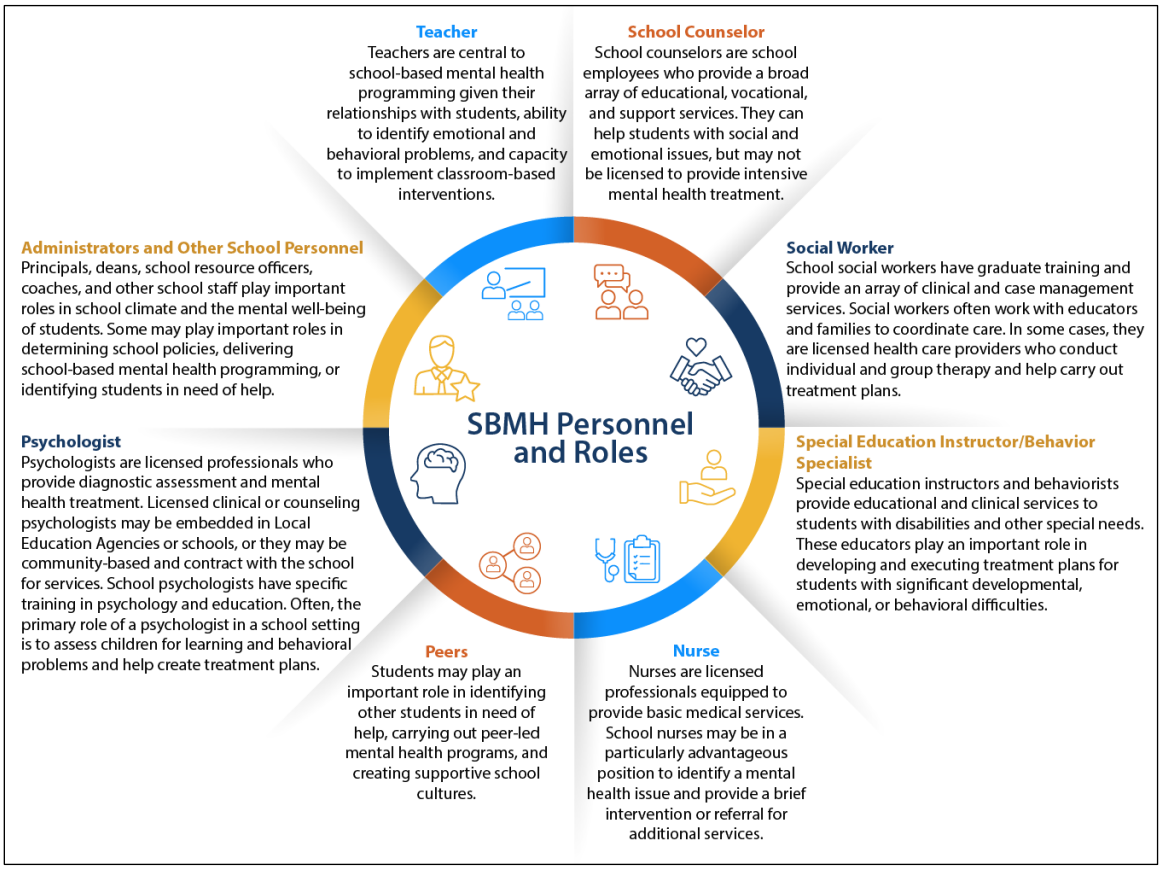
[34] Sunyoung Park, Samantha Guz, Anao Zhang, et al., "Characteristics of Effective School-Based, Teacher-Delivered Mental Health Services for Children," *Research on Social Work Practice*, vol. 30, no. 4 (2020), pp. 422-432.

[35] Joseph A. Durlak, Allison B. Dymnicki, Rebecca D. Taylor, et al., "The Impact of Enhancing Students' Social and Emotional Learning: A Meta-Analysis of School-Based Universal Interventions," *Child Development*, vol. 82, no. 1 (January/February 2011); and Park et al., "Characteristics of Effective School-Based Teacher-Delivered Mental Health Services," (2020).

from clinical skills outside of regular classroom teachers' professional training. These programs may require delivery by school counselors, social workers, or other mental health professionals for effectiveness.[36] Similarly, mental health treatment services may be most appropriately delivered by credentialed mental health professionals. In some cases, a license to practice mental health care may be necessary. The scope of practice for educators and SBMH professionals is typically determined at the state level.[37]

Figure 1. School-Based Mental Health (SBMH) Personnel and Roles

Professionals and Peers Involved in School-Based Mental Health Activities



Source: Congressional Research Service, based upon a review of the literature.

Notes: The personnel listed in this figure are not exhaustive. Other professionals may play important roles in school-based mental health implementation, assessment, and treatment. These could include psychiatrists, occupational therapists, speech-language pathologists, classroom aides, pediatricians, or outside consultants, for instance. States determine scope of practice for education and health care professionals. In addition to professionals, other school personnel—including students, parents, or volunteers—may also play formal or informal roles in SBMH activities. According to the American School Counselor Association, the historical term "guidance counselor" has evolved to "school counselor" to more accurately reflect the role of these professionals. See American School Counselor Association, *Guidance Counselor vs. School Counselor*, available at

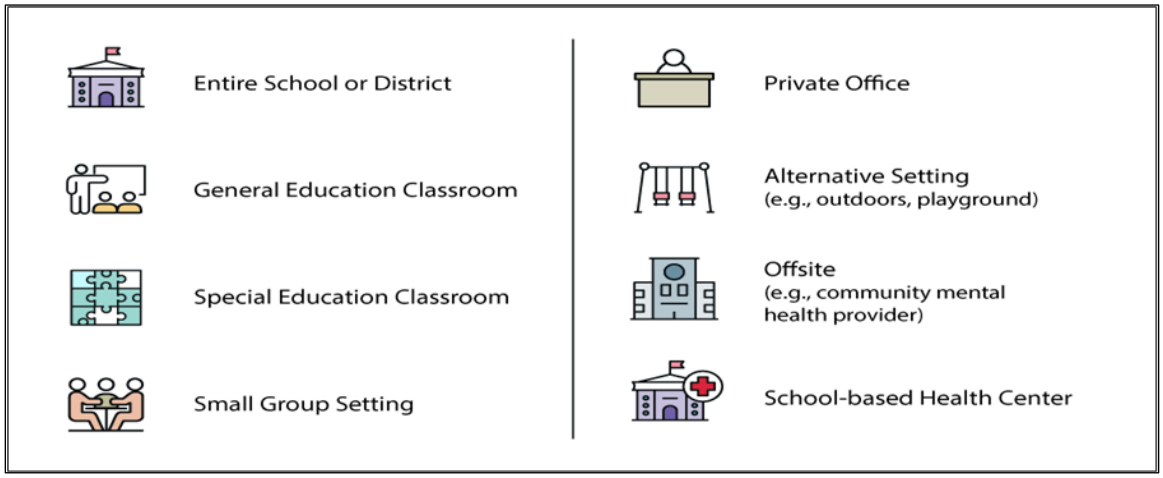
[36] Durlak et al., "The Impact of Enhancing Students' Social and Emotional Learning," 2020.

[37] States typically have different certification or licensure requirements depending on the professional field and scope of practice. Professionals who are education-certified often have specialized training and practice in school settings; they may or may not be licensed to provide intensive mental health treatment. On the other hand, independently licensed professionals may or may not have specialized experience working in schools but are able to provide mental health treatment services. See Andy J. Frey, Brandon D. Mitchell, Michael S. Kelly, et al., "School-Based Mental Health Practitioners: A Resource Guide for Educational Leaders," *School Mental Health*, vol. 14 (2022), pp. 789-801.

https://www.schoolcounselor.org/getmedia/c8d97962-905f-4a33-958b-744a770d71c6/Guidance-Counselor-vs-School-Counselor.pdf.

Not every school—or even every school district—employs a full-time mental health professional.[38] Psychologists and other professionals often provide services part time or are split across multiple schools or geographic areas. In many cases, SBMH services are delivered by community-based providers in school buildings.[39] In these scenarios, integration into the school setting may vary. Some professionals providing SBMH services may be embedded within a team of school staff, while others may be contracted to independently provide specialized services. (See more on the locations of SBMH activities in **Figure 2**.)

Figure 2. Locations of School-Based Mental Health Activities



Source: Congressional Research Service, based upon a review of the literature.

Notes: School-Based Health Centers (SBHCs) are health facilities that exist on or near school grounds and provide a range of care, including preventive health services, oral health care, routine screenings, acute care, and mental or behavioral health services. SBHCs are typically sponsored by a local partner facility, such as a federally qualified community health center, hospital, or local health department, among other entities. According to the School-Based Health Alliance, an organization that advocates on behalf of SBHCs, there were roughly 3,900 SBHCs nationwide in 2022. See School-Based Health Alliance, *Findings from the 2022 National Census of School-Based Health Centers*, Washington, DC, 2023.

The personnel involved in implementing SBMH programming extends beyond the point of care. Principals and school administrators, superintendents, parents, school boards, local educational agencies (LEAs), state educational agencies (SEAs), governors, and state legislatures may all play roles in determining and implementing SBMH activities.[40] Collaborative efforts across school personnel are often beneficial for systemic adoption of schoolwide programs and

[38] U.S. Department of Education, National Center for Education Statistics, *Characteristics of 2020-21 Public and Private K-12 Schools in the United States: Results From the National Teacher and Principal Survey First Look, NCES 2022-111*, Washington, DC, 2022, https://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2022111.

[39] Beth Doll, Bonnie Nastasi, Laura Cornell, et al., "School-Based Mental Health Services: Definitions and Models of Effective Practice," *Journal of Applied School Psychology*, vol. 33, no. 2 (2017).

[40] Darren W. Woodruff, David Osher, Catherine Hoffman, et al., *The Role of Education in a System of Care: Effectively Serving Children with Emotional or Behavioral Disorders*, American Institutes for Research, Systems of Care: Promising Practices in Children's Mental Health 1998 Series, Volume III, Washington, DC, 1999, https://files.eric.ed.gov/fulltext/ED429421.pdf.

policies.[41] In some instances, comprehensive SBMH programs recruit participation from entire school communities.

Federal Definitions of School-Based Mental Health Provider

The primary source of federal aid for elementary and secondary education is the Elementary and Secondary Education Act (ESEA). The ESEA was enacted in 1965 (P.L. 89-10) and was most recently comprehensively amended and reauthorized in 2015 by the Every Student Succeeds Act (ESSA; P.L. 114-95). ESSA stated that, for the purposes of that law, the "term 'school-based mental health services provider' includes a State-licensed or State-certified school counselor, school psychologist, school social worker, or other State licensed or certified mental health professional qualified under State law to provide mental health services to children and adolescents." The IDEA includes psychological services, social work services, and counseling services in its definition of "related services," meaning "developmental, corrective, and other supportive services … as may be required to assist a child with a disability to benefit from special education."[42] The IDEA's regulations require states to set qualifications for related services personnel that "are consistent with any State-approved or State-recognized certification, licensing, registration, or other comparable requirements that apply to the professional discipline in which those personnel are providing special education or related services."[43] Throughout this report, the group of professionals that provide psychological, social work, and counseling services in K-12 schools are collectively referred to as school-based mental health providers.

Collaboration with Community-Based Providers

Some strategies to bolster mental health services in schools emphasize partnering with community providers to deliver care. Rather than increase the capacity of internal school staff to address student mental health needs, collaborative community-involved models connect students, families, and schools with existing community resources, bringing these systems together within the school context.[44] Collaborations between schools and community providers—including the integration of community providers into the school system—can decrease barriers for students to connect to care.[45] Potential clinical partners include private practitioners, local community mental health centers, hospitals and academic medical facilities, public substance use treatment clinics, and local community health centers, among others. An advantage of using licensed community-based professionals to provide SBMH services is that they are qualified to provide clinical behavioral health services and, in general, bill third-party payers (e.g., private health insurance, Medicaid) for services rendered. On the other hand, community-based providers may not have training or experience specific to school-based settings. They may not be optimally positioned to work alongside educators or fit seamlessly into school environments when necessary.[46]

In addition to community mental health providers, schools may also collaborate with faith communities, law enforcement, medical health care providers, local businesses, government agencies, and other community health organizations.[47]

[41] Durlak et al., "The Impact of Enhancing Students' Social and Emotional Learning" (2011).

[42] IDEA, §602(26).

[43] 34 CFR 300.156(b).

[44] Ann DiGirolamo, Dimple Desai, Deana Farmer, et al., "Results From a Statewide School-Based Mental Health Program: Effects on School Climate," *School Psychology Review*, vol. 50, no. 1 (2020), pp. 81-98.

[45] DiGirolamo, "Results from a Statewide," 2020.

[46] National Association of School Psychologists, *Comprehensive School-Based Mental and Behavioral Health Services and Schools Psychologists*, Bethesda, MD, 2021, https://www.nasponline.org/resources-and-publications/resources-and-podcasts/mental-and-behavioral-health/additional-resources/comprehensive-school-based-mental-and-behavioral-health-services-and-school-psychologists; and Frey et al., "School-Based Mental Health Practitioners" (2022).

[47] Sharon A. Hoover, Nancy A. Lever, Nisha Sachdev, et al., *Advancing Comprehensive School Mental Health*
(continued...)

Prevalence of School-Based Mental Health Activities

The availability of mental health activities in schools varies widely among communities.[48] Federal agencies collect data through surveys on school health policies and practices. Responses to surveys, however, may vary depending on how the terms are defined. For instance, according to multiple federal surveys, most schools report providing some type of SBMH support,[49] but less than half offer specific treatment for mental health disorders (see **Figure 3**).[50] Other estimates have found that schools serve as a common location for mental health services. In a 2020 analysis of mental health service utilization across settings, schools represented a leading location for mental health treatment.[51]

Systems: Guidance from the Field, National Center for School Mental Health, University of Maryland School of Medicine, 2019, http://www.schoolmentalhealth.org/AdvancingCSMHS; and Frey et al., "School-Based Mental Health Practitioners," (2022).

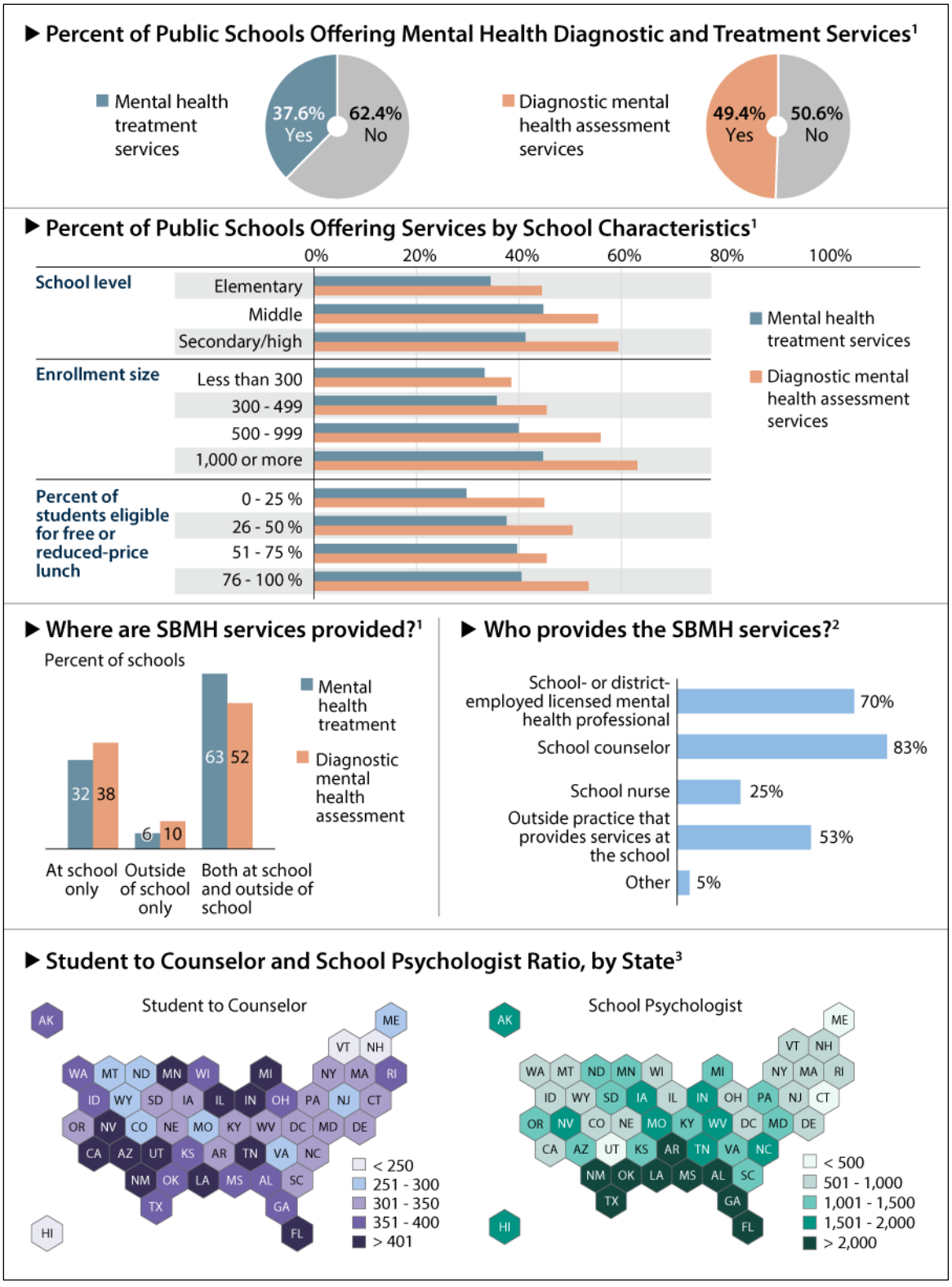
[48] Hoover and Bostic, "Schools As a Vital Component of the Child and Adolescent Mental Health System," 2021.

[49] U.S. Department of Education, Institute of Education Sciences (IES), National Center for Education Statistics (NCES), *School Pulse Panel*, April 2022, https://ies.ed.gov/schoolsurvey/spp/; and U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), *School Health Profiles*, 2022, https://www.cdc.gov/school-health-profiles/about/index.html.

[50] U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics (NCES), *Prevalence of Mental Health Services Provided by Public Schools and Limitations in Schools' Efforts to Provide Mental Health Services, School Year 2021-2022, Condition of Education, 2024*, https://nces.ed.gov/programs/coe/indicator/a23.

[51] Mylien T. Duong, Eric J. Burns, Kristine Lee, et al., "Rates of Mental Health Service Utilization by Children and Adolescents in Schools and Other Common Service Settings: A Systematic Review," *Administration and Policy in Mental Health and Mental Health Services Research*, vol. 48 (2021), pp. 420-439. Of general population youth, 7% had received school-based mental health services. For youth with elevated mental health symptoms or diagnoses, 22% had been served by school-based mental health services.

Figure 3. Prevalence of School-Based Mental Health (SBMH) Services and Providers



Source: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics (NCES).

Notes:
1. Percentage of Public Schools Providing Diagnostic Mental Health Assessments and Treatment to Students, by Selected School Characteristics: School Year 2021-2022. *Prevalence of Mental Health Services Provided by Public Schools and Limitations in Schools' Efforts to Provide Mental Health Services,* Condition of Education, 2024, https://nces.ed.gov/programs/coe/indicator/a23.
2. Institute of Education Sciences (IES), *School Pulse Panel*, April 2022, https://ies.ed.gov/schoolsurvey/spp/.
3. Student to Counselor Ratio by State, 2023-2024 School Year, and Student to School Psychologist Ratio by State, 2023-2024 School Year, Common Core of Data (CCD), "State Nonfiscal Public Elementary/Secondary Education Survey," 2023-24 v.1a.

In its professional standards, the National Association of School Psychologists recommends that the ratio of school psychologists to students "should not exceed one school psychologist for every 500 students." See National Association of School Psychologists (NASP), *The Professional Standards of the National Association of School Psychologists*, Bethesda, MD, 2020, p. 12, https://www.nasponline.org/standards-and-certification/nasp-2020-professional-standards-adopted. The American School Counselor Association recommends a ratio of one school counselor for every 250 students. See American School Counselor Association, *National Student to School Counselor Ratio 1986-2020*, Alexandria, VA, 2022, https://www.schoolcounselor.org/getmedia/6fee3243-2d8b-4efa-82e5-4f7b01049e7c/National-Ratios-1986-2021.pdf.

Multi-Tiered Model of School-Based Mental Health

SBMH activities often follow a *multi-tiered system of support* (MTSS) that integrates emotional and behavioral programming across a continuum based on the needs of students.[52] In the most recent comprehensive reauthorization of the Elementary and Secondary Education Act (ESEA) as the Every Student Succeeds Act (ESSA; P.L. 114-95), MTSS is defined as "a comprehensive continuum of evidence-based, systemic practices to support a rapid response to students' needs, with regular observation to facilitate data-based instructional decisionmaking."[53] Rooted in a public health model of prevention, a multi-tiered system of support for school-based mental health includes universal mental health promotion activities for all students, targeted intervention services for students at higher risk for problems, and treatment for students with identified issues and more intensive needs.[54] An MTSS is designed to appropriately respond to the needs of all students by considering their level of risk for certain behavioral health outcomes. An MTSS framework can be used to employ a variety of activities and services within each level. In addition to using an MTSS for implementing mental-health programs, MTSS frameworks are also used in K-12 schools for academic interventions and behavioral supports. This report focuses on the most common MTSS framework used in elementary and secondary schools for implementing mental and behavioral health programs and services.

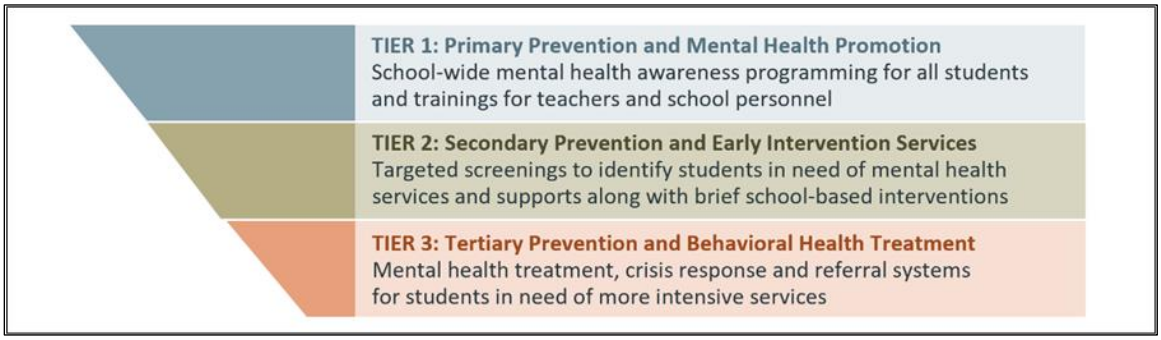
[52] Robert Hendren, Rhona Birrell, and John Orley, *Mental Health Programmes in Schools*, World Health Organization, Geneva, Switzerland, 1994, https://iris.who.int/bitstream/handle/10665/62308/WHO_MNH_PSF_93.3_Rev.1.pdf; Patricia J. Mrazek and Robert J. Haggerty, *Reducing Risk for Mental Disorders*, Institute of Medicine, Consensus Study Report, Washington, DC, 1994, https://nap.nationalacademies.org/catalog/2139/reducing-risks-for-mental-disorders-frontiers-for-preventive-intervention-research; and Elinore McCance-Katz and Calder Lynch, *Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools*, Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare & Medicaid Services (CMS) Center for Medicaid & CHIP Services, Joint Informational Bulletin, July 1, 2019.

[53] ESSA, §8101(33). The statutory language defines a "multi-*tier* system of support." These terms are used interchangeably in this report. For more information, see CRS Report R45977, *The Elementary and Secondary Education Act (ESEA), as Amended by the Every Student Succeeds Act (ESSA): A Primer*.

[54] Michael L. Sulkowski and Kurt Michael, "Meeting the Mental Health Needs of Homeless Students in Schools: A Multi-Tiered System of Support Framework," *Children and Youth Services Review*, vol. 44 (2014), pp. 145-151; Hoover & Bostic, "Schools as a Vital Component" (2021); and Rones and Hoagwood, "School-Based Mental Health Services" (2000). For more information on the public health model of prevention, see CRS Infographic IG10083, *Public Health Prevention and the Determinants of Health*.

A three-tiered MTSS framework is the most commonly used approach for SBMH activities. Within the three-tiered MTSS framework, each level encompasses a target population and scope of service (see **Figure 4**).[55] *Tier 1* programs are used among the general student population without regard for individual risk level. These activities or policies focus on awareness, wellness promotion, or primary prevention and are typically applied at the school or general classroom level. Tier 1 interventions are often referred to as *universal* since they are most commonly implemented for all students. *Tier 2* interventions (also known as *selective* interventions) target students with identified risk factors for certain issues, or those with emerging problems. They are often used with a smaller segment of the student population and are commonly implemented in group settings. *Tier 3* interventions (also known as *indicated* interventions) offer more intensive services to students with identified needs or those exhibiting symptoms of mental health or behavioral disorders.[56] Tier 3 activities typically employ small group or individualized services and are comparable to treatment for diagnosed conditions. More detail on the MTSS is provided in **Figure 4** below. Programs and interventions used within an MTSS framework are frequently implemented seamlessly along levels as a continuum; they may appear more integrated than discrete.

Figure 4. SBMH Multi-Tiered System of Support (MTSS)



Source: See Elinore McCance-Katz and Calder Lynch, *Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools*, Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare & Medicaid Services (CMS) Center for Medicaid & CHIP Services, Joint Informational Bulletin, July 1, 2019; and Michael L. Sulkowski and Kurt Michael, "Meeting the Mental Health Needs of Homeless Students in Schools: A Multi-Tiered System of Support Framework," *Children and Youth Services*, vol. 44 (2014), pp. 145-151.

Notes: This SBMH MTSS framework follows the public health prevention model. See Hugh Rodman Leavell and E. Gurney Clark, *Preventive Medicine for the Doctor in His Community* (New York: McGraw-Hill, 1953), pp. 20-21.

Tier 1: Primary Prevention and Mental Health Promotion (Universal)

Tier 1 universal prevention and mental health promotion programs are designed for all students (and therefore often referred to as *universal*). They often include schoolwide policies or classroom-based programs that promote a positive school climate and foster healthy functioning.[57] To encourage healthy development and prevent the onset of behavioral health

[55] J. Michael Murphy, Madelaine R. Abel, Sharon Hoover, et al., "Scope, Scale, and Dose of the World's Largest School-Based Mental Health Programs," *Harvard Review of Psychiatry*, vol. 25, no. 5 (September/October 2017).

[56] Greenberg et al., "Social and Emotional Learning" (2017); Murphy et al., "Scope, Scale, and Dose" (2017).

[57] Elinore McCance-Katz and Calder Lynch, *Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools*, Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare & Medicaid Services (CMS) Center for Medicaid & CHIP Services, Joint Informational Bulletin, July 1, 2019.

problems, Tier 1 programs often aim to instill social-emotional competencies in students. The theory behind universal SBMH efforts purports that by improving school climate and fostering social and emotional skills, these programs will reduce the probability that students will develop mental health concerns or engage in problem behavior.[58] Universal skills can then buffer any negative effects of risk factors. Such skills may also lead to a reduction in undesirable or harmful behaviors, attitudes, and characteristics.[59] Therefore, universal programming promotes skill development to prevent the onset of various behavior problems. A single Tier 1 program might reduce emotional and behavioral problems, early substance use, delinquency, bullying, and school violence, for instance.[60]

Universal SBMH interventions may focus on aligning school policies with objectives that promote student well-being. For instance, Tier 1 efforts may involve curricula that promote knowledge of mental health issues or teach specific skills to all children in a classroom.[61] Examples include widespread mental health or substance use awareness campaigns, social-emotional learning curricula, and activities that promote social and emotional skill development or behavior regulation. Universal programming may also support skill development for teachers and staff. Trainings can help teachers and staff identify students in a mental health crisis or work with students who have experienced trauma. Examples of Tier 1 programs are displayed in **Figure 5**.

Figure 5. SBMH Multi-Tiered System of Support Tier 1 Examples

Selected Examples of Universal SBMH Programs

Primary Prevention and Mental Health Promotion **Universal** For all students	**Promoting Alternative Thinking Strategies (PATHS)**	**LifeSkills Training Program**
	POPULATION School-age children (K-6)	POPULATION Early adolescents in middle school
	GOALS To reduce aggression and behavior problems	GOALS To prevent teenage substance use, violence, and other risky behaviors
	SETTING General classroom	SETTING General classroom
	DESCRIPTION Classroom curriculum used by educators and counselors to improve student self-control, emotional understanding, positive self-esteem, relationships, and problem-solving skills.	DESCRIPTION Thirty classroom sessions taught by educators over three years to teach students personal self-management, social skills, and resistance skills related to substance use.

Source: Blueprints for Healthy Youth Development, Registry of Experimentally Proven Programs, Boulder, CO, 2024, https://www.blueprintsprograms.org/. For more examples of empirically supported SBMH programs, see Gayle L. Macklem, *Evidence-Based School Mental Health Services: Affect Education, Emotional Regulation Training, and Cognitive Behavioral Therapy* (New York: Springer, 2011).

Notes: Research on the PATHS program has shown a variety of benefits related to student behavior and social and emotional functioning. See Jieping Shi, Alan C. K. Cheung, and Aohua Ni, "The Effectiveness of Promoting Alternative Thinking Strategies Program: A Meta-Analysis," *Frontiers in Psychology*, vol. 13 (2022). Research on the

[58] Richard Catalano, Lisa Berglund, Jeanne Ryan, et al., "Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs," *Prevention & Treatment,* vol. 5, no. 1 (2002).

[59] Greenberg et al., "Social and Emotional Learning," 2017; Marcin Sklad, Rene Diekstra, Monique De Ritter, et al., "Effectiveness of School-Based Universal Social, Emotional, and Behavioral Programs: Do They Enhance Students' Development in the Area of Skill, Behavior, and Adjustment?," *Psychology in the Schools*, vol. 49, no. 9 (2012).

[60] Greenberg et al., "Social and Emotional Learning," 2017, and Sklad et al., "Effectiveness of School-Based Universal," 2012.

[61] Greenberg et al., "Social and Emotional Learning," 2017.

LifeSkills Training program have shown significantly lower cigarette use, marijuana use, polysubstance use, aggression, delinquency, and other risky behaviors in participants compared with teens who did not participate. See Gilbert J. Botvin and Kenneth W. Griffin, "Life Skills Training: Empirical Findings and Future Directions," *Journal of Primary Prevention*, vol. 25, no. 2 (October 2004).

Tier 1 activities can offer a number of benefits. Programs provided universally reach more students than individualized services, for instance. Schools may effectively deliver universal programs with existing staff during the regular school day and incorporate programming into routine educational practice.[62] Universal SBMH activities may be less stigmatizing since they are often framed positively and provided to all students.[63] They also raise awareness and literacy around mental health issues and can increase school and parent involvement.[64] Since implementation is widespread, the effects of Tier 1 programs often extend beyond the individual level to the school culture, home, and peer groups.[65] At the same time, Tier 1 programs can pose logistical challenges. For example, they usually require participation from more school personnel to be effective. Additionally, Tier 1 programs do not provide treatment in most cases and therefore may not effectively address existing mental health concerns.[66]

Universal Mental Health Promotion and Prevention Policies in Schools

Sometimes universal SBMH prevention and promotion efforts do not involve specific programs or interventions at all. Rather, efforts to improve student mental health can include school policies designed to reduce risk factors and create climates that enhance mental wellness. Some of these school-wide or classroom-based policies aim to address the underlying causes of mental health conditions before they result in further problems. For example, some schools have sought to promote better mental health by replacing structured activities with more play-based learning time—a strategy that some research suggests may improve cognitive and emotional functioning in youth.[67] Similarly, based on the emerging research that smartphones and social media may pose

[62] Joseph A. Durlak, Allison B. Dymnicki, Rebecca D. Taylor, et al., "The Impact of Enhancing Students' Social and Emotional Learning: A Meta-Analysis of School-Based Universal Interventions," *Child Development*, vol. 82, no. 1 (January/February 2011).

[63] Greenberg et al., "Social and Emotional Learning" (2017).

[64] Amanda L. Sanchez, Danielle Cornacchio, Bridget Poznanski, et al., "The Effectiveness of School-Based Mental Health Services for Elementary-Aged Children: A Meta-Analysis," *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 57, no. 3 (March 2018), and Elinore McCance-Katz and Calder Lynch, *Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools*, Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare & Medicaid Services (CMS) Center for Medicaid & CHIP Services, Joint Informational Bulletin, July 1, 2019.

[65] Greenberg et al., "Social and Emotional Learning" (2017).

[66] See the "Considerations for Congress" section in this report for a more thorough discussion of the possible benefits or drawbacks to Tier 1 activities.

[67] See, for example, Heather Macpherson Parrott and Lynn E. Cohen, "Advocating for Play: The Benefits of Unstructured Play in Public Schools," *School Community Journal*, vol. 30, no. 2 (2020), pp. 229-254; and Yeshe Colliver, Linda J. Harrison, Judith E. Brown, et al., "Free Play Predicts Self-Regulation Years Later: Longitudinal Evidence from a Large Australian Sample of Toddlers and Preschoolers," *Early Childhood Research Quarterly*, vol. 59 (2022), pp. 148-161.

harms to adolescent mental health,[68] impede attention and learning,[69] or increase bullying,[70] many schools have instituted *phone-free* policies, limited social media, or restricted phone and social media to designated locations and times.[71] Initial studies on these school policies suggest possible benefits for student learning, social skills development, and emotional functioning,[72] though a more complete understanding of their effects awaits further research.[73]

Tier 2: Secondary Prevention and Brief Intervention Services (Selective)

Tier 2 programs target students at higher risk for developing behavioral health problems. Referred to as *selective*, these specialized prevention and brief intervention services are delivered to students with identified risk factors, including life experiences that place them at higher risk for poor behavioral health outcomes, or to students already experiencing mild symptomology. These early interventions aim to identify emerging issues and reduce the likelihood of problems developing.[74] For instance, a selective SBMH program might screen students for specific risk factors or emerging symptoms, then enroll certain students in interventions designed to prevent the development of conditions or behaviors.[75] Identifying students who may benefit from Tier 2 activities can involve formal (e.g., screening tools) or informal (e.g., teacher referrals) methods.[76] The most common mental health issues targeted by SBMH programs involve internalizing problems (e.g., depression, anxiety) and externalizing behaviors (e.g., violence, substance use).[77]

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[68] Sei Yon Sohn, Philippa Rees, Bethany Wildridge, et al., "Prevalence of Problematic Smartphone Usage and Associated Mental Health Outcomes Amongst Children and Young People: A Systematic Review, Meta-Analysis and GRADE of the Evidence," *BMC Psychiatry*, vol. 19, no. 356 (2019); and Jean M. Twenge, Gabrielle N. Martin, and W. Keith Campbell, "Decrease in Psychological Well-Being Among American Adolescents After 2012 and Links to Screen Time During the Rise of Smartphone Technology," *Emotion*, vol. 18, no. 6 (2018).

[69] See, for example, Jeanette Skowronek, Andreas Seifert, and Sven Lindberg, "The Mere Presence of a Smartphone Reduces Basal Attentional Performance," *Scientific Reports*, vol. 13, no. 1 (2023); Quan Chen and Zheng Yan, "Does Multitasking with Mobile Phones Affect Learning? A Review," *Computers in Human Behavior*, vol. 64 (2016 2016); Tiziano Gerosa , Marco Gui, and Moritz Buchi, "Smartphone Use and Academic Performance: A Pervasiveness Approach Beyond Addiction," *Social Science Computer Review*, vol. 40, no. 6 (2022); and Susan M. Ravizza, David Z. Hambrick, and Kimberly M. Fenn, "Non-Academic Internet Use in the Classroom is Negatively Related to Classroom Learning Regardless of Intellectual Ability," *Computers & Education*, vol. 78 (2014).

[70] Raman Deep, Poonam Suman, Poonam Ahlawat, et al., "Social Media Usage Habits and Cyberbullying," *Age (in years)*, vol. 17, no. 19 (2022).

[71] Mark Oppenheimer, "The Schools the Ban Smartphones," *The Atlantic*, February 18, 2023.

[72] Pilar Beneito and Oscar Vicente-Chirivella, "Banning Mobile Phones in Schools: Evidence from Regional-Level Policies in Spain," *Applied Economic Analysis*, vol. 30, no. 90 (October 14, 2022); Louis-Philippe Beland and Richard Murphy, "Ill Communication: Technology, Distraction, & Student Performance," *Labour Economics*, vol. 41 (August 2016); and Sara Abrahamsson, *Smartphone Bans, Student Outcomes and Mental Health*, Institutt for Samfunnsøkonomi, NHH Dept. of Economics Discussion Paper 01, February 22, 2024.

[73] See, for example, Victoria A. Goodyear, Amie Randhawa, Peymane Adab, et al., "School Phone Policies and Their Association with Mental Wellbeing, Phone Use, and Social Media Use (SMART Schools): A Cross-Sectional Observational Study," *The Lancet Regional Health - Europe*, February 4, 2025.

[74] Samantha Reaves, Jill Bohnenkamp, Ashley Mayworm, et al., "Associations Between School Mental Health Team Membership and Impact on Service Provision," *School Mental Health*, vol. 14 (2022), pp. 672-684.

[75] Maria Balle and Miguel Tortella-Feliu, "Efficacy of a Brief School-Based Program for Selective Prevention of Childhood Anxiety," *Anxiety, Stress, & Coping*, vol. 23, no. 1 (July 2008).

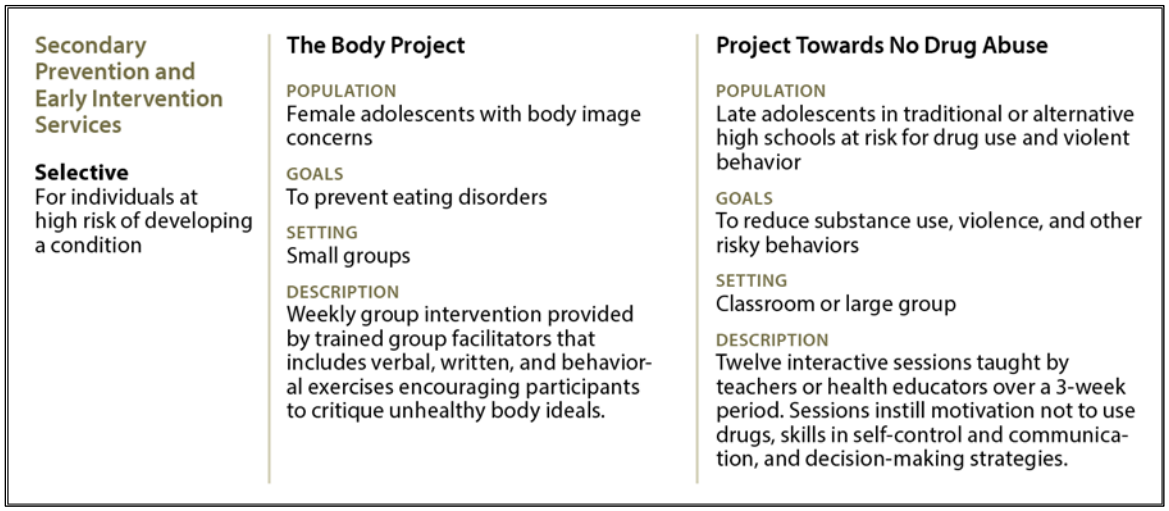
[76] See the "Screening for Mental Health Issues in Schools" **text box** below.

[77] Internalizing behaviors are typically considered those with anxiety, depressive, and somatic symptoms, while externalizing behaviors are typically characterized by impulsive, disruptive conduct, and substance use symptoms. See Sunyoung Park, Samantha Guz, and Anao Zhang, "Characteristics of Effective School-Based Teacher-Delivered Mental Health Services," *Research on Social Work Practice*, vol. 30, no. 4 (2019), pp. 422-432.

Tier 2 interventions can include small group therapies, brief individualized counseling, and low-intensity classroom-based supports, among others. Tier 2 interventions can be individualized or employ school-wide programming for communities experiencing certain adversities, such as a traumatic incident. Examples of Tier 2 programs also include homework groups, social skills groups, and grief and loss groups.[78] Two examples of selective interventions are described in **Figure 6**.

Figure 6. SBMH Multi-Tiered System of Support Tier 2 Examples

Selected Examples of Selective SBMH Programs



Source: Blueprints for Healthy Youth Development, Registry of Experimentally Proven Programs, Boulder, CO, 2024, https://www.blueprintsprograms.org/. For more examples of empirically supported SBMH programs, see Gayle L. Macklem, *Evidence-Based School Mental Health Services: Affect Education, Emotional Regulation Training, and Cognitive Behavioral Therapy* (New York: Springer, 2011).

Notes: Research on the Body Project has shown healthier body attitudes and fewer eating disorder symptoms for participants. See Eric Stice, Paul Rohde, Jeff Gau, et al., "An Effectiveness Trial of a Dissonance-Based Eating Disorder Prevention Program for High-Risk Adolescent Girls," *Journal of Consulting and Clinical Psychology*, vol. 77, no. 5 (2009), pp. 825-834. Research on the Project Towards No Drug Abuse has found lower substance use rates and other problem behaviors for participants compared to nonparticipants. See Steve Sussman, Clyde W. Dent, and Alan W. Stacy, "Project Towards No Drug Abuse: A Review of the Findings and Future Directions," *American Journal of Health Behavior*, vol. 26, no. 5 (2002), pp. 354-365.

Tier 2 activities offer several benefits. Selectivity allows for early intervention and targeted support for students at higher risk of problems. These activities intervene before issues fully manifest and may help resolve problems before they lead to adverse outcomes or more intractable conditions.[79] Selective programming can also direct resources to individuals or groups that might benefit most, in turn promoting a more measurable return on investment. One challenge to implementing these programs effectively involves identifying students in a timely manner. The window of opportunity—the period of time in an individual's development when Tier 2 services could be effective—may be shorter than for universal or indicated interventions. In some

[78] Park et al., "Characteristics of Effective School-Based Teacher-Delivered Mental Health Services" (2020).

[79] Elinore McCance-Katz and Calder Lynch, *Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools*, Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare & Medicaid Services (CMS) Center for Medicaid & CHIP Services, Joint Informational Bulletin, July 1, 2019.

communities, risk factors for certain behavioral outcomes may be so common as to make implementing selective interventions on a larger scale challenging.

Screening for Mental Health Issues in Schools

Schools may be an advantageous venue in which to detect early signs of mental health problems in youth.[80] To identify students who may benefit from additional services and supports, some schools employ school-wide universal screenings for mental health issues.[81] Effective screening for mental health symptoms in schools usually involves using a systematic process and validated tools.[82] Results from these assessments can help make decisions on when students may need additional Tier 2 or Tier 3 services. Assessment results may also be useful in monitoring the effectiveness of programs or the progress of individual students. The Substance Abuse and Mental Health Services Administration (SAMHSA) has recommended that instruments used in SBMH screenings be empirically validated, reliable, sensitive and specific, trauma-informed, and culturally and linguistically appropriate.[83] Catalogues of empirically supported SBMH screening instruments have been assembled by some SBMH organizations.[84]

When implemented within a multi-tiered system of support, universal screenings may help some students receive services earlier than they otherwise would—and may prevent the need for more intensive services later on. Using validated screening tools may be particularly useful in the absence of known risk factors or otherwise obvious problems (e.g., internalizing behaviors that can be more difficult to notice). However, screening for mental health issues may be only as effective as the resources available to address any identified concerns.[85] Screening on its own, without proper referral pathways or adequate student supports, could be counterproductive and potentially harmful. Other issues for consideration when conducting mental health screenings include school capacity for data collection and maintenance; the required funding, time, and resources to effectively implement mental health screening; issues with privacy and confidentiality; and obtaining parental consent and student assent.[86]

Tier 3: Tertiary Prevention and Behavioral Health Treatment (Indicated)

Tier 3 programs are generally for students experiencing mental health or substance-related difficulties, or other problem behaviors. Referred to as *indicated* interventions, Tier 3 programming includes mental health crisis response or treatment for students in need of more intensive services. Tier 3 services typically consist of individualized therapeutic support services that address specified behaviors or conditions.[87] Such services commonly include individual psychotherapy, comprehensive treatment planning and case management, and family services.

[80] Kelly Y. C. Lai, Se-Fong Hunh, Hannah W. S. Lee, et al., "School-Based Mental Health Initiative: Potentials and Challenges for Child and Adolescent Mental Health," *Frontiers in Psychiatry*, vol. 13 (June 9, 2022).

[81] Ellen M. McCabe, Beth E. Jameson, and Shiela M. Strauss, "Mental Health Screenings: Practices and Patterns of These and Other Health Screenings in U.S. School Districts," *The Journal of School Nursing*, vol. 40, no. 2 (2021), pp. 144-154.

[82] Substance Abuse and Mental Health Services Administration, *Ready, Set, Go, Review: Screening for Behavioral Health Risk in Schools*, Rockville, MD, 2019.

[83] SAMHSA, *Ready, Set,* Go, 2019. Universal mental health screenings differ from psycho-educational evaluations for special education eligibility determinations, diagnostic assessments for specific disorders, or risk for violence assessments.

[84] See, for example, National Center for School Mental Health, University of Maryland School of Medicine, *School Health Assessment and Performance Evaluation System*, https://www.schoolmentalhealth.org/ and https://theshapesystem.com/.

[85] See Jonathan Cantor, Ryan K. McBain, Jacquelin Rankine, et al., "Screening for Mental Health Problems in US Public Schools," *JAMA Network Open*, vol. 8, no. 7 (July 18, 2025).

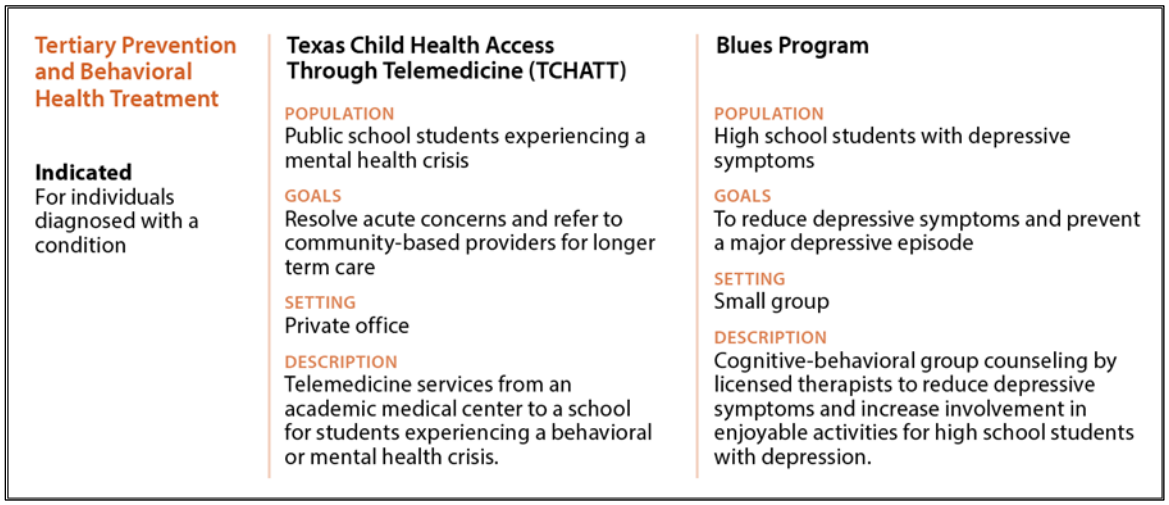
[86] For a fuller exploration of the potential benefits and drawbacks of SBMH activities such as mental health screenings, see the "Considerations for Congress" section of this report.

[87] Elinore McCance-Katz and Calder Lynch, *Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools*, Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare & Medicaid Services (CMS) Center for Medicaid & CHIP Services, Joint Informational Bulletin, July 1, 2019.

Tier 3 resources reflect the role schools may play in addressing acute clinical needs such as substance use, trauma, or difficult behavior in the classroom.[88] Examples of Tier 3 SBMH activities are included in **Figure 7**. While many Tier 3 SBMH interventions are implemented on-site, schools may also arrange formal partnerships with community-based providers to link students with more comprehensive care.

Figure 7. SBMH Multi-Tiered System of Support Tier 3 Examples

Selected Examples of Indicated SBMH Programs



Source: Blueprints for Healthy Youth Development, Registry of Experimentally Proven Programs, Boulder, CO, 2024, https://www.blueprintsprograms.org/. For more examples of empirically supported SBMH programs, see Gayle L. Macklem, *Evidence-Based School Mental Health Services: Affect Education, Emotional Regulation Training, and Cognitive Behavioral Therapy* (New York: Springer, 2011).

Notes: The TCHATT program provides students access to a multidisciplinary care team of behavioral health experts including psychiatrists, psychologists, nurses, and social workers who provide assessment, brief intervention, and care coordination via a telemedicine platform. According to the Texas Child Mental Health Care Consortium, over 4 million students in Texas have access to services through the TCHATT program. See https://tcmhcc.utsystem.edu/tchatt/. Research on the Blues Program has found a greater reduction in depression and an increase in life enjoyment for participants. See Paul Rohde, Frederic N. Biere, and Eric Stice, "Major Depression Prevention Effects for a Cognitive-Behavioral Adolescent Indicated Prevention Group Intervention Across Four Trials," *Behaviour Research and Therapy*, January 2018, pp. 1-6.

One benefit of Tier 3 interventions includes greater precision of the intervention; Tier 3 services target specific issues, conditions, or behaviors. They are usually narrower in scope, more individualized, and more intensive, which often promotes greater effectiveness. Challenges to Tier 3 programs include greater costs and resource intensiveness of services per student (compared with more wide-reaching Tier 1 programs). Tier 3 services often require highly qualified staff, such as licensed mental health professionals with advanced training and credentials.[89] When Tier 3 interventions involve direct mental health care treatment services, schools may encounter challenges with payment structures. Third-party payors may or may not

[88] Mark D. Weist and Kathleen E. Albus, "Expanded School Mental Health," *Behavior Modification*, vol. 28, no. 4 (July 2004).

[89] See the "School-Based Mental Health Personnel" section in this report.

cover such services; otherwise, states, schools or school districts are responsible for funding these activities.[90]

Examples of MTSS Applications in SBMH

The MTSS framework and other data-based models are often used in K-12 schools to address behavioral health issues, as well as other issues beyond mental health. For example, in 2004, a decade before the term MTSS terminology was defined in the ESEA,[91] a comprehensive reauthorization of the IDEA provided support for two programs using an MTSS framework. Emerging research suggested that both programs influenced positive results for children with disabilities, with one program focused on academic supports and the other on behavioral interventions.

The first of these two MTSS-based programs, Positive Behavioral Interventions and Supports (PBIS), was included in the IDEA in its 1997 and 2004 reauthorizations.[92] In 1997, the IDEA advised IEP teams that they needed "in the case of a child whose behavior impedes his or her learning or that of others, [to] consider, when appropriate, strategies, including positive behavioral interventions, strategies, and supports to address that behavior."[93] The 2004 IDEA (P.L. 108-446) included multiple references to PBIS. For example, the law says training in PBIS should be provided to administrators, teachers, related services personnel, behavioral specialists, and other school staff. It allows states to use their IDEA Part B funding to "assist local educational agencies in providing positive behavioral interventions and supports and appropriate mental health services for children with disabilities."[94] PBIS implements multiple tiers of progressively intensive and individualized interventions to support children's prosocial behaviors and decrease incidents of discipline problems.

One study examining the effects of PBIS—the multi-tiered system of support for behavior (MTSS-B) trial—examined student outcomes for children both with and without behavior problems.[95] Overall scores for schools implementing Tier 1 school-wide PBIS showed significant improvements in direct classroom observations of behavior, teacher-rated teacher-student relationships, and staff collegiality. The 15% of students who received additional behavior supports (Tier 2) showed significant improvements in teacher-rated behavior and reading achievement.

A second MTSS-based program, referred to in the IDEA as Coordinated Early Intervening Services (CEIS) but commonly called Response to Intervention (RTI), involves implementing increasingly individualized academic interventions, often to provide additional support for children who are struggling academically but have not yet been determined eligible for special education and related services.[96] In 2011, the U.S. Department of Education issued a memorandum stating that "States and LEAs have an obligation to ensure that evaluations of

[90] See the "School-Based Mental Health Funding and Payment" section for more on funding and the "What Barriers Exist in Addressing Student Behavioral Health via School-Based Mental Health Activities?" section for more discussion of challenges to SBMH implementation.

[91] ESSA, §8101(33).

[92] P.L. 105-17 and P.L. 108-446.

[93] P.L. 105-17, §614(d)(3)(i).

[94] IDEA, §611(e)(2)(C)(iii).

[95] McIntosh, K., Herman, K., Bradshaw, C., et al., *IES MTSS-B trial: Key takeaways for district and state leaders,* Center on PBIS, University of Oregon, 2023, http://www.pbis.org.

[96] CRS Report R41833, *The Individuals with Disabilities Education Act (IDEA), Part B: Key Statutory and Regulatory Provisions*.

children suspected of having a disability are not delayed or denied because of implementation of an RTI strategy."[97] The memo laid out four elements of all RTI multi-tier systems of support:

- students receive high-quality, research-based instruction in their general education setting;
- students receive continuous monitoring of their performance;
- students are screened for academic and behavioral problems; and
- students receive multiple levels (tiers) of instruction that are progressively more intense, based on students' response to instruction.[98]

While RTI frameworks focus on academic interventions, the components of all MTSS are similar: a researched-based program for the whole group and screening of students' needs and continuous monitoring of students' response to the MTSS program, followed by multiple tiers of increasingly intense and individualized interventions for the students who need them most.

Other multilevel approaches include Project ACHIEVE, a school systems-level process designed to help schools effectively support at-risk or underachieving students.[99] Project ACHIEVE helps schools develop classroom interventions for students with academic and behavioral problems, enhance teachers' classroom management skills, increase support services to students with academic difficulties, and facilitate a positive school climate. Another multilevel program—Project Northland—aims to prevent adolescent alcohol use through a multiyear course that includes classroom behavioral curricula, parent involvement programs, peer participation, and community task force activities.[100]

MTSS in Practice

The MTSS framework offers a comprehensive approach to SBMH activities based on the public health prevention model. A benefit of an MTSS SBMH approach includes appropriate alignment of services with student needs. Schools aspiring to promote mental health, prevent mental or behavioral issues, identify students in need of support, and provide appropriate services may invest resources along the entire MTSS continuum. However, comprehensive MTSS programs involve multiple components, which can make them difficult to implement. For example, schools attempting to implement additional required components may risk a reduction in program quality.[101]

Schools need not implement formal programs at each MTSS level to create environments that promote mental well-being and respond to identified problems in students. In many cases, schools may not have the funding or capacity—or perceive the need—to implement comprehensive SBMH programs at each MTSS level. Rather, some schools may institute specialized

[97] Melody Musgrove, Director of the Office of Special Education Programs, *A Response to Intervention (RTI) Process Cannot be Used to Delay-Deny an Evaluation for Eligibility under the Individuals with Disabilities Education Act (IDEA)*, U.S. Department of Education, Memorandum to State Directors of Special Education, Washington, DC, January 21, 2011, pp. 1-3.

[98] See footnote 97.

[99] Howard M. Knoff and George M. Batsche, "Project Achieve: Analyzing a School Reform Process for At-Risk and Underachieving Students," *School Psychology Review*, vol. 24, no. 4 (1995).

[100] Cheryl L. Perry, Carolyn L. Williams, Sara Veblen-Mortenson, et al., "Project Northland: Outcomes of a Communitywide Alcohol Use Prevention Program during Early Adolescence," *American Journal of Public Health*, vol. 86, no. 7 (July 1996); and Blueprints for Healthy Youth Development, Registry of Experimentally Proven Programs, *Project Northland*, Boulder, CO, 2024, https://www.blueprintsprograms.org/project-northland/.

[101] Durlak et al., "The Impact of Enhancing Students' Social and Emotional Learning," 2011.

programming at one level or target only certain outcomes (e.g., bullying, substance use, violence) at all levels. In some instances, school-based programs or services may be limited to certain populations (e.g., students exhibiting behavior problems or mental health symptomology). In other situations, schools may focus on training teachers to identify students in need of additional support and on building out referral networks, for example. The MTSS approach provides a broad perspective for organizing mental health-related efforts, along with flexibility for schools to implement SBMH activities within this framework.

Social and Emotional Learning (SEL)

Social and emotional learning (SEL) is a broad approach to teaching and education that prioritizes the development of prosocial behaviors and the acquisition of emotion-regulation skills along with academic learning. The philosophy behind SEL hypothesizes that the development of universal social and emotional skills will lead to a reduction in problem behavior and increase the likelihood of academic success.[102] More specifically, SEL theory posits that by acquiring competencies to manage emotions, set positive goals, appreciate the perspectives of others, maintain positive relationships, make responsible decisions, and handle interpersonal situations constructively, students will in turn gain greater confidence in themselves, increase their engagement in school, improve their academic achievement, and reduce conduct problems while increasing desirable behaviors.[103]

SEL programs in schools aim to teach students specific skills and to create classroom cultures that enhance these skills.[104] Within school contexts, SEL programming involves instruction in applying social and emotional skills in developmentally, contextually, and culturally appropriate ways. Additionally, SEL programming seeks to establish safe, caring learning environments that encourage widespread use of these skills. Both goals typically involve training school staff to interact with students in new ways to promote students' competence. According to several studies, when implemented effectively, SEL programs can promote greater social-emotional skills, positive self-image, prosocial behaviors, and better academic performance while reducing conduct problems, emotional distress, and substance use problems.[105] According to the Department of Health and Human Services, training students on prosocial behaviors and skills development has been associated with improved school climates, an enhanced sense of safety, and the perception of greater trust and respect in student-teacher relationships.[106] Critics assert that SEL programs detract from academic learning and require teachers to use their limited time on activities outside of their expertise. A more comprehensive exploration of the potential benefits and drawbacks of SBMH activities such as SEL programming is included in the "Considerations for Congress" section of this report.

Effectiveness of School-Based Mental Health Programs

Research shows that when implemented properly, school-based mental health programs can effectively promote healthy development and mental well-being, and reduce an array of social, emotional, and behavioral problems in students. Studies on SBMH interventions typically evaluate their effects on positive social behaviors and skills, negative behaviors (e.g., conduct problems and violence), emotional problems (e.g., depression and anxiety), self-confidence and

[102] *Handbook of Social and Emotional Learning: Research and Practice*, ed. Joseph A. Durlak, Celene E. Domitrovich, Roger P. Weissberg (Guilford Publications, 2015); and Sklad et al., "Effectiveness of School-Based Universal Social, Emotional, and Behavioral Programs," 2012.

[103] Greenberg et al., "Social and Emotional Learning" (2017).

[104] Greenberg et al., "Social and Emotional Learning" (2017).

[105] Durlak et al., "The Impact of Enhancing Students' Social and Emotional Learning" (2011); Greenberg et al., "Social and Emotional Learning" (2017); and Hoover and Bostic, "Schools As a Vital Component of the Child and Adolescent Mental Health System," 2021. See also *Building Academic Success on Social and Emotional Learning: What Does the Research Say?*, ed. Joseph E. Zins, Roger P. Weissberg, Margaret C. Wang, et al. (New York: Teachers College Press, 2004).

[106] Elinore McCance-Katz and Calder Lynch, *Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools*, Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare & Medicaid Services (CMS) Center for Medicaid & CHIP Services, Joint Informational Bulletin, July 1, 2019.

self-esteem, social climate, and academic achievement.[107] Several studies have found that universal classroom and school-wide SBMH programs (Tier 1) can be effective in

- increasing social skills and prosocial behaviors;[108]
- reducing mental distress, including anxiety and depression;[109]
- preventing aggressive and antisocial behavior, conduct problems, and substance use;[110]
- reducing student suspensions and office discipline referrals;[111]
- improving student self-image;[112] and
- enhancing attitudes toward school and school achievements[113]

For an example of an evidence-based universal (Tier 1) SBMH program, see **Figure 8**.

Studies have also found that more targeted school-based interventions can have positive effects on students' anxiety and depression,[114] posttraumatic stress symptoms,[115] substance use,[116] and out-of-school suspensions.[117] One review found that the magnitude of effects appeared to vary by tier, with many selective (Tier 2) and indicated (Tier 3) programs showing large and medium effects, respectively, while universal (Tier 1) prevention programs typically demonstrated small but significant effects.[118] Other studies have shown no effects for certain SBMH interventions. One review of the research found mixed results for SBMH interventions that targeted anxiety and

[107] Sklad et al., "Effectiveness of School-Based Universal Social, Emotional, and Behavioral Programs," 2012.

[108] John Payton, Roger Weissberg, Joseph A. Durlak, et al., *The Positive Impact of Social and Emotional Learning for Kindergarten to Eighth-Grade Students: Findings from Three Scientific Reviews*, Collaborative for Academic, Social, and Emotional Learning (CASEL), Technical Report: Findings from Three Scientific Reviews, Chicago, IL, December 2008; Durlak et al., "The Impact of Enhancing Students' Social and Emotional Learning," 2011; and Sklad et al., "Effectiveness of School-Based Universal Social, Emotional, and Behavioral Programs," 2012.

[109] Alison Neil and Helen Christensen, "Efficacy and Effectiveness of School-Based Prevention and Early Intervention Programs for Anxiety," *Clinical Psychology Review*, vol. 29, no. 3 (2009), pp. 208-215.

[110] Robert Hahn, Dawna Fuqua-Whitley, Holly Wethington, et al., "The Effectiveness of Universal School-Based Programs for the Prevention of Violent and Aggressive Behavior," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, vol. 56, no. 1, August 11, 2007; Fabrizio Faggiano, Federica D. Vigna-Taglianti, Elisabetta Versino, et al., "School-Based Prevention for Illicit Drug Use: A Systematic Review," *Preventive Medicine*, vol. 46, no. 5 (2008), pp. 385-396.

[111] Catherine P. Bradshaw, Mary M. Mitchell, and Philip J. Leaf, "Examining the Effects of Schoolwide Positive Behavioral Interventions and Supports on Student Outcomes," *Journal of Positive Behavior Interventions*, vol. 12, no. 3 (July 2010); and Durlak et al., "The Impact of Enhancing Students' Social and Emotional Learning" (2011).

[112] Sklad et al., "Effectiveness of School-Based Universal Social, Emotional, and Behavioral Programs," 2012.

[113] Sandra Jo Wilson and Mark W. Lipsey, "School-Based Interventions for Aggressive and Disruptive Behavior: Update of a Meta-Analysis," *American Journal of Preventive Medicine*, vol. 33, no. 2 (August 2007).

[114] Aleisha Clarke, Miriam Sorgenfrei, James Mulcahy, et al., *Adolescent Mental Health: A Systematic Review of the Effectiveness of School-Based Interventions*, Early Intervention Foundation, July 2021.

[115] Qiyang Zhang, Jun Wang, and Amanda Neitzel, "School-Based Mental Health Interventions Targeting Depression or Anxiety: A Meta-Analysis of Rigorous Randomized Controlled Trials for School-Aged Children and Adolescents," *Journal of Youth and Adolescence*, vol. 52 (2023), pp. 195-217.

[116] Tara Carney, Bronwyn J. Myers, Johann Louw, et al., *Brief School-Based Interventions and Behavioural Outcomes for Substance-Using Adolescents*, Cochrane Library, Cochrane Database of Systematic Reviews, 2016.

[117] Christina D. Kang-Yi, David S. Mandell, Trevor Hadley, et al., "School-Based Mental Health Program Evaluation: Children's School Outcomes and Acute Mental Health Service Use," *Journal of School Health*, vol. 83, no. 7 (July 2013).

[118] Amanda L. Sanchez, Danielle Comacchio, Bridget Poznanski, et al., "The Effectiveness of School-Based Mental Services for Elementary-Aged Children: A Meta-Analysis," *Journal of the American Academy of Child & Adolsecent Psychiatry*, vol. 57, no. 3 (2018), pp. 153-165.

depression, for instance.[119] Another study testing the benefits of a school-based mindfulness program found no support for the program's impact on student mental health and well-being.[120]

Most of the research on SBMH programs has evaluated the immediate effects of interventions, though some studies suggest that participation in SBMH programming may have long-term benefits. For instance, one review of several long-term studies found that, generally, positive effects of SBMH interventions persisted months after the programs ended.[121] Another review similarly found that immediate effects of SBMH interventions were often strongest, but that many programs showed long-term benefits for several outcomes, including social skills, antisocial behavior, substance use, self-image, academic achievement, general mental health, and prosocial behavior.[122]

While research mostly shows social and emotional benefits of SBMH programs, the benefits for academic achievement appear less clear. Studies evaluating the effects of SBMH activities on academic outcomes have produced inconsistent results.[123] Some studies show modest benefits for academic performance.[124] Other studies, in contrast, have found no significant effects of SBMH programs on academic engagement or achievement.[125] One meta-analysis of over 200 studies found that the benefits of a SBMH intervention on student academic performance depended on who delivered the program: academic performance appeared to improve when school personnel conducted the intervention but remained unchanged when nonschool personnel led the intervention.[126]

[119] Deborah M. Caldwell, Sarah R. Davies, Sarah E. Hetrick, et al., "School-Based Interventions to Prevent Anxiety and Depression in Children and Young: A Systematic Review and Network Meta-Analysis," *Lancet Psychiatry*, vol. 6, no. 12 (December 2019).

[120] Willem Kuyken, Susan Ball, Catherine Crane, et al., "Effectiveness and Cost-Effectiveness of Universal School-Based Mindfulness Training Compared with Normal School Provision in Reducing Risk of Mental Health Problems and Promoting Well-Being in Adolescence: The MYRIAD Cluster Randomised Controlled Trial," *Evidence Based Mental Health*, vol. 25 (2022), pp. 99-109.

[121] Durlak et al., "The Impact of Enhancing Students' Social and Emotional Learning" (2011).

[122] Sklad et al., "Effectiveness of School-Based Universal Social, Emotional, and Behavioral Programs," 2012.

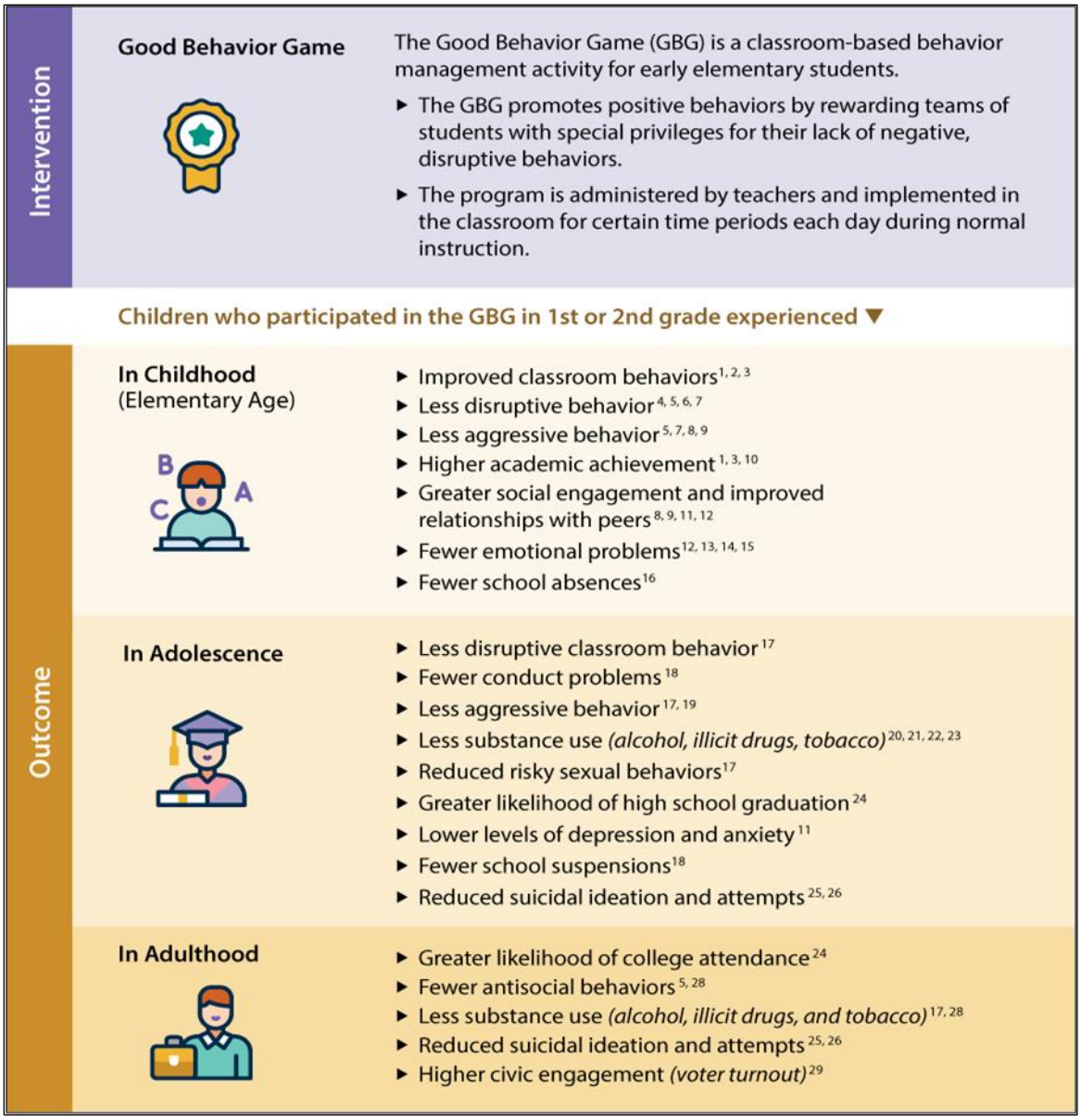
[123] Michael Arenson, Philip Hudson, NaeHyung Lee, et al., "The Evidence on School-Based Health Centers: A Review," *Global Pediatric Health*, vol. 6 (2019); Ann M. DiGirolama, Dimple Desai, Deana Farmer, et al., "Results From a Statewide School-Based Mental Health Program: Effects on School Climate," *School Psychology Review*, vol. 50, no. 1 (2021); and Sanchez et al., "The Effectiveness of School-Based Mental Services for Elementary-Aged Children: A Meta-Analysis," 2018.

[124] Catherine Bradshaw, "Impacts of School-Wide Positive Behavioral Interventions and Supports on Student Academics, Behavior, and Mental Health," *International Journal of Psychological and Behavioral Sciences*, vol. 5, no. 6 (2018); Courtney Kase, Sharon Hoover, Gina Boyd, et al., "Educational Outcomes Associated with School Behavioral Health Interventions: A Review of the Literature," *Journal of School Health*, vol. 87, no. 7 (2017); and Sheryl Katoaka, Lisa Jaycox, Marleen Wong, et al., "Effects of School Outcomes on Low-Income Minority Youth: Prelimary Findings from a Community-Partnered Study of School Trauma Intervention," *Ethnicity & Disease*, vol. 21 (2011).

[125] Carmel Cefai, Liberato Camilleri, Paul Bartolo, et al., "The Effectiveness of a School-Based, Universal Mental Health Programme in Six European Countries," *Frontiers in Psychology*, August 8, 2022.

[126] Durlak et al., "The Impact of Enhancing Students' Social and Emotional Learning," 2011.

Figure 8. Example of an Evidence-Based Intervention: The Good Behavior Game



Source: Congressional Research Service review of studies. For complete list of citations, see the **text box** in the **Appendix**.

Notes: The Good Behavior Game (GBG) is a Tier 1 classroom-based intervention for elementary students developed in the 1960s (see Harriet H Barrish, Muriel Saunders, and Montrose M. Wolf, "Good Behavior Game: Effects of Individual Contingencies for Group Consequences on Disruptive Behavior in a Classroom 1," *Journal of Applied Behavior Analysis* vol. 2, no. 2 [1969], pp. 119-124). Based on a review of the randomized controlled trials (RCTs) of the GBG, this figure provides a general overview of research findings, not a complete presentation of the literature. Considerable research on the GBG shows positive effects on several behavioral, emotional, and developmental outcomes immediately after participating and later in life. Outcomes from research on the GBG vary in effect size, and may depend on the setting and population participating. Effects for the GBG appear strongest for outcomes related to externalizing behaviors (e.g., aggression, substance use, classroom disruption) and social functioning, particularly for boys and especially for boys who may be at higher risk for poor behavioral or academic outcomes. Effects for outcomes related to school engagement and academic performance—particularly when the GBG is paired with a supplemental instructional intervention—are generally positive but less robust. The research does not suggest the GBG is a panacea. A couple of studies have shown limited

effectiveness, null results, or iatrogenic effects in which some participating students showed worse outcomes (see, for example, Neil Humphrey, Alexandra Hennessey, Patricio Troncoso, et al., "The Good Behaviour Game Intervention to Improve Behavioural and Other Outcomes for Children Aged 7-8: A Cluster RCT," *Public Health Research*, vol. 10, no. 7 [2022], pp. 1-128).

Characteristics of Effective School-Based Mental Health Programs

Research on SBMH has shown that certain program characteristics matter for achieving desired outcomes.[127] For instance, SBMH activities appear to be more effective when they have sound theoretical foundations, defined goals, explicit guidelines, adequate training, and appropriate staffing compared with those based on loose guidelines and broad principles.[128] Simply offering SBMH programming does not guarantee that student mental health will improve.[129] In some instances, studies have found that poorly implemented programs or interventions misaligned to the populations served can have deleterious effects on student mental health.[130] Research has identified several features of SBMH programming that maximize the potential for effectiveness. Qualities of SBMH programs that promote effectiveness are outlined in **Figure 9**.

SBMH interventions with substantial empirical support—provided they are implemented appropriately—are more likely to produce desired outcomes (though newer, "promising" programs yet without a body of research may still demonstrate potential).[131] Implementing SBMH programs with fidelity and adaptability appears particularly important for maximizing potential mental health benefits. Fidelity refers to how closely the activities in a school reflect the SBMH model that was designed, tested, and found effective.[132] Greater fidelity to a program's intended design improves the probability of achieving desired outcomes.[133] Because testing environments do not always reflect real-world conditions (and because it is impossible to test a program in every situation in which it will be implemented), programs that allow for sufficient adaptability to different populations, settings, and conditions can be more widely adopted.[134] Flexibility to context can be especially important when trying to implement culturally and linguistically aligned services.[135] Continued monitoring and evaluation of programs via data collection may also allow for iterative improvements and a greater probability of achieving program goals.[136] Additionally,

[127] Gayle L. Macklem, *Evidence-Based School Mental Health Services: Affect Education, Emotional Regulation Training, and Cognitive Behavioral Therapy* (New York: Springer, 2011); and Park et al., "Characteristics of Effective School-Based Teacher-Delivered Mental Health Services" (2020).

[128] Katherine Weare and Melanie Nind, "Mental Health Promotion and Problem Prevention in Schools: What Does the Evidence Say?," *Health Promotion International*, vol. 26 (December 1, 2011).

[129] Sklad et al., "Effectiveness of School-Based Universal Social, Emotional, and Behavioral Programs," 2012.

[130] Jesus Montero-Marin, Matthew Allwood, Susan Ball, et al., "School-Based Mindfulness Training in Early Adolescence: What Works, for Whom and How in the MYRIAD Trial?," *BMJ Mental Health*, vol. 25, no. 3 (2022), pp. 117-124.

[131] Blueprints for Healthy Youth Development, Registry of Experimentally Proven Programs, Boulder, CO, 2024, https://www.blueprintsprograms.org/.

[132] Jennifer D. Allen, Rachel C. Shelton, Karen M. Emmons, et al., "Fidelity and Its Relationship to Implementation Effectiveness, Adaptation, and Dissemination," in *Dissemination and Implementation Research in Health: Translating Science to Practice*, ed. Ross C. Brownson (Oxford University Press, 2018), pp. 267-284.

[133] Rones et al., "School-Based Mental Health Services: A Research Review," 2000.

[134] Anne Richter, My Sjunnestrand, Maria Romare Strandh, et al., "Implementing School-Based Mental Health Services: A Scoping Review of Literature Summarizing Factors That Affect Implementation," *International Journal of Environmental Research and Public Health*, vol. 19 (2022).

[135] Richter et al., "Implementing School-Based Mental Health," 2022.

[136] Sheppard G. Kellam, C. Hendricks Brown, Jeanne Poduska, et al., "Effects of a Universal Classroom Behavior Management Program in First and Second Grades on Young Adult Behavioral, Psychiatric, and Social Outcomes," (continued...)

systems-level factors—such as administrative support, professional development, and a robust organizational structure for implementation—appear particularly influential in the success of SBMH programs.[137]

Figure 9. Characteristics of Effective School-Based Mental Health Programs

Features of SBMH Programs that Increase the Likelihood of Achieving Desired Outcomes

Source: Congressional Research Service, based upon a review of the research literature. Cited sources provided in figure notes below.

Notes:

1. Mark T. Greenberg, Celene E. Domitrovich, Roger P. Weissberg, et al., "Social and Emotional Learning as a Public Health Approach to Education," *The Future of Children*, vol. 271 (2017), pp. 13-32.
2. Amanda L. Sanchez, Danielle Cornacchio, Bridget Poznanski, et al., "The Effectiveness of School-Based Mental Health Services for Elementary-Aged Children: A Meta-Analysis," *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 57, no. 3 (2018), pp. 153-165.
3. Anne Richter, My Sjunnestrand, Maria Romare Strandh, et al., "Implementing School-Based Mental Health Services: A Scoping Review of Literature Summarizing Factors That Affect Implementation," *International Journal*

Drug and Alcohol Dependence, vol. 95 (June 1, 2008); and R. Hendgren, R. Birrell Weisen, and J. Orley, *Mental Health Programmes in Schools*, World Health Organization, 1994.

[137] Audra K. Langley, Erum Nadeem, Sheryl H. Kataoka, et al., "Evidence-Based Mental Health Programs in Schools: Barriers and Facilitators of Successful Implementation," *School Mental Health*, vol. 2, no. 3 (May 11, 2010).

of Environmental Research and Public Health, vol. 19 (2022).
4. Michelle Rones and Kimberly Hoagwood, "School-Based Mental Health Services: A Research Review," *Clinical Child and Family Psychology Review*, vol. 3, no. 4 (2000).
5. Aleisha Clarke, Miriam Sorgenfrei, James Mulcahy, et al., Adolescent Mental Health: A Systematic Review of the Effectiveness of School-Based Interventions, Early Intervention Foundation, July 2021.
6. Christina D. Kang-Yi, Aparajita Kuriyan, Grace Kinkler, et al., "Generating Actionable Evidence for School-Based Mental Health Service Delivery: Public-Academic Partnership Based Evaluations," *Community Mental Health Journal*, vol. 59 (2023).
7. Kelly Y. C. Lai, Se-Fong Hunh, Hannah W. S. Lee, et al., "School-Based Mental Health Initiative: Potentials and Challenges for Child and Adolescent Mental Health," *Frontiers in Psychiatry*, vol. 13 (June 9, 2022).
8. Carl E. Paternite, "School-Based Mental Health Programs and Services: Overview and Introduction to the Special Issue," *Journal of Abnormal Child Psychology*, vol. 33, no. 6 (December 2005), pp. 657-663.

Results from research on SBMH programs have also emphasized the importance of selecting appropriate programs for the populations served. Improper selection of SBMH programs can have counterproductive effects.[138] Delivering a program with poor quality, or a misalignment between the intentions of an intervention and the needs of the student population, can exacerbate the problems the program is intended to address.[139] Research has also shown that the personnel delivering SBMH programs can be particularly important for achieving desired outcomes. For instance, studies have found that universal (Tier 1) programs may be most effective when carried out by teachers.[140] Conversely, other studies suggest that some selective (Tier 2) and indicated (Tier 3) services may produce better outcomes when provided by qualified mental health professionals.[141]

Other characteristics of SBMH programs appear less important for achieving positive outcomes. For instance, several studies have found that the duration of a program may matter less than the intensity of the services delivered.[142] Relatively brief services delivered multiple times per week appear more effective than long-term programs that provide intermittent support, for example.[143] Additionally, although offering supports at all MTSS levels increases the comprehensiveness of SBMH programming, some studies have found that interventions with multifold components and

[138] Lauren J. Harvey, Fiona A. White, Caroline Hunt, et al., "Investigating the Efficacy of a Dialectical Behaviour Therapy-Based Universal Intervention on Adolescent Social and Emotional Well-Being Outcomes," *Behaviour Research and Therapy*, vol. 169 (2023); and Montero-Marin et al., "School-Based Mindfulness Training in Early Adolescence: What Works, for Whom and How in the MYRIAD Trial?," 2022.

[139] For example, one study delivered a clinical therapeutic treatment (Tier 3) as a universal intervention across an entire grade level and recorded worse mental health and family relationship outcomes for students receiving the intervention compared with the control group. The researchers concluded that the deleterious effects may be in part explained by a mismatch in the design of the intervention (i.e., as a clinical treatment) and the population (all students regardless of mental health symptoms and need for services). The authors also noted that it was difficult to make confident conclusions regarding iatrogenic harms in the study since many participants did not fully complete assigned at-home activities. See Harvey et al., "Investigating the Efficacy of a Dialectical Behaviour Therapy-Based Universal Intervention on Adolescent Social and Emotional Well-Being Outcomes," 2023. Similarly, another study testing a Tier 1 school-based mindfulness program found that students with clinical symptoms had worse outcomes after participating. The researchers concluded that the mismatch between a low-intensity (Tier 1) intervention and a population of students with mental health needs likely contributed to the detrimental outcomes. They noted that low-intensity program may not provide sufficient support to enhance resilience for youth with mental health needs who may be better supported by more intensive (i.e., Tier 3) services. See Montero-Marin et al., "School-Based Mindfulness Training in Early Adolescence," 2022.

[140] Sanchez et al., "The Effectiveness of School-Based Mental Health Services for Elementary-Aged Children: A Meta-Analysis," 2018, and Sklad et al., "Effectiveness of School-Based Universal Social, Emotional, and Behavioral Programs," 2012.

[141] Clarke et al., *Adolescent Mental Health*, 2021.

[142] Park et al., "Characteristics of Effective School-Based Teacher-Delivered Mental Health Services" (2020).

[143] Sanchez et al., "The Effectiveness of School-Based Mental Health Services for Elementary-Aged Children: A Meta-Analysis," 2018.

greater complexity are not necessarily better than simpler, single-component programs implemented well.[144] These studies suggest that the length of a SBMH program matters less than its frequency and quality.

Implementing specific SBMH programs may not be the only way to promote a positive school climate or promote good mental health. Schools may create healthy school environments and promote mental wellness in a variety of manners, such as outside of "packaged programs and curricula."[145] However, experts note that using practices that have been evaluated and shown effective may increase the likelihood for benefits.[146] Additionally, schools and communities cannot always afford to wait for the lengthy research process to demonstrate effectiveness with a similar population or in a comparable environment. Often, practical application of SBMH programs necessitates some adjustment; implementing activities using every best practice outlined can prove challenging. Recent proposals have offered strategies for expediating the research-to-practice process to assist stakeholders in implementing SBMH programs. For example, employing artificial intelligence to summarize the scientific literature and identify programs, or to update evidence reviews in a rapid and continuous manner, could potentially provide benefits to stakeholders implementing SBMH practices.[147]

Statutory Definition of "Evidence-Based" in the ESEA

As the ESEA explains, "the term ''evidence-based,', when used with respect to a state, local educational agency, or school activity, means an activity, strategy, or intervention that—

(i) demonstrates a statistically significant effect on improving student outcomes or other relevant outcomes based on—

(I) strong evidence from at least 1 well-designed and well-implemented experimental study;

(II) moderate evidence from at least 1 well-designed and well-implemented quasi-experimental study; or

(III) promising evidence from at least 1 well-designed and well-implemented correlational study with statistical controls for selection bias; or

(ii) (I) demonstrates a rationale based on high-quality research findings or positive evaluation that such activity, strategy, or intervention is likely to improve student outcomes or other relevant outcomes; and

(II) includes ongoing efforts to examine the effects of such activity, strategy, or intervention." [20 U.S.C. 7801]

Identifying Evidence-Based School Mental Health Programs

For states, local educational agencies, and schools interested in offering SBMH services, identifying effective and appropriate programs can prove challenging.[148] Several resources can help stakeholders identify applicable evidence-based programs and practices (EBPs), which are interventions that have been evaluated by researchers and supported by empirical data that demonstrate improved outcomes.[149] Schools have numerous EBPs to choose from to respond to

[144] Durlak et al., "The Impact of Enhancing Students' Social and Emotional Learning" (2011).

[145] Gayle L. Macklem, *Evidence-Based School Mental Health Services: Affect Education, Emotional Regulation Training, and Cognitive Behavioral Therapy* (New York: Springer, 2011), p. 19.

[146] Macklem, *Evidence-Based School Mental Health Services*, 2011.

[147] David Anderson, Leya Mohsin, and Susannah Schoeffel, *Harnessing Innovation: Implementing Living Evidence at the Institute of Education Sciences*, Federation of American Scientists, April 2025, https://fas.org/wp-content/uploads/2025/04/Harnessing-Innovation-Implementing-Living-Evidence-at-IES.pdf.

[148] Macklem, *Evidence-Based School Mental Health Services*, 2011.

[149] Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare & Medicaid Services (CMS) Center for Medicaid & CHIP Services, Joint Informational Bulletin, July 1, 2019; and Macklem, *Evidence-Based School Mental Health Services*, 2011.

the needs of their students. Federal agencies and several other organizations have compiled lists of SBMH EBPs, typically in the form of *clearinghouses* (or *registries*).[150] These clearinghouses display programs identified as having met a certain standard of evaluation and evidence supporting their efficacy. Selection of EBPs in these compilations—and the thresholds for inclusion—differ by clearinghouse. Some use a binary approach (programs meet a standard and are listed, or not), while others label programs along a spectrum of empirical strength ranging from promising to robust.[151]

Federal agencies operating clearinghouses for EBPs not only provide information to the public on SBMH models, they also offer federal grant recipients a streamlined location to explore options.[152] The Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services (HHS), for instance, previously operated the National Registry of Evidence-based Programs and Practices (NREPP), a searchable repository of effective, science-based interventions for behavioral health issues—including those delivered in school settings. All interventions listed in the NREPP met certain minimum requirements for effectiveness. NREPP offered resources to support the selection, adoption, and implementation of EBPs. SAMHSA discontinued the NREPP in 2018.[153]

Similar to NREPP, the Department of Education's (ED) *What Works Clearinghouse* (WWC) is a centralized source of scientific evidence on education programs and practices.[154] The WWC employs external review teams to identify interventions that meet rigorous empirical standards and summarize research findings. Currently, several of the WWC review teams—such as the team conducting reviews using the "Children Identified With or at Risk for an Emotional Disturbance Evidence Review Protocol"—are inactive.[155]

The Department of Justice (DOJ) Office of Juvenile Justice and Delinquency Prevention (OJJDP) supports a *Model Programs Guide*, which contains information about evidence-based juvenile justice and youth delinquency prevention programs.[156] The *Model Programs Guide* includes programs related to youth violence, substance use, mental health, and trauma that have met certain evidence standards. Similarly, the DOJ National Institute of Justice operates *Crime Solutions*, a clearinghouse of EBPs for crime prevention—some of which contain school-based

[150] The National Academies of Sciences, Engineering, and Medicine identified over three dozen behavioral health prevention clearinghouses. See National Academies of Sciences, Engineering, and Medicine, *Blueprint for a National Prevention Infrastructure for Mental, Emotional, and Behavioral Disorders*, Consensus Study Report, Washington, DC, 2025.

[151] Sharon F. Mihalic and Delbert S. Elliott, "Evidence-Based Programs Registry: Blueprints for Healthy Youth Development," *Evaluation and Program Planning*, vol. 48 (2015), pp. 124-131. See https://www.blueprintsprograms.org/.

[152] Kevin D. Hennessy, Richard Finkbiner, and Gary Hill, "The National Registry of Evidence-Based Programs and Practices: A Decision-Support Tool to Advance the Use of Evidence-Based Services," *International Journal of Mental Health*, vol. 35, no. 2 (Summer 2006), pp. 21-34.

[153] Substance Abuse and Mental Health Services Administration, "Statement of Elinore F. McCance-Katz, MD, PhD, Assistant Secretary for Mental Health and Substance Use regarding the National Registry of Evidence-based Programs and Practices and SAMHSA's new approach to implementation of evidence-based practices (EBPs)," press release, January 11, 2018, https://www.samhsa.gov/newsroom/press-announcements/201801110330. SAMHSA now operates an Evidence-Based Practices Resource Center, which lists SAMHSA publications that provide "communities, clinicians, policy-makers and others with the information and tools to incorporate evidence-based practices into their communities or clinical settings." For more information, see https://www.samhsa.gov/resource-search/ebp.

[154] U.S. Department of Education, Institute of Education Services, *What Works Clearinghouse, Who We Are*, https://ies.ed.gov/ncee/wwc/whoweare.

[155] HHS, IES, *WWC/About/Review Teams*, https://ies.ed.gov/ncee/wwc/ReviewTeams#.

[156] U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, *Model Programs Guide*, https://ojjdp.ojp.gov/model-programs-guide/about-mpg.

behavioral interventions for youth.[157] As required by the Bipartisan Safer Communities Act (P.L. 117-159), the Department of Homeland Security (DHS), in partnership with ED, HHS, and DOJ, operates a federal clearinghouse on school safety evidence-based practices. The website, *SchoolSafety.gov*, offers resources related to bullying, school climate, mental health, and violence prevention, among others.

At the request of HHS, the National Academies of Sciences, Engineering, and Medicine (NASEM) provided recommendations for federal operation of behavioral health-related clearinghouses in its 2025 report *Blueprint for a National Prevention Infrastructure for Mental, Emotional, and Behavioral Disorders*.[158] The report noted that federal management of a clearinghouse offers several benefits, including dedicated funding, centralization of information, broader dissemination, and the ability to pair the information with technical assistance on implementation, especially for federal grantees. It is possible, however, that a new federal effort would have some redundancy with the clearinghouses already in existence.

Other independent organizations outside of federal agencies operate clearinghouses for empirically supported school-based interventions for youth. For example, *Blueprints for Healthy Youth Development* provides a registry of positive youth development programs based on scientific evaluations that have strong evidence for effectiveness.[159] Originally launched as an HHS and DOJ initiative, the Blueprints Program operates out of the University of Colorado Boulder and is supported primarily by philanthropic funding.[160] Similarly, the Collaborative for Academic, Social, and Emotional Learning (CASEL) *Program Guide*, a clearinghouse focusing on social and emotional learning in schools, is funded by philanthropic organizations.[161] Other compendiums of evidence-based programs include the California Evidence-Based Clearinghouse for Child Welfare;[162] the RAND Corporation's *Programs that Work, from the Promising Practices Network on Children, Families and Communities*;[163] and the Arnold Ventures' *Social Programs That Work* project.[164]

School-Based Mental Health and School Violence

School-based mental health programs can help prevent school violence and address the mental health consequences of school violence. In a MTSS framework, Tier 1 violence prevention programs in schools can be used to prevent bullying or minimize student aggression, for instance.[165] Programs in Tier 2 may include peer mediation and classroom management strategies

[157] U.S. Department of Justice, National Institute of Justice, *Crime Solutions*, https://crimesolutions.ojp.gov/.

[158] National Academies of Sciences, Engineering, and Medicine, *Blueprint for a National Prevention Infrastructure for Mental, Emotional, and Behavioral Disorders*, Consensus Study Report, Washington, DC, 2025.

[159] Blueprints for Healthy Youth Development, *About Blueprints*, 2022, https://www.blueprintsprograms.org/about/.

[160] As of July 2024, Blueprints for Healthy Youth Development suspended new activity and was placed into dormancy due to lack of sustainable funding. For more information, see https://www.blueprintsprograms.org/issue-no-29/.

[161] Collaborative for Academic, Social, and Emotional Learning (CASEL), *CASEL Program Guide*, Chicago, IL, https://pg.casel.org/.

[162] California Department of Social Services and Rady Children's Hospital-San Diego, *California Evidence-Based Clearinghouse for Children and Families (CEBC)*, October 28, 2022, https://www.cebc4cw.org/topic/mental-health-prevention-and-or-early-intervention-child-adolescent-programs/.

[163] M. Rebecca Kilburn, Jill S. Cannon, Teryn Mattox, et al., *Programs that Work, from the Promising Practices Network on Children, Families and Communities*, RAND Corporation, Santa Monica, CA, September 26, 2014, https://www.rand.org/pubs/tools/TL145.html.

[164] Arnold Ventures, *Social Programs That Work*, 2025, http://evidencebasedprograms.org/.

[165] Clarke et al., *Adolescent Mental Health: A Systematic Review of the Effectiveness of School-Based Interventions*, 2021.

for students exhibiting interpersonal conflicts or early signs of aggressive behavior.[166] Tier 3 school violence prevention interventions are applied primarily in situations where students display aggressive or antisocial behaviors. The mechanisms of these interventions differ, from those that intervene with the child, parent, teacher, or peers to those that provide behavior management in the classroom, social skills training, or more intensive therapeutic services. For students who have made threats of school violence, the *threat assessment* model is designed to evaluate the severity of the threat and triage students at risk of violence into appropriate services with mental health or criminal justice professionals (see the **text box** below).[167]

School-based programs can also help mitigate adverse mental health effects associated with school violence.[168] Communities experiencing pervasive violence or schools that have experienced a single traumatic incident may benefit from SBMH programs that address associated mental health symptoms and prevent subsequent behavioral health disorders. These programs often employ trauma-informed approaches sensitive to the experiences of young people exposed to actual or threatened death, serious injury, or sexual violence. Many students who witness or experience violence may benefit from longer-term services. A comprehensive trauma-informed MTSS can provide interventions for all students, while identifying at-risk students who may be in need of more intensive services. Ensuring that interventions have empirical support can be especially important when addressing traumatic experiences. Evaluations of post-traumatic interventions—even intuitive ones—have shown that certain practices can be counterproductive and may exacerbate the consequences of traumatic events.[169]

For more information on school safety and security, including federal efforts to support school climate, student safety, and campus security, see CRS Report R46872, *Federal Support for School Safety and Security*.

Threat Assessment

Efforts to prevent school violence may involve identifying an explicit threat of violence and intervening before it occurs. *Threat assessment* is an empirically supported process of evaluating the likelihood a threat of violence will occur and intervening with a comprehensive, team-led response.[170] The model tasks schools with creating a team to assess the likelihood that an explicit threat of violence by a student may be carried out. Team members receive specialized training on the threat assessment evaluation and intervention process. Explicit threats of violence made by students or other warning signs of imminent violent behavior trigger an immediate investigation. When a potential threat of violence is investigated, the team—typically led by a school administrator—follows a series of steps to determine whether the threat is transient or substantive.[171] Interventions to prevent the violent behavior aim to resolve the issue that led the student to make a threat. Multiple factors in each given situation are

[166] Rones and Hoagwood, "School-Based Mental Health Services" (2000).

[167] Recent Congresses have emphasized broad efforts to create safe, healthy spaces within schools as opposed to targeted initiatives aimed at stopping mass incidents of violence. From H.Rept. 116-450: "the Committee encourages the Department to continue efforts to promote proactive and evidence-based efforts to foster a positive school climate that benefits all students, as opposed to simply attempting to stop rare acts of school violence. (pp. 249-250)." For more information on school safety and security, including federal efforts to support school climate, student safety, and campus security, see CRS Report R46872, *Federal Support for School Safety and Security*.

[168] Lisa H. Jaycox, Lindsey K. Morse, Terri Tanielian, et al., *How Schools Can Help Students Recover from Traumatic Experiences*, RAND, A Tool Kit for Supporting Long-Term Recovery, Santa Monica, CA, 2006.

[169] See, for example, Suzanna C. Rose, Jonathan Bisson, Rachel Churchill, et al., "Psychological Debriefing for Preventing Post Traumatic Stress Disorder (PTSD)," *Cochrane Database of Systematic Reviews*, April 22, 2002.

[170] Dewey Cornell, Peter Sheras, Anne Gregory, et al., "A Retrospective Study of School Safety Conditions in High Schools Using the Virginia Threat Assessment Guidelines Versus Alternative Approaches," *School Psychology Quarterly*, vol. 24, no. 2 (2009), pp. 119-129.

[171] Cornell et al., "A Retrospective Study," 2009.

considered when determining a response.[172] Interventions could include immediate security measures, such as notifying law enforcement. Responses can also include developing a treatment plan that may involve intensive mental health services. In the most serious cases, a multidisciplinary team conducts a comprehensive safety evaluation that includes a law enforcement investigation and a mental health assessment of the student.[173] The Federal Bureau of Investigation and the Secret Service, in collaboration with the Department of Education, have recommended that schools adopt a threat assessment approach to prevent targeted acts of violence.[174]

Researchers at the University of Virginia have developed guidelines for school administrators in response to reported threats of violence.[175] Studies on schools using the Virginia Threat Assessment model have found that students report less bullying and teasing in the school, a more favorable learning environment, and greater willingness to seek help from adults.[176] Another example of a threat assessment approach is the Dallas Threat of Violence Risk Assessment (DTVRA), developed by staff of the Dallas Independent School District.[177] Research on the DTVRA suggests that school safety is best achieved through proactive rather than reactive means.[178]

School-Based Mental Health Funding and Payment

School-based mental health activities are most commonly funded through school budgets, though some services may be paid for by private health insurance plans and state Medicaid programs, among other sources. Most funding for education and school-related activities is provided by states and localities.[179] Therefore, school budgets—including funds for SBMH activities—are determined primarily at the state and local levels. State budgets, which vary substantially, represent the largest share of funding for school mental health programming.[180] To fund schools and school-based programs, states might use funds provided through specific appropriations in the state budget, tax revenue earmarked for programs, or federal support provided through various mechanisms. For example, according to one analysis, at least 37 states appropriate funds specifically for activities related to student mental health in their state budgets.[181] Another analysis found that in the 2021–2022 school year, over half of schools (57%) reported receiving

[172] Randy Borum, Dewey G. Cornell, William Modzeleski, et al., "What Can Be Done About School Shootings? A Review of the Evidence," *Educational Researcher*, vol. 39, no. 1 (January/February 2010), pp. 27-37.

[173] Borum et al., "What Can Be Done," 2010.

[174] Robert A. Fein, Bryan Vossekuil, William S. Pollack, et al., *Threat Assessment in Schools: A Guide to Managing Threatening Situations and to Creating Safe School Climates*, United States Secret Service and United States Department of Education, Washington, DC, May 2002; and Mary Ellen O'Toole, *The School Shooter: A Threat Assessment Perspective*, Federal Bureau of Investigation, Quantico, VA, 2000.

[175] Dewey G. Cornell, *Comprehensive School Threat Assessment Guidelines* (Charlottesville, VA: School Threat Assessment Consultants LLC, 2018).

[176] Cornell et al., "A Retrospective Study," 2009.

[177] Russell Van Dyke, Kim Ryan-Arredondo, Bert Rakowitz, et al., "The Dallas Independent School District's Threat Assessment Procedures: Summary of Findings After Four Years of Implementation," in *Appraisal and Prediction of School Violence*, ed. Michael J. Furlong, Michael P. Bates, Douglas C. Smith, Paul M. Kingery (Hauppauge, NY: Nova Science Publishers, Inc., 2004); and Borum et al., "What Can Be Done About School Shootings?".

[178] Russell Van Dyke and Jennifer L. Shroeder, "Implementation of the Dallas Threat of Violence Risk Assessment," in *Handbook of School Violence and School Safety: From Research to Practice*, ed. Shane R. Jimerson and Michael J. Furlong (Lawrence Erlbaum Associates Publishers, 2006).

[179] See CRS In Focus IF12519, *Funding for Public Elementary and Secondary Schools*; CRS Report R45827, *State and Local Financing of Public Schools*; and U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, *Public School Revenue Sources*, Revenues for Public Elementary and Secondary Schools, by Revenue Source: School Years 2010-11 through 2020-21, May 2024, https://nces.ed.gov/programs/coe/indicator/cma/public-school-revenue.

[180] Hoover and Bostic, "Schools as a Vital Component," 2021.

[181] Alyssa Rafa, Meghan McCann, Cassidy Francies, et al., *State Funding for Student Mental Health*, Education Commission of the States, Policy Brief, March 2021.

funding for mental health services from district or school funds.[182] In addition, schools may fund different components of their SBMH activities through different sources. For example, according to one stakeholder report on SBMH funding, Pennsylvania uses Medicaid, the state Children's Health Insurance Program (CHIP), and private health insurance reimbursement for certain services, while using other state and federal funds for school-based substance use prevention programs.[183]

Federal support for SBMH can come from a variety of mandatory and discretionary funding mechanisms. These may include Medicaid benefits available under state plan authority and non-Medicaid authorities, such as the IDEA and Title I of the ESEA.[184] Schools may receive funds through Medicaid for SBMH activities through reimbursement for medically necessary services that are part of a student's individualized education plan (IEP), or reimbursement for eligible health services—including some behavioral health services—provided to Medicaid-enrolled students (in states that allow it).[185] Funds can also come from block grants and other discretionary grants administered by federal agencies such as ED and HHS (see **Table A-1** in the **Appendix** for examples).

Behavioral health services provided through community-based providers may be supported by federal and state grants, philanthropic or nonprofit organizations, or partnerships with local hospitals and public health departments.[186] One study found that school mental health services in the United States are commonly delivered through contractual partnerships with community mental health organizations.[187] Care in these models varies widely; contracted providers may offer one SBMH component or a more comprehensive multi-tiered system of supports.[188]

Certain SBMH services may be covered through private health insurance. Private health insurance coverage depends on whether a student is enrolled in a plan that covers such services, whether such services are considered medically necessary, and whether the provider delivering the services has the capacity to submit claims and receive payment from the plan (i.e., whether the provider is in the plan's network).[189] (This generally limits private health coverage to Tier 3 services provided to individual students.) Private health insurance does not appear to be a major

[182] Fifty-two percent of schools reported receiving federal grants for mental health services. See Nirmita Panchal, Cynthia Cox, and Robin Rudowitz, *The Landscape of School-Based Mental Health Services*, Kaiser Family Foundation, San Francisco, CA, September 6, 2022, https://www.kff.org/mental-health/issue-brief/the-landscape-of-school-based-mental-health-services/; and Kang-Yi et al., "Generating Actionable Evidence," 2023.

[183] National Center for School Mental Health (NCSMH), *School Mental Health Quality Guide: Funding and Sustainability*, Baltimore, MD, 2023, https://www.schoolmentalhealth.org/media/som/microsites/ncsmh/documents/quality-guides/Funding-&-Sustainability.pdf.

[184] SAMHSA and CMS, *Guidance to States and School Systems*, 2019. For more information, see CRS Report R43357, *Medicaid: An Overview* and CRS Report R46600, *ESEA: Title I-A Poverty Measures and Grants to Local Education Agencies and Schools*.

[185] Medicaid is a federal-state program that jointly finances medical and behavioral health services to low-income populations, including certain eligible children. For more information, see CRS Report R47310, *Bipartisan Safer Communities Act (P.L. 117-159): Section-by-Section Summary*, and CRS Report R43357, *Medicaid: An Overview*.

[186] Centers for Disease Control and Prevention, *Results from the School Health Policies and Practices Study*, School Health Policies and Practices Study, Atlanta, GA, August 2017.

[187] Reaves et al., "Associations Between School Mental Health Team Membership," 2022.

[188] Kang-Yi et al., "Generating Actionable Evidence," 2023.

[188] SAMHSA and CMS, *Guidance to States and School Systems*, 2019.

[189] For background on private health insurance benefit coverage and provider networks in general, see CRS Report R47507, *Private Health Insurance: A Primer*.

source of financing for SBMH overall, though the precise role private health insurance plays in funding SBMH services is difficult to quantify.[190]

Educator Mental Health

In addition to student wellness, teacher well-being may also be of interest to policymakers.[191] Teachers have considerable demands placed upon them.[192] Studies have found that teaching professionals often have higher rates of job-related stress than many other fields.[193] For example, in a RAND survey of nearly 1,500 public K-12 teachers, more than half reported experiencing high rates of stress and burnout.[194] A quarter of those surveyed specifically reported difficulties coping with the stress of their teaching job.[195] Nearly half (45%) of these teachers reported that managing student behavior was the most stressful part of their job. Challenges associated with the COVID-19 pandemic appeared to have had considerable negative mental health effects for teachers.[196]

While little research has been devoted to educator mental health specifically, some studies have offered insights into strategies to improve teacher well-being.[197] In particular, several studies have shown that implementing comprehensive SBMH programs for students may provide benefits for teachers, perhaps due to the effects of student behavioral health on teacher well-being or the exposure teachers may gain to cognitive and emotional management skills.[198] According to the 2024 National Center for Education Statistics School Pulse Panel survey, 59% of public schools nationwide offer employee assistance programs (EAPs) with a mental health component. Fewer schools offer referrals to mental health services outside of school (33%), mental health-related professional development (33%), proactive outreach to staff (15%), or group/peer support interventions (8%).[199] Some studies have cautioned against heavy investments in individualized mental health services for teachers, instead advocating for policies that address the determinants of teacher well-being, such as school climate, working conditions, and compensation.[200]

Considerations for Congress

Are Schools an Appropriate Setting for Mental Health Services?

Determining whether schools should offer mental health programming raises logistical questions regarding the capacity of schools to deliver services, as well as philosophical questions about the

[190] Panchal et al., *The Landscape of School-Based Mental Health Services*, 2022.

[191] Centers for Disease Control and Prevention, Division of Adolescent and School Health (DASH), *Promoting Mental Health and Well-Being in Schools: An Action Guide for School and District Leaders*, December 2023.

[192] Christina Gray, Gabrielle Wilcox, and David Nordstrokke, "Teacher Mental Health, School Climate, Inclusive Education, and Student Learning: A Review," *Canadian Psychology/Psychologie Canadienne*, vol. 58, no. 3 (2017).

[193] Melissa Corrente, Kristen Ferguson, and Ivy Lynn Bourgeault, "Mental Health Experiences of Teachers: A Scoping Review," *Journal of Teaching and Learning*, vol. 16, no. 1 (2022), pp. 23-43.

[194] RAND, *Teachers Are Still Stressed and Underpaid Post-COVID*, August 22, 2024, https://www.rand.org/pubs/articles/2024/teachers-are-still-stressed-and-underpaid-post-covid.html.

[195] Sy Doan, Elizabeth D. Steiner, and Rakesh Pandey, *Teacher Well-Being and Intentions to Leave in 2024*, RAND, Findings from the 2024 State of the American Teacher Survey, June 18, 2024, https://www.rand.org/pubs/research_reports/RRA1108-12.html.

[196] Matthew J. Hirshberg, Richard J. Davidson, and Simon B. Goldberg, "Educators Are Not Alright: Mental Health During COVID-19," *Educational Researcher*, vol. 52, no. 1 (2023), pp. 48-52.

[197] Lindsey Jaber, "Centering Educator Mental Health and Wellness in Education," in *Understanding Mental Health Across Educational Contexts: Promoting Wellness in Classrooms*, ed. Lindsey Jaber (Toronto: Canadian Scholars, 2024), pp. 82-91.

[198] See, for example, Hoover and Bostic, "Schools As a Vital Component of the Child and Adolescent Mental Health System," 2021; and Montero-Marin et al., "School-Based Mindfulness Training in Early Adolescence," 2022.

[199] U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, *School Pulse Panel*, March 2024, https://nces.ed.gov/surveys/spp/results.asp.

[200] See, for example, Lara Corr, Kay Cook, Elise Davis, et al., "Early Childhood Educator Mental Health: Performing the National Quality Standard," *Australasian Journal of Early Childhood*, vol. 42, no. 4 (December 2017).

purpose of public education. The appropriateness of SBMH activities depends in part on the primary purpose of school, and on whether or not SBMH efforts align with this mission. Even if attending to the mental wellness of students is a core objective of schools, questions arise around whether schools are functionally empowered to carry out mental health initiatives.

The Case for School-Based Mental Health Activities

Proponents of SBMH argue that the purpose of formal education is to cultivate not only the intellectual development of students but also their social and emotional development. As one group of stakeholders asserted:

> There is broad agreement among educators, policy makers, and the public that educational systems should graduate students who are proficient in core academic subjects, able to work well with others from diverse backgrounds in socially and emotionally skilled ways, practice healthy behaviors, and behave responsibly and respectfully.[201]

SBMH advocates point to the foundational principles of public education in the United States as justification for fostering student growth beyond pedagogy. The public school system was established not only to teach academic skills but to help create a competent citizenry composed of critical thinkers who could work effectively with others and participate in a democratic society.[202] Such advocates contend that cultivating a citizenry capable of perpetuating a democracy requires that children possess more than the ability to read and write. It also requires a versatile range of cognitive, personal, and social competencies necessary to realize civic values.[203]

These advocates assert that schools, therefore, play an essential role in nurturing the personal and civic development of young people. This role includes promoting the type of vocational and social development necessary to perpetuate a self-governing society.[204] Societal changes—such as the shift to a more informational and service economy—call for learning stress management skills and collaborative group work, for instance. According to a joint American Enterprise Institute and Brookings report, economists, employers, and corporate leaders increasingly recognize the importance of "soft skills" such as emotion regulation, responsible decisionmaking, and social competence for success in the labor market and the nation's productivity.[205] Proponents of SBMH, therefore, believe that to meet individual and societal needs, schools should expand beyond academic instruction to include social and emotional development as core to their mission.[206] In addition, some parents have expressed a desire for schools to do more than teach academics. Surveys of parents have revealed concerns related to student preparation for work in a global economy and citizenship skills.[207]

Adequate social and emotional development and healthy mental health functioning may moderate academic success for students also. As some experts have argued, emotional, behavioral, or social

[201] Durlak et al., "The Impact of Enhancing Students' Social and Emotional Learning" (2011).

[202] Patricia Albjerg Graham, *Schooling America: How the Public Schools Meet the Nation's Changing Needs* (New York: Oxford University Press, 2005), and Greenberg et al., "Social and Emotional Learning," 2017.

[203] Graham, *Schooling America*, 2017.

[204] Greenberg et al., "Social and Emotional Learning," 2017.

[205] AEI/Brookings Working Group on Poverty and Opportunity, *Opportunity, Responsibility, and Security: A Consensus Plan for Reducing Poverty and Restoring the American Dream*, American Enterprise Institute/Brookings, Washington, DC, 2015, p. 59, https://www.brookings.edu/wp-content/uploads/2016/07/Full-Report.pdf.

[206] Sklad et al., "Effectiveness of School-Based Universal Social, Emotional, and Behavioral Programs," 2012.

[207] Nancy Sconyers, *What Parents Want; A Report on Parents' Opinions about Public Schools*, Center on Families, Communities, Schools, and Children's Learning; Office of Educational Research and Improvement, U.S. Department of Education, Washington, DC, 1996.

difficulties left unaddressed can negatively influence learning and the academic environment for other children.[208] Schools have a duty, according to this perspective, to attend to the social and emotional well-being of students for the sake of their academic progress and to cultivate environments that foster learning.

Some SBMH supporters assert that schools provide an optimal setting for advancing mental well-being for practical reasons. Outside of the family environment, schools represent the next social environment where youth spend most of their time.[209] Some argue that the amount of time children spend in schools, partly due to compulsory school attendance, makes school an ideal environment to teach certain skills and promote healthy social and emotional development. Since school systems offer such expansive reach, scaling up SBMH efforts—particularly universal programs—may have significant public health benefits.[210] Many argue that schools are natural, inclusive settings.[211] They often provide safe, non-stigmatizing, and supportive environments in which children, youth, and families can easily access prevention, early intervention, and treatment resources.[212]

It could also be argued that the accessibility of mental health services represents another functional benefit to SBMH activities. Schools may resolve some of the known barriers that prevent access to mental health services for children and adolescents.[213] These barriers commonly include difficulties locating providers, costs or lack of insurance, stigma associated with treatment, or lack of transportation.[214] When provided at no-cost to students and their families in schools, SBMH services can remove many structural barriers, such as lack of transportation. This access may help make mental health services available to youth who may not otherwise receive care.[215] SBMH resources may be especially beneficial in areas that lack adequate community-based options.[216] Further, participating in SBMH activities may have less stigma attached to it, increasing the chances students and families participate in needed care.[217] One study, for example,

[208] Carl E. Paternite, "School-Based Mental Health Programs and Services: Overview and Introduction to the Special Issue," *Journal of Abnormal Child Psychology*, vol. 33, no. 6 (December 2005), pp. 657-663; Rones and Hoagwood, "School-Based Mental Health Services" (2000).

[209] Kelly Y. C. Lai, Se-Fong Hunh, Hannah W. S. Lee, et al., "School-Based Mental Health Initiative: Potentials and Challenges for Child and Adolescent Mental Health," *Frontiers in Psychiatry*, vol. 13 (June 9, 2022).

[210] Greenberg et al., "Social and Emotional Learning," 2017.

[211] See, for instance, Hoover and Bostic, "Schools As a Vital Component of the Child and Adolescent Mental Health System," 2021.

[212] Youth.gov, *School Based Mental Health*, May 2022, https://youth.gov/youth-topics/youth-mental-health/school-based.

[213] Ezra Golberstein, Irina Zainullina, Aaron Sojourner, et al., "Effects of School-Based Mental Health Services on Youth Outcomes," *Journal of Human Resources*, vol. 59 (September 2024).

[214] Richter et al., "Implementing School-Based Mental Health Services," 2022.

[215] See, for example, Ricardo Eiraldi, Rachel Comly, Jessica Goldstein, et al., "Development of an Online Training Platform and Implementation Strategy for School-Based Mental Health Professionals in Rural Elementary Schools: A Mixed-Methods Study," *School Mental Health*, vol. 15 (2023), pp. 692-709; DiGirolamo et al., "Results From a Statewide School-Based Mental Health Program," 2020; Lai et al., "School-Based Mental Health Initiative," 2022; and Paternite, "School-Based Mental Health Programs," 2005.

[216] Sanchez et al., "The Effectiveness of School-Based Mental Health," 2018, and Kang-Yi et al., "Generating Actionable Evidence," 2023.

[217] Julia E. Koppich and Michael W. Kirst, "Integrating Services for Children-Prospects and Pitfalls-Introduction," *Education and Urban Society*, vol. 25, no. 2 (1993), pp. 123-128.

found that youth referred to SBMH services were more likely to successfully access treatment than youth referred to community-based services.[218]

In addition to the accessibility of services, SBMH models may offer opportunities for more coordinated care. SBMH activities often include interdisciplinary teams of professionals familiar with students and their families. Integrated teams operating in a school could provide more comprehensive care compared with the community-based behavioral health system, which may be segregated from the rest of a student's support team (e.g., teachers and school counselors).[219] Teachers may be particularly important members of an integrated care team. Teachers possess knowledge of students' strengths and weaknesses and an ability to identify strategies that may promote student success.[220] Schools, therefore, may be uniquely situated to coordinate comprehensive care compared with siloed community providers operating independently. Some proponents assert that adequately staffing schools to provide SBMH services for student behavioral health needs could eliminate a school's dependency on external mental health professionals altogether.[221]

SBMH has a diverse constellation of supporters, from international health organizations to domestic school-based professional trade groups. The World Health Organization has recommended the use of social and emotional learning programs for all countries, for instance.[222] The National Association for Secondary School Principals has recommended that "federal and state governments should encourage local communities to focus on schools as the hub for delivery of mental health, wellness, and social services" and that "superintendents and school boards should promote comprehensive school-based mental health programs."[223] One study found notable support among teachers as well. A survey of 1,000 teachers found that they preferred having additional school mental health personnel over a 10% salary increase or a reduction in class size.[224] In the past few decades, several U.S. presidential administrations have advocated for SBMH programming in schools.[225] Recent Congresses have also emphasized efforts to create safe, healthy spaces within schools, particularly as a strategy to reduce school violence.[226]

[218] Mathilde M. Husky, Marian Sheridan, Leslie McGuire, et al., "Mental Health Screening and Follow-Up Care in Public High Schools," *Journal of the American Academy of Child & Adolescent Psychiatry*, vol. 50, no. 9 (2011), pp. 881-891.

[219] Hoover and Bostic, "Schools As a Vital Component of the Child and Adolescent Mental Health System," 2021; and Lai et al., "School-Based Mental Health Initiative," 2022.

[220] Darren W. Woodruff, David Osher, Catherine Hoffman, et al., *The Role of Education in a System of Care: Effectively Serving Children with Emotional or Behavioral Disorders*, American Institutes for Research, Systems of Care: Promising Practices in Children's Mental Health 1998 Series, Volume III, Washington, DC, 1999, https://files.eric.ed.gov/fulltext/ED429421.pdf.

[221] Woodruff et al., *The Role of Education in a System of Care*, 1999.

[222] World Health Organization, *Mental Health*, Fact Sheet, June 17, 2022, https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.

[223] National Association of Secondary School Principals, *Mental Health in Middle Level and High Schools*, Position Statement: Mental Health, 2020, https://www.nassp.org/mental-health-in-middle-level-and-high-schools/.

[224] Virginia S. Lovison and Cecilia Hyunjung Mo, "Investing in the Teacher Workforce: Experimental Evidence on Teachers' Preferences," *American Educational Research Journal*, vol. 61, no. 1 (2023), pp. 108-144.

[225] Woodruff et al., *The Role of Education in a System of Care*, 1999, and SAMHSA and CMS, *Guidance to States and School Systems*, 2019.

[226] See, for example, CRS Report R47310, *Bipartisan Safer Communities Act (P.L. 117-159): Section-by-Section Summary*; and U.S. Congress, House Appropriations Committee, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2021, report to accompany H.R. 7614 together with Minority views, 116th Cong., 2nd sess., July 15, 2020, H.Rept. 116-450, pp. 249-250.

The Case Against School-Based Mental Health Activities

SBMH detractors argue that conducting behavioral health-related activities in school settings—including SEL programming—is neither feasible nor consistent with the purpose of the formal education system. Some believe that promoting healthy emotional, behavioral, and social development should be primarily the work of families, religious or civic organizations, or other community institutions.[227] By centralizing the school in this endeavor, it is argued, schools may be "usurping" this role and implicitly abdicating the responsibility of other institutions that should be central in child development.[228] For instance, the experiences that youth have in their homes, their communities, and through the media may be just as influential in their development as their experiences in school.[229]

Such observers often assert that asking schools to be responsible for the emotional health of students may be beyond a school's purview. SBMH could lead to a mission creep in which schools further expand their role in child welfare—but in many cases without commensurate resources. Schools may already feel pressure to enhance academic performance across a set of demanding and often changing metrics.[230] A mandate that schools provide treatment for health issues, according to many, not only lies beyond the mission of schools, but may detract from their ability to educate students. Separating child health from instruction may allow schools to more effectively focus on educating students, their primary objective.[231] Additionally, character-building and healthy emotional development may not be skill-based endeavors achieved through empirically based programs.[232] Some have claimed that widespread SBMH activities can cause unintended harms.[233] An overemphasis on emotions, for example, could interfere with natural resilience-building and prove counterproductive in promoting well-being.[234] Others have claimed that increasing SBMH activities could lead to an "overdiagnosis" of children.[235]

To those believing that the education system's primary purpose is instructional in nature—to teach specific academic or vocational skills and knowledge—effort spent on psychosocial or emotional development can be seen as detracting from that endeavor. Studies examining the effects of SBMH programs on academic outcomes have produced inconsistent results, raising the question of whether SBMH programs (when judged on academic outcome measures) are

[227] Robert Pondiscio, *The Unexamined Rise of Therapeutic Education: How Social-Emotional Learning Extends K-12 Education's Reach into Students' Lives and Expands Teachers' Roles*, American Enterprise Institute, October 2021, https://www.aei.org/wp-content/uploads/2021/10/The-Unexamined-Rise-of-Therapeutic-Education.pdf.

[228] Pondiscio, *The Unexamined Rise*, 2021.

[229] Graham, *Schooling America*, 2005. As those other influences can be difficult to regulate, leveraging educational institutions becomes more attractive since education policies are often more susceptible to public influence.

[230] Durlak et al., "The Impact of Enhancing Students' Social and Emotional Learning," 2020.

[231] Carolyn Chan, Donna Dennis, Soo Jung Kim, et al., "An Integrative Review of School-Based Mental Health Interventions for Elementary Students: Implications for Occupational Therapy," *Occupational Therapy in Mental Health*, vol. 33, no. 1 (2017), pp. 81-101.

[232] Pondiscio, *The Unexamined Rise*, 2021.

[233] Lucy Foulkes, Jack L. Andrews, Tessa Reardon, et al., "Research Recommendations for Assessing Potential Harm from Universal School-Based Mental Health Interventions," *Nature Mental Health*, March 2024.

[234] Lucy Foulkes and Jack L. Andrews, "Are Mental Health Awareness Efforts Contributing to the Rise in Reported Mental Health Problems? A Call to Test the Prevalence Inflation Hypothesis," *New Ideas in Psychology*, vol. 69 (January 2023).

[235] Carolyn D. Gorman, *School-Based Mental Health Initiatives: Challenges and Considerations for Policymakers*, The Manhattan Institute, Report, September 202; see also Eva Charlotte Merten, Jan Christopher Cxik, Jurgen Margraf, et al., "Overdiagnosis of Mental Disorders in Children and Adolescents (in Developed Countries)," *Child and Adolescent Psychiatry and Mental Health*, vol. 11 (2017).

reasonable uses of schools' limited time and resources.[236] Universal SBMH activities, for instance, could be considered an inefficient use of resources, as they expend time and effort on students who may not need additional support.[237] Some experts have suggested that resources ought to be directed exclusively towards at-risk individuals and groups.[238] Others have questioned whether schools can effectively deliver SBMH activities with adequate quality. Some have raised concerns, for example, about the risks of implementing activities incompletely.[239] A limited ability to execute SBMH programming with sufficient standards (see **Figure 9**) could have adverse consequences beyond an ineffective use of resources. Requiring schools—particularly those with limited resources—to play a larger role in mental health care for children without appropriate evidence-based support could do certain students and their parents "more harm than good."[240] Stretching resources across too many requirements for schools could result in a worse performance across all outcomes, for example.

Others have argued that asking schools to provide SBMH programming poses logistical challenges. Schools typically do not have the internal capacity to meet all levels of student mental health needs, for example. Funding for SBMH activities, which often comes from state general funds or federal discretionary grants, may be unstable.[241] Schools are generally not equipped to bill third-party payers for health care services, and establishing the infrastructure to do so could be prohibitively burdensome.[242] Schools are also not set up to communicate with the broader health care system where other complementary services exist.[243]

SBMH services may be duplicative of resources already available in the community.[244] Some have observed that prioritizing SBMH activities may be an attempt to compensate for "the limitations of existing mental health systems that are not truly accessible for too many students."[245] With a more robust and accessible community-based mental health system, services delivered in schools may be less necessary.

Many SBMH activities require teacher involvement, prompting questions about teacher qualifications and effective use of educators' time. Certain SBMH activities may require teachers to work outside of their training and expertise.[246] Others have argued that implementing SBMH activities in the classroom fundamentally changes the role of the teacher "from pedagogue to

[236] Moshe Zeidner, Richard Roberts, and Gerald Matthews, "Can Emotional Intelligence Be Schooled? A Critical Review," *Educational Psychologist*, vol. 37, no. 4 (2002), pp. 215-331; and Durlak et al., "The Impact of Enhancing Students' Social and Emotional Learning" (2011).

[237] Ellen Barry, "Are We Talking Too Much About Mental Health?," *The New York Times*, May 6, 2024.

[238] Clarke et al., *Adolescent Mental Health*, 2021.

[239] Rones et al., "School-Based Mental Health Services: A Research Review," 2000.

[240] Michael F. Cannon and Marie Gryphon, *Schools Shouldn't Play Doctor*, CATO Institute, Commentary, July 14, 2004.

[241] Jamie Chamberlin, *Schools Expand Mental Health Care*, Monitor on Psychology, January 2009, https://www.apa.org/monitor/2009/01/school-clinics.

[242] AASA, The School Superintendents Association, *Structural Inefficiencies in the School-Based Medicaid Program Disadvantage Small and Rural Districts and Students*, Alexandria, VA, February 2019.

[243] Lai et al., "School-Based Mental Health Initiative," 2022.

[244] Chamberlin, *Schools Expand Mental Health Care*, 2009.

[245] Hoover et al., "Schools as a Vital Component," 2021, p. 46. See also, Mark D. Weist, Jennifer Axelrod Lowie, Lois T. Flaherty, et al., "Collaboration Among the Education, Mental Health, and Public Health Systems to Promote Youth Mental Health," *Psychiatry Services*, vol. 52, no. 10 (September 1, 2001).

[246] Frey et al., "School-Based Mental Health Practitioners," 2022; and Sanchez et al., "The Effectiveness of School-Based Mental Health," 2018.

something more resembling a therapist, social worker, or member of the clergy."[247] Surveys of teachers have shown mixed support for implementing SBMH in the classroom. Some teacher surveys have revealed uncertainty about their roles in supporting students with mental health problems. In one study, for instance, some teachers reported that SBMH activities felt beyond their competencies since they were not trained in mental health.[248] Other studies exploring classroom-based interventions have found logistical challenges with teacher-led activities. Teachers have reported difficulties finding time to complete necessary tasks for SBMH programs due to competing demands.[249]

What Role Might SBMH Programs Play in the Mental Health Continuum of Care?

Many believe that because of the prominent role of schools in students' lives, any efforts to improve youth mental health necessitates *some* involvement of schools in the continuum of mental health care. Those taking this position assert that rather than placing primary responsibility for student mental wellness on schools—or excluding schools from youth mental health initiatives entirely—best practices ought to involve collaborative partnerships between school and community services.[250] Furthermore, they contend that promoting youth mental health depends upon linking students into collaborative family-school-community systems of care that combine resources to address "the entire environment that affects kids."[251] As a result, many school districts partner with community mental health providers to increase the array of services available to students. School partners can include local mental health centers, local health departments, university-affiliated centers, nongovernmental organizations and nonprofit entities, private sectors companies, and individual consultants or clinicians.[252] Partnerships can range from small contracts centered on specific mental health services delivered by a single health provider to multifaceted collaborations with organizations providing support at every tier of intervention.[253] Collaboration between schools and community-based entities recognizes that schools cannot meet the mental health needs of students on their own, and may be overburdened by demands that could be addressed with the help of other community systems.[254]

The goal of family–school–community partnerships may be a more robust continuum of mental health prevention, assessment, early intervention, and treatment services for youth. Some have asserted that schools could be well situated to coordinate child-serving systems in working toward mutual goals.[255] For example, the National Association for Secondary School Principals has recommended that communities focus on schools as a hub for mental health, wellness, and social services.[256] Others have asserted that SBMH should strive not just for coordination among

[247] Pondiscio, *The Unexamined Rise*, 2021.

[248] Anne Graham, Renata Phelps, Carrie Maddison, et al., "Supporting Children's Mental Health in Schools: Teacher Views," *Teachers and Teaching*, vol. 17, no. 4 (2011), pp. 479-496.

[249] Kang-Yi et al., "Generating Actionable Evidence," 2023.

[250] Hoover et al., "Schools as a Vital Component," 2021.

[251] Woodruff et al., *The Role of Education in a System of Care*, 1999, p. 15.

[252] Kang-Yi et al., "Generating Actionable Evidence," 2023.

[253] See, for example. Sharon A. Hoover, *Investing in School Mental Health: Strategies to Wisely Spend Federal and State Funding*, Think Bigger Do Good, Spring 2024, https://thinkbiggerdogood.org/investing-in-school-mental-health-strategies-to-wisely-spend-federal-and-state-funding/.

[254] Paternite, "School-Based Mental Health Programs," 2005.

[255] Hoover et al., "Schools as a Vital Component," 2021.

[256] NASSP, *Mental Health in Middle Level*, 2020.

entities, but integration across all delivery systems (e.g., health care, child welfare).[257] SBMH programming appears to have greater sustainability, for instance, when community mental health providers are accepted and well-integrated within schools.[258]

Another benefit to a collaborative model is the ability for community resources to deliver mental health services within existing payment systems. This relieves some pressure on schools to be a one-stop-shop for all student mental health needs. Unlike most schools, independently licensed mental health professionals are qualified to provide clinical services and bill third-party payers like private health insurance for services in most states. (Drawbacks to this system include challenges with coordination of care, such as privacy laws, and potential ambiguity of roles and responsibilities. See below for more information.) Commitments to address student mental health require determining funding sources: who pays for what activities may be influenced by existing structures and policies. For example, Medicaid or private health insurance may pay for services provided by a community-based provider delivered in school, or those for a diagnosed behavioral disorder, whereas activities conducted by school personnel, and those promoting positive behavior generally, may be funded through school budgets or other sources.

Effectively providing mental health care in locations other than schools requires adequate resources in the community and a willingness to collaborate. In other words, adequately meeting students' mental health needs is a function of the availability and quality of accessible community-based mental health services. Schools interested in effectively addressing student mental health may depend on a behavioral health system that operates independently of the education system and outside its sphere of influence.

What Barriers Exist in Addressing Student Behavioral Health via School-Based Mental Health Activities?

Implementing school-based mental health activities faces a number of challenges. In feasibility studies, stakeholders most commonly cite time, resources, and cost as barriers to offering SBMH programs and services.[259] ED's 2022 Institute for Education Sciences (IES) Pulse Panel survey found that insufficient mental health staff coverage, inadequate access to mental health professionals, and insufficient funding were the top factors inhibiting schools' efforts to provide SBMH services to students in need (see **Figure 10**). Low-resourced schools and those in rural settings may especially lack the personnel necessary to implement mental health services without significant support.[260]

[257] See, for example, *Handbook of School Mental Health: Research, Training, Practice, and Policy*, ed. Mark D. Weist, Nancy A. Lever, Catherine P. Bradshaw, Julie Sarno Owens, 2nd ed. (New York: Springer, 2014).

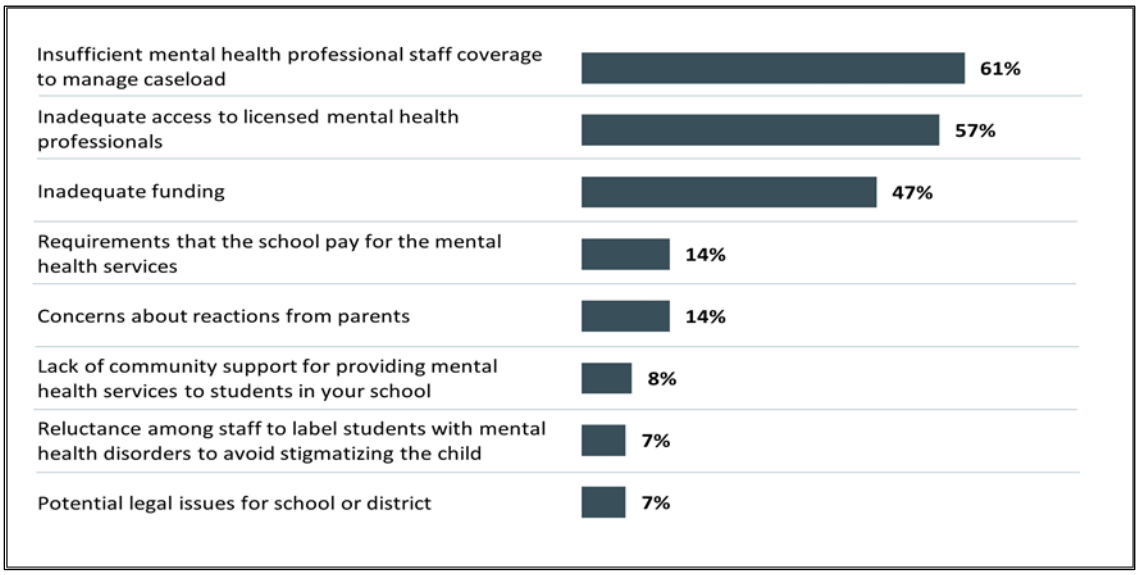
[258] DiGirolamo et al., "Results From a Statewide School-Based Mental Health Program," 2020.

[259] Emma Soneson, Emma Howarth, Tamsin Ford, et al., "Feasibility of School-Based Identification of Children and Adolescents Experiencing, or At-Risk of Developing, Mental Health Difficulties: A Systematic Review," *Prevention Science*, vol. 21 (2020), pp. 581-603.

[260] Sharnia Moore, Zach Timpe, Catherine N. Rasberry, et al., "Disparities in the Implementation of School-Based Mental Health Supports Among K-12 Public Schools," *Psychiatric Services*, vol. 75, no. 1 (January 2024); Eiraldi et al., "Development of an Online Training Platform," 2023; and Sanchez et al., "The Effectiveness of School-Based Mental Health Services," 2018.

Figure 10. Factors Limiting School Efforts to Provide SBMH Services

Factors Cited by Public Schools in the IES Pulse Survey



Source: U.S. Department of Education, Institute of Education Sciences (IES), National Center for Education Statistics (NCES), *School Pulse Panel*, April 2022, https://ies.ed.gov/schoolsurvey/spp/ and https://nces.ed.gov/whatsnew/press_releases/05_31_2022_2.asp.

Notes: Figure depicts responses from the 46% of public schools that did not strongly agree that they can effectively provide mental health services to all students in need. A total of 830 schools participated in the April 2022 survey.

An inadequate supply of qualified behavioral health professionals is the most commonly reported barrier to widespread implementation of SBMH programs. Within the U.S. Department of Health and Human Services, the Health Resources and Services Administration (HRSA)'s National Center for Health Workforce Analysis assesses shortages of health professionals in geographic areas, facilities, or populations via their Health Professional Shortage Area (HPSA) metric. According to HRSA, over half of the U.S. population currently lives in a mental health HPSA.[261] HRSA projects that by 2036, unmet need for psychologists, mental health and school counselors, and school social workers will increase by at least 50%.[262] Schools may find challenges recruiting and retaining school behavioral health professionals, or difficulties finding community partners who have adequate capacity to help. As a result, some stakeholders argue that the SBMH field should look beyond efforts to increase the number of practitioners who provide direct clinical services and focus instead on implementing models that emphasize prevention and service integration with community providers.[263]

Schools also face systemic and logistical challenges in implementing SBMH programs. Besides maintaining a qualified workforce, barriers to implementing SBMH programs include securing the ongoing support of school leaders and staff, negotiating time in the school day and adequate physical space, and providing ongoing training, technical assistance, and support to school staff

[261] Health Resources and Services Administration (HRSA), *Behavioral Health Workforce, 2023*, Health Workforce, December 2023, https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf.

[262] HRSA, *Behavioral Health Workforce*, 2023.

[263] Kutash et al., *School-Based Mental Health: An Empirical Guide for Decision-Makers*, 2006.

implementing the intervention.[264] Schools are subject to demands of various authorities and stakeholders. They must often balance competing and frequently changing priorities. Teachers, policymakers, or parent groups may not believe it is the school's responsibility to provide mental health services to students, or they may prefer that the school's resources be devoted to other endeavors.[265] Mental health treatment may also have stigma associated with it, which may lead parents to resist SBMH initiatives.[266]

Ensuring adequate funding for SBMH activities can be particularly challenging. Although some schools receive Medicaid funds to provide services to students enrolled in state Medicaid plans, schools are not often equipped to bill third-party payers for SBMH services.[267] Schools rely predominantly on funds from state and local budgets for SBMH activities, which may vary considerably by location. Whereas federal funds for SBMH activities may help supplement state and local efforts, some stakeholders have expressed concerns that federal funding alone may be unreliable in sustaining programs.[268] The impetus for federal SBMH investment often arises in the wake of catastrophes—such as incidents of mass violence—sometimes without a long-term strategy to maintain programming.[269]

Schools seeking to outsource mental health services through collaborations with community-based behavioral health providers face obstacles to effective SBMH coordination. Education and mental health systems largely operate in separate silos. Schools and other care agencies have discrepant organizational structures, different cultures, and sometimes conflicting imperatives. As one report described, "They work on different time schedules, speak different languages, and are often accountable to different constituencies."[270] Despite evidence suggesting that collaboration may represent best practices, seamless coordination between SBMH participants (e.g., classroom teachers, counselors, and psychologists) remains less common, particularly when SBMH service providers are contracted from local agencies outside the school system.[271] When students receive mental health or social services outside of the school, these services are typically disconnected from the school's strategy for the student. In addition, collaboration between schools and community partners may be inhibited by relevant privacy laws governing the education and health care sectors, leaving the burden of coordination on the students' families.

Schools empowered to provide SBMH activities and services may still experience a myriad of challenges in effectively implementing programs. Identifying interventions appropriate for the school population and demonstrating adequate evidence for effectiveness can be difficult for many schools. Some surveys suggest that many schools do not use evidence-based programs or

[264] See Paternite, "School-Based Mental Health Programs," 2005.

[265] Woodruff et al., *The Role of Education in a System of Care*, 1999.

[266] Nathaniel Beers and Shashank V. Joshi, "Increasing Access to Mental Health Services Through Reduction of Stigma," *Pediatrics*, vol. 145, no. 6 (June 2020).

[267] Centers for Medicare and Medicaid Services (CMS), *Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming*, 2023, https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf.

[268] Hoover et al., "Schools As a Vital Component," 2021.

[269] Sharon A. Hoover, Jeff Q. Bostic, and Libby K. Nealis, "What is the Role of Schools in the Treatment of Children's Mental Illness?," in *The Palgrave Handbook of American Mental Health Policy*, ed. Howard H. Goldman, Richard G. Frank, Joseph P. Morrissey (New York: Springer, 2020).

[270] Woodruff et al., *The Role of Education in a System of Care*, 1999, p. 15. See also Reaves et al., "Associations Between School Mental Health Team Membership," 2022.

[271] Greenberg et al., "Social and Emotional Learning," 2017.

frequently use them with poor quality and fidelity.[272] These challenges can occur for a variety of reasons: schools may not be aware of effective programs, may fail to select the most appropriate ones for their goals and populations, may implement the interventions incorrectly, or may discontinue programs before they demonstrate effectiveness.[273] There are no clearly established best practices for the universal prevention of youth mental health conditions; nor is there clear consensus on essential components to such programs, making it difficult for schools to navigate an unsettled industry landscape.[274]

Even when schools do select evidence-based interventions, they may encounter barriers in implementing these programs effectively. Much of the research on SBMH programs has evaluated services delivered by highly trained research professionals in controlled conditions, not school staff in natural school environments.[275] Programs that have been found to be effective in one context do not necessarily translate to other contexts.[276] Some research has shown that certain interventions transferred from one cultural context to another had no impact, for example.[277] In other words, a gap remains between research and practice in SBMH—an obstacle schools may encounter when attempting to implement evidence-based programs and practices.[278]

Are There Other Options for Addressing Mental Health Besides School-Based Mental Health Services?

Formal SBMH programs and services may not be the only options for promoting student mental health. Some believe that creating environments where youth can thrive or addressing the factors contributing to poor mental health can be effective approaches to improving mental wellness. These approaches, which challenge traditional diagnostic and treatment systems that may pathologize individual children, contend that the environment in which a youth exists is perhaps the strongest determinant of mental health outcomes.[279] Therefore, rather than concentrate mental health resources on individual students, proponents of this approach maintain that schools should target the conditions in which students work and play within the school environment. Instead of increasing the number of mental health professionals providing individualized SBMH services, for example, proponents of *upstream* preventive approaches (such as those featured in Tier 1 of the MTSS framework) advocate for school policies that enhance conditions that affect student mental wellness. For instance, some believe that unstructured, child-led free play may be more effective in improving mental well-being than standardized, adult-directed activities—even if those activities are in the service of mental health.[280] Strategies promoting free play aim to

[272] See, for example, Denise C. Gottfredson and Gary D. Gottfredson, "Quality of School-Based Prevention Programs: Results from a National Survey," *Journal of Research in Crime and Delinquency*, vol. 39, no. 1 (2002), pp. 3-35.

[273] Durlak et al., "The Impact of Enhancing Students' Social and Emotional Learning," 2011.

[274] Thomas J. Nehmy and Tracey D. Wade, "Reduction in the Prospective Incidence of Adolescent Psychopathology: A Review of School-Based Prevention Approaches," *Mental Health & Prevention*, vol. 2, no. 3-4 (2014), pp. 66-79.

[275] Sanchez et al., "The Effectiveness of School-Based Mental Health Services," 2018.

[276] Wilson et al., "School-Based Interventions," 2007.

[277] Cefai et al., "The Effectiveness of a School-Based," 2022.

[278] John R. Weisz, Irwin N. Sandler, Joseph A. Durlak, et al., "Promoting and Protecting Youth Mental Health Through Evidence-Based Prevention and Treatment," *American Psychologist*, vol. 60, no. 6 (2005).

[279] Nick Gillespie, "The End of Play: Why Kids Need Unstructured Time," *ReasonTV*, April 25, 2017, https://www.youtube.com/watch?v=zB5_KAOjboc.

[280] Regina Lai Tong Lee, Shelly Lane, Graeme Brown, et al., "Systematic Review of the Impact of Unstructured Play Interventions to Improve Young Children's Physical, Social, and Emotional Wellbeing," *Nursing and Health Sciences*, vol. 22, no. 2 (June 2020), pp. 184-196; and Peter Gray, *Free to Learn: Why Unleashing the Instinct to Play Will Make Our Children Happier, More Self-Reliant, and Better Students for Life* (New York: Basic Books, 2013).

cultivate healthy youth development and prevent mental health issues from occurring. School policies that increase unstructured recess time or convert asphalt playgrounds into greener schoolyards to provide access to nature, for instance, may prove more beneficial for students than adding structured, adult-led activities to the school day.[281] (Empirical comparisons between these approaches awaits further research.)

Some upstream prevention approaches in schools focus on improving access to recreational facilities and green spaces,[282] providing mentoring programs, offering sports[283] and art activities,[284] limiting smartphone or social media use, and connecting students to civic institutions and youth-serving organizations.

What Are Other Considerations for Congress?

Timeline for effectiveness. Policymakers considering youth mental health programs using a SBMH multi-tiered system of support may note the time period for effects. Results of prevention programs are not always revealed immediately. Often, the further upstream (regarding level of risk) an intervention, the longer it may take to observe results. For instance, one study found no immediate differences in mood between students who participated in a 10-week school-based anxiety prevention program and students who did not receive the intervention.[285] However, 12 months after the program completed, participants in the program had significant reductions in anxious symptoms compared with the other students.

Delays in effects can cause a misalignment between sectors providing the investment for programs and those receiving the returns. Prevention programs delivered in one setting may actually provide the benefits to another sector. For example, SBMH programs targeting youth behavior may be a cost to schools but ultimately reduce costs for the criminal and juvenile justice systems.[286] Referred to as the *wrong pockets problem*, this discrepancy between investment and return can disincentivize sector leaders from efforts that might not deliver direct benefits to their specific sector.[287] Overcoming the wrong pockets problem in SBMH could involve collaboration

[281] Virginia C. Hodges, Erin E. Centeio, and Charles F. Morgan, "The Benefits of School Recess: A Systematic Review," *Journal of School Health*, vol. 92, no. 10 (October 2022), pp. 959-967; Amy Lieberman, April Shaw, Ashleigh Dennis, et al., *Six Policies That Advance Mental Health*, The Network for Public Health Law, Policy Brief, 2024, https://www.networkforphl.org/resources/six-policies-that-advance-mental-health/; and Rebecca A. London, "The Right to Play: Eliminating the Opportunity Gap in Elementary School Recess," *Phi Delta Kappa*, vol. 101, no. 3 (October 28, 2019).

[282] Nuria de la Osa, Jose-Blas Navarro, Eva Penelo, et al., "Long-Term Exposure to Greenspace and Anxiety from Preschool and Primary School Children," *Journal of Environmental Psychology*, vol. 93 (Feb. 2024); and Dianne A. Vella-Brodrick and Krystyna Gilowska, "Effects of Nature (Greenspace) on Cognitive Functioning in School Children and Adolescents: A Systematic Review," *Educational Psychology Review*, vol. 34 (March 19, 2022), pp. 1217-1254.

[283] See, for example, Isabelle Dore, Catherine M. Sabistan, Marie-Pierre Sylvestre, et al., "Years Participating in Sports During Childhood Predicts Mental Health in Adolescence: A 5-Year Longitudinal Study," *Journal of Adolescent Health*, vol. 64, no. 6 (June 2019).

[284] Tasha Golden, Richard W. Ordway, Susan Magsamen, et al., "Supporting Youth Mental Health with Arts-Based Strategies: A Global Perspective," *BMC Medicine*, vol. 22, no. 7 (2024).

[285] Paula M. Barrett, Sally Lock, and Lara J. Farrell, "Developmental Differences in Universal Preventive Intervention for Child Anxiety," *Clinical Child Psychology and Psychiatry*, vol. 10, no. 4 (2005), pp. 539-555.

[286] Monica Mielke and David P. Farrington, "School-Based Interventions to Reduce Suspension and Arrest: A Meta-Analysis," *Aggression and Violent Behavior*, vol. 56 (January-February 2021).

[287] See, for example, John K. Roman, *Solving the Wrong Pockets Problem*, Urban Institute, Pay for Success Initiative, September 2015, https://www.urban.org/sites/default/files/publication/71501/2000427-solving-the-wrong-pockets-problem_0.pdf.

between schools and other institutions, along with cross-sector investment through blended funding, among other possible strategies.[288]

Privacy, confidentiality, and consent. Other issues Congress may want to consider relate to privacy and consent. Typically, mental health services provided in traditional health care settings are subject to federal privacy laws, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104-191, as amended).[289] School activities, however, are subject to separate federal laws, such as the Family Educational Rights and Privacy Act (FERPA).[290] To prevent conflicts, federal policymakers might consider ways to better align federal health and school privacy laws as they relate to SBMH activities. Congress might also consider tailoring privacy laws to SBMH activities specifically, or directing relevant federal agencies to issue corresponding regulations.

Another relevant issue for Congress pertains to consent to participate in SBMH programs. While mental health services nearly always require consent from parents or guardians (and *assent* from participants who are minors),[291] universal SBMH activities integrated into school climate programs or classroom activities may not legally require the same processes. Informed consent laws are typically determined at the state level, while ethics codes related to consent and confidentiality may be determined by various trade groups governing SBMH professionals.[292] Informed consent in school settings may involve multiple stakeholders, including parents and individual students but also outside professionals delivering services, principals, and teachers. When legislating on SBMH activities, federal lawmakers may also consider pathways for students and families to opt out of activities, where appropriate.[293]

[288] Stuart Butler and Marcela Cabello, *An Antidote to the "Wrong Pockets" Problem?*, Urban Institute, Pay For Success Perspectives, October 8, 2018, https://pfs.urban.org/pay-success/pfs-perspectives/antidote-wrong-pockets-problem.html.

[289] For more information on the HIPAA privacy rule, see CRS In Focus IF12759, *The HIPAA Privacy Rule: Overview and Issues*.

[290] For more information on FERPA, see CRS Report R46799, *The Family Educational Rights and Privacy Act (FERPA): Legal Issues*.

[291] Assent is the informed agreement to participate mental health services on the basis of information that is appropriate to the child's level of cognitive and emotional development. Assent carries considerable authority but typically needs to be supplemented by informed consent, usually by the child's parents or guardian, to be fully binding. See Heike Felzmann, "Ethical Issues in School-Based Research," *Research Ethics Review*, vol. 5, no. 3 (2009), pp. 104-109.

[292] Anne Richter, My Sjunnestrand, Maria Romare Strandh, et al., "Implementing School-Based Mental Health Services: A Scoping Review of Literature Summarizing Factors That Affect Implementation," *International Journal of Environmental Research and Public Health*, vol. 19 (2022).

[293] Libby Stanford, "Despite Their Promise, School Mental Health Screenings Face Resistance," *EducationWeek*, May 5, 2023, pp. https://www.edweek.org/leadership/despite-their-promise-school-mental-health-screenings-face-resistance/2023/05.

Appendix. Federal School-Based Mental Health Programs

Table A-1 presents federal programs that support mental health services in elementary and secondary schools. The table includes the program's authorizing legislation, a brief description of relevant uses of funds, and the program's funding levels for FY2022-FY2025. The first section of the table displays programs authorized by the Elementary and Secondary Education Act (ESEA) and administered by the U.S. Department of Education (ED).[294] The second section presents programs authorized under the Public Health Service Act (PHSA) and administered by the U.S. Department of Health and Human Services (HHS).

The information presented in **Table A-1** is not a comprehensive list of all federal programs that address the mental health of school-age children, or of all federally supported school-based activities. As discussed in the "School-Based Mental Health Funding and Payment" section of this report, federal funding for SBMH activities comes from multiple sources, including Medicaid and several ED or HHS block grants to states. **Table A-1** presents federal programs that explicitly support school-based mental health services; individual programs that support teacher training or student academic achievement that may also, in part, support children's mental health; and programs designed to support children's mental health that may be implemented in community-based settings, including, but not limited to, public schools. For some of the programs included, the use of funds for mental health activities or school-based services may be one of many authorized activities under the program. Federal programs that provide services supporting individual children with mental health needs, but that do not support services broadly available within schools or that represent school-wide efforts addressing children's mental health needs, are not included.[295] Programs exclusively providing indirect federal support for SBMH, such as technical assistance, are also largely omitted.[296]

[294] The Department of Education announced in November 2025 that it is entering into interagency agreements to have other federal agencies provide services to support the administration of ED grant programs. It is beyond the scope of this report to cover those agreements.

[295] As an example, mental health services may be provided to a child with a disability served under Part B of the Individuals with Disabilities Education Act (IDEA; P.L. 108-446) as a related service specified in the child's Individualized Education Program (IEP). However, IEPs are developed only for qualifying students with disabilities and are individualized to each student's needs and goals, meaning that not every student with an IEP will receive mental health services, and IDEA, Part B funds cannot generally be used to support school-based mental health programs for children without IEPs. For more information on the IDEA and the IEP process, see CRS Report R41833, *The Individuals with Disabilities Education Act (IDEA), Part B: Key Statutory and Regulatory Provisions*.

[296] For a more comprehensive list of HHS resources, see Department of Health and Human Services, *School-Based Health Services - HHS Resources*, March 2022, https://www.hhs.gov/sites/default/files/school-based-health-services-resources.pdf.

Table A-1. Federal Programs Supporting School-Based Mental Health Services

Programs authorized by the Elementary and Secondary Education Act administered by the U.S. Department of Education and programs authorized under the Public Health Service Act administered by the U.S. Department of Health and Human Services

Program	Authorizing Legislation	Brief Description of Relevant Uses of Funds	FY2022-FY2025 Funding
Elementary and Secondary Education Act (ESEA) Programs Administered by the U.S. Department of Education (ED)			
Student Support and Academic Enrichment Grants (SSAE)	ESEA, Title IV-A, Sections 4104 and 4108	States may use funds reserved for state activities to support local educational agencies (LEAs) in implementing mental health awareness training programs and expanding access to or coordinating resources for school-based counseling and mental health programs. LEAs may use the funds for SBMH services, SBMH services partnership programs, and school counseling, among numerous other uses of funds.	FY2022: $1,280,000,000[a] FY2023: $1,380,000,000[a] FY2024: $1,380,000,000[a] FY2025: $1,380,000,000[a]
Promise Neighborhoods	ESEA, Title IV-F, Section 4624	Grantees must use funds to provide "pipeline services,"[b] which may include mental health services and support, and must facilitate the coordination of the provision of social, health, and mental health services and supports for children, their families, and community members.	FY2022: $85,000,000 FY2023: $91,000,000 FY2024: $91,000,000 FY2025: See table note [c]
Full-Service Community Schools	ESEA, Title IV-F, Section 4625	Grantees must provide "pipeline services,"[d] which may include mental health services and supports.	FY2022: $75,000,000 FY2023: $150,000,000 FY2024: $150,000,000 FY2025: See table note [c]
National Activities for School Safety *Grants to States for Emergency Management* *Mental Health Service Professional Demonstration Grants* *Project Prevent*	ESEA, Title IV-F-3, Section 4631	The Secretary of Education can use funds for grants, contracts, or cooperative agreements to carry out activities to improve students' safety and well-being. Of the current programs funded under the ESEA, Title IV-F National Activities for School Safety program, two specifically focus on school-based mental health: (1) Mental Health Service Professional Demonstration Grants, which received $63,125,000 in FY2024, and (2) School-Based Mental Health Services Grants, which received $74,645,000 in FY2024. The National Activities for School Safety programs are listed under	FY2022: $201,000,000[a] FY2023: $216,000,000[a] FY2024: $216,000,000[a] FY2025: See table note [c]

Program	Authorizing Legislation	Brief Description of Relevant Uses of Funds	FY2022-FY2025 Funding
School-Based Mental Health Services Grants *School Climate Transformation Grants*		"Safe Schools and Citizenship Education" in appropriations laws and accompanying documents.	
Project School Emergency Response to Violence (Project SERV)	ESEA, Title IV-F, Section 4631	Project SERV grants are awarded to LEAs, institutions of higher education (IHEs), and the Bureau of Indian Education (BIE) for schools that have experienced a violent or traumatic crisis to initiate or strengthen violence prevention programs and other activities designed to restore learning environments disrupted by a crisis or traumatic event. Examples of allowable services and activities related to mental health that LEAs may use Project SERV funds toward include mental health assessments, referrals, and services related to the traumatic event for students, faculty, other school personnel, and members of their immediate families; and overtime for teachers, counselors, and other staff.	FY2022: $3,753,000 FY2023: $5,000,000 FY2024: $5,000,000 FY2025: See table note [c]
Public Health Service Act (PHSA) Programs Administered by the U.S. Department of Health and Human Services (HHS)			
Federal Health Center Program	PHSA, Section 330	The Federal Health Center Program funds outpatient primary care services to four types of health centers: community health centers, health centers for the homeless, migrant health centers, and health centers for residents of public housing. Any of these entities (though it is most frequently community health centers) may operate school-based health centers that provide mental and physical health services to students. In July 2025, there were 4,490 school sites.	FY2022 Discretionary: Discretionary amount determined by formula that is based on the amount appropriated for the preceding fiscal year, with an adjustment for increases in costs per patient served and an adjustment for increases in the total number of patients served. FY2022 Mandatory: $3,905,348,000 (of which $30,000,000 is for school-based health centers).[d] FY2023 Discretionary: Discretionary amount determined by formula that is based on the amount appropriated for the preceding fiscal year, with an adjustment for increases in costs per patient served and an adjustment for increases in the total number of patients served. FY2023 Mandatory: $3,905,348,000 (of which $55,000,000 is for school-based health centers).[d]

Program	Authorizing Legislation	Brief Description of Relevant Uses of Funds	FY2022-FY2025 Funding
			FY2024 Discretionary: Discretionary amount determined by formula that is based on the amount appropriated for the preceding fiscal year, with an adjustment for increases in costs per patient served and an adjustment for increases in the total number of patients served. FY2024 Mandatory: $5,400,000,000 (estimated) (of which $55,000,000 is for school-based health centers).[d]
Community Mental Health Services Block Grant (MHBG)	PHSA, Section 1911 et seq.	The MHBG supports community mental health services for adults and children. SAMHSA distributes MHBG funds to states according to a formula specified in statute. Each state may distribute MHBG funds to local government entities and nongovernmental organizations—which may include SEAs or LEAs—to provide outpatient community mental health services, including those that may be provided in schools. States have flexibility in the use of MHBG funds within the framework of the state plan and federal requirements.	FY2022: $857,571,000 FY2023: $1,007,571,000 FY2024: $1,007,571,000 FY2025: $1,007,571,000
Substance Use Prevention, Treatment, & Recovery Block Grant (SUBG)	PHSA, Section 1921 et seq.	The SUBG (or SUPTRS) supports services to prevent and treat substance use disorders. SAMHSA distributes SUBG funds to states according to a formula specified in statute. Each state may distribute SUBG funds to local government entities, service providers, and administrative service organizations—which may include SEAs or LEAs—for substance use prevention and treatment activities, including those that may be provided in schools. States have flexibility in the use of SUBG funds within the framework of the state plan and federal requirements.	FY2022: $1,908,079,000 FY2023: $2,008,079,000 FY2024: $2,008,079,000 FY2025: $2,008,079,000
Youth Prevention and Recovery	PHSA, Section 514 (as amended by P.L. 115-271)	Section 7102 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271) amended Section 514 of the PHSA (42 U.S.C. 290bb-7) to establish a grant program that explicitly supports evidence-based substance use disorder prevention, treatment, and recovery programs for	FY2022: $0 FY2023: $2,000,000 FY2024: $2,000,000 FY2025: See table note [c]

Program	Authorizing Legislation	Brief Description of Relevant Uses of Funds	FY2022-FY2025 Funding
		children, adolescents, and young adults. Since FY2023, the Secretary of HHS, in consultation with ED, has awarded competitive three-year grants to specified eligible educational or community-based entities such as LEAs, SEAs, and institutes of higher education, among others.	
Strategic Prevention Framework	PHSA, Section 516	Administered by SAMHSA, the Strategic Prevention Framework (SPF) supports the development and delivery of substance misuse prevention and mental health promotion services.[e] SAMHSA awards SPF grants to states and communities that commonly collaborate with SEAs, LEAs, and schools.	FY2022: $10,000,000 FY2023: $10,000,000 FY2024: $10,000,000 FY2025: See table note [c]
Project AWARE State Grants	PHSA, Section 520A	Project AWARE State Grants consist of competitive grants for school-based mental health programs and services. The state grants—the largest component of Project AWARE—aim to build SEA capacity, in partnership with state mental health agencies, to (1) increase mental health awareness among school-aged youth, (2) provide training for school personnel to identify mental health issues, and (3) connect school-aged youth and families with needed services.[f]	FY2022: $100,501,000[a] FY2023: $110,501,000[a] FY2024: $110,501,000[a] FY2025: See table note [c]
Trauma-Informed Services in Schools	SUPPORT Act, Section 7134 PHSA, Section 520A	Established in FY2022, School-Based Trauma-Informed Support Services and Mental Health Care for Children and Youth (Trauma-Informed Services in Schools) grants are awarded to LEAs, SEAs, and tribal entities to support student access to evidence-based, culturally relevant, and trauma-informed mental health care with the purpose of improving identification, referral, early intervention, treatment, and support services for students that need specialized support. The Trauma-Informed Services in Schools grants are administered as part of Project AWARE.	FY2022: $7,000,000[a] FY2023: $12,000,000[a] FY2024: $12,000,000[a] FY2025: See table note [c]
Resiliency in Communities After Stress and Trauma (ReCAST) Grants	PHSA, Section 520A	The purpose of the ReCAST program is to assist high-risk youth and families to promote (1) resilience and equity in communities that have recently faced civil unrest through implementation of evidence-based violence prevention and youth engagement programs,	FY2022: $12,500,000[a] FY2023: $17,500,000[a] FY2024: $17,500,000[a]

Program	Authorizing Legislation	Brief Description of Relevant Uses of Funds	FY2022-FY2025 Funding
		and (2) linkages to trauma-informed behavioral health services. The ReCAST grants are administered as part of Project AWARE.[f]	FY2025: See table note [c]
Mental Health Awareness Training (MHAT)	PHSA, Section 520J	The Mental Health Awareness Training (MHAT) program provides training to teachers and school personnel (among others) on how to recognize a mental illness, provide initial help in a mental health crisis, and connect individuals to appropriate care through Mental Health First Aid training. Originally part of Project AWARE, the MHAT program received its own authorization in the PHSA via the 21st Century Cures Act (P.L. 114-255).[f]	FY2022: $24,945,000[a] FY2023: $27,963,000[a] FY2024: $27,963,000[a] FY2025: See table note [c]
Seclusion and Restraint	PHSA, Section 520A	SAMHSA funds a regionally based technical assistance effort focused on providing supports and services for individuals living with mental disorders, including schoolchildren. The purpose of the network is to disseminate trauma-informed practices and promote alternatives to restraint, seclusion, and other coercive practices.	FY2022: $1,147,000 FY2023: $1,147,000 FY2024: $1,147,000 FY2025: See table note [c]
Project LAUNCH	PHSA, Section 520A	Project LAUNCH is a collaborative PHS Agency initiative providing grants to states for activities promoting the wellness of young children ages birth to eight years by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development to ensure children enter school ready to learn and succeed. Project LAUNCH includes workforce development initiatives to train teachers and early education providers in children's social-emotional functioning. Activities also include school-based screenings for children and mental health consultation to early childhood education programs and elementary schools.	FY2022: $23,605,000 FY2023: $25,605,000 FY2024: $23,605,000 FY2025: See table note [c]
Children's Mental Health Initiative (CMHI)	PHSA, Sections 561-565	Within the Children's Mental Health Initiative, the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbance (Systems of Care Expansion and Sustainability Grants) grants support systems of care for children with serious	FY2022: $125,000,000 FY2023: $130,000,000 FY2024: $130,000,000

Program	Authorizing Legislation	Brief Description of Relevant Uses of Funds	FY2022-FY2025 Funding
		emotional disturbances. Funds are used to create infrastructure and facilitate access to community-based or school-based mental health services. Educational professionals also coordinate with CMHI-funded systems of care for referrals, service planning meetings, and evaluation of outcomes.	FY2025: See table note [c]
National Child Traumatic Stress Initiative (NCTSI)	PHSA, Section 582	Through the NCTSI, SAMHSA provides grants, education and training, technical support, data collection, evaluation services, and information on evidence-based interventions for trauma care for use in child mental health clinics, schools, child welfare, and juvenile justice settings. Grantees include state and local governments, universities, and other organizations (42 U.S.C. 290hh-1).[g]	FY2022: $81,887,000 FY2023: $93,887,000 FY2024: $98,887,000 FY2025: $98,887,000
What Works in Schools	PHSA, Section 301(a) PHSA, Section 317(k)(2)	Administered by the Division of Adolescent and School Health (DASH) within the Centers for Disease Control and Prevention (CDC), the *What Works in Schools* program helps promote adolescent health and well-being in schools. As part of CDC's school health activities, What Works in Schools funding supports implementation of primary prevention programs and school-based surveillance of youth health and well-being. Activities include professional development for school personnel, assessment of student access to school and community-based services, and health education instructional programs, among others.	FY2022: $17,400,000 FY2023: $19,400,000 FY2024: $19,400,000 FY2025: See table note [c]

Source: Table prepared by the Congressional Research Service using relevant legislation and materials from ED and HHS.

Notes: While most federal grants for SBMH activities are administered by ED and HHS, some grant programs administered by other executive branch agencies, such as those within the Department of Justice, may support related activities, including those pertaining to school safety, bullying, or delinquent behavior. For more information on these programs, see CRS Report R46872, *Federal Support for School Safety and Security*. Of note, the Department of Education announced in November 2025 that it is entering into interagency agreements to have other federal agencies provide services to support the administration of ED grant programs. It is beyond the scope of this report to cover those agreements. It is beyond the scope of this report to cover those agreements. CDC=Centers for Disease Control and Prevention; ED=U.S. Department of Education; ESEA=Elementary and Secondary Education Act; HHS=U.S. Department of Health and Human Services; LEA=Local Educational Agency; PRNS=Programs of Regional and National Significance; PHSA=Public Health Service Act; SAMHSA=Substance Abuse and Mental Health Services Administration; SEA=State Educational Agency.

a. In addition to funding provided through annual appropriations, this program also received funding through direct appropriations provided in the Bipartisan Safer Communities Act (P.L. 117-159). For more information on the amount, see CRS Report R47310, *Bipartisan Safer Communities Act (P.L. 117-159): Section-by-Section Summary*.

b. "The term 'pipeline services' means a continuum of coordinated supports, services, and opportunities for children from birth through entry into and success in postsecondary education, and career attainment." 20 U.S.C. 7272(3).

c. Full-year FY2025 appropriations for HHS and ED programs were funded under the Full-Year Continuing Appropriations and Extensions Act, 2025 (P.L. 119-4). Funding distribution amounts for individual programs, projects, or activities are typically specified in report language or explanatory statements accompanying annual appropriations laws. In general, the FY2025 full-year CR funded discretionary programs at the same level and under the same conditions as in FY2024, though no accompanying report or explanatory statement specified PPA amounts. This approach differs from how regular annual appropriations acts specify funding, and presents challenges in determining FY2025 LHHS funding levels. For more information, see CRS Report R48598, *Overview of FY2025 Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations*.

d. Health centers can operate school-based health centers using funding beyond the amount explicitly reserved for school-based health centers. For information about mandatory funding for health centers, see CRS Report R45136, *Bipartisan Budget Act of 2018 (P.L. 115-123): CHIP, Public Health, Home Visiting, and Medicaid Provisions in Division E*.

e. Substance Abuse and Mental Health Services Administration, Justification of Estimates for Appropriations Committees for FY2025, https://www.samhsa.gov/sites/default/files/samhsa-fy-2025-cj.pdf.

f. For more information on Project AWARE, see CRS In Focus IF12478, *Project AWARE*.

g. U.S. Department of Health and Human Services, SAMHSA, *About NCTSI*, Programs and Campaigns, Rockville, MD, August 7, 2023, https://www.samhsa.gov/child-trauma/about-nctsi.

List of Citations from Figure 8

1. Nicholas S. Ialongo, Lisa Werthamer, Sheppard G. Kellam, et al., "Proximal Impact of Two First-Grade Preventive Interventions on the Early Risk Behaviors for Later Substance Abuse, Depression, and Antisocial Behavior," *American Journal of Community Psychology*, vol. 27, no. 5 (1999), pp. 599-641.
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Table A-2. Abbreviations Used in This Report

Abbreviation	Definition
BSCA	Bipartisan Safer Communities Act
CASEL	Collaborative for Academic, Social, and Emotional Learning
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
DASH	Division of Adolescent and School Health
DHS	U.S. Department of Homeland Security
DOJ	U.S. Department of Justice
EAPs	Employee Assistance Programs
EBPs	Evidence-Based Programs and Practices
ED	U.S. Department of Education
ESEA	Elementary and Secondary Education Act
ESSA	Every Student Succeeds Act
FAPE	Free Appropriate Public Education
FERPA	Family Educational Rights and Privacy Act
GBG	Good Behavior Game
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Plan
IES	Institute of Education Statistics
IHE	Institutions of Higher Education
LEA	Local Educational Agency
MHAT	Mental Health Awareness Training
MHBG	Community Mental Health Services Block Grant
MTSS	Multi-Tiered System of Support
NASEM	National Academies of Science, Engineering, and Medicine
NCES	National Center for Education Statistics
NCTSI	National Child Traumatic Stress Initiative
NREPP	National Registry of Evidence-based Programs and Practices
PBIS	Positive Behavioral Interventions and Supports
PHSA	Public Health Service Act
PRNS	Programs of Regional and National Significance
ReCAST	Resiliency in Communities After Stress and Trauma
RTI	Response to Intervention

SAMHSA	Substance Abuse and Mental Health Services Administration
SBMH	School-Based Mental Health
SEA	State Educational Agency
SEL	Social and Emotional Learning
SPF	Strategic Prevention Framework
SUBG (or SUPTRS)	Substance Use Prevention, Treatment, and Recovery Block Grant
U.S.C.	*United States Code*
WWC	What Works Clearinghouse

Source: Congressional Research Service.

Author Information

Johnathan H. Duff
Specialist in Health Policy

Kyrie E. Dragoo
Analyst in Education Policy

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