Advancing Measurement-Based Care in School Mental Health

2025

Part of the *Advancing Crisis Care and Beyond* series on next steps for promoting safety and fostering well-being

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Advancing Measurement-Based Care in School Mental Health

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Abstract

More children's mental health services are provided in schools than in any other child-serving setting, but the quality of care—including availability of evidence-based practices—is highly variable. In the context of rising unmet children's mental healthcare needs, schools are a logical setting to invest in strategies to ensure that the services children and families are most likely to receive are of high quality. Measurement-based care (MBC) is one evidence-based clinical practice to improve the quality of school mental health early intervention and treatment services delivered by school- or community-employed clinicians. This review summarizes the research evidence supporting MBC with children, the value and fit of MBC in schools, and considerations for MBC implementation in the school context. Drawing from practical examples, policy and financing recommendations are also included to inform systems change efforts led by mental health and education partners to advance MBC in schools.

Highlights

- Investing in ways to improve mental healthcare quality in schools is imperative as schools provide more children's mental health services than any other child-serving setting.
- MBC is well suited to school mental health care, where students are diverse and present with a range of strengths and needs.
- Evidence of MBC implementation and effectiveness in specialty mental healthcare settings can inform research, practice, and policy to increase adoption of MBC in schools.
- Successful MBC implementation in schools requires attention to barriers and opportunities at the levels of the student, family, clinician, school, and system.
- Recent state legislative and funding efforts that support school mental health intervention progress monitoring offer exemplars for advancing MBC in schools.

Recommendations

1. Learn about and communicate the value of MBC to state leadership, clinicians, community partners, students, and their caregivers by focusing on collaborative, data-informed, family-centered clinical decision-making.
2. Provide access to brief and validated progress measures with ongoing professional development to support their data collection, scoring, interpretation, and use in school mental health interventions.
3. Encourage and/or require that special education and behavioral health system records contain documentation of routine progress measurement data collection and use.
4. Advocate for local and state policies and legislation to incentivize and promote implementation of MBC in schools.

Introduction

Although one in five children and adolescents experience a diagnosable mental health condition, fewer than half of these receive needed services.[1,2,3] Of those who do receive services, disparities in access to and engagement in care are persistent, with racial and ethnic minoritized youth less likely to initiate or stay in treatment.[4] Unmet mental health needs of children and their families in the United States have been further exacerbated by the COVID-19 pandemic, and children's mental health is currently recognized as a national emergency.[5,6] The children's mental health crisis in the United States reflects a broader global phenomenon, with the increasing need for mental health care outpacing available resources worldwide.[7] From a systems perspective, this gap is a call to action to identify and invest in innovative solutions to ensure that all children and their families are receiving needed services.

Schools continue to provide more mental health services than any other child-serving sector in the United States.[8,9] School mental health service utilization is most pronounced among Black youth and youth in low-income families, further signaling how critical the school setting is to addressing the crisis in children's mental health, including inequities in access to care.[10] Although access to services is often made possible through schools, effective and evidence-based interventions are inconsistently implemented in school mental health practice.[11] These factors raise questions for school and education system leaders about how to improve the consistent delivery of high-quality mental health services in schools. State mental health leaders and policymakers, likewise, have been called on to invest in effective models of mental healthcare delivery in schools, where such services are most accessible to children and families.

The implementation gap found in schools can also occur in specialty mental healthcare systems such as community child guidance clinics, so some of the solutions to increase care quality through improved implementation are likely similar across school and community settings. However, schools are a nontraditional mental healthcare setting, focused primarily on education, presenting unique contextual factors and barriers to systematic implementation of high-quality mental health services. Also, evidence-based interventions are only one aspect of effective care in schools.[12,13,14] Multiple dimensions of care, including flexible treatment delivery and family engagement, must be included to improve outcomes.[15,16]

Advancing Measurement-Based Care in School Mental Health is part of the 2025 Technical Assistance Coalition paper series Advancing Crisis Care and Beyond: Promoting Safety and Fostering Well-Being. This series aims to build upon the work being done to implement the 988 Suicide & Crisis Lifeline and the behavioral health services continuum that complements it, while pushing forward progress in prevention, safety, resiliency, and recovery. Beginning with the "umbrella paper" that covers leading policy themes related to each of the subsequent papers, the series highlights key areas of consideration and puts forth recommendations for specific strategies to advance crisis care, promote personal and community safety, and foster well-being.

What Is Measurement-Based Care?

Measurement-based care (MBC) is an evidence-based clinical practice that has been recommended to improve mental healthcare quality,[17,18] including the quality of care for children and their families.[19,20] MBC is the routine collection and use of patient-reported outcome measures (PROMs) to inform intervention planning, progress monitoring, and treatment plan adjustments.[21] Although there has been some lack of consensus on MBC definitions and terminology,[22] the Collect, Share, Act model of MBC has emerged as a leading national framework to clarify and disseminate the core components of this practice to clinicians.[23] Collect, Share, Act emphasizes providing clinicians with a clear rationale for the use of PROMs, selecting measures with the person being served to align with their personal goals, administering PROMs regularly, sharing data with the individual in care, verifying to what degree the data matches their subjective experience of care, and appraising progress and making decisions together about treatment adjustments.[24] Importantly, research on progress feedback underscores that collection and use of PROMs is more effective when it is a collaborative effort between the person being served and the clinician to promote transparency, communication, and shared decision-making.[25] MBC typically involves collecting standardized, diagnosis-specific symptom PROMs[26] that can include measures of life quality, functioning, goal attainment, and therapeutic alliance.[27] Therapeutic alliance is the collaborative bond between the person being served and the therapist; it has been shown to predict treatment outcomes.[28] In child psychotherapy, caregiver-reported alliance with the therapist also matters, as it predicts treatment engagement and can be measured with parallel forms.[29] Clinicians using MBC should take 5 minutes at the start of a session to complete a brief PROM, view results, discuss the person's experience of progress, and decide together on any treatment adjustments. Alternatively, alliance measures are sometimes collected and discussed at the end of a session.

Patient-reported outcome measures (PROMs) are standardized questionnaires for clients to self-report their health quality of life. At the individual level, they support patient-centered care. At the aggregate level, PROMs can inform quality improvements.

Examples of PROMs for youth mental health include these:

- The Young Person's CORE
- PROMIS (Patient-Reported Outcomes Measurement Information System) Measures
- Patient Health Questionnaire for Adolescents (PHQ-A; see Appendix A)
- Revised Children's Anxiety and Depression Scale
- Pediatric Symptom Checklist
- Vanderbilt Assessment Scale

Resource: The SHAPE System Screening and Assessment Library is a searchable repository of free or low-cost PROMs appropriate for school mental health. Each measure has been reviewed by the National Center for School Mental Health and is summarized with sample items, scoring information, and links to the measures in brief two-page guides. Access this resource by creating a free account at www.theshapesystem.com.

Of the domains included in the Institute of Medicine's healthcare quality framework,[30] MBC addresses effectiveness, patient-centeredness, and equity.[31] SAMHSA's Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) released a report on MBC[32] featuring numerous national examples of MBC in use in community behavioral health and public healthcare systems, such as those of the Veterans Administration, Department of Defense, Federally Qualified Health Centers, and Kaiser Permanente. Such examples align with the ISMICC's work to promote data-driven services and supports for people with serious mental illness and serious emotional disturbance, as outlined in its 2024 report to Congress.[33] The momentum of MBC among behavioral healthcare systems as well as the growing evidence base of MBC with children and adolescents (reviewed below) offers a natural foundation to realize the promise of MBC to improve school mental health treatment quality.

The Value of Measurement-Based Care in Schools

Comprehensive school mental health systems offer a full continuum of multitiered supports, including universal prevention for all students (Tier 1), targeted early intervention for students with mild impairment or showing early signs of risk for developing a mental health condition (Tier 2), and treatment services for students with an identified mental health diagnosis or disability (Tier 3).[34] Community partnerships are a hallmark of comprehensive school mental health systems to augment the capacity of the education system to meet the wide array of social, emotional, and behavioral health needs of students. Therefore, Tier 2 and 3 services and supports are delivered by school-based mental health professionals, who can be either school-employed (e.g., school counselors, school psychologists, and school social workers, often but not always serving students in special education), or by professionals who are community-employed and contracted or otherwise approved to deliver mental health treatment on school grounds (e.g., professional counselors, social workers, psychologists, or psychiatrists, often but not always for students in general education). Community partners sometimes deliver school-based services at a school-based health center (SBHC); however, given that only about 3% of schools have established SBHCs, often school buildings and systems contract directly with community mental health organizations that offer services on campus outside of a formal clinic or center.[35] The community-partnered school behavioral health model to expand and augment the capacity of school-employed mental health professionals has been established for decades.[36] Recent investments such as the Bipartisan Safer Communities Act have provided funding to further expand equitable access to community providers on school campuses across the country.[37] MBC in schools applies only to Tier 2 and 3 supports in the form on ongoing individual, group, and/or family interventions delivered by a school-based mental health professional to reduce symptoms or improve functioning related to identified targets or goals. Hereafter, we refer to MBC's application to school mental health treatment to clarify the relevant type of school mental health supports within the multitiered system.

When done well, MBC has the potential to increase the impact of mental health treatment in schools and is aligned with the way mental health services are delivered in the education system. For example, in a recent school-based MBC implementation pilot, clinicians delivering individual and group interventions reported that collecting and using progress measures promotes effectiveness of interventions by providing structure, consistency, and clinically valuable information.[38] School clinicians also reported that MBC supported a patient-centered approach to care by increasing transparency as well as child and caregiver engagement.[39] Middle and high school students who received school-based counseling with MBC reported that the use of measures and sharing of feedback made their sessions more helpful.[40] Indeed, MBC is already recognized as a person-centered practice that can improve outcomes in traditional mental healthcare settings through mechanisms of engagement, alliance, and

experience of care,[41] and a recent meta-analysis of 58 youth and adult studies, mainly in outpatient settings, found that dropout was reduced by 20 percent when progress feedback was used.[42] Also, new implementation of standardized assessments in a large network of community-partnered school mental health clinicians was reported to have a positive impact on rapport with the caregiver and student.[43] The potential impact of MBC on authentic student and caregiver engagement in services could be one strategy to address the long-standing challenge in school mental health care of including caregivers as coequal partners in the intervention process.[44]

MBC is also well suited to some of the typical mental health interventions provided by school-based clinicians and is at home in a culture and climate supportive of data-informed decision-making through progress monitoring in school mental health.[45,46,47] In school mental health treatment services, students present with various concerns, disabilities or diagnoses, severity of symptoms, and social determinants of health,[48] and clinician practices and training in evidence-based approaches vary widely.[49,50] MBC can be added to any treatment plan[51] and presents a systemwide quality-of-care approach to support all providers.[52,53,54] School clinicians are a heterogenous workforce based on their discipline and whether they are school- or community-employed.[55,56] In school-based settings, MBC is a student and family–centered, data-informed practice for students in general education or special education, and by professionals, either school- or community-employed, who provide services on school grounds.

“The potential impact of MBC on authentic student and caregiver engagement in services could be one strategy to address the long-standing challenge in school mental health care of including caregivers as coequal partners in the intervention process.

In addition, as a “minimal intervention needed for change” to support the individual’s involvement in treatment processes and decisions,[57,58] MBC is a good fit for schools, which have limited resources and infrastructure to support costly evidence-based interventions. Data system infrastructure for digital measure collection with graphical displays and decision support may be helpful for some clinicians and students, but results are mixed given the additional learning curve associated with new data systems. Fortunately, such systems are not necessary for MBC, a clinical practice that can occur effectively with paper-and-pencil administration and use.[59,60] As with any practice change or new implementation, school systems will of course have to invest in adequate training and ongoing support to promote implementation and sustainability.

Finally, MBC also fits among related data-informed decision-making practices in comprehensive school mental health. Data-informed decision-making is emphasized in national best practices for comprehensive school mental health systems as well as in professional guidelines for school psychologists, counselors, and social workers. Data-informed decision-making encompasses a wide array of practices including initial screening or systematic identification of students potentially in need of additional mental health supports; initial assessment of student strengths and needs to match students to appropriate services; and data-informed goal identification in partnership with students, families, and teachers. At the local level, MBC follows the initial assessment and goal identification for students in early intervention or treatment services; it offers a route for collaborative progress monitoring of the goals over time through student, parent, and (when appropriate) teacher reporting. Federal legislation supports progress monitoring in schools to inform shared, data-informed decision-making about students’ response to interventions.[61] Although this establishes a clear foundation for MBC in schools, data-informed decision-making is a challenge to implement in practice. “Usual care” school and community clinician decisions are often driven by crises, progress note review, or clinician memory.

Also, progress monitoring in schools—particularly in special education—is usually based on observable student behavior and best suited to monitoring inattention, disruptive behavior, and social skills. It often omits measures and practices to assess progress on goals related to symptoms of depression, anxiety, trauma, or other internal emotional functioning treatment targets. MBC thus offers a relative advantage over "usual care" practice in schools by offering a tangible practice to increase use of student- and parent-reported progress data in decisions about interventions.[62]

This review summarizes the research evidence supporting MBC with children and families, the value of MBC in schools, and considerations for MBC implementation in the school context. Drawing from practical examples, policy and financing recommendations are also included to inform systems change efforts led by mental health and education partners.

EVIDENCE FOR MEASUREMENT-BASED CARE

While research on successful implementation of and subsequent student outcomes associated with MBC in schools is still in its early stages, there is robust evidence to suggest that individuals do better in mental health care when providers integrate MBC. Numerous reviews and meta-analyses demonstrate that "usual care" services with MBC are associated with improved mental health outcomes, clinicians' ability to detect deterioration earlier on, better communication between provider and person being served, and increased retention in services.[63,64,65,66,67] MBC use in mental health care is also associated with faster goal attainment and symptom reduction, compared with mental health care without MBC.[68] The greater improvements with MBC tend to be for people not progressing as expected, because MBC offers an early "signal alarm" to clinicians to adjust treatment to be more personalized and thus more effective.[69] Two recent, large-scale randomized controlled trials found significantly lower dropout rates and greater symptom reduction with client feedback.[70,71]

Although the majority of evidence supporting MBC is with adult populations, similar results with children and adolescents are emerging,[72] including faster symptom improvement and a dose-response effect (i.e., the more often MBC is used, the greater the improvements).[73,74,75] In fact, a recent meta-analysis of 31 studies on MBC using a measurement feedback system found significantly larger effects for children and adolescents than for adults.[76] MBC at each encounter, timely review and use of progress data, and use of MBC data results to adjust care are the practices associated with the strongest effects on outcomes.[77] A rigorous study with 138 ethnoracially diverse children ages 5–15 found that when child- and caregiver-reported progress measures were used to personalize care, those children had better attendance and their symptoms improved faster than those of children in treatment without MBC.[78] Most of the evidence on MBC with children and adolescents is derived from research studies on individual therapy provided in university clinics and/or community behavioral health settings, using a relatively small handful of validated progress measures.[79,80,81,82]

EVIDENCE FOR MEASUREMENT-BASED CARE IN SCHOOLS

Research evidence on student outcomes associated with MBC in school mental health treatment is still very early in its development. For example, student outcomes associated with MBC were included in a dissertation conducted in three therapeutic day schools in the United States,[83] and two other studies have been conducted in the United Kingdom using the Partners for Change Outcome Measures.[84,85] Together, these studies show an initial or sustained reduction in symptoms with MBC, though patterns of outcomes vary by student, caregiver, and/or therapist report, which is common in child psychotherapy.[86] A recent large-scale study of 701 students receiving MBC in group treatment in 58

primary schools in Norway did not show significant added benefit to student outcomes with MBC, but detection of effects was likely limited by low implementation and measurement challenges.[87]

Given the unique challenges of mental health treatment implementation in school settings, and the necessity of implementing MBC to measure child outcomes, most domestic MBC research in schools has focused on its implementation among school providers, rather than on its effectiveness in terms of student outcomes. These implementation studies include school clinician–reported barriers and facilitators to MBC in the school context, some of which are described below in the discussion of considerations for MBC implementation in schools.[88] There are also preliminary studies on the use of measurement feedback systems to support MBC data collection, visualization, and decision-making in schools[89,90,91]; school clinician implementation outcomes associated with brief online training and post-training consultation[92]; and an equity-focused implementation strategy to improve MBC with racial and ethnic minoritized students.[93] Most of this foundational MBC implementation research in schools has been with school mental health clinicians opting to participate in funded research studies.

The next step to advance MBC in schools is to explore systemwide implementation solutions and innovations to introduce this practice under the typical conditions of a school mental health system. Two systemwide demonstrations of MBC with school district leaders and community-partnered clinicians in Maryland showed promising adoption of standardized assessments, but there was no strong emphasis on ongoing collection, discussion, and use of measures throughout the school year. In one school-year pilot, standardized mental health assessments were implemented with 95 clinicians in 4 community behavioral health organizations serving 97 schools,[94] with 71.4 percent data submission for 88 students.[95] In another study, MBC scale-up in a large public school district using a measurement feedback system with 80 school-based clinicians from 5 community mental health organizations serving about 2,000 students showed increases in clinician fidelity and child effect sizes each year.[96,97] A greater number of sessions with outcome measures was significantly related to better student outcomes. In the 3rd year of implementation, clinicians who logged into the feedback system at least 24 times had larger average outcome improvements across students than are usually seen in published child psychotherapy research.[98,99] These improvements were measured based on a severity-adjusted effect size using a standardized measure of global child symptoms, social skills, and functioning called the Client Feedback Form.

Perhaps one of the most impactful areas for advancement of MBC in schools is rolling out MBC across an entire school system. Although research studies have uncovered important considerations for MBC training of school professionals while understanding what barriers and facilitators they face, school systems adopting MBC need pragmatic guidance on launching MBC for everyone. A multicomponent implementation strategy package for districtwide MBC rollout in schools has also been developed, based on a national sample of stakeholder feedback; it has undergone initial pilot testing in two Connecticut school districts.[100,101] This implementation strategy package is called Feedback and Outcomes for Clinically Useful Student Services (FOCUSS) and includes six strategies:

1. Assess clinician readiness
2. Identify and prepare clinicians
3. Develop a usable implementation plan
4. Provide initial MBC practice training
5. Provide access to and ongoing training on use of a feedback system

6. Offer post-training group consultation
7. Give performance feedback to individual clinicians

In summary, evidence for MBC in schools is emerging, and continued research–practice partnerships are needed to further develop the evidence base for effective implementation strategies and impact on student outcomes. Hybrid designs to study implementation and effectiveness as well as mixed-methods research including student, caregiver, and clinician perspectives are recommended to advance the evidence for MBC in schools.

Considerations for MBC Implementation in Schools

Because of primary and secondary schools' potential to reach students and achieve positive mental health outcomes with the integration of high-quality services, it is not surprising that the initial focus on MBC in schools has been on implementation. Understanding the levers of MBC implementation is a necessary first step to establish this practice and then be able to assess the effect of MBC on student outcomes. Also, the implementation context for behavioral health interventions in schools is unique because school is a nontraditional mental healthcare delivery setting.[102,103] MBC barriers in schools are similar to those in community-based behavioral healthcare settings but have unique factors in terms of limited access to measures, limited resources to support administration and scoring of measures, and difficulty obtaining caregiver-reported data.[104] Multilevel, multicomponent implementation strategies optimize the likelihood of addressing these barriers and reaching desired patient outcomes.[105,106,107,108] **Table 1** offers a list of school context–specific best practices for clinicians and school system leaders in MBC implementation. The discussion that follows offers considerations for implementing MBC in the school context, drawn from research and practice literature on both MBC and school mental health.

Table 1: MBC Best Practices Specific to School Mental Health Care

Role	Best Practice
Clinicians	Introduce MBC to students and caregivers in the beginning of the school year and discuss how it fits with their prior experiences and expectations of treatment
	Communicate that MBC is intended to center student and family voice and active partnership in their services
	Develop intervention goals and objectives transparently with students and caregivers so everyone is aware of the purpose of the school-based intervention(s)
	Select brief measures with student and caregiver input to match intervention goals and objectives
	Collect data from multiple reporters and explore discrepancies to build a shared understanding of different perspectives through collaborative discussion
	Offer flexible data completion options for caregivers (e.g., over the phone) and teachers (e.g., in person, electronically) and share feedback in real time or as soon as possible
	Bring progress data to student team meetings to inform intervention adjustments, including data-informed "graduation" from interventions when goals are met

Role	Best Practice
School System Leaders	Offer a short menu of progress measure options for clinicians, students, and caregivers to flexibly select what best suits the intervention goals
	Provide ongoing professional development including expert and peer consultation with case review
	Reduce burdensome documentation including allowing for paper-and-pencil initiation of MBC when desired to help clinicians integrate MBC into their workflows
	Identify and support the professional development of eager clinician champions and/or district-employed leaders to build internal capacity for training and consultation
	Assess clinician-reported barriers and facilitators to select and/or develop tailored implementation solutions
	If data aggregation for outcome monitoring is a long-term goal of MBC, allow for several years of implementation supports to establish clinician practices first
	Monitor and act to reduce amount of time spent on nonclinical duties and other competing priorities that impede MBC and other evidence-based approaches to early intervention and treatment services

STUDENT AND FAMILY FACTORS

There is a higher proportion of underrepresented and minoritized children among those whose mental health needs are served in schools than among those using community clinics. Similarly, underserved populations, particularly students and families who identify as racial and ethnic minorities and those from low-income households, tend to access more of their mental health services in schools than in community mental health settings.[109,110] Schools are also the de facto setting for mental health care in rural and urban communities with higher rates of poverty and/or lack of access to outpatient behavioral health providers.[111,112] Therefore, children and families accessing school mental health services may be particularly likely to experience barriers to traditional mental health care such as stigma and healthcare mistrust due to systemic and structural discrimination. As a result, culturally responsive care is especially important in school mental health treatment. For these reasons, MBC in schools should be delivered in a culturally responsive manner and in the context of culturally responsive treatment services.[113] Some proposed culturally responsive MBC practices include, but are not limited to, providing clinicians with a clear rationale for MBC, emphasizing the importance of student and family voice in their own services, assessing the child's or family's treatment expectations, and selecting measures that capture progress on both individualized goals and therapeutic alliance.[114,115] Clinicians should seek to understand and address student and family treatment expectations and perspectives such as hesitation about data collection, storage, and use. Caregiver engagement is also different in school mental health than in clinic-based services, because students are seen by their clinician during the school day and can be initially referred by teachers or other school staff. These factors necessitate intentional outreach, partnership, and communication with families to invite their involvement in goal setting and progress monitoring through MBC. Fortunately, MBC can be leveraged as a practical, concrete tool for clinicians to develop authentic partnerships with youth, their families, teachers, and community mental health providers.

CLINICIAN FACTORS

For more about improving the crisis system for children, youth, and their families, see another paper in the 2025 "Advancing Crisis Care and Beyond series, *A Safe Place for Help: Supporting Children and Youth and Their Families With the Crisis Services Continuum*.

Despite the emphasis in schools on data-informed decision-making about student intervention selection and adjustment over time, school mental health providers are less likely to collect standardized progress measures than clinic-based mental health providers.[116] This may be due to a variety of factors related to the challenging position of delivering a full array of multitiered mental health prevention and intervention programs in an education setting. Indeed, school clinicians who are school- or community-employed have expanded roles to include universal mental health promotion (Tier 1), early intervention groups and brief interventions (Tier 2), treatment services for students identified with mental health needs (Tier 3), behavioral health crisis response, and nonclinical and administrative duties. Moreover, school clinicians in an education setting may have limited access to preservice training or ongoing professional development in evidence-based mental health interventions and progress monitoring.[117] The expansive role of a school mental health clinician must be taken into account when implementing any new practice, including MBC, to improve care quality and equity for students and families. Clinical supervision and case consultation has been found to be particularly supportive of clinicians learning MBC.[118] School mental health professionals sometimes receive clinical support and information from district or community behavioral health leaders about key initiatives to improve care quality, but they are evaluated by the building principals who oversee their day-to-day duties on campus.[119] This supervisory structure can be complex for school clinicians to navigate as they provide mental health services in an educational setting. District and building administrators should collaborate and coordinate their oversight of school clinicians to clarify priorities, duties, and sources of support for clinical (including MBC) and nonclinical duties.

SCHOOL CONTEXTUAL FACTORS

A range of contextual factors make a school, as compared with a traditional mental healthcare setting, a unique place to implement any evidence-based mental health practice.[120,121] There are several school contextual factors that specifically influence MBC. First, attention to the school calendar is imperative in any school implementation effort. Initial training for school clinicians is often best provided at the beginning of the school year, with ongoing support that is sensitive to school breaks and other disruptions in workflows due to crises, special events, and standardized testing. Also, MBC must be aligned with special education documentation, requirements, and processes when delivered by school-employed mental health professionals. Individualized education program (IEP) goals and objectives tend to be structured for observed behavioral indicators of progress instead of student-, caregiver-, or teacher-reported psychosocial progress monitoring. School-employed clinicians need specialized training and supports to integrate MBC into interventions under IEPs.[122] This integration can include rewriting IEP goals and objectives to support the use of MBC.

School-employed mental health professionals are represented by labor unions in some states. Given the ever-increasing workload on school mental health professionals, especially since COVID-19, unions are uniquely positioned to protect and support the well-being and scope of duties of these personnel. The school mental health professional workforce is also diverse in terms of discipline and therefore required to work collaboratively on multidisciplinary teams as the "front line" for children's mental health prevention, promotion, and intervention. These factors introduce an array of system-level scope-of-

practice issues around who is responsible for assessment and intervention in schools, and how professionals are supported and expected to fulfill various roles and functions in their limited time allocations.[123] Thus, mandates to use evidence-based practices such as MBC must be approached carefully and may even be subject to collective bargaining if they are required instead of encouraged or gradually phased in with tailored implementation supports.

SCHOOL MENTAL HEALTH SYSTEM EXAMPLES OF MBC IMPLEMENTATION

Practice-based examples of MBC implementation in school systems in the United States and abroad provide guideposts for continued advancement of MBC in schools. **Table 2** features exemplars to illustrate recent efforts to integrate MBC in the education system. Each example is a systemwide effort within a network of school communities across a state or a network of school boards across a province. The Ontario and Connecticut examples illustrate district-level MBC implementation efforts that focus on developing infrastructure such as data systems, staff roles, and/or other practices to integrate MBC into the school system.

Table 2: School Mental Health System Examples of MBC Implementation in Practice

Sponsor/ Funder	Partners	Data System or Platform	Details
State/Province: Connecticut[124]			
National Institute of Mental Health; Stamford Public Schools	Student Support Departments in Stamford and West Haven Public Schools	Better Outcomes Now (Partners for Change Outcome Measurement System; Outcome Rating Scale and Session Rating Scale)	• MBC pilot implementation for 1 to 3 school years with school social workers and school counselors • District leaders and clinicians voluntarily joined, based on interest in participating in an MBC implementation research study • Voluntary participation in year 1 was followed by districtwide implementation to use MBC as a quality improvement initiative • Each school year, clinicians received a 1-day training followed by monthly post-training group consultation during professional development days and other FOCUSS implementation supports
State/Province: Maryland[125]			
Maryland Community Health Resources Commission (CHRC), by the Maryland General Assembly	Maryland Consortium on Coordinated Community Supports; University of Maryland National Center for School Mental Health	Sites select and/or build their own data systems to conduct MBC and submit outcome data to CHRC	• MBC as an expansion of training on evidence-based practices in children's mental health, focused on community–school partnerships • MBC identified as one of several evidence-based practices for providers to be trained on • Over 100 community behavioral health agencies partnering with schools are participating in the statewide MBC learning community • Working toward procurement of a universal data system • Community behavioral health organizations participate in selecting outcome metrics and advising on the MBC learning community[126]

Sponsor/ Funder	Partners	Data System or Platform	Details
State/Province: Massachusetts[127]			
N/A	Massachusetts School Mental Health Consortium (MASMHC); Massachusetts Partnerships for Youth; 175 school districts across the state	School Health Assessment and Performance Evaluation (SHAPE) System for systemwide quality improvement priorities followed by various low-cost data system options to support MBC (e.g., Google forms, Microsoft Office, integration with the existing student information systems)	• School districts voluntarily join MASMHC to participate in comprehensive school mental health system quality assessment and improvement • MBC is part of the MASMHC community of practice, including training and capacity building on screening and progress monitoring • MASMHC director provides individualized support on MBC integration in special education services to districts upon request based on 5–6 school years of MBC implementation in Methuen, Massachusetts • Leading innovations in MBC–IEP integration by changing IEP goals and objectives to include psychosocial progress monitoring
State/Province: Ontario, Canada[128]			
Ontario school boards	Algoma, Burkevale Protestant, and York Catholic school boards	Greenspace	• Several school boards implementing MBC via Greenspace • Originally initiated MBC as part of Brief Intervention for School Clinicians (BRISC) and found that system-wide MBC was compatible with the primary presenting concerns of students (i.e., anxiety and depression) • The foundation of MBC in schools is also grounded in long-standing MBC emphasis in the Ontario children's mental health system[129]
State/Province: Michigan[130]			
Michigan Department of Education statewide grants and state Medicaid expansion	Various Michigan school districts	BHWorks	• Statewide adoption of BHWorks behavioral and mental health software for school–community partnerships • School systems are creating a foundation for MBC by increasing data system capacity around referral management and universal mental health screening, and using a data platform that offers MBC as soon as systems are ready to implement

Policy Implications to Promote Implementation and Sustainability

Ultimately, education and behavioral health leaders can take a number of actions to improve uptake, implementation, and sustainment of MBC in schools. A first step is for education and behavioral health leaders to learn about and communicate the value of MBC to fellow leaders, clinicians, community partners, families, and students. Such communication includes emphasizing what MBC can offer to augment “usual care” school mental health treatment, such as promoting student and family–centered services as well as collaborative, data-informed consistency, equity, and quality of care. Next, awareness of education and behavioral health system policies and structures that support or impede MBC in schools can inform policy reform at the state and local levels. For example, when IEP or third-party reimbursement requirements and/or documentation systems change at the state level, MBC champions in leadership roles can advocate for MBC to be included.

Specifically, measurable goals and objectives should include student-, caregiver- and/or teacher-reported psychosocial progress monitoring on standardized measures and/or goal ratings over time. Menus of approved measures and examples of measurable goals with progress monitoring benchmarks can support integration of MBC in IEPs and other treatment planning documentation. For community-employed school mental health clinicians, The Joint Commission sets a standard for use of MBC among accredited behavioral healthcare organizations that is one lever to drive MBC adoption.[131]

Education and behavioral health leaders will want to identify funding opportunities to stimulate and/or sustain MBC over time. Federal funding opportunities such as Project AWARE (Advancing Wellness and Resiliency in Education) or Children’s Mental Health Initiative (CMHI) grants can leverage evidence-based practices to improve behavioral health system quality. For example, in Connecticut, a CMHI grant project titled CONNECT-IV focuses on improving school–community partnerships through technical assistance for district teams to assess and improve their school mental health systems based on local priorities.[132] In fact, any state behavioral health initiative that focuses on evidence-based practices could logically include MBC, as did the California Children and Youth Behavioral Health Initiative. At the state level, funded and unfunded legislation related to school safety has in the past been used in the southeastern United States to stimulate new school mental health initiatives.[133] School districts can also apply to state departments of education for Title IV funding for professional development and consultation on an array of evidence-based practice initiatives, including student behavioral health.

Conclusion

In conclusion, we recommend the continued advancement of mental health–education integration to realize the potential of MBC in schools. As MBC is gaining rapid momentum in the behavioral healthcare system, early efforts to expand to other nontraditional mental healthcare settings signal the unique value of MBC in schools. Specifically, MBC is aligned with the goals of data-informed student interventions in schools delivered to students in both general and special education. Further, MBC offers a practical approach to school–family–community collaboration and coordination to increase the provision of efficient, effective, and equitable services for students. Overall, MBC is also a clinical practice that can improve the quality and effectiveness of “usual care” mental health services, resulting in better outcomes for children and families who receive mental health care in schools and other child-serving settings. Improved care quality and effectiveness in children’s mental health services can have far-reaching effects on the current state of crisis in children’s mental health. For instance, MBC is a best

practice that can alleviate the need for crisis mental health care through offering clinicians, children, and their families a data-informed communication tool during treatment[134] that has been found to provide an “early signal alarm” of deterioration or nonresponse to treatment.[135] MBC has also been integrated into more intensive treatment services for children and adolescents,[136] and it can facilitate the continued communication and monitoring of care that is essential among members of a care team to support individuals before, during, and after a crisis.[137]

To advance MBC, state leaders are in a position to incentivize providers for using individual progress measures with children and families in various child-serving settings. In addition to the policy recommendations detailed above, state leaders can also advocate for schools and community behavioral health organizations to have access to data systems that support MBC in practice. Although any new technology comes with a learning curve, measurement feedback systems have been found to facilitate ease of data collection, visualization, and collaborative decision-making among providers and the people they serve. Encouraging and/or requiring documentation of data collection, discussion, and use is also a future direction that state leaders can take to ensure that MBC becomes part of routine practice. Notably, there is debate around whether and how MBC for clinician–individual communication and shared decision-making can or should be used in aggregate for outcomes monitoring. Yet value-based care is on the horizon in the behavioral healthcare system, and while actual progress data may not need to be submitted for aggregation, documentation of data collection and use can be a quality metric used to promote accountability, support MBC, and drive value. With the expansion of Medicaid support for community-employed school mental health clinicians, there may be future pressure to use MBC in schools. Ultimately, school and district leaders’ awareness of MBC and interest in driving MBC forward in school settings can foster additional practice-based evidence of MBC in schools. With the expansion of MBC in schools, future opportunities will arise for within- and across-state learning opportunities to share best practices and innovations for establishing MBC in schools.

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Appendix

PHQ-9 modified for Adolescents (PHQ-A)

Name: ___________________________ **Clinician:** ________________________ **Date:** ________

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.				
	(0) Not at all	**(1) Several days**	**(2) More than half the days**	**(3) Nearly every day**
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** __________

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

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