# Wisconsin School Mental Health Services: Comparative Analysis and Successful Practices

**Prepared for**

Wisconsin Office of Children's Mental Health

**By**

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# Table of Contents

# List of Figures



# List of Tables

# Foreword

This report was written for the Wisconsin Office of Children's Mental Health (OCMH) by students at the La Follette School of Public Affairs at the University of Wisconsin–Madison. The learning objective of the La Follette School is to provide graduate students the opportunity to improve their policy analysis skills while providing the client an analysis of a policy problem on which a decision or set of decisions needs to be made.

The La Follette School offers a two-year graduate program leading to a Master of Public Affairs (MPA) or a Master of International Public Affairs (MIPA) degree. Students study policy analysis and public management, and they spend the first year and a half of the program taking courses in which they develop the expertise needed to analyze public policies, including skills in statistics, economics, and policy analysis. The authors of this report all are in the final semester of their degree program and enrolled in the Workshop in Public Affairs course. Although acquiring a set of policy analysis skills is important, there is no substitute for doing policy analysis as a means of experiential learning. The Workshop in Public Affairs gives graduate students that capstone opportunity as they produce a report for a real-world client about a question of importance to the organization.

I am grateful to OCMH for partnering with the La Follette School on this project. OCMH staff members have been generous with their time to support the students' work. The students have collectively contributed hundreds of hours to the project and in the process developed critical insights about K-12 school-based mental health services. The La Follette School is grateful for this collaborative effort and hopes the report proves valuable.

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# Acknowledgements

We extend our deepest gratitude to all the individuals who contributed their expertise, mentorship, and time to this report. We thank our client Linda Hall, Director of the Wisconsin Office of Children's Mental Health (OCMH), for the opportunity to conduct this work on behalf of OCMH. The OCMH is an office that reports directly to the governor but receives administrative support from the Wisconsin Department of Health Services. We also extend our thanks to Allyson Forseth at the Wisconsin Association of Family and Children's Agencies, who acted as an additional primary contact. Additionally, we thank Dr. Katie Eklund and Ellen Anderson at UW–Madison for sharing their research expertise in this topic.

We also thank the hardworking school-based mental health stakeholders across Wisconsin who took the time to answer OCMH's survey and participate in additional interviews to provide detailed information about the successes of their schools' mental health services and barriers to service growth. Special thanks to those interviewees who granted us permission to quote their insights.

Finally, we thank the instructors of the La Follette School's Workshop in Public Affairs: Dr. J. Michael Collins, Dr. Greg Nemet, and Dr. Sarah Halpern-Meekin. We give special thanks to Dr. Halpern-Meekin, who served as our project faculty advisor. We express gratitude for her continued support.

We acknowledge that we wrote this report, which examines the state of mental health services at Wisconsin K-12 schools, without interviewing a representative group of school mental health stakeholders. Our report focuses on differences between rural and nonrural school districts, so we strived to interview stakeholders from these areas. However, other district demographics may impact the quantity and quality of mental health services accessible to students.

The views, opinions, and recommendations in this report represent those of the authors alone and do not reflect findings, recommendations, or policies of the University of Wisconsin–Madison, the La Follette School, the Wisconsin Office of Children's Mental Health, or the Wisconsin Association of Family and Children's Agencies.

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# Abbreviations

| | |
|---|---|
| ACES | Adverse Childhood Experiences |
| CESA | Cooperative Educational Service Agency |
| DHS | Department of Health Services |
| DPI | Department of Public Instruction |
| IEP | Individualized Education Program |
| LEA | Local Education Agency |
| NAMI | National Alliance on Mental Health |
| NCSMH | National Center for School Mental Health |
| OCMH | Wisconsin Office of Children's Mental Health |
| PBIS | Center on Positive Behavioral Interventions and Supports |
| SHAPE | School Health Assessment and Performance Evaluation |
| WAFCA | Wisconsin Association of Family and Children's Agencies |
| YRBS | Youth Risk Behavior Survey |

# Executive Summary

The Wisconsin Office of Children's Mental Health (OCMH) is charged with improving children's mental health services through research and initiatives. Our team analyzed Wisconsin's K-12 school mental health system by comparing it to that of other states, analyzing survey data from stakeholders previously collected by OCMH, and conducting and analyzing follow-up interviews with survey respondents. This report contributes to a statewide and nationwide conversation about the mental health needs of students, as evidenced by the increasing prevalence of youth suicide, anxiety, depression, and substance abuse. Mental health services in schools play an important role in identifying at-risk students and connecting them to in-school services or community providers.

This report includes:

(1) A comparison of state policies regarding K-12 mental health services in Wisconsin, states geographically proximal to Wisconsin, states with similar legislative makeups as Wisconsin, and states that are national leaders in school mental health.
(2) An analysis of survey responses and interviews with school mental health professionals regarding the status of mental health services offered within their district.
(3) Barriers to school-based mental health service provision within Wisconsin schools.
(4) Resources and conditions that support schools with successful mental health services.

School-based mental health services are a critical component of support systems for students, particularly in the context of the COVID-19 pandemic. Recent efforts to increase resources for school districts through funding and training contributed to significant growth of school-based mental health service access across Wisconsin. That said, the status of mental health services in Wisconsin's K-12 schools varies widely, from districts with few structures in place to districts with 10 years of structure-building experience. OCMH seeks to understand the conditions that facilitate or inhibit the development of successful school mental health practices. Furthermore, OCMH is interested in comparing Wisconsin's mental health initiatives to those of other states with similar legislative leadership and geographic contexts. While Wisconsin recently increased funding for school mental health at the state level, a comparative analysis of states with similar characteristics to Wisconsin may identify politically feasible areas of growth to codify school mental health in state law.

## Findings

- Wisconsin's policies at the state level provided limited support to school mental health services compared to the other six states included in our analysis.
- Our comparative analysis of states identified major areas for growth, including the number of school mental health professionals available, teacher and staff training, funding supports, and well-being checks.
- 73 percent of surveyed respondents noted they have some structures in place to identify students in need of mental health services and connect them to resources, but they are limited or at capacity.
- Both survey respondents and interviewees identified that schools and districts need tangible resources, such as funding, staff, and technical assistance to grow their mental health services.

## Recommendations

Based on the aggregate findings from the state comparative analysis, the OCMH's School Mental Health Survey, and interviews with school mental health professionals, we developed recommendations for OCMH and partners to pursue at both the state level and district level.

State-level recommendations include:

- Supporting increased, ongoing funding specifically for school-based mental health services.
- Offering support to schools in utilizing telehealth services and to policies that expand Medicaid eligibility as supplemental methods to mitigate the impact of the mental health provider shortage.
- Supporting legislative efforts that codify dedicated, sustainable mental health trainings for school staff.

District-level recommendations include:

- Facilitating connections and collaborations between schools and available resources, specifically Cooperative Educational Service Agencies (CESAs).
- Advocating for the increased robustness of school mental health data collection and analysis through the implementation of statewide student mental health screenings.
- Incentivizing schools to commit time for staff to develop skills to support student needs and wellness.
- Assisting individual schools and districts in taking small, immediate steps to improve the provision of mental health services.

# Introduction

The Wisconsin Office of Children's Mental Health (OCMH) is charged with improving the coordination of children's mental health services through research and initiatives. OCMH envisions a Wisconsin where "children are safe, nurtured and supported to achieve their optimal mental health and well-being" and where "systems are family-friendly, easy to navigate, equitable, and inclusive of all people" ("Overview" n.d.). OCMH pursues its charge and vision through three foundational pillars: systems change; the lived experience of parents, caregivers, and young people; and research and data ("Overview" n.d.).

Drawing on these pillars, OCMH asked our group to analyze Wisconsin's K-12 school mental health services by identifying successful practices as well as barriers to them. To accomplish this, we first provide context for our analysis by including background information on school mental health programs. The background discusses the value of school mental health services, provides an overview of school mental health services nationally, and includes information on access to services in Wisconsin schools. We then analyze school mental health statutes in Wisconsin and Colorado, Florida, Illinois, Indiana, Iowa, and Minnesota. We build on the comparative state analysis by incorporating stakeholder input. This includes analyzing data received from the stakeholder survey OCMH distributed prior to us joining the project. The report expands on the survey findings in the following section, where we present and analyze testimonial from our interviews with school mental health stakeholders in Wisconsin. We then briefly discuss our project's limitations. Synthesizing the findings from all three sources—the state comparison, the survey, and the interviews—we identify commonalities that inform the seven recommendations we provide for state- and district-level actions to improve school mental health services in Wisconsin.

## Background on school mental health services

Comprehensive school mental health systems are collaborations between schools and community partners put in place to proactively reduce and respond to the prevalence and severity of mental illness for K-12 students. These systems involve interactions between district and school staff members, students, families, and mental health providers. Appendix D includes a description of the multi-tiered system often used to describe the range of mental health services offered to students. In the following sections, we discuss the importance of school mental health systems on students' academic and health outcomes, the inequities in accessing mental health services broadly and within schools, and the school mental health resources available in Wisconsin.

### Importance of school mental health for student academic and health outcomes

Longitudinal and cross-sectional research has connected students' mental health to their academic outcomes. Student mental health issues have been linked to decreases in grade point average, unexcused absences, increased likelihood of dropout, and decreased likelihood of college entry and completion (Breslau 2008). Mental health challenges are also connected to factors known to negatively impact academic achievement, such as decreased self-rated well-being and the use of drugs and alcohol (Burnett-Zeigler 2012).

While students and their families can connect with community-based mental health providers outside of an educational setting, school-based services reduce barriers that could prevent students from receiving services (e.g. transportation, cost, waitlists). Students and parents may not recognize the signs of depression, anxiety, or other forms of psychological distress; they may also struggle to understand care options and access community resources. Providing services within schools also improves access and equity, increases utilization and follow-up, and can reduce stigma (Center for Health and Health Care in Schools 2021).

### Inequities in mental health access

While Wisconsin faces shortages of mental health providers, rural communities face exacerbated challenges with recruiting and maintaining these professionals (Wisconsin Policy Forum 2018). Therefore, people in

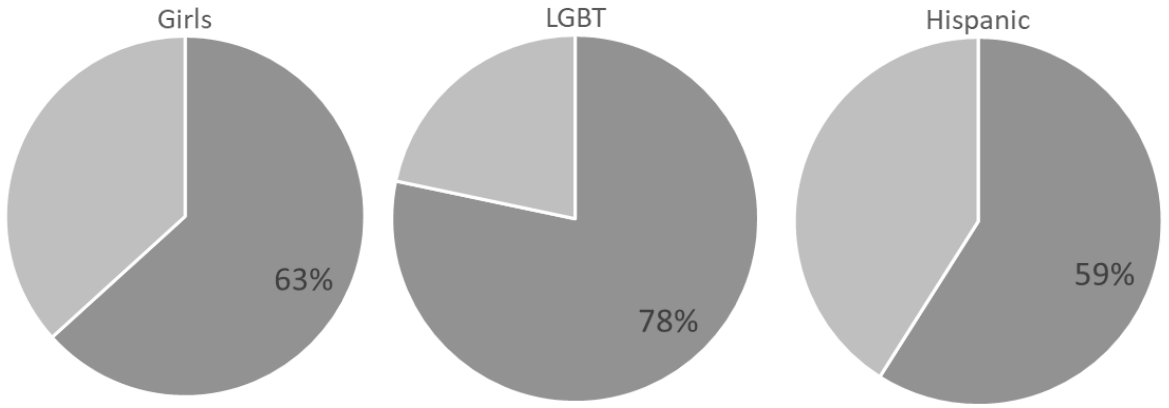
rural communities may have to drive long distances or seek virtual options to access services. The lack of access to broadband is a major issue in rural Wisconsin, making virtual service less viable in rural areas.

In general, telehealth services increased during the pandemic, but a survey of companies that write comprehensive health insurance policies in Wisconsin shows only 47 percent of respondents stated that they intended to maintain their expanded telehealth services (Afable 2021). Wisconsin does not have a telehealth parity law, which would require private insurance companies to reimburse telehealth services the same way as in-person services. This makes virtual options inaccessible to some. However, the state Medicaid program does have parity through SB380 for live video telehealth with eligible providers (Wisconsin State Legislature 2019). This is particularly relevant in rural communities, given the role that Medicaid played in increasing insurance coverage in those areas (Benitez, Seiber, and Benitez 2018). Therefore, Medicaid coverage of telehealth services in rural communities helps mitigate limited access to in-person providers, but the effect of this coverage may be limited by reliable broadband access.

Inequities also exist due to systemic racism and discrimination within the U.S. health system. Patients of color are often underrepresented in primary care mental health services, such as counseling for those with moderate mental health concerns, but they are often overrepresented in secondary care mental health services, such as clinical psychiatry provided at an institution or hospital for more complex disorders. Social, political, and economic factors contribute to this over-institutionalization. While there have been increases in the number of people in marginalized groups receiving psychology doctorates in recent years, the U.S. psychologist workforce remains 84 percent white (American Psychological Association 2020). Furthermore, many providers, especially those who identify as white, lacked confidence in their ability to ask questions about a patient's ethnicity, culture, or experiences of racism because they were concerned about making mistakes or offending the patient (Naz 2019).

The ability of providers to address such questions remains crucial, as studies show that members of historically marginalized groups are more likely to experience distress and decreased psychological well-being related to racial, ethnic, sexual, or other identities (Wong 2014). For example, those with multiply marginalized identities, such as Black trans individuals, are more likely to experience stressors from prejudice and stigma related to their identities (Wong 2014). This is also true for young people in schools. According to the 2019 Youth Risk Behavior Survey (YRBS), Wisconsin middle and high schoolers from historically marginalized groups were more likely to report feelings of anxiety, as illustrated in Figure 1.

**Figure 1: Percentage of Select Marginalized Groups Among Wisconsin Youth Self-Reporting Anxiety in 2019**




*Wisconsin Youth Risk Behavior Survey 2019*

## School mental health resources in Wisconsin

The development of school-based mental health services can be difficult for schools and districts due to a lack of community and school providers, low school staff salaries relative to corresponding private sectors,

students' diverse needs, and limited funding. Wisconsin attempts to support schools in this process with several resources. The 12 Cooperative Educational Service Agencies (CESA), funded by the Wisconsin Department of Public Instruction (DPI), provide regional trainings on a wide range of topics to school districts. DPI and the CESAs cultivate networks for educators with a specific focus, such as a regional special education network. Offerings that may be helpful to schools developing a mental health program include trainings on non-violent crisis prevention and intervention, mental health first aid, classroom strategies that build positive culture, bullying prevention, and embedding telehealth into school mental health system (CESA 1 2022). CESAs hold trainings in person at CESA offices, by phone, or virtually, with varying costs for attendance. Districts may be unable to utilize CESA services due to lack of funding, distance to their CESA office, or the capacity of their staff. For example, CESA 1, located in Pewaukee, serves a more geographically compact area than CESA 12 in Ashland, which may make traveling to in-person trainings more difficult for schools in the latter area.

As part of the American Rescue Plan Act, Wisconsin received $24.6 million in supplemental Community Mental Health Services Block Grant funds and $22 million in supplemental Substance Abuse Prevention and Treatment Block Grant funds. Additionally, DPI provides two-year funding cycles aligned with the Wisconsin biennial budget through its statewide, school-based mental health grant program. The most recent budget appropriated $10.5 million for competitive grants, resulting in 153 grant awards representing 144 school districts, eight consortia, and three charter schools in 2021–2023 (WDHS 2022). These funding opportunities contribute significantly to the breadth of school mental health resources across the state.

# Comparative Analysis of School Mental Health Services in Wisconsin and Other States

To contextualize school mental health services in Wisconsin, we gathered information about six states to examine how Wisconsin's services compare. In the following sections, we discuss the methodology for selecting states, comparative characteristics, and our findings.

## Methodology

To compare state policies, our analysis draws primarily from the 2022 American School Mental Health Report Card ("the Report Card") by the Hopeful Futures Campaign. This comprehensive report aggregates stakeholder feedback, publicly available national and state data, and state statutory requirements. To supplement this analysis, we also draw information from DPI, national policy maps and mental health assessments, and peer-reviewed articles on varied aspects of school mental health services.

The Report Card compares state progress in eight policy areas (see Table 1). Stakeholders identified these characteristics as important components of a comprehensive school mental health framework in focus groups consisting of:

- students, parents, and general voters
- the National Alliance on Mental Health (NAMI);
- the National Center for School Mental Health (NCSMH);
- Mental Health America
- other Hopeful Futures Campaign partners.

**Table 1: Characteristics Selected to Compare State Policies**

| |
|---|
| School mental health professionals |
| School-family-community partnerships |
| Teacher and staff training |
| Funding supports |
| Well-being checks |
| Healthy school climate |
| Skills for life success |
| Mental health education |

*Authors, Hopeful Futures Campaign*

Rankings in the eight policy areas serve as benchmarks in our analysis to compare Wisconsin's school mental health services to those in six other states. Furthermore, these characteristics align with our client's interests in understanding how Wisconsin fits within the school mental health landscape. It is important to note that state–level statutes give an important but incomplete analysis of state progress on school mental health ("America's School Mental Health Report Card" 2022, 6). For example, a state may have a relatively comprehensive statute on mental health training for teachers and staff; however, implementation capacity may vary in individual districts due to intervening factors such as staff shortages. Despite this limitation, state policies contribute to the broader environmental conditions that either inhibit or facilitate the growth of school mental health services. Therefore, they offer a helpful perspective on state progress and statewide school requirements.

The states selected for comparative analysis were of particular interest to OCMH and have one or more of the following factors: geographical proximity to Wisconsin, similar legislative composition to Wisconsin's, and/or national models of successful school mental health services. We used geographic proximity or the makeup of the legislature to represent political feasibility, as Wisconsin is more likely to adopt state policy alternatives previously adopted in neighboring states or states with similar Republican legislative leadership. We also included states that have made recent progress in their school mental health services to analyze possibilities for growth in Wisconsin. Therefore, we selected Colorado, Florida, Iowa, Illinois, Indiana, and Minnesota. We selected Colorado, Florida, and Minnesota because they recently made notable progress on school mental health. We selected Iowa, Illinois, Indiana, and Minnesota due to their geographic proximity to Wisconsin. Finally, we selected Florida, Iowa, and Indiana because of their Republican-led legislatures.

## Key findings

The Report Card ranked each policy area as *no, some, meaningful,* or *substantial progress*. States received scores based on the state statutes and data regarding school mental health as of 2021. Importantly, these scores only reflect the presence of statute and data availability; they do not reflect a rating of implementation, fidelity, or effectiveness. Table 2 summarizes how each state scored in each policy area. Most notably, the Report Card found Wisconsin state policies demonstrated little to no progress or only some progress in 75 percent of the policy areas and meaningful progress in 25 percent. Wisconsin did not demonstrate substantial progress in any of the policy areas.

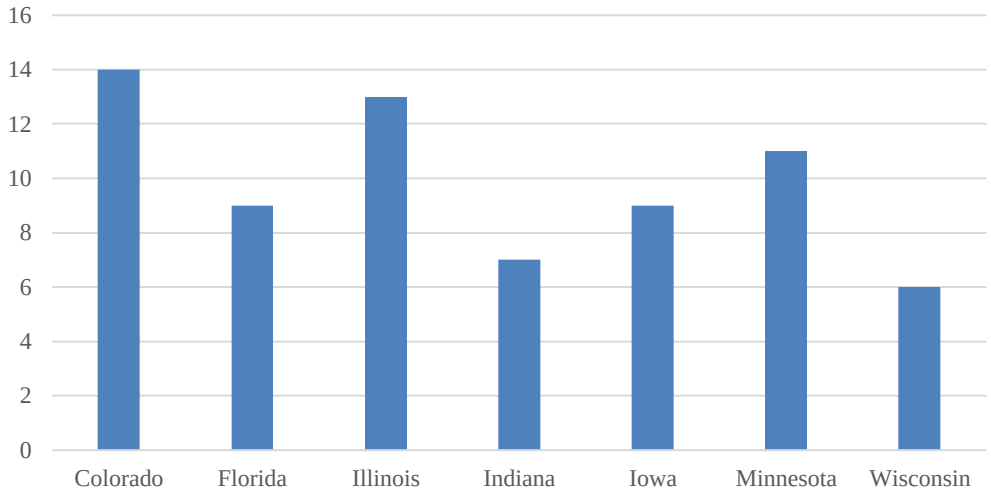
**Table 2: Comparison of State-Level Policies Addressing School-Based Mental Health**

| | Little to no progress | Some progress | Meaningful progress | Substantial progress |
|---|---|---|---|---|
| **School mental health professionals** | **WI**, CO, MN, FL, IA, IN, IL | | | |
| **School-family-community partnerships** | | IL | **WI**, CO, FL, IN | MN, IA |
| **Teacher and staff training** | **WI** | CO, IA, IN | MN, FL, IL | |
| **Funding supports** | **WI** | IA, IN | MN, IL | CO, FL |
| **Well-being checks** | **WI**, CO, MN, FL, IA, IN, IL | | | |
| **Healthy school climate** | | **WI**, FL, IA, IN | MN | CO, IL |
| **Skills for life success** | FL | | **WI**, CO, MN, IN, IL | IA |
| **Mental Health Education** | MN, IA, IN | **WI**, FL | | CO, IL |

*Note: A score of 0 indicates the state achieved little or no progress in that policy area; 1 indicates some progress achieved, 2 indicates meaningful progress, and 3 indicates substantial progress. Scores for each state are totaled in Figure 2.*

*Authors, Hopeful Futures Campaign*

**Figure 2: State Comparison of Total Scores across Eight School-Based Mental Health Services Policy Areas**




*Authors, Hopeful Futures Campaign*

## School mental health professionals

Hopeful Futures Campaign used the ratio of school psychologists, social workers, and school counselors to students, as found in the School Health Assessment and Performance Evaluation (SHAPE) System's publicly available data, to evaluate the status of school mental health professionals. All the states we analyzed, including Wisconsin, received a score of 0 for this characteristic, as they all failed to achieve the recommended ratio of school mental health professionals to students: 1:250 for school counselors and social workers and 1:500 for school psychologists. While Wisconsin may not meet the recommended ratio—currently 1:414 for school counselors, 1:1750 for social workers, and 1:901 for school psychologists—the state has made improvements to its ratios in recent years due to increased funding to address this shortage ("America's School Mental Health Report Card" 2022). Wisconsin received $10 million over five years from the Department of Education's School-Based Mental Health Provider Grant Program to increase the number of school-based mental health service professionals, with priority to attract individuals who reflect the racial and ethnic diversity of the local education agency's (LEA) community (WDHS 2022).

## School-family-community partnerships

Sates with any of the following infrastructures in place were given higher school-family-community partnership scores: statutory requirements for family and community engagement plans; statutes to support partnerships; advisory councils or task forces focused on school mental health services; or community school models in which schools work with community services to support whole child wellness. Wisconsin's Section 1116 of 20 USC § 6318 follows federal guidelines by requiring schools to engage parents and family members of children in Title I programs; however, Wisconsin does not statutorily require districts to adopt family engagement plans for all students (Wisconsin Department of Public Instruction 2022). Although the state does not have any statutory requirements specific to school mental health and community partnerships, a grant program under Wis. Stat. § 115.367 provides funding opportunities for districts to partner with community mental health providers (Hopeful Futures Campaign 2022). However, these grants are competitive and provide limited funding. Thus, Wisconsin's infrastructure development in this policy area demonstrates meaningful progress but can improve by statutorily requiring rather than encouraging family engagement and community partnerships specific to school mental health.

Iowa, which has a Republican-led legislature and is in the same geographic region as Wisconsin, has made recent progress in partnership building. State law requires Iowa school districts to establish plans, policies, or strategies that aim to engage families in the educational process. The school or school district must seek input from the local community about its statement of philosophy, beliefs, mission, or vision;

major educational needs; and student learning goals at least once every five years (National Association of State Boards of Education 2022). While it is not explicitly required that schools and school districts receive feedback on mental health education, this policy provides an opportunity for community members to provide feedback about mental health education and social-emotional learning goals for their students. The recently created Iowa Center for School Mental Health also represents considerable progress in relationship-building between the University of Iowa and the Iowa Department of Education, as it promotes state and research partnerships to improve school mental health through training and service development.

## Teacher and staff training

The Hopeful Futures Campaign measures progress on teacher and staff training by the presence of statutory requirements for teacher training on suicide prevention, mental health, and substance use. Wisconsin does not have any statutory requirements for teachers or staff members to receive mental health training. All other states included in our analysis required some form of mental health training; however, the states differ in the focus, frequency, and staff required to attend these trainings. For example, Indiana requires employees who instruct grades 5-12 to attend at least two hours of youth suicide awareness and prevention training every three years. Iowa requires all school personnel to attend annual training on adverse childhood experiences (ACES) and toxic stress response mitigation. However, individual districts and schools within Wisconsin may have their own requirements and opportunities for staff mental health training. In 2022, Wisconsin Governor Tony Evers announced a "Get Kids Ahead" initiative, which provides schools funding for student mental health support, specifying that funds may be used for mental health first aid and trauma-based care training. He also attempted to allocate $10 million over 2021–23 for additional or improved student health services related to mental and behavioral health, including additional or improved staffing, training, operations, assessment, and prevention. However, this provision was removed from his final biennial budget bill (Office of the Governor 2022).

## Funding supports

Funding for school mental health programs comes from several sources, including district tax levies, foundations, and state or federal grants. But as students without access to insurance coverage must pay out-of-pocket or apply for Medicaid (if eligible), this category focuses on policies that support Medicaid-eligible students. Approximately 54 percent of Wisconsin youth use Medicaid funds for their mental health service, and 64 percent relied on Medicaid-funded and/or county-provided services (Wisconsin Mental Health and Substance Abuse Needs Assessment 2019). Only students with an individualized educational program (IEP) qualify for telehealth school-based mental health service under Medicaid (Hopeful Futures Campaign 2022). Many districts do not bill for Medicaid-eligible school-based services due to difficulties with paperwork and seeking reimbursement, increasing financial strain on schools and families. Wisconsin relies primarily on community mental health providers who deliver services to bill Medicaid for services either in-person or through telehealth. Colorado has made substantial progress in expanding Medicaid access for students, as its state Medicaid programs cover school-based mental health services, including telehealth, for all Medicaid-eligible students. Removing barriers like requiring an IEP to access Medicaid reimbursement may decrease administrative burden and increase access to services.

## Well-being checks

Well-being checks and mental health screenings aim to monitor mental health and measure risk for students and staff within a school, meaning mental health providers can tailor services to the stated needs of respondents. No state that we analyzed, including Wisconsin, demonstrated progress in this policy area; that is, no state had any statutory requirements for well-being checks or mental health screenings (Hopeful Futures Campaign 2022). However, many school districts conduct well-being checks or screenings voluntarily. For example, the YRBS is administered by DPI in Wisconsin every two years to a representative group of students, which included 45 schools in 2019 (McCoy 2020). While this survey can tell researchers about statewide trends in mental health, it does not provide community-specific information, limiting its use for mental health providers within schools.

### Healthy school climate

Bullying, a lack of belonging, discrimination, exclusionary disciplinary measures, and strict policies against mental health absences all contribute to a school climate that can negatively impact the mental health of students (Hopeful Futures Campaign 2022). The Report Card measures substantial progress in terms of state polices requiring schools to address these issues through grants, school climate surveys, and state statutes. Wisconsin has made some progress, as it requires schools to have an anti-bullying policy as per Stat. § 118.46 and provides for excused mental health absences in Stat. § 118.15 (Hopeful Futures Campaign 2022). States such as Colorado and Illinois go beyond these requirements. Illinois requires schools to administer an annual survey to teachers and students that evaluates how they perceive their school climates and how it affects their behaviors ("What Survey Results Mean" 2020). The survey evaluates school climates in terms of suicide prevention and awareness education programs, requirements against exclusionary discipline practices, guidance regarding the protection of transgender students and religious or race-based bullying based on the Illinois Human Rights Act, and overall learning environment (Hopeful Futures Campaign 2022). The Illinois Board of Education factors in these results when determining school successes.

### Skills for life success

When students have skills to build healthy relationships, make responsible decisions, and be socially aware, their mental health during school and after graduation benefits. Wisconsin has made progress in this area, as DPI has developed life skill competencies for PreK-12 students by adapting competencies from the Collaborative for Academic, Social, and Emotional Learning (CASEL), one of the most-cited frameworks for SEL ("Social and Emotional Learning | Wisconsin Department of Public Instruction" n.d.) While DPI provides guidelines for implementation, districts ultimately choose how to engage with SEL. In contrast, Iowa supplements the competencies provided by its Department of Education by incorporating SEL into statutory health education standards. Moreover, several studies suggest that dedicated SEL instruction time, combined with integrated SEL in the school day, support optimal learning outcomes (Jagers, Rivas-Drake, and Williams 2019, 172). Therefore, Wisconsin could strengthen its SEL competencies by creating statutory standards to require SEL for K-12 students, similar to Iowa's standards.

### Mental health education

State requirements for mental health education ensure students have time in school dedicated to mental health awareness and recognizing mental health risks in peers, along with help-seeking behaviors regarding personal mental health concerns. Wisconsin has statutory language requiring health education for students (Wis. Stat. § 121.02 and Wis. Stat. § 118.076), but it does not specifically require schools to teach about mental health. State education standards reference mental health in grades 3-5 and 9-12, but there is no requirement to provide this coursework. However, Colorado has a statute (Colo. Rev. Stat. § 22-7-1005) that requires mental health education in K-12 schools. It does not provide many specifics aside from i suicide prevention is included. Comparatively, Florida statute only requires that mental health education be taught in middle and high school. However, it is unique in that it specifies a minimum of five annual hours of instruction to be used for mental health, substance abuse, and suicide prevention.

## Conclusion

While this comparative analysis does not present a comprehensive evaluation of the progress states have made regarding school-based mental health, it offers several suggestions for policies Wisconsin could enact to strengthen school mental health services. Considering Wisconsin's recent progress in growing school-based mental health services, as well as policy opportunities identified by the Hopeful Futures Campaign and their partners, key opportunities for growth include:

- improving ratios of mental health professionals in schools through telehealth services, as well as directing incoming grant funds toward workforce development programs that incentive careers in school-based mental health;

- expanding teacher and staff training by pairing incoming grant funds with statutory requirements for dedicated, funded training time;
- increasing funding support by allowing Medicaid-eligible students without an IEP to receive Medicaid reimbursements;
- codifying well-being checks through statutory requirements for universal screenings for all staff and students ("America's School Mental Health Report Card" 2022, 222-223).

# Analysis of OCMH Survey Responses

To understand the state of school mental health programs throughout Wisconsin, it is important to hear from schools and districts themselves. Prior to our work on this report, OCMH surveyed school professionals with an emphasis on mental health. Below, we provide quantitative and qualitative analysis of the information the office collected from 115 respondents across 113 districts.

## Survey overview

In December 2021, OCMH issued a "School Mental Health Survey" to all school districts in Wisconsin. It received 115 out of a possible 421 responses, a response rate of about 27 percent. This strengths-based survey contained 20 questions, two of which were open-ended short answer responses. Closed-ended questions asked mental health services stakeholders (either in school or district roles) to identify their mental health service offerings and label their district's ability to refer students to services as successful ("awesome"), in progress ("developing" or "beginning"), or not yet started. One open-ended question asked respondents who marked their services as in progress or not yet started to describe the factors that would allow them to rank their services as successful. Another open-ended question asked all respondents to identify what, if anything, they would like to know about mental health services in other districts. Respondents were not consistently able to identify all the services offered in their district, as some reported the survey only allowed them to select one grade level (elementary, middle, or high school) per service; Appendix A includes a summary of services most commonly selected.

The survey response analysis focuses on how respondents self-identify their services status, the factors affecting that status, and what respondents would like to know about services in other districts. In the following sections we discuss our methodology and findings for both the quantitative and qualitative analysis. While respondents may have identified the status of their services differently ("awesome," "developing," etc.), the descriptions of their services in the short answer responses included similar challenges (like funding), regardless of status. Small rural districts in particular seek to learn from districts with similar characteristics as their own, and all districts call for additional resources, particularly funding and staffing.

## Methodology

Given that this analysis is focused on a subsection of the broader survey, we first cleaned the survey response data file. The survey did not collect any district demographic information; therefore, we merged the survey responses with two reports publicly available from the Wisconsin Department of Public Instruction (DPI): the "District Report Card" and the "School Report Card." We labeled schools as being in rural or urban areas based on definitions from the Wisconsin Office of Rural Health (WI ORH). We assigned percentage groups to race/ethnicity, income, and disability status based on the individual district demographic percentages included in the "District Report Card" or "School Report Card." To conduct descriptive analyses on the quantitative responses, our team used Stata to tabulate the self-identified service status responses by geographic area, as well as by the makeup of the district's student population by race/ethnicity, income, and disability status.

In their responses to the short answer questions, participants assessed their needs for their current mental health services and identified key aspects of mental health work by other districts about which they would like to know. To conduct analyses on the qualitative responses, we coded the short answer responses for themes using a combination of deductive and inductive coding. We identified seven key themes based on OCMH's key points of interest, our findings from our comparative analysis of state school mental health frameworks, and the survey responses themselves. An overview of key themes is summarized below.

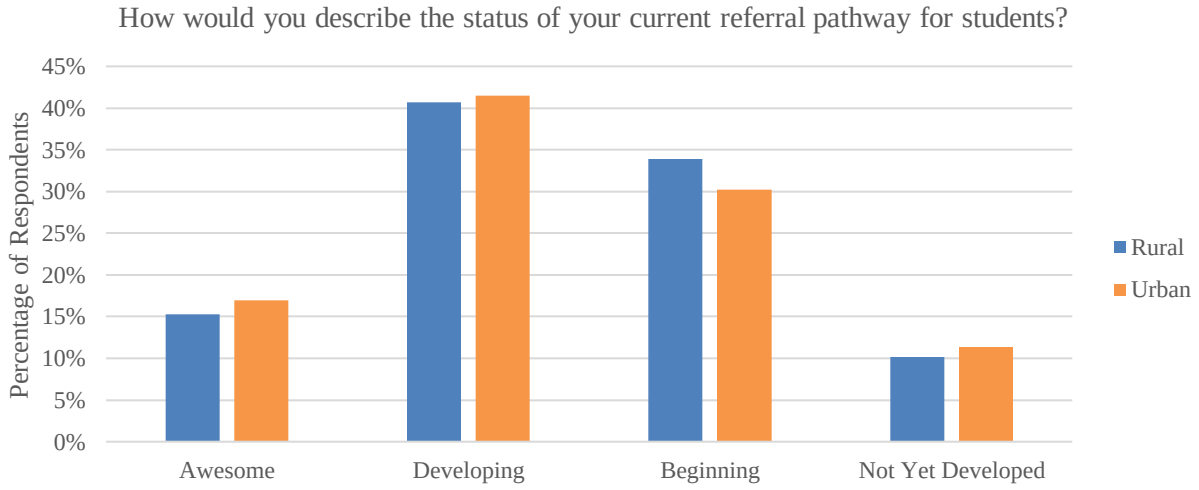
## Quantitative results

Overall, we find some variation in the district demographics of survey respondents when examining the response distribution by self-reported services status and environmental context. We find slightly higher proportions of students with disabilities in districts where respondents reported "awesome" and "not yet developed" services, particularly in rural areas. We also find higher proportions of students from families with low incomes in districts in rural areas compared to urban areas, regardless of self-reported services status. We further explore these findings in the following subsections.

### Similar distributions across environmental contexts and services status

Survey respondents are relatively evenly split between urban and rural contexts. 52 percent of respondents are from districts WI ORH identified as "rural," and 47 percent are from districts WI ORH identified as "urban." The response distribution of service status is similar within rural and urban areas, with roughly 16 percent identifying as "awesome," 41 percent identifying as "developing," 32 percent identifying as "beginning," and 11 percent identifying as "not yet developed." Figure 3 illustrates this distribution, disaggregated by environmental context. Most respondents (about 73 percent) indicate they have at least some structures in place to connect students with mental health services.

**Figure 3: Response Distribution of Self-Reported Mental Health Services Status**



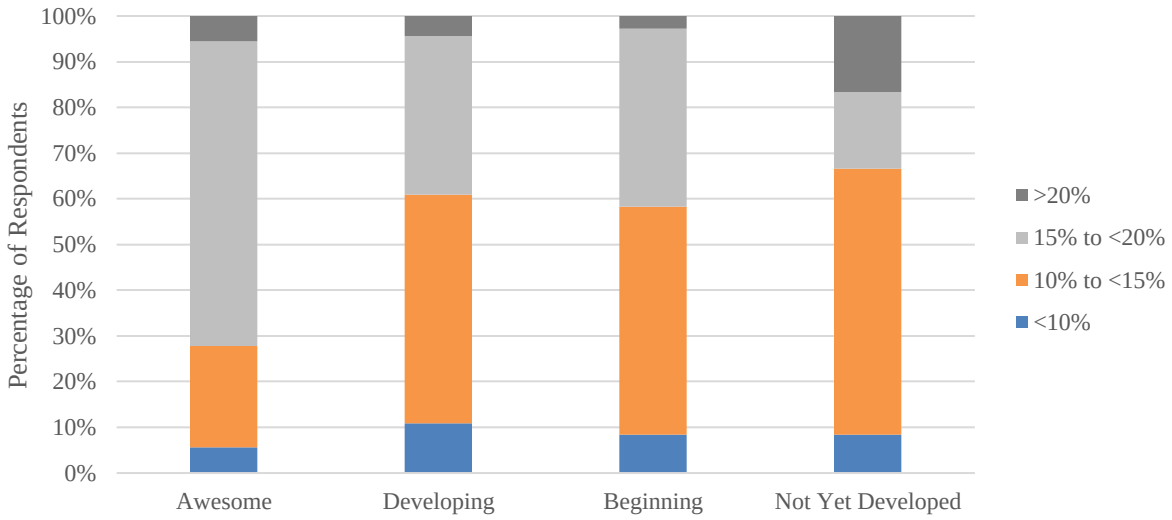

*Data from the Dec. 2021 School Mental Health Survey by OCMH*

### Respondents self-reporting their services as "awesome" have slightly higher proportions of students with disabilities

We see some variation in how districts identify students with disabilities associated with service status. The majority of respondents (72 percent) with "awesome" mental health services are from districts in which 15 percent or more of students have disabilities. This is higher than the proportion of respondents with any other service status (41 percent of respondents with "beginning" and "developing" services and 33 percent of respondents with "not yet developed" services are in districts where 15 percent or more of students have

disabilities). However, a higher proportion of respondents reporting "not yet developed" services are in districts where 20 percent or more of students have disabilities. Figure 4 summarizes these observations.

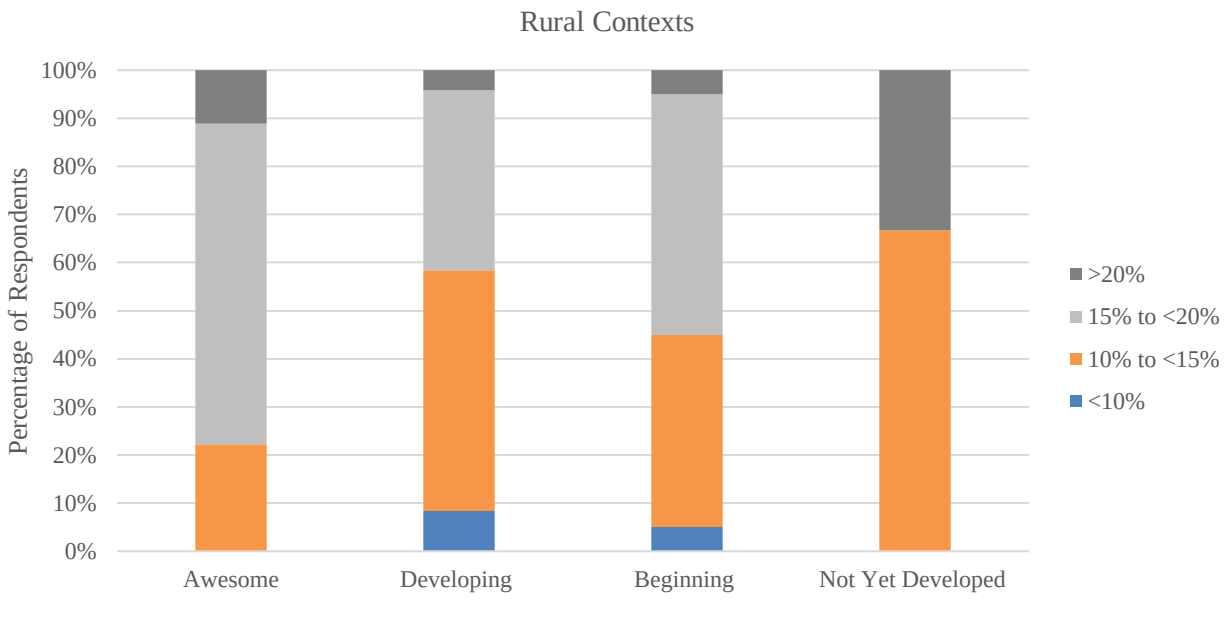
**Figure 4: Response Distribution by Self-Reported Service Statues: Percentage of Students with Disabilities (All Contexts)**




*Data from the Dec. 2021 School Mental Health Survey by OCMH*

When we disaggregate those observations by environmental context, respondents in rural areas with "awesome" and "not yet developed" services are in districts with higher proportions of students with disabilities. All respondents from districts with "not yet developed" mental health programs and where more than 20 percent of students have disabilities are in rural contexts, as shown in Figure 5. That figure also shows that 78 percent of respondents in rural areas with "awesome" mental health services are from districts where more than 15 percent of students have disabilities. Although sample size and variation in categorizing students as having a disability limit our conclusions, this finding suggests further review of mental health service structures in specific contexts, like rural areas, may be warranted.

**Figure 5: Response Distribution by Self- Reported Services Status: Percentage of Students with Disabilities in the Districts (Rural Contexts)**

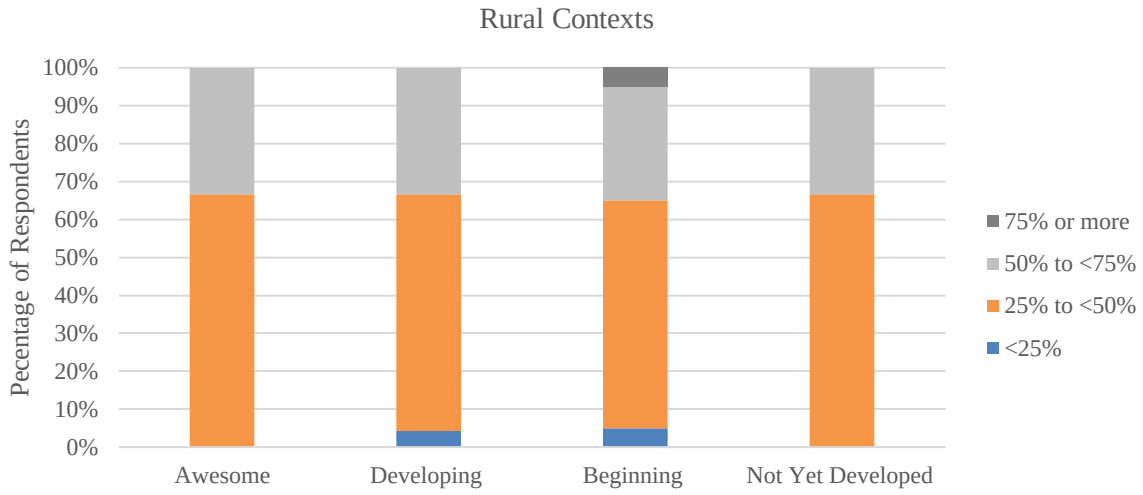



*Data from the Dec. 2021 School Mental Health Survey by OCMH*

## Higher proportions economically disadvantaged students in rural areas across services status

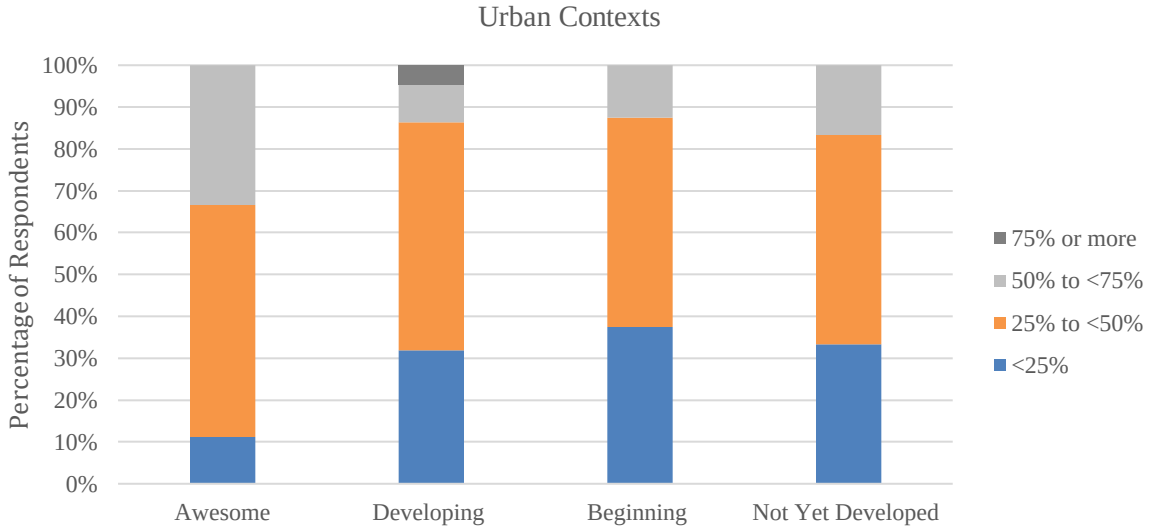
Overall, just over half of survey respondents are from districts where 25 to 50 percent of students in the district are economically disadvantaged, regardless of self-reported mental health services status. However, 100 percent of respondents in rural areas with "awesome" services are in districts where at least 25 percent of students are economically disadvantaged. Moreover, less than 5 percent of respondents in rural areas are in districts where less than 25 percent of students are economically disadvantaged. In contrast, just over a third of survey respondents in urban areas are from districts where less than 25 percent of students are economically disadvantaged. Figure 6 shows the distribution of respondents from districts with varying proportions of students with low income in rural contexts; Figure 7 shows the same, but in urban contexts. This may suggest that respondents in rural districts face additional challenges funding mental health services than those in urban districts, although additional research is necessary to confirm.

**Figure 6: Respondents in Rural Contexts Have Higher Proportions of Students with Low-Incomes across Service Statuses**




*Data from the Dec. 2021 School Mental Health Survey by OCMH*

**Figure 7: Respondents in Urban Contexts Have Lower Proportions of Students with Low-Incomes across Service Statuses**




*Data from the Dec. 2021 School Mental Health Survey by OCMH*

## Qualitative results

Of 115 respondents, 93 completed at least one of the open-ended survey questions. Most categorized their mental health services "developing" or "beginning." We identified seven themes in their responses about communication, the impact of COVID-19, funding, general resources, service providers, staffing, and systems development; detailed descriptions can be found in Appendix B. We highlight four key findings:

1) respondents noted similar challenges, successes, and interests across self-reported mental health services statuses;

2) scaffolded systems of supports are needed for services in the earliest stages of development and in small rural districts;
3) districts need unrestricted funding to hire in-school counselors, psychologists, and social workers; and
4) districts need more service providers and community connections.

## Key finding #1: Similar challenges, successes, and interests across self-reported mental health services statuses

Regardless of whether respondents identified their referral pathway as "awesome," "developing," or "beginning," they noted similar successes and challenges in their school mental health services. Two respondents with more infrastructure for their services ("awesome" or "developing") expressed interest in learning more about the additional supports other districts offer students at "Tier 2" of the multi-tiered system of school mental health supports (Center for Health and Health Care in Schools 2021). Although respondents with services in the "awesome" category could not access the first short answer question ("What would it take to get you to awesome?"), responses to the second short answer questions ("What would you like to know about other districts mental health services?") still referenced challenges with resources and an insufficient number of service providers in the school and/or community. For example, one respondent (self-reporting as "awesome") noted that after five years of developing their mental health services, "we have a robust and highly functioning system; however, we are presently at capacity with our needs and resources. We now know that we need to really look at honing in on accessing more resources as the student needs continue to grow." Another respondent (self-reporting as "developing") noted that "we do a great job of providing information and referrals to families outside of school and supporting students with times with our guidance counselor and psychologist" but that they need additional resources to share with students and families. In a similar vein, another respondent (self-reporting as "beginning") noted that "we have a great system in place but a grossly insufficient number of providers for the need."

In all three examples, those who self-reported their services as "awesome," "developing," or "beginning" identified similar effective aspects of their referral process. These include a formalized referral system, family and staff communication strategies, and community relationships. However, respondents situated that success in the potential to grow their mental health services with additional resources, like community providers. This suggests that some components of mental health services, like strong communication between schools and families, can be accomplished with limited resources. It also suggests that commonly identified challenges, like with staffing and funding, persist across all levels of success and limit growth.

## Key finding #2: Scaffolded systems supports needed for services in the earliest stages of development and in small rural districts

The majority of those who identified their services as "not yet developed" were more likely to identify that they needed a plan to fully develop their referral system structure or that they were unsure how to get started with building out their services. Similarly, those interested in hearing from other districts most wanted to know the specific steps other districts had taken to establish a referral system. Moreover, responses to both questions included a call for support in coordinating their limited resources, like staff, so that they may start to establish mental health services. Only one person identified having a dedicated coach to support them through this process. Furthermore, at least one response noted the pandemic exacerbated these specific challenges as well as general challenges at the school.

Those who identified their services in the "beginning" or "developing" stages also noted their desire for scaffolded support systems. However, several responses clarify respondents are most interested in learning about systems from other districts with similar demographics. Such requests most often came from small rural districts: as one respondent noted, "I would like to know how other small school districts have been able to commit to the training and how they have managed their school schedule so that their teams can meet regularly and continue moving forward with their mental health plans." This reflects the

organization of small districts, in which student services staff often hold dual roles and have limited capacity to plan and develop mental health services.

Respondents in small rural districts specified the importance of demographic similarities in peer learning. However, survey responses across district size and location consistently suggest peer learning as a path for growing referral system structures. Building on the previous finding, sharing and learning about the specific actions districts take to facilitate strong communication between schools and families, for example, is one way to address respondents call for systems development support. Moreover, this key aspect of effective mental health services in school is free or low-cost. It can work in tandem with long-term structural support like permanent staff to coordinate services growth.

## Key finding #3: Unrestricted funding to hire in-school counselors and support staff

Across survey respondents, there was a call for additional funding and time for full time staff members to address mental health needs. Respondents identified the need for unrestricted funding and capacity building; they were also curious as to how other districts acquired and used their funding.

Respondents also identified that commitments outside of providing mental health services restricted the capacity of existing staff. Schools identified that time with students was constrained by obligations like subbing in classrooms or other administrative duties. Additionally, respondents identified that dedicated time for service development could be valuable to increase program success. The majority of respondents who identified these as key characteristics self-identified as having "beginning" or "developing" programs. However, self-identified "awesome" programs also identified staff's constrained time with students as a barrier to expanding services. This indicates that increased strategic planning time is critical for the growth of mental health services at any level. Respondents indicated that hiring dedicated to in-school direct service providers, like school psychologists, as well as service development professionals, like mental health navigators, increase capacity and allow for planning. They also noted that consistent funding that does not restrict hiring for these roles facilitates, or would facilitate, expanded services.

## Key finding #4: More service providers and community connections

Survey responses identified that having a list of service providers within their communities would be helpful in achieving program success, with "beginning" and "developing" programs highlighting this need most often. There was also mention of insurance obstacles and physical distance to community service providers as barriers to utilizing community connections.

Schools also identified that building community connections and relationships would be a helpful step for improvement almost as many times as they identified the need for service providers. While the number of providers is important, several respondents noted that fostering strong relationships with those external service providers helps successfully connect students and families to services. Furthermore, several respondents noted that stigma in the community contributed to families' reluctance to move forward with a referral to a service provider outside the school. Respondents indicated that conversations with families and community members increase community buy-in, and they identified that building partnerships separate from community providers is necessary. This includes local government agencies, nonprofits, or other community-based organizations invested in youth mental health. For example, a United Way chapter in Wisconsin co-organized an initiative called "Providing Access to Healing," through which partner mental health agencies place service providers in schools to mitigate any transportation and insurance barriers to access. ("PATH Impact Report 2020-2021" n.d.). Community partnerships like these increase service capacity when schools have limited on-staff service providers. References to such partnerships were prominent in survey responses from respondents reporting "beginning" and "developing" programs. Overall, survey answers indicated that successful programs would need to connect with outside resources to provide stronger services to students.

## Survey conclusion

In our analysis of the "School Mental Health Survey" OCMH conducted in December 2021, we examined how district mental health stakeholders perceived their school-based services. While we see slightly higher proportions of students with disabilities in districts where respondents reported "awesome" and "not yet developed" school-based mental health services, we can draw limited conclusions. District determinations of who is labeled as disabled and what constitutes a disability vary by district. In qualitative section, the four key findings suggest that:

1) structural challenges persist across levels of mental health services, but some developmental progress is possible with limited resources;
2) identifying small action steps from other districts is a low-cost strategy to support development of referral systems;
3) ongoing funding to hire on-staff mental health providers and professionals can increase mental health services capacity; and
4) expanded mental health services requires strong connections with providers and other community partnerships.

The first two points indicate short-term actions for schools and districts but are not sustainable without statewide change. The last two points indicate long-term systemic changes, echoing the need identified in the comparative analysis to leverage different funding mechanisms to pay for providers and grow mental health services in Wisconsin.

# Analysis of School Mental Stakeholder Interviews

Our team conducted 11 interviews with 12 school district mental health stakeholders to expand on the data collected in the OCMH survey. Below we provide an overview, methodology, and key themes.

## Overview

Throughout March, our team conducted interviews with mental health stakeholders from Wisconsin schools. We interviewed a mix school district staff who previously identified their programs as beginning, developing, or successful in the OCMH survey. Our sample consisted of urban and rural school district staff who held a variety of positions. The goal of the interviews was to provide more context to the findings of the OCMH survey. Furthermore, the interviews provided participants an opportunity to expand on their experiences with mental health in schools. We asked questions regarding what districts need to have successful mental health services, what mental health services districts currently have in place, what is going well with these services, and what challenges districts are facing.

We identified five key themes in the interviews: sustainable funding for school-based mental health services, staffing on-site mental health professionals, relationships and partnerships at school and in the community, staff development, and staff wellness. Each theme represents a characteristic of successful school mental health services. Below we provide our methods for selecting interview participants and coding the interviews. We then offer an analysis of the five themes, which includes a description of each theme along with evidence from our interviews to support it.

## Methodology

We sent invitations for interviews to respondents of the OCMH survey in phases, first to 20 respondents. This random subsample was stratified to include respondents from both urban and rural contexts, as well as respondents from each of the self-reported service statuses. Due to a low response rate and OCMH's interest in gaining insight to successful practices, we then sent invitations to an additional 16 respondents

who self-reported their services as "awesome." We interviewed every person who indicated they were willing to participate, resulting in a total of 11 interviews and 12 interviewees. The remaining 25 survey respondents we contacted for interviews did not respond to our invitation. Interviewees came from both urban and rural districts and from schools that self-identified as successful, developing, or beginning in the OCMH survey. Seven interviewees identified their mental health services as successful, one identified their services as developing, and four identified their services as beginning. Interviewees work in a variety of positions, including Director of Student Services, Executive Director of Student Services, Director of Pupil Services, Director of Special Education, Director of People Services, District Administrator, Middle and High School Principal, School Psychologist, District Superintendent, and a school district's Collaborative for Children's Mental Health Manager. Some interviewees held two or three of the above positions. To maintain anonymity, names interviewees and the school districts they work in are not included.

Our interview guide included seven primary questions (see Appendix C). We constructed our questions to identify traits of successful school mental health services, barriers to achieving success, how well schools currently serve their students, schools' referral processes to mental health services, and what types of data schools collect about mental health. We asked follow-up questions during the interview for clarification and to make interviews more conversational. We conducted interviews via Zoom video conference with the interviewee and two members of our team. Interviews were recorded with interviewees' permission and automatically transcribed using the Zoom platform. During the interviews, one of our team members asked interviewees questions while the other team member took notes.

Our team used a combination of inductive and deductive coding to identify thematic trends. We began by parsing through the automated transcripts and our notes from each interview to identify similar themes to the OCMH survey qualitative data. Then we watched each recording, searching for other potential themes that may not have been coded for in the survey data. Five main themes emerged: sustainable funding for school-based mental health services, staffing on-site mental health professionals, relationships and partnerships at school and in the community, staff development, and staff wellness. By looking at the interviews through two different approaches, we aimed to get the most robust evidence possible to speak to themes of successful mental health programming. Using the recordings, transcripts, and notes, we pulled quotes from the interviews and assigned quotes to themes. We shared any quotes we wanted to include in our report with interviewees to gain their consent and ensure we had correctly interpreted their words[1]; this method is known as member checking or respondent validation (Stoecker and Witkovsky 2022).

## Analysis of interview themes

Five themes appeared in nearly all 11 interviews. Respondents consistently mentioned having continuous, non-competitive funding; mental health professionals in schools; connections with students and the broader community; mental health trainings for staff; and wellness support for staff as critical to finding and maintaining high-quality mental health services.

### Sustainable funding for school-based mental health services

A characteristic across interviewees who identified their services as "awesome" is the diverse funding sources they use for both their school- and community-based mental health services. Grants included those at the county level, like Dane County Mental Health Grants, and at the state level, like the non-competitive grants from Kids Get Ahead Initiative by DPI.

Some interviewees sought out grants or used district discretionary funds to cover the cost of services for students and families without insurance or for whom they could not seek Medicaid reimbursement for school-based services. An interviewee from a district in an urban context (self-reporting their services as "awesome") offers school- and community-based mental health clinics through district funding coordinated by the school board for community services. Interviewees across self-reported service status emphasized the importance of state funding in creating positions for a mental health navigator, school

[1] Some quotes were edited for clarity.

psychologist, social worker, or other student services role where none previously existed. One interviewee expressed how greatly their school district needed sustainable funding to have these types of positions. They explained the district does not have the funding to provide a full-time mental health professional to their students during school hours nor space for privacy within the school for a professional to provide services.

Every interviewee mentioned that funding was essential to having successful mental health services and was often considered a prerequisite to the other themes. School districts have to find creative ways to fund their mental health services, such as using COVID-19 relief. While federal emergency funds relief support mental health services, long-term non-competitive funding from the state was deemed most important for sustainable services.

### Staffing on-site mental health professionals

Another theme was that mental health professionals in schools are essential, yet their impacts are limited if there is not enough time for providers to meet with students. Some interviewees who identified their programs as beginning or developing indicate that having professionals in the building is an important sign of successful mental health programming. Many administrators highlight the work of their in-school professionals and the need for services in the school. On this subject, one interviewee said: "*I think there is a strong need for services provided onsite at school. We've tried several different approaches and achieved varied levels of success.*" Another interviewee noted that having staff in the schools was important, but a key to successful mental health programming was "*having highly qualified staff. From the school angle, having highly qualified and a low enough ratio that students don't slip through the cracks*." Furthermore, some districts need staff with specialized skills in their schools. As one interviewee described having "*not enough people, particularly to serve students and build relationships with families whose primary language is a language other than English*." This illustrates the importance of not just hiring in-school providers, but hiring and retaining high-quality, specialized professionals.

While several other interviewees mentioned that their schools had on-site professionals or increased hiring, there were still long waitlists, forcing schools to create priority systems for students and recognize they are unable to service all who demonstrate need. Thus, staffing of school mental health professionals remains the main focus for district level professionals in charge of mental health services.

### Relationships and partnerships at school and in the community

In addition to sustainable funding and on-site mental health professionals, respondents identified strong relationships and partnerships in both schools and communities as critical to sustaining their mental health services. Several interviewees noted that while referrals frequently come from universal screenings, referrals from parents, teachers, and student services staff—particularly nurses and social workers—are also common. Moreover, these referrals result from relationships staff build with students, especially in small rural districts. One interviewee noted, "*We know all of our students; we know when they're off, when something is going on... we make sure we are giving them the attention they need at school. A quick 'hello, how's it going.' Just check-ins. Making sure they feel relevant, especially within our walls*." This highlights how informal conversations allow staff to screen in ways that are not stigmatizing. Another interviewee noted that a strength of small rural districts is that "*we get to know kids very easily, and when you have longevity in the district you get to see them grow from kindergarten through high school. So you get to also follow up and maintain relationships with families and students after you've already provided some services*." These in-school relationships support the efficacy of school mental health frameworks.

Furthermore, several interviewees—particularly those from districts that have been developing their mental health services for many years—note that the continuation of their mental health services partly results from the wider community's investment. For example, one interviewee in a rural district noted that a student with disabilities died by suicide a few years ago; the broader community—including local counseling agencies and a hospital—collaborated to bring community-based mental health professionals into their schools. This district-community partnership, called "Counseling for All to Reach Emotional Success" or CARES, also funds services for students without insurance through grants and community-

family engagement events sponsored in part by local businesses. That said, the interviewee noted they "*had a lot of conversations and had a hard time getting it going*," over the course of 10 years. The time required to build out services was echoed by another interviewee—it took years of concerted effort. When discussing the role of community in developing mental health service clinics, an interviewee noted that "*it's the buy-in, it's the training, it's the learning, it's the understanding, and really engaging that community so that you can find the support in it. Because we could open up clinics, and if our community didn't support it, no kids are going*." Both interviewees quoted here—as well as others—emphasized that the strategies for sustainable community buy-in for school mental health services depend in part on the broader sociopolitical context and on dedicated time for relationship-building among stakeholders. Nevertheless, when school districts and communities have strong partnerships they are able to creatively address student mental health, such as the district and community that were able to bring clinics to the area to serve students and community members.

## Staff development

Interviewees also discussed the role of mental health trainings school staff receive in supporting student mental health. By "development" we are not only referring to the training received by mental health professionals, but also to the mental health trainings that are available to all staff, such as school administrators and teachers. Providing trainings to staff, especially teachers, who interact with students every day is valuable because they know the students well and thus can more easily identify when a student is in need of mental health assistance. One interviewee explained the importance of providing mental health trainings to staff who are in contact with students regularly: "*It's also teaching skills of how to have that conversation around mental health. You know, what does that look like? And we've really been doing some great work with our teaching staff on this, and it's been a wonderful experience for me because...they walk away from the training and say, 'this was so helpful to me because now I can do it differently.*'" Another interviewee stated, "Y*ou can build those skills that can lead down the road of mental health. If you can build a student's resiliency—if you can build the trusted adults around a student—it doesn't necessarily have to be a pupil services person or a counselor that has to do that.*" This interviewee, among others, signals that it is not just the mental health professionals who can assist students with their mental health; all staffers need the proper tools and skills. This is especially relevant for school districts that do not have on-site mental health professionals. Without mental health professionals, school administrators and teachers become the mental health supports for the students. Therefore, staff must be properly equipped to help students navigate their mental health.

However, the second interviewee noted above also highlighted a challenge with providing mental health training: *"This of course takes away from academic time...It costs resources.*" School districts do not always have the available staff or time in the day to take teachers and administrators out of their classrooms and offices to participate in trainings. It is not as simple as making trainings available, but also ensuring they are accessible. Accessibility pertains not only to the ability to participate in the trainings, but also ensuring the content of the trainings reflects real experiences. One interviewee voiced: "*Sometimes I feel like the people leading these trainings don't have the lived experience, so I feel like our team who went through that were kind of disappointed in a way. We didn't really feel like we got a lot out of [the trainings] other than that the tool was great and now that gave us some direction.*" Both quotes indicate that staff development trainings must be tailored to the intended audience and adequately funded to be useful.

## Staff wellness

While it is important for staff to develop mental health skills, some interviewees commented that ensuring staffers themselves were healthy mentally was an important step to caring for and educating students. One interviewee expressed the burnout his staff is experiencing from having to balance students' mental health needs, meeting state academic requirements, and the challenges brought by the COVID-19 pandemic: "*My staff are worn out. I mean...this is a lot to ask. You know, the state doesn't let up on the academics just because there's some, you know, thing like COVID that sets you back a year developmentally.*" Another interviewee notes, "*I am seeing a breaking point across the nation," in reference to school staff and the*

*various duties they must manage, even when it puts them "way beyond their hours.*" One interviewee asked rhetorically, "*Wait, don't we have to have mental health first before kids can actually learn, and don't we have to take care of those adults in the building before we can actually get back to taking care of kids?*" This final quote represents the value in maintaining staff mental health. As staff struggle to care for themselves, their ability to care for students is inhibited.

## Interviews conclusion

The themes identified in the interview portion of our analysis provide further details that support the findings in both the state comparative analysis and the survey analysis, particularly those related to funding. In 11 interviews, experienced school mental health professionals identified five key components to robust mental health services: continuous funding, on-site mental health service providers, relationships and partnerships within the school and community, staff professional development, and staff mental wellness. Since we drew interviewees from survey respondents, crossover themes are unsurprising. However, the additional details gathered in interviews provide insight as to how districts with "awesome" services utilize existing resources and where additional communication would facilitate use among districts with "developing" or "beginning" services.

# Recommendations

This section includes seven recommendations to strengthen mental health systems in Wisconsin schools. Our team formulated them based on the analysis of the surveys and interviews, along with the information gathered from the comparative analysis. While creating these recommendations, we applied special weight to what we learned from survey respondents and interviewees, as these stakeholders know best what is needed to improve school mental health. Our recommendations are separated into two categories: recommendations for OCMH to implement at the state-level and recommendations for OCMH to implement at the school district and individual school level.

## OCMH and state-level recommendations

**Recommendation 1: Support increased sustainable school funding specifically for mental health services.**

Sustainable funding sources were mentioned as a critical aspect of school mental health services across the comparative analysis, survey, and follow-up interviews. While there have been state budget allocation increases to student services funding and school mental health collaboration grants, district staff—often already in split roles—spends a significant amount of time searching and applying for grants to fill funding gaps. Interviewees described grant applications as competitive and time-consuming. Furthermore, grants offer funding for a limited time, so when the grant funding ends, mental health services may face financial struggles and providers may suffer job insecurity. Limited funding has caused statewide shortage of mental health providers, both in schools and communities. Therefore, many students face long waitlists to receive care even when their family can afford mental health services or their school provides mental health services.

To support schools in securing funding, the application process for school mental health grants should be simplified. This would decrease the amount of time staff in schools must spend applying for grants while increasing their time to meet with students and focus on mental health resources within the school. Simplifying the grant application process could be done by increasing the duration of the grant so applications do not have to be filled out as often. The length of the application process could also be decreased by reducing the number of questions and required documents. Finally, it should be ensured that when a new grant is available, the funding entity holds an information session to provide schools with information about applying. Information sessions would be especially helpful to schools just beginning mental health services and unfamiliar with the grant process for mental health funding. OCMH should

directly assist in these strategies by communicating the funding frustrations of school districts to Wisconsin departments (like DPI) that offer grants. Additionally, OCMH can converse with DPI and other state agencies on ways to best reduce funding barriers, such as the options recommended above.

**Recommendation 2: Support legislative efforts to expand Medicaid reimbursements for telehealth services as a supplemental method to mitigate the impact of the mental health provider shortage.**
Both interviewees and survey respondents consistently identified long wait times for existing service providers or a limited number of service providers in their community generally. Survey respondents rarely mentioned telehealth services. Interviewees, however, regularly commented that it was difficult for students to build relationships with providers in online settings; moreover, it was difficult for them and their staff to hold students and parents accountable for keeping appointments. Telehealth expands access to providers by removing commuting time for both families and providers; however, issues with broadband access are greater in rural areas, which could limit the utility of telehealth option.

Furthermore, DHS recently updated the temporary COVID-19 Medicaid coverage policy and billing guidelines for school-based telehealth to be permanent (Forward Health Update 2022-02). However, Wisconsin's Medicaid coverage for school-based services—telehealth or otherwise—only applies to students with documented need in their IEPs. Other states with Republican legislatures (Florida, Illinois, and Iowa) expanded or submitted amendments to expand their school Medicaid coverage policy and billing guidelines to cover all students eligible for Medicaid, regardless of IEP ("America's School Mental Health Report Card"). We therefore recommend that OCMH support state-level policies that expand school-based Medicaid coverage for all eligible students to further broaden access to practicing mental health providers. This could include policies formulated in the state legislature, the Governor's Office, or a government department. However, increasing student accessibility to providers must be done in tandem with our first recommendation, as additional funding is necessary to address the shortage of mental health providers in the state. For example, in March 2022 Governor Tony Evers and DHS announced a $5 million investment in telehealth. The investment will fund two new grant programs, one of which is dedicated to expanding telehealth for child psychiatry services ("Gov. Evers Announces" 2022). OCMH should applaud this progress in telehealth and promote this future grant.

**Recommendation 3: Support legislative efforts to codify dedicated, sustainable mental health training for school staff.**
District school mental health leaders emphasize that staff members need both substantive ongoing training on supporting students as well as dedicated time to attend to their own wellness. Survey respondents and interviewees identified limited classroom time due to increased student academic expectations, increased environmental pressure (due to the pandemic, for example), and limited confidence in their mental health literacy as conditions inhibiting staff from regularly engaging students in conversation about their wellness.

OCMH should support statutorily required structured time for staff training. For example, Iowa statutes require trainings for staff on various identification, prevention, and intervention strategies (School Mental Health Report Card). OCMH offers several trainings on similar themes, as do CESAs. It is possible that these statutes face similar challenges in implementation to those described by the stakeholders—namely, that staff spend one to two days on such trainings rather than having continuous, holistic engagement. Nonetheless, codifying dedicated time for this wellness support may contribute to a long-term cultural shift toward normalizing regular engagement with the practices described.

## OCMH and district-level recommendations

**Recommendation 4: Facilitate connections and collaborations between schools and available resources, specifically Cooperative Educational Service Agencies (CESAs).**
Both schools and resource providers value community connection in mental health services. Using examples from interviews, connections could take the form of partnering with local clinics to provide mental health services to students or simply building relationships with parents to make the referral process

run more smoothly. Wisconsin DPI, OCMH, and other state agencies have pre-existing resources that schools can use to improve their mental health programming and build valuable connections. In particular, CESAs provide a link between school districts and the state (Wisconsin State Statute, Chapter 116, 1983). The 12 CESAs in the state can facilitate regional partnerships and coaching services that are specialized to the needs of the schools in those regions.

However, there are barriers that may prevent schools from accessing existing resources. Despite the regional locations of CESAs, there can still be difficulties traveling to the CESA office in more rural areas. While virtual sessions are available at some offices, many of the district staff members we interviewed explained their already burdened schedules impede their ability to attend the virtual sessions. Once again, funding may also limit a school's ability to receive CESA training, as districts use grants or other school funds to attend trainings held in person. These factors diminish the number of CESA services in which schools can participate. Promoting DPI and OCMH resources regularly, as well as working to reduce some of the barriers that may inhibit staff from accessing CESA resources, will allow schools to strengthen their services and build stronger relationships within the school mental health community.

**Recommendation 5: Advocate for the increased robustness of school mental health data collection and analysis through the implementation of statewide student mental health screenings.**

Data collection and analysis for the purpose of identifying students or staff members who may need mental health services appeared in the comparative analysis, survey results, and interviews. Often, schools use climate surveys or mental health screenings to get an individual connected to mental health offerings at the school or within the community. Encouraging districts to use well-being checks in elementary, middle, and high schools aids in evaluating mental health needs as early as possible. Continuing to reevaluate students over the course of several years will create more robust data within districts.

Stakeholders identify the difficulties of dedicating time to mental health initiatives due to the emphasis on academics during the school day. Therefore, Wisconsin's policymakers could support this recommendation by creating a statute to require districts to evaluate the mental health needs of their students and dedicate a specified number of hours within a school year to this evaluation process. Given that many schools districts currently evaluate mental health through climate surveys and mental health screenings, codifying evaluation requirements should not result in an additional responsibility for school districts. OCMH could also advocate for a statute that creates a minimum for how long mental health data is stored. Based on interviews, some school districts do not keep the data collected from surveys and screenings for extended periods of time. Therefore, these districts cannot see how students' mental health progresses over years and do not have much data to provide while applying to grants that could be used to demonstrate their need for funding. Furthermore, if mental health data were to be anonymized and reported to DPI, it could be used to justify the funding of mental health services and evaluate the success of programs receiving grants from the state.

**Recommendation 6: Incentivize schools to commit time for staff to develop skills needed to support student mental health, along with their own.**

This recommendation directly ties to the state-level recommendation to support legislative efforts to codify dedicated, sustainable mental health training for school staff. As mentioned above, stakeholders cited a lack of time in the school day and a lack in mental health literacy as barriers for staff to attend to students' and their own. This is a major barrier for school districts that have yet to develop mental health services or are in the early stages of development. A lack in mental health literacy is especially prominent in school districts without mental health professionals and district staff have no professional mental health training. We therefore recommend OCMH guide school districts in finding creative ways to commit time for staff to develop skills to support both students' and their own mental health.

Successful school mental health programs in both Wisconsin and comparison states exemplify this recommendation in several ways. As mentioned in the comparative analysis and third recommendation, states like Iowa have codified training for school staff. However, if requiring staff training is not feasible at the state level, OCMH and its partners can provide simple and ongoing training to ensure staff members

are prepared to handle student mental health needs. Many interviewees mentioned a need and desire to increase staff training. OCMH should ensure training is accessible to staff, considering how academic expectations constrain available staff time for mental health support. OCMH should work with school district administrators to find ways to incentivize staff to participate in mental health training outside of the school day, as that is likely when staff will have the most availability. However, it is important to note that even with incentives, special consideration should be given to staff well-being, and training should be ongoing and responsive to staff needs.

**Recommendation 7: Assist school districts and individual schools in taking small, immediate actions to improve student mental health.**

Most of our above recommendations require long-term implementation. However, student mental health is an urgent issue that must be addressed in the short term, as both the research and stakeholders confirm. With that in mind, we recommend that OCMH assist schools in taking small steps toward improving student mental health that can be implemented immediately. This final recommendation will best serve school districts that identified as "not yet developed," as they seem to be the most in need of additional guidance and ways to quickly implement change. This recommendation will also help districts at all levels of mental health services immediately begin strengthening mental health services for Wisconsin students.

There are numerous government and non-governmental organizations that provide a variety of resources and technical assistance intended to help school districts and individual schools take immediate actions to strengthen their mental health services. Entities include the Center on Positive Behavioral Interventions and Supports (PBIS), DPI, the Coalition for Expanding School-Based Mental Health, the Wisconsin Safe and Healthy Schools Center, and OCMH itself, to name just a few. These entities provide free resources including, but not limited to, surveys, screening instruments, evaluation tools, tips on using data to enhance mental health efforts, guidelines for implementing a comprehensive framework, and resources devoted to help families collaborate with schools on their children's mental health. Additionally, research is available on how to improve mental health and create a mental health positive culture by combating negative feelings such as loneliness and lack of belonging.

Despite these available resources, survey respondents and interviewees commonly mentioned they felt there was a lack of useful resources on how to improve mental health services. This was especially common for districts in rural areas, districts in the early stages of developing mental health services, and districts with staff who have minimal mental health training. As for survey respondents and interviewees who mentioned they do utilize these resources, all identified limited time as a factor inhibiting further exploration. Regardless of why stakeholders struggle to find useful resources, there is clearly a gap in the information sharing pipeline regarding mental health resources. To reduce the gap, OCMH could partner with the entities listed above and others to compile available resources into a single guide, which could be organized by resource topic and provide top resource recommendations that are evidence-based.

The resource guide could also include research-based methods to create a positive mental health culture in schools. For example, the guide could include the concept of *interruptibility*, which signals that one is approachable and willing to halt work to listen to another's mental health struggles (Van Cohen 2022). Interruptibility is intended to combat loneliness, which can have serious effects on one's mental health (Van Cohen 2022). It would be especially valuable for schools that do not currently have on-site mental health professionals by having teachers and staff implement strategies of interruptibility into their workdays. This could include avoiding the use of technology in between class periods and acknowledging students as they enter and leave the classroom. Interruptibility could be done more explicitly, like inviting students to stop by after class, during lunch, or during a free period if they need assistance on homework. This may open the door for students to feel more comfortable expressing personal concerns with staff. Furthermore, interruptibility should not be applied only on a staff-to-student basis, but also staff-to-staff. As reflected in the interviews, staff wellness is a prerequisite to student wellness. School staff should feel as though they can turn to one another for support on both school related and personal concerns. OCMH should collaborate with DPI on disseminating information and strategies to help schools implement a culture of interruptibility. OCMH and DPI should also work together on identifying ways that they can be

interruptible so that schools and school districts feel they can turn to OCMH and DPI for resources and guidance.

In conjunction with the resource guide, OCMH should develop a step-by-step plan that walks school districts through ways to connect with students' families and the community on student mental health. As the interviews highlighted, having buy-in from parents and the community was essential to creating strong mental health systems. However, some interviewees expressed challenges in collaborating due to stigma or being in a rural area that lacked proximity to potential partners. A family and community collaboration plan rooted in some of the available family resources could help schools navigate and strengthen these relationships through simple processes. For example, PBIS provides a rubric that helps integrate families into the classroom. A classroom engagement strategy such as PBIS's could be included, along with tips on how to lead a community conversation on student mental health. Furthermore, in collaboration with other entities, OCMH should provide opportunities for districts and schools to meet and exchange ideas on how to involve the local community in student mental health. This may potentially help districts and schools find creative ways to navigate some of the more challenging relationships.

# Assumptions and Limitations

## Sample sizes

As indicated during the survey analysis section, OCMH distributed its "School Mental Health Survey" to all 421 school districts in Wisconsin. The survey had a response rate of 27 percent. Given the low response and corresponding small sample size, we were unable to draw generalized claims from the data. However, the survey still provided valuable insight into the mental health services of the districts that responded.

A small sample size is an issue also found within our interviews. We selected interviewees from the list of survey respondents using a stratified random sampling technique because we wanted to interview a mix of urban and rural stakeholders, as well as a mix of stakeholders who identified their services as beginning, developing, or successful in the survey. We sent interview invitations to 36 survey respondents and interviewed 12 respondents total in 11 district interviews. Our subsample was entirely white, roughly split between male and female interviewees. Most interviewees self-reported their services as "awesome" due to targeted outreach based on OCMH's interest in successful practice. We did not receive any response from survey respondents who self-reported their services as "not yet developed." While we sought to interview respondents with different experiences, our interview data is not representative of these identities, nor is it representative of the state of school mental health services in Wisconsin as a whole. However, similar to the survey data, the interviews we conducted still provided in-depth context to the literature review of school mental health in our report and allowed us to include educators' voices and real-life experiences.

## Findings

All findings rely on self-reported data. Respondents in different districts may have similar mental health resources and structures in place but may interpret the status of their referral pathway differently relative to their experience. Moreover, all respondents selected to participate in the survey and interviews; unknown underlying factors may influence nonrespondents' ability to participate.

Furthermore, the quantitative survey findings rely on demographic data reported to DPI. Students with disabilities may be over or under-reported in different districts due to implicit biases, externalized behaviors, or other factors. Some districts may include students with physical disabilities and cognitive disabilities, while other districts may only include cognitive disabilities. Our findings do not capture these nuances in defining disabilities and therefore are limited by the assumption of a homogenous definition.

# Conclusion

School-based mental health services are a critical component of support systems for students, particularly in the context of the COVID-19 pandemic. Recent efforts to increase resources for school districts through funding and training opportunities contributed to significant growth of school-based mental health service access across Wisconsin. That said, the status of mental health services in Wisconsin's K-12 schools varies widely, from districts with few structures in place to districts with 10 years of structure-building experience. OCMH seeks to understand the conditions that facilitate or inhibit the development of successful mental health practices in Wisconsin's schools. Furthermore, they are interested in comparing Wisconsin's school mental health initiatives to other states with similar legislative leadership and geographic contexts. While Wisconsin recently increased funding for school mental health at the state level, a comparative analysis of states with similar characteristics to Wisconsin may identify politically feasible areas of growth to codify school mental health in state law.

To that end, we conducted a comparative analysis of six states with legislative and geographic contexts similar to Wisconsin's. We also examined survey responses from and conducted interviews with school mental health stakeholders from districts across the state to gain further insights into how schools develop and sustain robust mental health services. This revealed more pervasive system challenges with mental health access, witnessed by respondents from all districts interviewed. We found that while districts face ongoing funding challenges and a shortage of mental health professionals, strong community partnerships and dedicated time for staff development can mitigate the impact of these resource limitations. We crafted five recommendations for OCMH to implement at the school district and state level to address ongoing challenges and facilitate community partnerships.

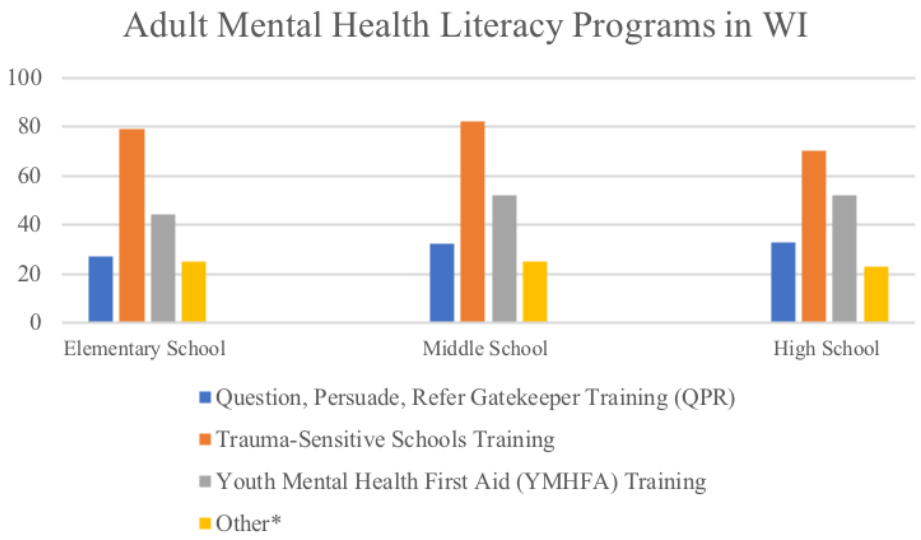
Building out the structures needed to support robust school-based mental health services requires significant investment from both districts and the community in which a school is located. Moreover, systemic challenges will persist if these efforts are not supported with sustainable funding coming from the state level. That said, efforts by OCMH, Wisconsin Association of Family and Children's Agencies, and all those in their communities seeking creative ways to support their students invite hope for continued progress toward expansive mental health services for all students.

# Appendices

## Appendix A: Additional information regarding programming in elementary, middle, and high schools in Wisconsin

In addition to asking districts to identify the status of their mental health program, OCMH was interested in learning about the distribution of specific programs across the state. Building upon work to map peer-led youth mental health groups across the state, survey respondents were able to identify what programs they were using in nine different areas of school mental health programming. These include adult mental health literacy education; youth mental health literacy education; SEL curriculum; alcohol and other drug abuse prevention; suicide prevention; staff wellness; small-group counseling provided by pupil service professionals; individual, group, or family therapy provided by community providers; and school mental health system work. Respondents were able to identify if their district used programs at the elementary, middle, or high school level and could write in programs if they used something other than the options given. However, some schools were not able to identify all the programs they use due to an error in the survey software. Figures 8 through 16 show the distribution of programs in each area across elementary, middle, and high schools.

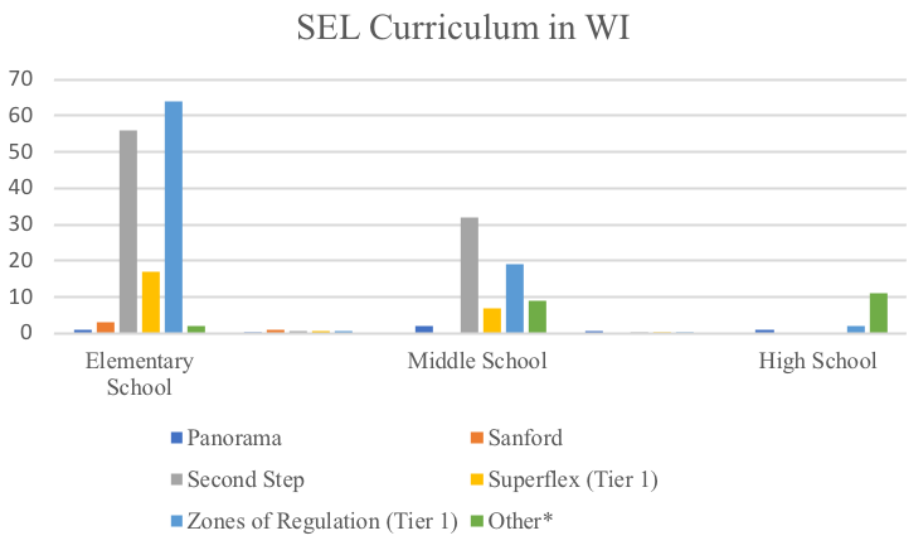
**Figure 8: Distribution of Adult Mental Health Literacy Programs across Elementary, Middle, and High Schools**




*Other may include programs such as ACES Training, Compassion Resilience, Mindfulness, Paper Tigers, and more

*Data from the Dec. 2021 School Mental Health Survey by OCMH*

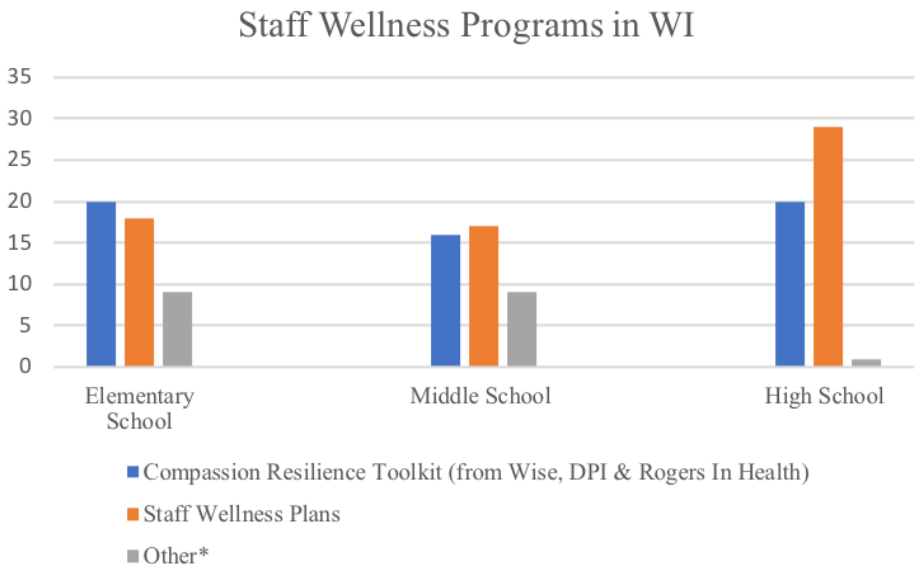
**Figure 9: Distribution of SEL Curriculum Programs across Elementary, Middle, and High Schools**




*Other may include Lions Quest, School Connect, Skillstreaming, and more, or a combination of programs

*Data from the Dec. 2021 School Mental Health Survey by OCMH*

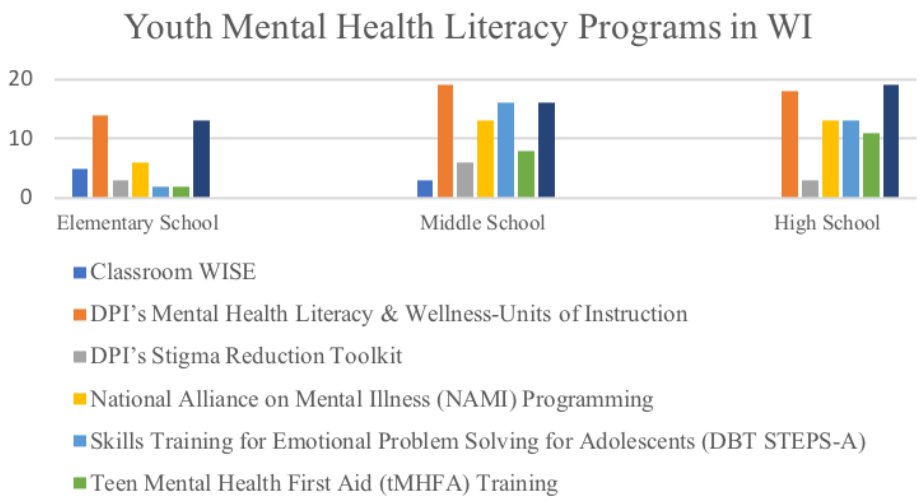
**Figure 10: Distribution of Staff Wellness Programs across Elementary, Middle, and High Schools**




*Other may include coaching, wellness activities and consultants, grants, and more

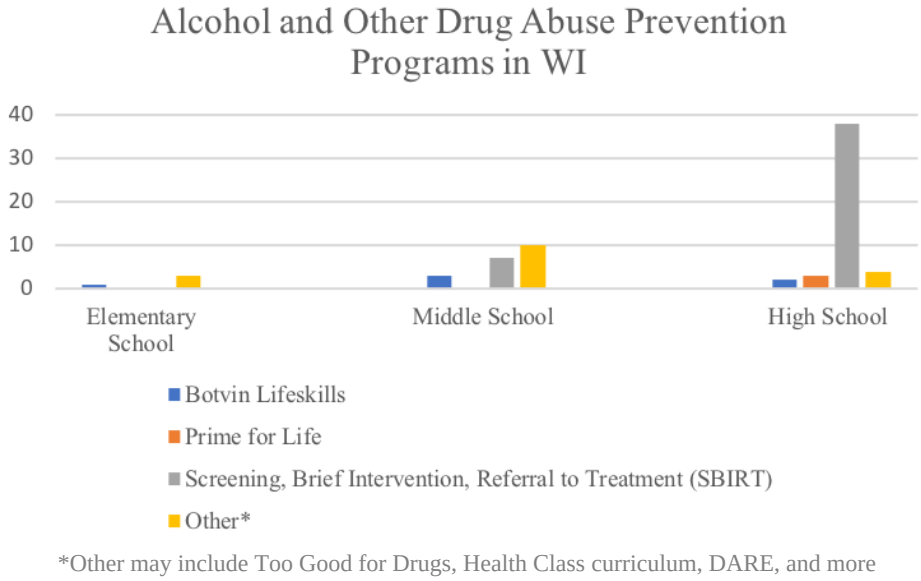
*Data from the School Mental Health Survey by OCMH*

**Figure 11: Distribution of Youth Mental Health Literacy Programs across Elementary, Middle, and High Schools**




*Data from the Dec. 2021 School Mental Health Survey by OCMH*

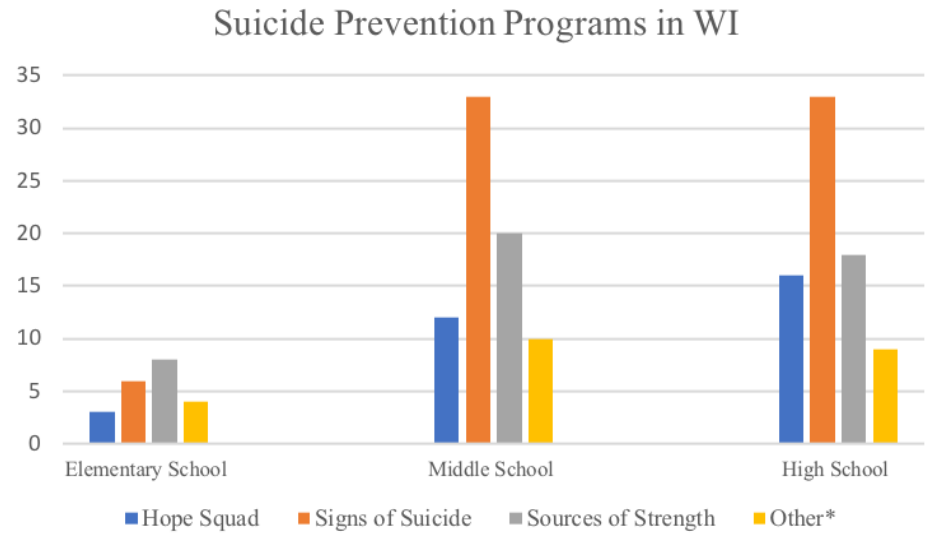
**Figure 12: Distribution of Alcohol and Drug Abuse Prevention Programs across Elementary, Middle, and High Schools**




*Other may include Too Good for Drugs, Health Class curriculum, DARE, and more

*Data from the Dec. 2021 School Mental Health Survey by OCMH*

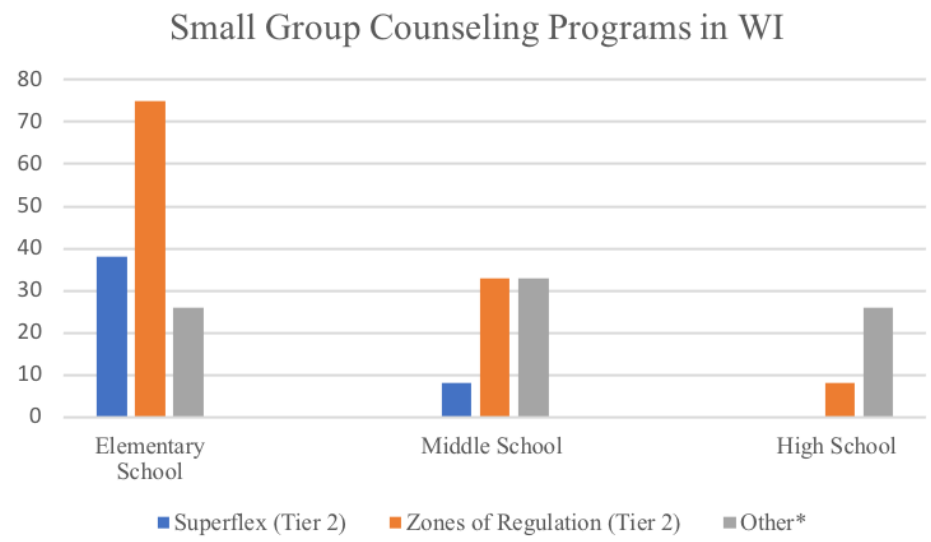
**Figure 13: Distribution of Suicide Prevention Programs across Elementary, Middle, and High Schools**




*Other may include Pathways, District programming, Erika's Lighthouse, Guidance class, and more

*Data from the Dec. 2021 School Mental Health Survey by OCMH*

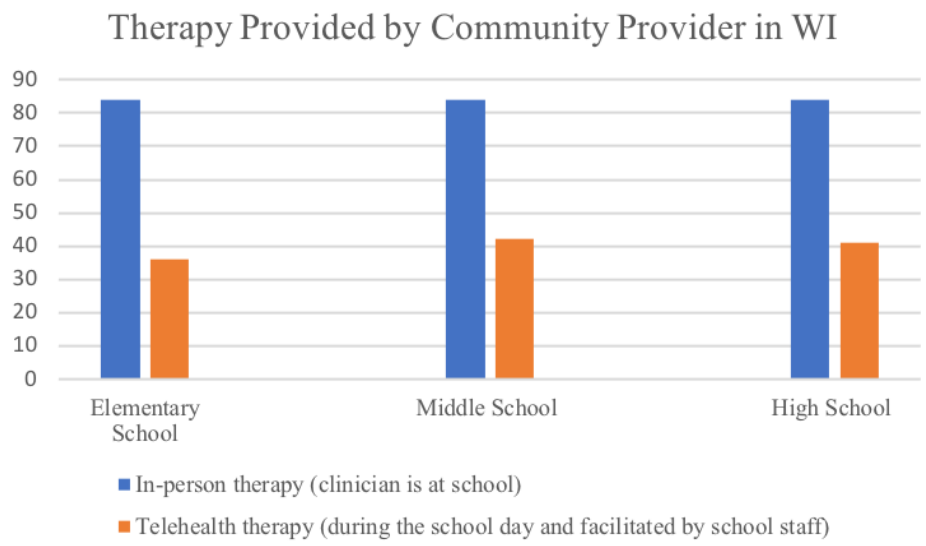
**Figure 14: Distribution of Small Group Counseling Programs across Elementary, Middle, and High Schools**




*Other may Mind UP, Mindfullness, Leader in Me, focus groups, a combination of several different programs, and more

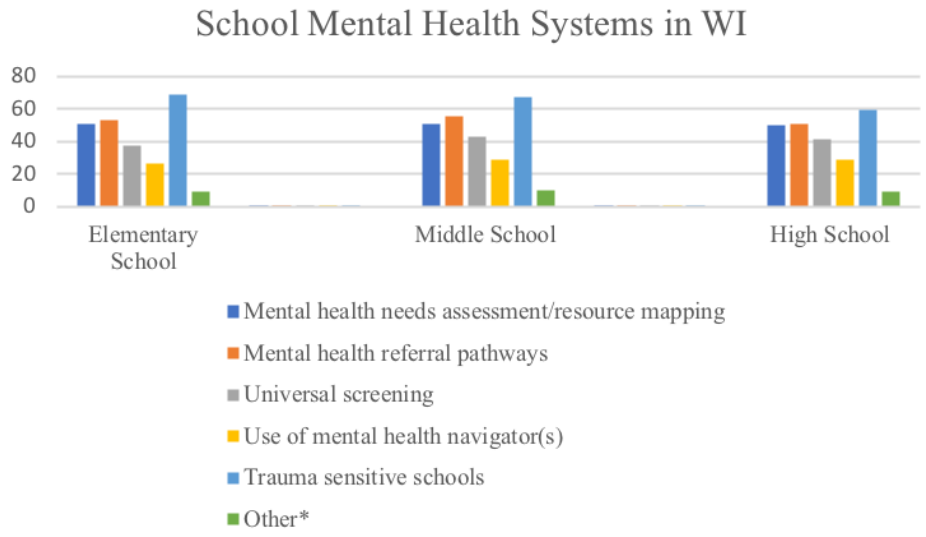
*Data from the Dec. 2021 School Mental Health Survey by OCMH*

**Figure 15: Distribution of Individual, Group, or Family Therapy Provided by Community Providers across Elementary, Middle, and High Schools**




*Data from the Dec. 2021 School Mental Health Survey by OCMH*

**Figure 16: Distribution of School Mental Health System Work Programs across Elementary, Middle, and High Schools**




*Other may include coaching from DPI, DHS, and Wisconsin Center for Resilient Schools, district hiring, and more.

*Data from the Dec. 2021 School Mental Health Survey by OCMH*

## Summary: Wide array of programming across the state

Through analysis of survey responses, no one pattern emerged about the types of programs used within elementary, middle, and high schools. For each category of interest, there were a few programs that stood out as popular at each level, with a few exceptions. For example, in the Adult Mental Health Literacy category, Question, Persuade, Refer Gatekeeper training (QPR) was the most popular program used among survey respondents at all levels. However, in the SEL curriculum category of interest, Zones of Regulation (Tier 1) was most popular at the elementary school level, Second Step programming was most popular in middle schools, and a combination of other programs was most popular in high schools. SEL Curriculum was more prominent in elementary schools overall. Staff wellness programming is another area of interest.

Survey respondents reported the use of the Compassion Resilience Toolkit in elementary schools; Staff Wellness Plans were used more in middle and high schools. The responses to these questions indicate that different programs are used more depending on the school level, but there are a few programs used throughout all grades.

## Appendix B: OCMH School Mental Health Survey themes and descriptions

Appendix B includes the themes we developed to code the two short answer questions on the OCMH School Mental Health Survey.

**Figure 1717: OCMH School Mental Health Survey: Short Answer Themes**

| Theme | Short Description |
|---|---|
| Communication | Respondents indicate communication challenges include addressing stigma within the community and effectively sharing resources with students and families |
| COVID-19 Impact | Respondents indicated the pandemic contributed to increased demand for services or exacerbated existing challenges with service delivery |
| Funding | Respondents identified funding (sustainable or grant-based) as critical to their mental health services growth |
| General Resources | Respondents called for additional resources, including dedicated time for mental health services development and community or district connections |
| Service Providers | Respondents identify a low number of providers in the community or challenges due to distance and insurance coverage |
| Staffing | Respondents called for additional in-school counselors, attention to staff wellness, or had general staffing concerns |
| Systems Development | Respondents identify a need to address systemic challenges in their referral pathway or are otherwise unsure how to grow their mental health services |

## Appendix C: Interview guide

Appendix C includes the questions from our interview guide. Along with our seven questions, our team included some potential follow-up questions. The purpose of having an interview guide was to give our interviews a conversational feel that allowed interviewees to lead the discussion. While the interview guide reminded us of what was important to uncovering during the interviews, we were not bound to asking the questions exactly as they are written below.

1. Can you confirm what school and school district you work in and tell us a bit about your position?
2. Tell me what you think makes for a successful school mental health service. (Probe, if necessary: What kinds of characteristics, resources, or services does a successful school mental health program have?)
    a. What components do you think promote school mental health services in schools?
3. It sounds your idea of good school mental health services includes X, Y, and Z. How does your school do on those fronts?
    a. So you're feeling good about X and Y, but Z sounds tricker in your school. Tell me about the challenges in making Z happen.
    b. Tell me about any efforts in your school these days to deal with barriers to Z.
4. Often, schools' mental health services work better for some types of students than others. Which types of students or student needs does your program best serve? (Probe, if necessary: What types of students are harder for your service(s) to serve well?)
5. Talk me through the process of how a student comes into connect with mental health services in your school.
6. Some schools track students' mental health or collect related kinds of data, and others don't. What types of data do you collect, if any, as part of your school mental health services?
7. As we're trying to learn what helps schools have successful mental health services, is there anything else you think I should know?

## Appendix D: Tiered system of mental health services

A multi-tiered system is often used to describe the range of mental health services offered to students. Tier 1 often refers to a program, curriculum, or framework that promotes a positive school climate and social, emotional, and behavioral skills for all students, also known as universal system supports. Tier 2 describes the additional support and interventions provided for students that are identified as at risk for mental health concerns. Finally, Tier 3 provides the most targeted services for students with serious mental health concerns that impact their daily lives. To support these three tiers of service, it is necessary to build a foundation that includes strong school-family-community partnerships and resources (Center for Health and Health Care in Schools 2021). All three tiers are necessary to support the mental health needs of all students; however, schools with new or developing mental health programs may only be able to provide services in selected tiers. The stakeholders we interviewed often mentioned which tier(s) their services best supported and which were met with challenges.

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