The Collaborative Task Force on Public School Mental Health Services

Year 3 Report

Contents

Acknowledgment: As an independent body, we acknowledge and appreciate the administrative support from the Texas Education Agency (TEA) to undertake this evaluation.

Executive Summary

In the two years following the release of the Collaborative Task Force on School Mental Health Services ("Task Force") Year 1 Report, Texas students have continued to grapple with the disruption, ambiguity, and tumult accompanying life in an ongoing pandemic and concerns related to school safety. At its inception, this task force studied state-funded supports to ensure school-based programs were meeting the very real mental health needs already alarmingly prevalent – and continuing to increase – on campuses across the state. Recent events have spotlighted youth mental health, but the need for school-based supports existed long before these catastrophes.

The data presented in this Year 3 Report reveals a staggering increase in the rate of students with mental health issues on Texas campuses since January 2020 - yet youth mental health concerns are not specific to Texas. This task force aims to play a crucial role in these students' recoveries by working diligently to determine the most impactful programs available to Texas school districts.

In addition to the pandemic and school safety concerns, challenges facing students include the following: economic, housing, and food security concerns and substance misuse - most alarmingly recognized as part of the national opioid crisis.

The key findings and recommendations listed here are based on a broad scan of current mental health services in Texas schools and will be discussed at length in the body of the report.

Key Task Force Findings

The Task Force made the following key findings:

- All students and staff need support. Rates of anxiety, depression, sleep disorders, suicidal behavior, and substance use disorders among students in Texas have risen. A significant majority of Texas school districts report increased student stress, anxiety, disengagement, behavior problems, and sadness/depression.
- School counselors need particular support to perform the mental and behavioral health counseling services as outlined in SB 179 (87 R).
- The availability of student mental health and behavioral health data varies across school districts and campuses. In this report, the Task Force responded to this gap by surveying districts about their **capacity** to collect student mental and behavioral health data.

Key Task Force Recommendations

The Task Force highlighted three primary gaps in the ability of school districts to address the emotional, behavioral, and mental health needs of students in Texas focused on (1) appropriate school staffing; (2) sufficient resources, including funding and effective training and coaching to implement evidence-based practices across the Multi-Tiered System of Support (MTSS) and (3) the collection of data that supports accountability and on-going quality improvement. The following represent the key recommendations from the Task Force to address these needs:

Gap 1: Appropriate Staffing to Address Student Needs and Supports

1. The Texas Legislature should allocate funds to TEA specifically dedicated funding to reduce counselor-to-student ratios, with the target ratio of 1 professional school counselor to every 350 students. In addition, the legislature should direct TEA to require that students at all campuses have access to a school counselor. TEA collects data on school staffing and should have the capacity to monitor district capacity to achieve this minimum ratio. Currently, the Public Education Information System (PEIMS) reports only district-level reporting of full-time equivalent (FTE) counselors, while data on counselor FTEs should be reported in PEIMS by campus to reinforce the importance of student access to a counselor on each school campus. The Task Force believes both this minimum staffing and reporting are required for districts to have the capacity to implement the Texas Model Guide and fulfill the intentions of SB 179 (87R).

2. To ensure that professional school counselors can dedicate at least 80% of their time to counselor duties, as reflected in SB 179, school leaders should attend required training

in the role of school counselors (as reflected in the Texas model) and the professional development needs of school counselors. Additionally, the Legislature could clarify language in SB 179 around what is mandated (versus recommended), the role of TEA in oversight, and accountability related to the law.

3. Workforce shortages exist across multiple roles, including professional school counselors, and shortages in one profession, such as teachers, impact other disciplines. The state should address the workforce shortages by increasing the number of people choosing a counselor career by offering student loan forgiveness, incentives, and scholarships for individuals to obtain the training needed for this profession and work in the field. Current concerns include staffing shortages with teachers and their effect on the teacher/student ratio, requiring more substitutes, and competing with teachers for staff positions.

Gap 2: Adequate Funding and Effective Training and Coaching to Implement an MTSS Framework.

1. Implementation of multi-tiered programs and strategies to address the social, emotional, and behavioral needs of students requires adequate funding for staffing, evidence-based programming, and training and coaching to support implementation. The Texas Legislature, the Texas Education Agency, and school districts should prioritize and dedicate resources needed to implement robust multi-tiered systems of support (MTSS) that provide for a coordinated array of promotion and prevention strategies, early intervention services, and linkages and referrals to community-based service providers for families seeking mental health services for their children. Priority funding strategies should include the following:
    a. Establish a Mental Health Allotment to provide districts with a consistent and dedicated funding stream to support schoolwide and targeted strategies that address the mental health needs of all students.
    b. In accordance with Medicaid #14-006, Health and Human Services Commission (HHSC) should be directed to amend the state Medicaid Plan to allow school districts that are Medicaid providers to be reimbursed for behavioral health services provided to students enrolled in Medicaid, beyond those provided to students with disabilities with an Individualized Education Plan (IEP). Additional guidance on leveraging Medicaid to support access to school-based services is found in this informational bulletin.
    c. Establish a grant program to which districts can apply to support the development and implementation of a comprehensive school mental health system of support, including access to enhanced training, technical assistance, and coaching in the use

of evidence-supported practices. Priorities for grant support should be based on identified needs, readiness, and plan. For example, see the Florida Department of Education Mental Health Plans and Grants for each school district as a Texas implementation model.

d. Continue promoting policies and best practices to support formal collaboration (e.g., Memorandums of Understanding or "MOUs") with external agencies to provide components of the MTSS for student mental health/behavioral health (MH/BH) at no cost to LEAs to provide access to services beyond the professional role and competencies of school counselors.

2. The Task Force recommends that the Texas Legislature fund a state center on school mental health or a consortium of higher education institutes to collaborate on supporting school-based mental health across the state. The state center could serve in one or more of the following roles:
    a. Collaborate with TEA, Education Service Centers (ESCs), and HHSC to identify a core menu of mental health trainings offered in every region, providing consistent and equitable access to district and campus staff.
    b. Provide train-the-trainer workshops to support the availability of core mental health trainings by ESC or district staff and monitor for quality and outcomes of training activities.
    c. Develop guidance documents, tools, and resources to support implementing mental health best practices selected by districts, reducing the overall cost of implementation.
    d. Provide direct technical assistance through structures such as learning communities around best practices and their implementation.
    e. Support job-embedded coaching with specific practices to support the implementation of the MTSS for mental health, allowing counselors or other appropriate staff to consult with teachers and support/coach classroom strategies for social, emotional, and behavioral wellness.
    f. Develop low-burden, effective programs that prevent or address mental health challenges and meet the specific needs of Texas schools.
    g. Provide guidance and support on braided funding strategies to support a comprehensive mental health MTSS, and
    h. Enhance the coordination between community-based organizations and schools to support students and families, using models appropriate to the community context (e.g., family resource centers, telehealth, school-based clinics).

3. The Task Force recommends the Texas Legislature direct The Texas School Safety Center (TxSSC), in partnership with TEA, to develop appropriate criteria - and corresponding metrics – to evaluate the effectiveness of a school district's Safe and Supportive Schools Program (SSSP) plan and MTSS framework about the use of practical mental and behavioral health safety strategies for implementation. For this recommendation to be successful, the legislature must attach funding to its directive.

   Once this evaluation framework has been established and approved by the legislature, the TxSSC, in cooperation with TEA, should conduct annual reviews of a sample of SSSP plans and MTSS frameworks for mental and behavioral health among a randomized sample of school districts, as well as others that are selected due to "at-risk" indicators, such as high ratios for counselors to students, high disciplinary actions, or lack of reporting on the SSSP data collection system. The external reviews could inform changes to SSSP training activities and assist districts with SSSP development.

Gap 3. Data Collection and Accountability for the MTSS for Mental Health

1. TEA should support the development of an electronic platform that school districts can use to conduct annual school climate surveys. The surveys collected by districts should be confidential and available only to the district administrators but could be shared with stakeholders at the district's discretion as a best practice. The platform should allow districts to customize the surveys to meet the district's needs while maintaining a core set of items required of all districts. The platform should include real-time access to data visualizations following the closure of the survey, as well as disaggregation by informant characteristics (e.g., grade and gender). The platform should include anonymous surveys completed by staff, students, and families. The platform should allow schools to benchmark their results against the average of Texas schools with similar characteristics and track results over time. Additionally, after school climate surveys are launched on the platform, TEA should consider adding optional survey modules allowing districts to measure student health and wellness and student social, emotional, and behavioral competencies.

2. The Task Force recommends that data collection processes for the Safe and Supportive School Program (SSSP) codified under Texas Education Code (TEC) §37.115 be amended to ensure regular and coordinated reporting of data elements to evaluate school mental health in compliance with HB 906. The following recommendations are based on responses to the task force's district survey conducted in 2022 and analysis of the SSSP reporting to TEA in 2020-2021 and 2021-2022.

a. All elements of the SSSP data collection should become mandatory for completion by districts.
b. The data collection tool should be formatted to ensure consistent formatting of responses (e.g., only numbers allowed) and parameters that limit the opportunity to enter inaccurate data.
c. Clear definitions should be provided for any data elements to ensure data tracking and reporting consistency.
d. The individual responsible for reporting on the SSSP data elements should be connected to TEA. TEA should follow up to clarify any data elements that appear inaccurate or inconsistent with other data. For example, current data submissions include some outliers that seem incongruous with the district's size.
e. The SSSP data collection should include the following data elements, which would require incorporation in PEIMS, with each including the total and broken down by gender, race, ethnicity, special education status, and educationally disadvantaged status:
    i. The school-based mental health supports or services available at Tiers 1, 2, and 3 of the MTSS for mental health, the number of students each support/service can serve, and any referral criteria.
    ii. The number of referrals for threat assessments related to the risk of harm to self and those associated with the risk of harm to others, total and broken down by gender, race, ethnicity, special education status, and educationally disadvantaged status.
    iii. The number of school-based mental health referrals to Tier 2 or Tier 3 services/supports, the number that resulted from a behavioral threat assessment, and the number of students who received the support/service. If the student did not receive the recommended support/service, the data collection should include why the service was not received (e.g., parent declined or lack of provider capacity).
    iv. The number of mental health referrals to Communities In Schools (CIS), TCHATT, Licensed Mental Health Authority (LMHAs), or another partner or community-based provider, the number that was the result of a behavioral threat assessment, and the number of students who received the support/service.
    v. The number of mental health referrals to a psychiatric hospital, acute care hospital, or emergency room to address acute mental health risks, the number from a behavioral threat assessment, and the number of students who received the support/service.

3. Require school districts to report the use of positive behavioral interventions), and alternatives to exclusionary discipline in Public Education Information Management System (PEIMS). Current requirements focus solely on exclusionary discipline and do not allow for examining the responses available to Local Education Agency (LEAs). Adding alternative options in PEIMS could prompt LEAs to consider these research-based options as part of meaningful discipline and learning actions. Positive behavioral interventions may include positive behavioral interventions and Supports (PBIS) strategies, classroom de-escalation strategies, counseling, skill building, student-family conferencing, restorative practices, wrap-around services, providing and connecting families with mental health services, etc.

Introduction

In November 2020, the Collaborative Task Force on Public School Mental Health released its first report, highlighting the vital role that school mental and behavioral health supports play in creating a safe and supportive school climate, increasing instructional time, and promoting academic success, health and wellness, and quality of life. In its charge to study and evaluate state-funded, school-based mental health services and trainings, the Task Force members identified services and trainings that met this definition, documented funding for state and federally funded services and gathered existing data on each service when it was available. The Task Force also outlined the vital role that an MTSS framework, adopted by the Texas Legislature in SB 11 (86R) as part of the SSSP and codified in TEC §37.1, plays in the establishment of a comprehensive school mental health system. This MTSS framework provides the infrastructure for evidence-based, best-practice approaches to preventing mental and behavioral health difficulties, promoting safety, and providing interventions and supports appropriate to a child's level of need.

In the two years since the Task Force submitted its first report, students in Texas have experienced disruption in their education, social isolation, family stress, economic instability, uncertainty about the future, loss of loved ones, and violence in their homes, schools, and communities. While these experiences aren't new, the number of students who have - and continue to be - affected is unprecedented. More than 14,000 children lost a parent or caregiver to COVID-19 in the first 15 months of the pandemic alone. The mass violence at Robb Elementary School in Uvalde in May 2022 was the latest mass trauma event to devastate an entire community and cause fear and anxiety among students, families, and educators across the state.

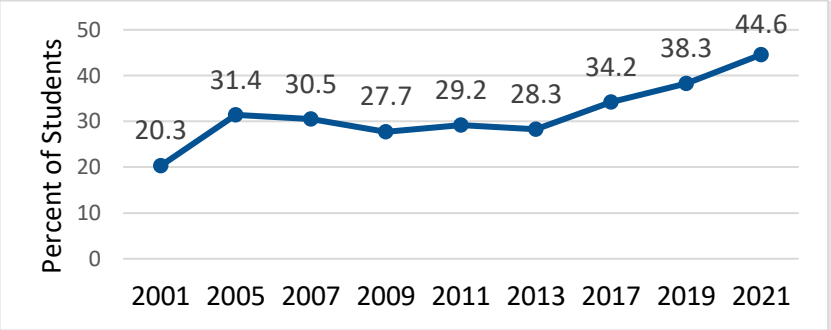
Schools will play a critical role in helping students recover from the cascade of challenges and traumas that put their mental health and education at risk.[1] Learning is fostered in environments where students' basic needs are met and where they feel safe, supported, challenged, and engaged.[2] There are evidence-based and research-informed strategies schools can use to create these conditions. Schools can also facilitate partnerships with and linkages to community-based services that help address adverse experiences and mental health concerns among students.

Schools that implement trauma-informed strategies and provide comprehensive and tiered levels of mental health support will support the education and well-being of all students and are critical in supporting the education and well-being of students affected by trauma and

those with or at risk for mental health concerns. Thankfully, children are resilient, and most will recover from their challenges. However, many will struggle even after their lives "return to normal." Any student can be affected, but some groups are at higher risk, including students in poverty, students of color, LGBTQ youth, and those with a history of trauma or mental health concerns.[3]

Impact on Students. National and Texas data point to many students being negatively affected during the pandemic, increasing risks to their health and education. Rates of mental health concerns among youth were high and rising before the pandemic and have gotten significantly worse since 2019. Data from the Centers for Disease Control and Prevention (CDC)'s Adolescent Behaviors, and Experiences Survey (ABES)[4] and the Texas Youth Risk Behavior Surveillance System (YRBSS) conducted during the pandemic bear witness to what the American Academy of Pediatrics and other leading children's health groups have declared a children's mental health crisis. Nearly one in two youth (45 percent) felt sad and hopeless for a prolonged period in the past 12 months - a 16 percent increase from 2019 and a 53 percent increase from 2011 (see Figure 1). One in three youth (33 percent) reported persistently feeling stressed, anxious, or depressed during the previous month. Less than half of youth (43 percent) felt like they mattered to people in their communities, an 18 percent decrease from 2019.

Figure 1. *Texas High School Students Who Felt Sad and Hopeless for at Least Two Weeks in a Row in the Past 12 Months*



Source: Texas YRBS Presentation by HHSC, 2021

Impact on Educators. Students aren't the only ones struggling. At school, teachers, support staff, and administrators are feeling stressed, depressed, overworked, and burned out, as well. Educators are leaving the education workforce at record rates, with nearly 43,000 Texas teachers leaving their job in the 2021-2022 school year. The Texas American Federation of Teachers reported that 70 percent of teachers in Texas were considering leaving the profession at the close of the same school year. Teachers and other adults in a school can't support their students if their districts do not support them. This includes having policies and practices in place at the district level to provide staff time and resources needed for each to perform their respective roles and having services and support in place for school personnel dealing with their own mental well-being.

District Perceptions of the Impact of the Pandemic on Students. As students returned to their school buildings, administrators and teachers were under pressure to address learning loss during remote learning, yet mental health concerns were rising. In a district survey conducted by the Task Force (described in more detail later), district teams were asked about changes they've seen in students following the pandemic. The responses from districts are alarming but not surprising.

- 86 percent reported increases in anxiety or stress.
- 64 percent reported increases in sadness or depressed mood.
- 61 percent reported increases in behavioral problems (acting out/tantrums/outbursts)
- 52 percent reported distress related to trauma or grief.
- 46 percent reported increases in suicidal ideation or behaviors.

When asked about changes school districts made in response to increased mental health needs among their students, more districts indicated they hired new staff to focus on academic interventions (61 percent) than districts who hired new staff to focus on social-emotional interventions (52 percent).

When asked which aspects of their school mental health systems have been changed because of the pandemic, districts reported the following:

- The most common changes school districts made in response to the pandemic were implementing positive school climate practices (78 percent) and positive behavior interventions and support practices (72 percent).
- More than half of districts implemented strategies to help students develop essential social, emotional, and resiliency skills (63 percent); developed new partnerships with community-based providers (61 percent); made changes to their mental health and prevention and intervention practices (54 percent); and hired new staff focused on social-emotional interventions (52 percent).
- Just under 50 percent of districts reported making changes to their suicide prevention practices (49 percent), grief and trauma-informed practices (47 percent), and providing new educator/staff wellness supports (47 percent).
- Less than 3 percent of districts indicated they did not change how they address student mental health in response to the pandemic.

The Task Force members embarked on their work with the recognition of the increasing urgency for an effective public health response to the mental health crisis impacting young people, both nationally and in Texas. Responding rapidly to the needs of youth experiencing a high level of distress will require the engagement of the many adults in a child's life – most

notably their parents, grandparents, and other family members - but also their teachers, school counselor, school nurse, pediatrician, and bus driver. Our state and community systems will need to provide these caring adults with the tools, resources, and supports they need to meet this challenge.

Status Update: Year 1 Report Recommendations as of November 2022

With its Year 1 Report, the Task Force set out to establish a preliminary report regarding current mental health services in school-based settings based upon data collected relevant to the Task Force's charge to "evaluate the efficacy of school-based mental health support services." Acknowledging significantly more data and analysis was needed for evaluation; the Task Force documented existing state-funded school-based mental health services alongside corresponding data when possible. Perhaps the most significant finding in the Year 1 Report pertains to the availability of state-level data on existing school mental health support services – reporting substantial gaps in the data necessary for the Task Force to respond to its legislative charge.

The Year 1 Report set the stage for future evaluations from the Task Force. Below, please find a review of the Task Force's recommendations from its Year 1 Report and corresponding updates as of November 2022.

Year 1 Report: Short-Term Recommendations

1. TEA should have statutory authority to select or develop a statewide climate survey and data collection and reporting system. Such authority should result in a standard climate measure for schools across the state. The survey suite should include developmentally appropriate versions completed by students, families, and school personnel.

   Current Status: The Task Force needs to be made aware of any progress on this recommendation.

2. At the request of the Task Force, TEA shall conduct a survey of schools in the fiscal year 2021 to document the current landscape of mental health services and supports in schools and identify what data elements may be currently tracked in most schools. The survey results would inform the Task Force's evaluation plan and the structure of the future reporting system.

Current Status: The TEA supported the task force in conducting a district-level survey in the fiscal year 2021. This survey is summarized in the current report and informs the current recommendations.

3. The Task Force strongly recommends that the legislature update HB 906 [TEC Sec. 38.308] evaluation metrics in the upcoming legislative session to support the collection of this data through PEIMS and provide funding to ensure that TEA could develop the structure to support collecting the additional data. TEA should collaborate with the Task Force to determine possible alignment points between Task Force evaluation metrics and those used by TEA in the Safe and Supportive School Program (SSSP).

   Current Status: The legislature updated HB 906 [TEC Sec. 38.308]. The Task Force has additional recommendations related to evaluation metrics for the Safe and Supportive School Program and data collection to support the charge given to the Task Force.

4. The Task Force — with support from TEA — should study the roles and responsibilities of professional school counselors and the proportion of time dedicated to each role/responsibility.

   Current Status: The Task Force gathered information from school districts on the proportion of time professional school counselors can spend on different responsibilities. The results are presented in the report. Additionally, the Task Force conducted focus groups with professional school counselors to understand better the factors that promote or hamper their ability to follow the Texas Model for Comprehensive School Counseling Programs, as laid out in SB 179 in the 87th Legislature.

Year 1 Report: Long-Term Recommendations

1. TEA should develop a state system for reporting professional development.

   Current Status: During the 87th legislature, SB 1267 amended the requirements for staff professional development and issued guidance for the State Board of Educator Certification (SBEC) to create a clearinghouse and advisory group for professional development and established the role of school districts in managing the training requirements. With the new role of the SBEC, the Task Force has updated its recommendations regarding professional development.

2. The Task Force recommends that the Texas Legislature consider funding a state center on school mental health or a consortium of higher education institutes that would provide training and technical assistance around best practices and their implementation, funding, collecting data and measuring outcomes, and facilitate research on effective methods that can be scaled and shared in Texas.

   Current Status: The Task Force is aware of no progress on this recommendation. This recommendation is carried forward in its current report, along with additional information about the role that a center could play in achieving the state mission of access to appropriate school mental health supports to support the academic success of all students.

87th Texas Legislature Update: Student Mental Health Legislation

In 2021, the Texas Legislature passed several laws explicitly supporting the mental health and wellness of students, administrators, and educators. The Legislature also took significant action regarding professional development requirements for educators. Based on the Task Force's area of work, summaries of the most impactful school-based mental health bills are below.

- **Task Force Data Collection (HB 2287)**. With the passage of HB 2287, the Texas Education Agency is authorized to request data from school districts, regional education service centers, and local mental health authorities to assist the Collaborative Task Force on Public School Mental Health Services in carrying out its duties to study and evaluate mental health services funded by the state and provided at a school district or open-enrollment charter school level. The Collaborative Task Force on Public School Mental Health Services is authorized to request and receive this data from TEA. (Note: None of the data collected nor shared will include personally identifiable information. The data collected will be used solely to evaluate school-based mental health programs, not a particular school district or open-enrollment charter school, nor its administrators and educators.)
- **Counselor Work Time (SB 179).** With the passage of SB 179, **s**chool boards shall adopt a policy requiring school counselors to spend at least 80 percent of the counselor's total work time on duties that are components of a school counseling program. If a board determines that it cannot comply with the 80 percent requirement because of staffing needs, the policy shall include the reasons why the counselor must spend less than 80 percent of work time on components of the counseling program, list the counselor's duties that are not components of the counseling program; and set a percentage of time the counselor must spend on critical elements of the counseling program.

- **Training and Continuing Education for School Staff (SB 1267).** With the passage of SB 1267, the State Board for Educator Certification (SBEC) is charged with creating a clearinghouse of information about continuing education and training requirements, including frequency, for educators and other school personnel on topics such as recognizing and responding to students who may be experiencing mental health concerns; trauma-informed practices; and suicide prevention tools. School boards and governing bodies of open-enrollment charter schools must adopt a professional development policy that includes a required training schedule for educators and other school personnel informed by clearinghouse recommendations.

Organizational Framework

Embarking on the research and writing for the current report, the Task Force remained committed to utilizing the findings from its initial report to establish a baseline of existing state-funded, school-based mental health programs and use the two-year interim period as an opportunity for examining trends over time in funding allocations, the number of individuals trained, the number of students served, and other measures of the impact of these investments. The passage of HB 2287 during the 87th legislative session authorized both TEA and the Task Force – through TEA - to request and receive non-identifiable data resulting from the implementation of state-funded programs by school districts and open-enrollment charter schools across the state.

The sections below document Task Force members' efforts to understand the outputs of the current school mental health system, changes that have occurred since the last Task Force report, and the short- and long-term outcomes that are associated with these outputs. The evaluation design does not allow members to determine whether the available inputs/outputs cause the observed outcomes; however, the observed relationships can inform evidence-based recommendations to improve or enhance the current system.

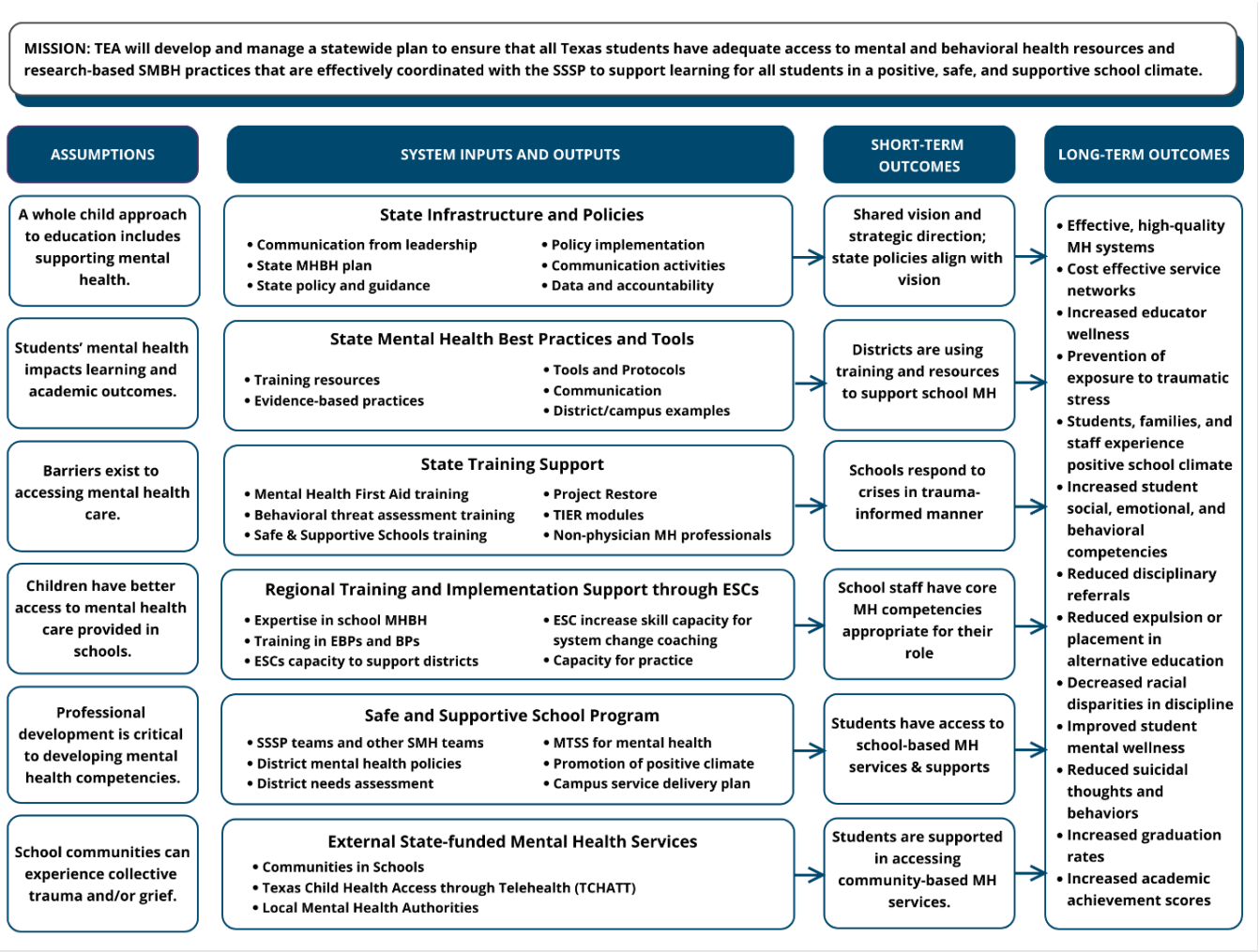
The Logic Model

Beginning in April 2021, Task Force members prioritized developing a framework to operationalize further the study and evaluation process with which it was charged. The framework defines the core features of the school-based mental health system to be evaluated (**inputs**), the expected results (**outputs)** of the school mental health system, and the short- and long-term **outcomes** that the Task Force believes are most relevant to measure whether the school-based mental health activities are having the desired or expected impact. The outcomes identified by the Task Force align with some of the metrics included in its charge but also

include other metrics that were more directly aligned with mental health services (e.g., improved school climate and attendance).

An abbreviated version of the framework is illustrated in Figure 1, with the entire framework included in Appendix A.

Figure 1. *Logic Model for the Evaluation of Public-Funded School Mental Health*



The logic model identifies the different inputs that make up the state's school mental health ecosystem, including existing state and regional infrastructure dedicated to supporting school and community-based mental health services and supports along with existing state-funded public mental health services. A comprehensive evaluation seeks to understand the extent to which the expected system inputs are available and occurring (e.g., educators receive training, mental health services are offered), whether short-term outcomes are achieved (e.g., access to services are increased), and, ultimately, whether long-term outcomes are achieved (e.g., increased positive school climate, reduced mental health concerns).

The focus of the current Task Force report is to document members' efforts to understand the outputs of the current school mental health system, changes that have occurred since the last Task Force report, and the short- and long-term outcomes associated with these outputs. The evaluation design does not allow members to determine whether the available inputs/outputs *cause* the observed outcomes; however, the observed relationships can inform evidence-based recommendations to improve or enhance the current system.

Methodology

The Task Force set out to gather information included in the study and evaluation by requesting data from relevant divisions of the Texas Education Agency (TEA), the Texas Health and Human Services Commission, and the Department of Family and Protective Services. This information included existing administrative data collected by the agencies relevant to the Task Force evaluation. The Task Force also examined publicly available data sources and existing reports and documents.

Survey of Districts

In the previous report, the Task Force concluded that many of the evaluation metrics identified in the statute were not currently collected by TEA or other state agencies. Going into this Year 3 report, the Task Force needed to understand the extent to which statutorily required metrics and other relevant data were tracked at the district or campus level to decide if a data request to districts/campuses would result in reliable and valid data. While the Task Force planned to conduct an initial request for data through a survey, members recognized that if data is not currently tracked locally, establishing local data collection standards would be a necessary next step in ensuring reliable data from LEAs. The Task Force proceeded to study what data was tracked locally through a survey to inform data collection recommendations made by the Task Force in this report. The methodology for the development and conduct of the survey is provided in Appendix B, as well as copies of the proposed district and campus surveys and the final district survey.

Results are presented from the final sample of 756 LEAs, representing a response rate of 62.1 percent of Texas districts and charter schools. The response rate varied across the education regions, with a low of 47.1 percent and a high of 76.5 percent responding to the survey (See Appendix D, Table 1). While the survey instructions requested that districts complete the survey as a team, over half of the surveys (59.7 percent) were completed by one respondent. Fifteen percent of districts had two or three respondents; 12.0 percent had teams of four or five

respondents, and the rest (12.2 percent) had teams of six or more complete the survey. The rate at which different types of individuals participated in the survey is presented in Appendix D, Table 2. The most common participants were directors or representatives of guidance and counseling (45.8 percent), superintendents (41.9 percent), directors or representatives of mental health or social and emotional well-being (31.5 percent), directors or representatives of special education (19.2 percent), and director or representative of programs serving at-risk students (18.3 percent).

Focus Groups

To further understand the perspectives of district and campus staff tasked with implementing school mental health supports, the Task Force conducted focus group interviews with a sample of school counselors across Texas. The Task Force developed questions to collect data on the counselors' experiences and perspectives.

The focus group data collection template reflected two significant categories. The first had questions on multi-tiered systems of support (MTSS) for student mental health and improved outcomes. The sub-categories queried whether available training aligned with the counselors' roles, the presence of any additional support and the effects of counselors on academic outcomes. The second major category of questions focused on the Texas Comprehensive Guidance and Counseling Model. The related questions asked whether the American School Counselor Association or Texas Model was being utilized, the model's effect on academic outcomes, and whether the time for counseling was adequate. The data collection template had eight sub-categories of questions that addressed successes, challenges, and recommendations. Overall, 104 Texas counselors participated in the nine focus groups. Further detail on the methodology and the characteristics of the respondents are provided in Appendix C.

Evaluation Questions

Using the framework of the logic model, the Task Force used the information it gathered to answer the following key evaluation questions:

1. Available Data: Is there data available at a state or local level to reliably measure the statutorily required metrics and additional measures identified by the Task Force?
2. Strategic Direction and Resources: Has the TEA and partner organizations created a shared vision and strategic direction for school mental health, and are resources aligned to support this vision?

3. Professional Development: Are state-funded professional development resources meeting current needs and resulting in a positive impact? Are changes needed to improve the access or impact of training resources?
4. Adequate Staffing: Do schools have adequate staffing to implement an MTSS for mental health? What factors support or prevent professional school counselors from fulfilling their role within an MTSS for mental health?
5. MTSS Implementation: To what extent have districts and campuses implemented the Safe and Supportive Schools Program, specifically the requirement for a multi-tiered system of support for mental health? What elements of a high-quality MTSS are more likely to be implemented than others? What elements of a high-quality MTSS might need more support for schools to implement one?
6. School Mental Health Partnerships: To what extent do schools and students access state-funded mental health supports provided by external organizations partnering with schools?
7. Short and Long-Term Outcomes: What impacts or outcomes may be associated with developing high-quality school mental health systems?

The following sections of the report will outline the key findings for each evaluation question, present the relevant evaluation results, and provide a summary of key recommendations related to the evaluation question. The recommendations provided by the Task Force are presented in Appendix E.

Part 1. Availability of School Mental Health Data Metrics

Evaluation Question: Is there data available at a state or local level to reliably measure the statutorily required metrics and additional measures deemed important by the Task Force?

Key Findings:

- While several data elements are available through state agencies, most are not available, and districts are not currently required to track them.
- Local capacity for data tracking varies. About half of the districts report the capacity to report on most data elements identified in the statute.
- Discipline-related data is more readily available than data on mental health services and supports.
- Few districts have access to electronic platforms to track student-level data.

Key Recommendations:

- To begin to address the evaluation at the level of mental health programming, the Task Force will need to collect information at a campus level, as variability in student needs and programming is likely to occur across the district. The Task Force recommends collecting additional data related to mental health programming and outcomes at a campus level in the next period, as the state moves to implement further data collection at a student level.
- A critical set of data should be collected at a student-level through the PEIMS system, with full protections for confidentiality of the data. The list of recommended data elements is included in Appendix E.
- The current SSSP data collection should include a recommended set of data elements (see recommended elements in Appendix E), with each data element including the total and broken down by gender, race, ethnicity, special education status, and educationally disadvantaged status.
- The Legislature should direct TEA to require school districts to report the use of positive behavioral interventions and alternatives to exclusionary discipline in PEIMS. Current requirements focus solely on exclusionary discipline and do not allow for an examination of the array of responses available to LEAs.

The Task Force analyzed the availability of each measure identified in the statute. The availability of the data within administrative data sets held by state agencies was explored. When the data was not collected at a state level, districts were asked whether the data was

tracked and available at the district level for the Task Force survey. Task Force members made determinations of the likelihood that each data element could be reliably collected at present and have made recommendations for data elements that TEA should collect to further the capacity of the state to evaluate publicly funded school mental health services (see Table 2).

Table 2. *Determination and Recommendations Related to Key Measures*

Measures Identified in Establishment Sec. 38.302(3)	Determination of Availability	Brief Recommendation (Full Recommendations in Appendix E)
The number of violent incidents in school districts or open-enrollment charter schools.	84% of districts report the availability of this data. Some elements are reported currently in PEIMS.	No recommendation.
The suicide rate of individuals provided with mental health services is described by subdivision (1).	53% of the districts report the availability of this data point. Death by suicide of children is a low occurrence, with 247 deaths by suicide for Texas youth (age 5-18) in 2020. Reports of the rate of suicide by school districts would not be a stable metric to evaluate mental health supports.	This element should not be used to assess school mental health. However, TEA should be granted the authority to develop a critical incident reporting system for any unexpected student death, including a public health response to reduce the traumatic stress within the campus community.
The number of public-school students referred to the Department of Family and Protective Services for investigation services and the reasons for those referrals.	DFPS collects data on referrals for abuse and neglect from school staff, which can be reported at a county level. Data on referrals has a brief retention period if the referral does not move to an investigation.	This data should not be used as a metric to evaluate school mental health due to difficulties in interpretation. Rates of child abuse and neglect in regions can indicate a potential need for mental health supports.
The number of individuals who are transported from each school district or open-enrollment charter school for emergency detention under	53% of the districts report being able to report on this data element. Emergency detention orders are not commonly used for child	This data should not be used as a metric to evaluate school mental health due to difficulties in interpretation.

Chapter 573, Health and Safety Code.	hospitalizations since legal guardians often make medical decisions.	
The number of public-school students referred to outside counselors per Section 38.010.	54.9% of the districts report being able to report on this data element.	TEA should be authorized to establish a standard definition of this data element and a mechanism for districts to report the number of students referred for mental health care.
The number of students enrolled in each school district and open-enrollment charter school.	This element is currently reported to TEA and available to the Task Force.	No recommendation.
The number of individuals to whom each school district or open-enrollment charter school provides the mental health services described by Section 38.302(1), and the race, ethnicity, gender, special education status, educationally disadvantaged status, and geographic location of these students.	66.2% of districts report the ability to provide data on this element, with 22.5% reporting the capacity to disaggregate the data based on the characteristics of students.	TEA should be authorized to establish a standard definition of this data element and a mechanism for districts to report the number of students referred for school-based mental health care.
The number of individuals for whom each school district or open-enrollment charter school has the resources to provide the mental health services described by Section 38.302(1).	The Task Force included a question within the current district survey to capture district leaders' perceptions about the adequacy of resources to provide mental health services. However, district leaders' perceptions may vary across the state, making this data subjective.	The Task Force recommends that the adequacy of available mental health resources be measured through an anonymous campus-based health survey completed by students and parents.
The number of individuals who receive school-based mental health services and	54.9% report the ability to identify the number of students referred to	TEA should be authorized to establish a standard definition of these data

are referred subsequently to an inpatient or outpatient mental health provider, their race, ethnicity, gender, special education status, educationally disadvantaged status, and geographic location.	outpatient mental health providers, and 52.5% report the ability to track the number of students referred for inpatient mental health care. Schools are unlikely to track a student's receipt of care, especially if not initiated by the school.	elements and a mechanism for districts to report the number of students referred to an inpatient or outpatient mental health care setting after or while receiving school-based mental health services.

Task Force members identified additional measures that they believed could be included in evaluating school mental health and surveyed districts about the availability and use of these data elements. The availability of the additional six key measures is summarized in Table 3.

Table 3. *Survey Respondents' Indications of Availability of Additional Key Measures*

Data Elements	District Indicates Data is Available	District Indicates Data is Used by Teams	Data is Disaggregated by Student Characteristics
Student referral to law enforcement	66.2%	38.3%	25.1%
Involvement of SRO in disciplinary event	41.3%	24.1%	15.9%
Length of time (days) of disciplinary actions	83.7%	54.5%	39.4%
Number of bullying allegations	79.2%	55.9%	35.8%
Number of students reporting discrimination-related concerns	58.0%	36.8%	23.8%
Number of students identified with risk of suicide	63.8%	40.7%	22.0%

Source: Collaborative Task Force for Public School Mental Health, District Survey results, 2022

The reliable tracking of key student-level indicators frequently requires a system for entering the relevant information about individual students. The data is more reliable when districts have a student-level electronic tracking tool in place. The Task Force survey asked districts if they have a data system or platform used by schools to monitor student progress across mental and behavioral health outcomes. Many districts indicated that they did not have a system (70.5 percent), with some respondents indicating they were unsure (13.7 percent) and a small proportion (15.8 percent) indicating that they do have a system. Respondents were asked to

identify their data systems to determine if there was any consistency across the state. A summary of all results is presented in Appendix D, Table 3.

Data Considerations. The Task Force acknowledges that most of the data metrics identified in the legislative charge are not currently collected by TEA or other state agencies due to a lack of legislative authorization. However, with the passage of HB 2287 (87 R), the legislature authorized TEA and the Task Force (via TEA) to request some of the data from the LEAs for reporting if the data is tracked locally and voluntarily. The Task Force strongly recommends that the Legislature require these data elements to be consistently tracked and reported. Data definitions must be documented to ensure that districts/campuses collect reliable and valid data. The ability to disaggregate these data metrics by relevant student characteristics further complicates data collection. While gathering information at a student level provides the most actionable data, the sensitivity of this data should warrant concern. Some identified elements are low base-rate incidents, which may threaten the confidentiality of submitted data, requiring masking to protect personally identifiable information.

Part 2: Strategic Direction and Resources

Evaluation Question: Has the TEA and partner organa shared vision and strategic direction for school mental health and are resources aligned to support this vision?

Findings:

- TEA has established a vision, mission statement, and strategic plan that can be utilized to guide implementation of school mental health in Texas.
- TEA has also provided templates, tools, and resources that LEAs and schools can use to more efficiently implement a locally-tailored approach.
- LEAs currently have no state-funding that is required to be spent on ensuring access to school- or community-based mental health services and TEA did not request funding for 88(R) through the Legislative Appropriation Request process for this purpose.
- TEA currently lacks the resources to monitor districts' compliance with requirements to develop a MTSS for mental health.

Key Recommendations:

- The Task Force recommends that the Texas Legislature fund a state center on school mental health or a consortium of higher education institutes to collaborate on supporting school-based mental health across the state. Further details on the role of the center is provided in Appendix E.
- The Texas School Safety Center, provided that funding is appropriated for this purpose, could conduct a review of the quality of the SSSP and MTSS for mental health within a sample of school districts. This could include some proportion of districts that are selected randomly and others that are selected due to "at-risk" indicators, such as high ratios for counselors to students, high disciplinary actions, or lack of reporting on the SSSP data collection system. The external reviews could inform changes to SSSP training activities, as well as technical assistance to districts on SSSP development.
- TEA should support the development of an electronic platform, provided funding is appropriated for that purpose, that can be used by school districts to conduct annual school climate surveys. The surveys collected by districts should be confidential and available only to the district but shared with stakeholders at the discretion of the district as a best practice. The platform should allow districts to customize the surveys to meet the district needs, while maintaining a core set of standardized items. The platform should include real-time access to data visualizations following the closure of the survey, as well as disaggregation by informant characteristics (e.g., grade and gender). The platform should include anonymous surveys that are completed by staff, students, and families.
- In alignment with the Logic Model, The Task Force reviewed state infrastructure and policies contributing to state-funded school-based mental health, as well as state mental health best practices and tools that have been developed to support student mental wellness. The Task Force noted and reviewed the following elements of state infrastructure and support.

TEA's Statewide Plan for School Mental Health. TEA has established a five-year statewide plan for school mental health, as required in statute [TEC 38.254], that sets out the TEA mission to "develop and manage a statewide plan to ensure that all Texas students have adequate access to mental and behavioral health resources, and research-based school mental and behavioral health practices, that are effectively coordinated with the SSSP to support learning for all students in a positive, safe, and supportive school climate." TEA defines adequate access as a continuum of mental and behavioral health services and supports (prevention, early intervention, and intensive intervention) that are available in the school (school-based) or community (school-connected). The plan identifies short- and long-term activities to support the mission, specifying those activities that can be pursued within current funding and those that can be pursued if additional funding is identified. Most activities planned within existing funding involve implementing existing statutory requirements, with additional activities needing either funding or legislative authority. Updates to the statewide plan provide an opportunity for TEA to inform the Legislature of needs (both financial and authority) to ensure adequate access to mental and behavioral health resources.

School Mental Health Toolkit. TEA has established a strategic direction for statewide school mental health by developing the Texas School Mental Health Framework and publishing a school mental health toolkit. The framework outlines key indicators of a high-quality school mental health system, incorporating the required components of a school mental health framework. The toolkit provides further guidance to districts and campuses on developing an effective school mental health system, and the tools and forms support greater consistency and efficiency in LEAs' capacity to develop effective systems.

Mental Health Resource Inventory. The TEA has supported the development of a statewide and regional mental health resource inventory, with resources identified by state agencies and ESCs. While the inventory was initially developed as an electronic file, TEA, with support from the Region 14 Comprehensive Center, has shifted the inventory to a searchable database, allowing for comparisons of mental health resources and summarization of resource information at different regional levels (e.g., county, ESC, state). As of December 2022, 1,674 total resources were identified in the database, with 60% representing community-based prevention and intervention services and 10% representing school-based prevention and intervention services. Another 10% reflected training and technical assistance resources.

Best Practice Registry. As required by TEC Sec. 38.351, the TEA and HHSC collaborate to annually update a list of best practice programs and research-based practices to address the components to be addressed in the school mental health system. This list can be used by

districts, schools, or community-based providers to incorporate best practice programs that meet the unique needs of local communities. The TEA, in partnership with HHSC and ESCs, is further developing this registry to be searchable and inclusive of additional information that can support district decision-making.

Safe and Supportive Schools Oversight. As one component of state oversight, the TEA is charged with gathering data from the Safe and Supportive Schools Program (SSSP) teams through TEC Sec. 37.115(k). To accomplish this, a survey was developed and collected in November 2020 and 2021. Each LEA completed the survey with some mandatory and other optional items. The survey results were shared with the Task Force for analysis. The Task Force noted that the survey format could be strengthened with data validation rules that would provide more consistent data reporting. For example, items requesting numerical responses could be entered in any format, therefore, a response could be "10", "ten," or "ten individuals." Similarly, there were no checks to ensure that the numbers were consistent when teams reported on the total number of reported threats and the outcomes of those assessments. Analyses suggested that there were 28% of LEAs for whom the numbers did not equate, suggesting some discrepancies. Despite these concerns, data is summarized on the mandatory items.

LEAs were asked if the district has established an SSSP team, with 93 percent responding affirmatively in November 2020 (*N*=1,241) and 95 percent in November 2021 (*N*=1201). LEAs also reported a slight increase in the proportion of team members trained in behavioral threat assessment between the 2020 and 2021 surveys, with responses summarized in Table 4.

Table 4. *LEA Estimates of Proportion of SSSP Team Members Trained in Behavioral Threat Assessment*

Survey Year	Sample Size	All Team Members	More than half of the Team	Less than Half of the Team	No Team Members
2020	1241	32.2%	30.6%	27.8%	9.4%
2021	1201	31.6%	38.5%	24.6%	5.2%

While data on the number of threats reported within the LEA for the 2019-2020 and 2020-2021 school years was a mandatory response, of the 1,200 LEAs in Texas, 880 LEAs reported in 2020, and 925 LEAs reported in 2021. Table 5 presents the mean number of threats reported and the proportions reported in each outcome category. The data contained some outliers that should be explored, as they significantly impacted the data, perhaps representing errors or anomalies

in program practices. The average number of behavioral threats reported increased significantly over the two school years. The outcomes of those threat assessments remained more stable, with between 63 and 69 percent identified as "no risk." Nine percent in 2020 and five percent in 2021 were identified as "eminent risk." While the information on a referral is gathered on the survey, the type of referral (e.g., disciplinary or mental health supports) is not collected. Definitions on the SSSP survey should clarify that difference.

Table 5. *LEA Reports of SSSP Behavioral Threat Reporting and Outcomes*

Survey Year	Total Behavioral Threats Reported	Average Behavioral Threats Reported per LEA	Outcomes of Behavioral Threat Reporting			
			No Risk / Not Referred	No Risk / Referred	Deemed to Pose Risk / Referred	Deemed Eminent Risk / Referred
2020	1,015	8.2	32.2%	30.6%	27.8%	9.4%
2021	1,145	40.0	31.6%	38.5%	24.6%	5.2%

Legislative Appropriation Request. The TEA released the agency's Legislative Appropriations Request (LAR) in September 2022 for the 2024-2025 biennium. As noted elsewhere in the report, there are no state funds currently appropriated for LEAs that must be spent to meet the mission of achieving adequate access to mental and behavioral health resources and school mental and behavioral health practices or to effectively coordinate with the SSSP to support learning for all students in a positive, safe, and supportive school climate. The current LAR identifies an exceptional item request for school safety; however, the details of this funding request have not been completed at the time of this report' The current description suggests that this funding request will "include funding for facilities upgrades, school-based safety personnel, technical assistance and other supports at TEA," Unfortunately, there was no mention in the LAR that funding for school mental or behavioral health supports would be included as an exceptional item request.

Part 3: Professional Development

Evaluation Questions:

- Are state-funded professional development resources meeting current needs and resulting in positive impact?
- Are changes needed to improve access or impact of training resources?

Key Findings:

- Changes have been made recently to requirements by decreasing state required training of school staff on mental health-related topics, and the impact of these changes is not yet known.
- Districts are most likely to report offering professional development in areas that have been mandated in statute or by state policy (e.g., suicide prevention, behavioral threat assessment).
- Districts are less likely to report offering professional development on specific programs or practices within the MTSS for mental health.
- Districts utilize the ESCs as their primary training resource, followed by online training systems.
- Access to training in Youth Mental Health First Aid or Mental Health First Aid dropped during the past two school years, but the training format has been adapted to allow virtual participation and most indicators suggest equivalent impact. Only a small proportion of school staff in the state receive training through this state-funded opportunity (between 1 and 2%) each year.

Key Recommendations:

- The SBEC should expand upon the current information shared within the clearinghouse to provide additional guidance for school boards in the development of local professional development policies. The guidance documents should clarify for school boards the purpose of specific trainings, as well as the expected outcomes, so that boards can make informed decisions about professional development opportunities for educators.
- The TEA and ESCs should seek more programmatic and MTSS implementation-based training on each tier level for counselors focusing on application of MTSS and not the identification of what is MTSS. Include Tier 1 implementation systems, techniques, and responses for the whole school, as well as restorative circle training, and Tier 2 and 3 practices that fit regional needs.

The Task Force examined recent changes to requirements for professional development, as it relates to student mental wellness and safe and supportive schools, that are likely to impact the evaluation of state-funded training in the future. The Task Force also explored available information on professional training to address the evaluation questions.

Updates on Legislative Actions. During the 87th legislature, the passage of SB 1267 amended the requirements for staff professional development, issued guidance for the State Board of Educator Certification (SBEC) to create a clearinghouse and advisory group for professional development, and established the role of school districts in managing the training requirements. The legislation removed the explicit requirement for training on "recognizing the signs of mental health conditions and substance abuse." Districts gained more local control over the frequency of training, with requirements such as training on an annual basis or during new employee orientation being removed by SB 1267. The requirements for training on suicide prevention strategies, establishing and maintaining positive relationships among students, including conflict resolution, and identifying, responding to, and reporting incidents of bullying remain a significant need. SB 1267 also added sections §21.4514 and §21.4515 to the TEC. The addition of §21.4514 requires SBEC to create an advisory group that reviews and provides input on clearinghouse information. §21.4515 requires SBEC to create a clearinghouse of information surrounding training and continuing education requirements for educators. The Clearinghouse was adopted and shared in the following July 7, 2022, "To The Administrator Addressed" correspondence: Continuing Education and Training Clearinghouse | Texas Education Agency. Since these changes were being implemented during the period in which the Task Force was examining mental health-related professional development, it is unclear how they will impact the current findings.

District-Offered Professional Development. The Task Force gathered information on professional development offered by LEAs through the district survey. Respondents (*N*=702) were asked to identify the mental health-related topic areas in which the district offered professional development within the past 12 months. Results are presented in Table 6. For counselors and mental health staff, the most offered training topics were recognizing the warning signs of suicide (offered by 76.7% of districts), behavioral threat assessment (69.4%), and trauma-informed practices (65.8%). For educators, the most offered professional development was recognizing the warning signs of suicide (82.5%), classroom positive behavior management (81.3%), and behavioral threat assessment (57.4%). Professional development on mental health topics was less commonly offered to other district staff; the most offered were recognizing the warning signs of suicide (65.0%), behavioral threat assessment (51.9%), and

classroom positive behavior management (45.2%). Districts were less likely to offer training in specific Tier 1, 2, or 3 programs/practices or specific evidence-based therapies.

Table 6. *District Professional Development Offerings in the Last 12 Months*

Focus of Professional Development	Counselors / MH Workforce	Educators	Other Staff
Recognizing Warning Signs of Suicide	76.78%	82.48%	64.96%
Behavioral Threat Assessment	69.37%	57.41%	51.85%
Classroom Positive Behavior Management	50.85%	81.34%	45.16%
Trauma-informed Practices	65.81%	55.56%	39.46%
Impact of Trauma	61.40%	49.57%	34.62%
MHFA/YMHFA	60.97%	46.15%	36.04%
Restorative Practices	42.31%	49.00%	28.63%
Grief-informed Practices	56.84%	31.05%	21.37%
Impact of Grief	53.99%	32.05%	20.80%
Specific Universal Program (Tier 1)	35.47%	29.91%	18.09%
Specific Program for Students (Tier 2/3)	40.46%	19.23%	12.54%
Evidence-based Therapies	36.18%	9.69%	7.41%
Psychological First Aid	26.21%	12.68%	9.40%

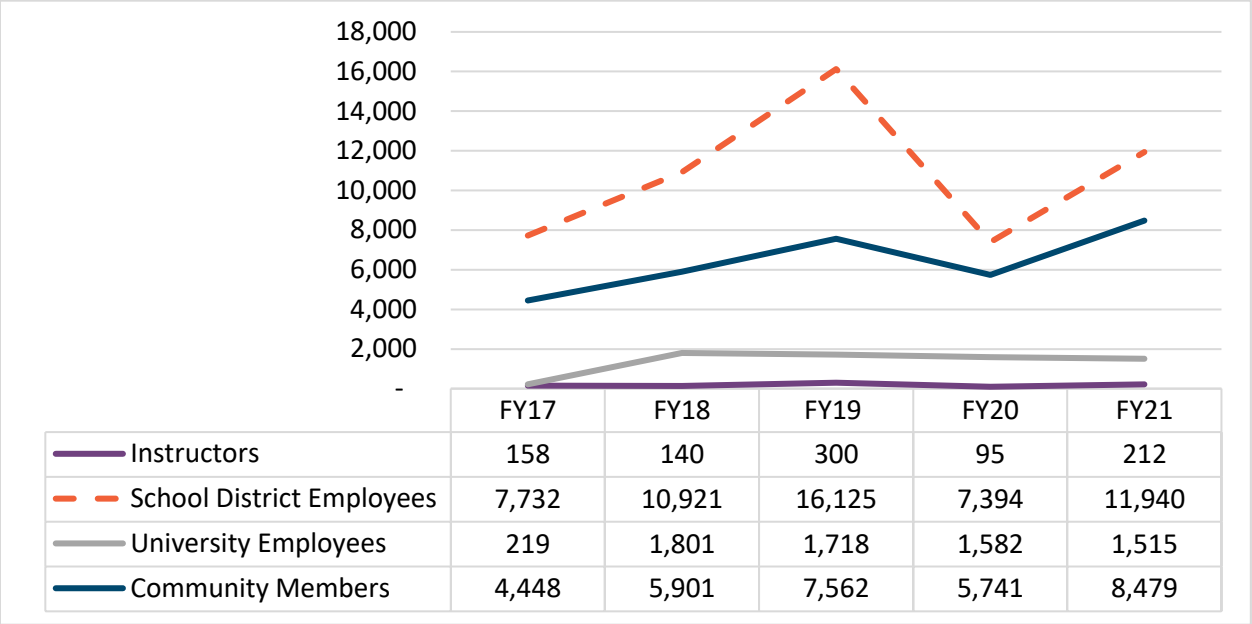
Source: Collaborative Task Force for Public School Mental Health, District Survey results, 2022

Districts were asked to identify the top two sources for professional development or training on mental health topics. Results are presented in Appendix D, Table 3. The most common response was the Education Service Center (ESC, 63.0%), followed by an online training system (44.6%), and internal district/school staff (41.9%).

Mental Health First Aid. The 83rd Texas Legislature allocated annual funding to the HHSC to contract with LMHAs to provide Mental Health First Aid (MHFA) or Youth Mental Health First Aid (YMHFA) to all school district educators, later expanding to all school district employees. The MHFA and YMHFA programs are national skills-based training courses that aim to teach participants how to help someone experiencing a mental health or substance use challenge. Figure 2 illustrates the number of individuals trained in MHFA/YMHFA across the past five years by the type of recipient. While the number of individuals trained each year grew since its inception in FY14, the number of participants fell in FY20, when in-person training was halted for public health concerns related to COVID-19. During this period, MHFA/YMHFA workshops could not be held, and the National Council for Mental Well-being (formerly the National Council for Behavioral Health) adapted the training to update content and allow for the hosting

of virtual workshops. The number of individuals trained in FY21 has rebounded but remains lower than the number of individuals trained before the pandemic. District employees trained in FY21 (N=11,940) represent 1.60% of all district FTEs (N=746,846) in the 2020-2021 school year.

Figure 2. *Number of Individuals Trained in MHFA by Setting/Audience Type*



	FY17	FY18	FY19	FY20	FY21
Instructors	158	140	300	95	212
School District Employees	7,732	10,921	16,125	7,394	11,940
University Employees	219	1,801	1,718	1,582	1,515
Community Members	4,448	5,901	7,562	5,741	8,479

Source: Personal Communication through Public Information Request, Texas HHSC, June 24, 2020, and April 28, 2022

The HHSC surveys MHFA/YMHFA participants in select years. The survey was collected in FY19, prior to the COVID-19 pandemic, and again in FY21. While the data available to the Task Force does not allow for analyses of differences across the two time periods, examination of survey results provides some comparison of participants' perceptions of the revised and adapted course offered in FY21 to the previous in-person format.

In FY19, all HHSC survey respondents completed the in-person course; in FY21, 22% of respondents completed the in-person course, 69% the virtual course, and 10% a hybrid virtual/in-person format. Results from these surveys are presented in Table 7. Respondent satisfaction with MHFA/YMHFA was high across both years, suggesting participants found both the in-person and virtual training helpful and would recommend it (note that FY21 data could not be disaggregated by format, but the majority completed virtually). Respondents in FY19 reported higher proportions who used the training to help a student and higher proportions who used the training to help a student who was thinking about suicide than was reported in

FY21. This could reflect an increased benefit from in-person training for educators, perhaps due to the opportunity to practice skills in a more natural format. However, this observation may also be due to differences in the sample for each survey time point. For example, suppose the FY21 sample consisted of a lower proportion of school personnel. In that case, the proportion using the skills with students may reflect that the item needs to be more relevant to respondents.

Table 7. *Results from Surveys of MHFA/YMHFA Participants*

Survey Areas	FY19 (N=994)	FY21 (N=2,222)
Found training helpful	96%	98%
Recommend training to others in their profession	95%	96%
Used the training with a coworker	48%	46%
Used the training with a friend	56%	59%
Used the training to help a student	72%	52%
Used the training to help a student who was thinking about suicide	41%	26%
Reported MHFA increased their compassion towards people with mental illness	94%	95%
Reported MHFA increased their crisis intervention skills	94%	97%
Reported MHFA increased their confidence to approach someone who might need help	93%	96%
Reported MHFA training will enable them to intervene during a mental health crisis	94%	96%

Sources: Texas HHSC, Report on the Mental Health First Aid Program for Fiscal Year 2021, December 2021; Texas HHSC, Broadcast Message No. 19.604, December 6, 2019; Texas HHSC, Broadcast Message No. 21.091, November 12, 2021

School Counselor Feedback on Professional Development. In focus groups, professional school counselors shared feedback on their experience with professional development. School counselors noted that much of the training materials and professional development opportunities they have access to are outdated or have little relevance to their work. School counselors shared that they would like to have more application-based training and advanced training that can build upon the foundational knowledge

> *[We] need to equip teachers with training since a counselor can't get to every situation.*

they have, as well as professional development that builds skills and aligns with practices that are effective for the populations served by their school. The counselors also shared an interest in programmatic training at each level of the MTSS that would allow counselors to support the implementation of programs at the universal, targeted, and intensive levels. School counselors also noted that teachers need additional tools and training to support student mental wellness in the classroom.

Part 4: Adequate Staffing for a Multi-tiered System of Support for Mental Health

Evaluation Questions:

- Do schools have adequate staffing to implement an MTSS for mental health?
- What factors support or prevent professional school counselors from fulfilling their role within an MTSS for mental health?

Key Findings:

- Texas staffing for professions that support the MTSS fall below nationally recommended staff to student ratios.
- The Task Force noted a trend across all health or mental health roles that staff-to-student ratios have been decreasing, moving towards the recommended ratios.
- Charter schools are more likely to not have access to a school counselor than traditional public schools.
- Rural and smaller districts tended to have higher school counselor-to-student ratios.
- Districts with a greater proportion of minoritized students tended to have lower counselor-to-student ratios.
- Districts with the smallest proportion of students identified as at risk tended to have the highest counselor-to-student ratios.
- Districts report school counselors spend an average of 42% of time on Tier 1-Tier 3 services and supports (although most had not completed a time study.)
- School counselors in some districts report continuing to have non-counselor duties that make it challenging to address school mental health.

Key Recommendations:

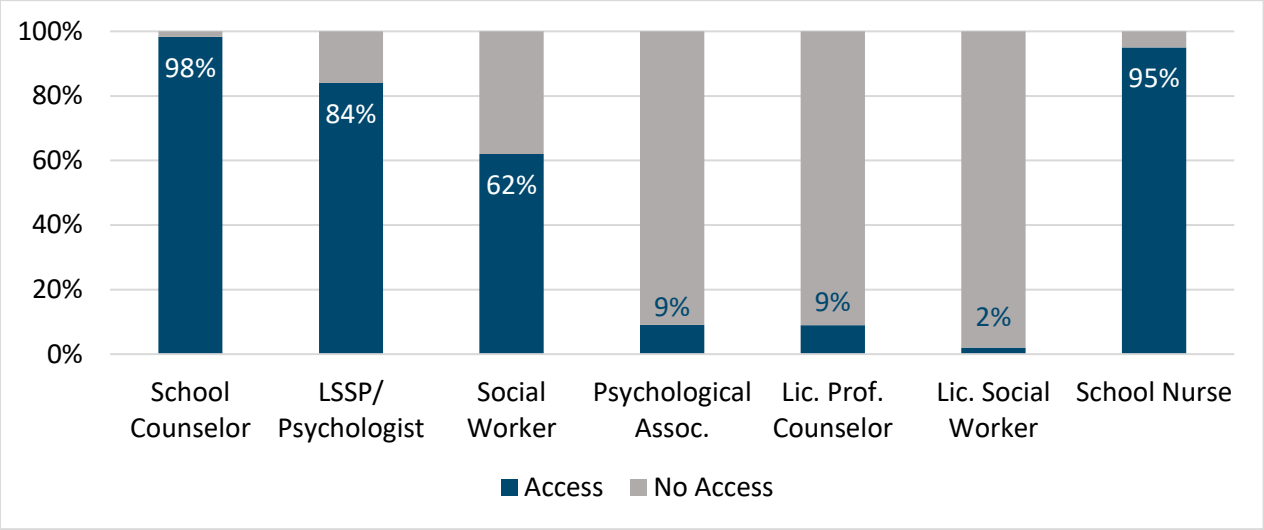
- Texas schools should receive targeted funding to reduce school counselor ratios to 1 to every 350 students and require that students at all campuses have access to a school counselor. TEA collects data on school staffing by district, and should have the capacity to monitor district capacity by campus to achieve this minimum ratio.
- The Task Force recommends that the legislature clarify language in SB 179 to provide clarity around elements that are mandated (versus recommended), the role of TEA in oversight, and mechanisms for accountability.
- The state should address critical workforce shortages by increasing the number of people choosing a counselor career by offering student loan forgiveness, incentives, and scholarships for individuals to obtain the training needed for this profession and work in the field.

The oversight of a comprehensive school mental health system, even if provided in partnership with community partners, requires adequate staffing and professional competencies tied to the specific roles (e.g., teacher, nurse, counselor, mental health provider). Professional school counselors are key staff in the operation of the MTSS for mental health, with many districts beginning to include additional professionals within the school mental health team, such as social workers and licensed mental health practitioners.

The Task Force examined staffing patterns over the past five years to understand state trends. Task Force members noted some significant limitations to the available data. TEA collects staffing data at the district level, which does not allow for an examination of the distribution of staff across school campuses. One staff member could serve only one campus, or several campuses, or be housed at the district in an administrative role. Therefore, an examination of staffing ratios assumes that all students in a district have access to all staff when access may actually be limited. The Task Force examined staffing data in three ways to try to understand the availability of staff to support student access to mental health supports: (1) the proportion of districts with any access to LEA staff in specific mental health roles; (2) statewide ratios of staffing to total student populations (assuming all students could access all staff); and (3) characteristics of districts that have a lower ratio of mental health staff to students, representing a possible inequitable distribution of resources.

Access to Any LEA Health or Mental Health Staff. Figure 3 illustrates the proportion of students with and without access to professional school counselors, social workers, licensed specialists in school psychology (LSSP)/psychologists, or school nurses in the 2021-2022 school year. The primary professionals available to most students are school counselors (98.3%) and school nurses (95.0%), meaning many students have a school counselor or nurse within the district. Many students are also in districts that employ LSSPs/psychologists (84.0%) and Social Workers (62.0%). Only a small proportion of students have access to other mental health professionals tracked by TEA, including psychological associates (9.1%), licensed professional counselors (9.0%), and licensed clinical social workers (2.0%).

Figure 3. *Proportion of Texas Students in a District with Access to Specific Mental Health Professionals 2021-2022 School Year*



Source: PEIMS; one district was an outlier and removed from the analysis.

Statewide Ratios of Staff to Students. Ratios of staff to students can provide information about whether sufficient staffing exists to manage the expected workload for different professional roles in the system. Table 8 lists the nationally recommended ratios for four key professionals and the observed ratios in Texas across the past five school years. The data suggests that there has been progress in lowering the professional-to-student ratios across all four roles, reflecting growth in the number of FTEs in roles that can support the MTSS for mental health. Texas is closer to nationally recommended ratios for school nurses and school counselors but remains far from the recommended ratio for social workers and LSSPs, or school psychologists.

Table 8. *District Staffing Ratios for Five-Year Period*

Professional Role	Ratios Recommended by National Professional Associations	2017 – 2018	2018 – 2019	2019 – 2020	2020 – 2021	2021 – 2022
Professional School Counselor	1:250	1:430	1:423	1:413	1:394	1:391
Social Worker	1:250	1:7,173	1:6,902	1:6,614	1:6,009	1:5,226
LSSP/School Psychologist	1:500	1:2,789	1:2,772	1:2,751	1:2,626	1:2,596
School Nurse	1:750	1:881	1:879	1:900	1:848	1:839

Source: TEA, PEIMS Staff FTE Counts and Salary Reports, Accessed at https://rptsvr1.tea.texas.gov/adhocrpt/adpeb.html

Differences in Counselor-to-Student Ratios. While an examination of the ratio of district professionals-to-students can illustrate the state's overall capacity, these ratios vary significantly across districts, suggesting varying student access. Since professional school counselors are key staff members within the MTSS framework for mental health, the Task Force examined the characteristics of districts with access to professional school counselors (e.g., lower versus higher staff-to-student ratios). To understand the factors related to access to professional school counselors, the Task Force examined district ratios by the characteristics of those districts.

The first analysis examined counselor ratios across the different district types, presented in Table 9. Public charter schools had larger counselor-to-student ratios than common or independent districts. Since charter schools may operate with different requirements, they were removed from the subsequent analyses that examined differences in counselor ratios.

Table 9. *Ratio of School Counselors to Students by District Type*

District Types	Ratio
Charter (N=109)	1:725
Common (N=4)	1:397
Independent (N=936)	1:512

Source: TEA, PEIMS Staff FTE Counts

Differences in school counselor-to-student ratios were also examined by locale, district size, minority enrollment, and proportion of students identified as at risk. Results are presented in Table 10, with key findings below.

- The highest average ratio of school counselors to students was found in rural schools, accounting for 59.7 percent of schools in the sample (with at least one school counselor in the district). Schools identified in city, suburban, and town locales had ratios that were similar to each other.
- Small and moderately small schools had higher counselor-to-student ratios than moderately large or large schools.
- Schools with lower minority enrollment tended to have higher school counselor-to-student ratios. Although not presented in the table, a similar trend was observed for districts with a lower proportion of students identified as economically disadvantaged.
- Schools with fewer students identified as at risk had higher school counselor-to-student ratios than those with a more significant proportion of at-risk students.

Table 10. *School Counselor to Student Ratios in Districts of Varying Characteristics*

Category	Ratio	Category	Ratio
District Locale		Minority Enrollment	
City (N=73)	1:375	0% to 25% (N=166)	1:650
Suburban (N=108)	1:396	26% to 50% (N=300)	1:566
Town (N=198)	1:379	51% to 75% (N=244)	1:466
Rural (N=561)	1:599	76% to 100% (N=231)	1:390
District Size		At-Risk Student Population	
Small ≤ 350 (N=177)	1:734	0% to 25% (N=122)	1:809
Mod. Small 351 – 900 (N=242)	1:598	26% to 50% (N=518)	1:490
Mod. Large 901 – 2700 (N=247)	1:387	51% to 75% (N=284)	1:436
Large >2700 (N=274)	1:405	76% to 100% (N=16)	1:292

Source: TEA, PEIMS Staff FTE Counts and Salary Reports, Accessed at https://rptsvr1.tea.texas.gov/adhocrpt/adpeb.html; TEA, Texas Academic Performance Report, 2020-2021, Accessed at https://tea.texas.gov/texas-schools/accountability/academic-accountability/performance-reporting/texas-academic-performance-reports

School Counselor Duties. Since school counselors are critical to the school mental health system, the Task Force examined the impact of recent legislation. During the 87th Texas Legislature, Senate Bill 179 was passed, leading school districts to adopt a policy that requires a school counselor to spend at least 80 percent of their work time on duties that are components of the Texas Model for Comprehensive School Counseling Programs.

In the Task Force's district survey, respondents were asked if their district had conducted a time study to identify the time spent on different duties. At the time of the survey, only nine percent of districts had completed a time analysis (see the full table in Appendix D, Table 5). Respondents were also asked to identify the proportion of time that the school counselors within the district (aggregated across individuals) spent on different tasks. Responses are presented in Table 11 and summarized below.

- Respondents estimated that an average of 41.7 percent of counselor time is spent on mental health activities, with the greatest proportion on Tier 1 universal supports.
- Respondents estimated that 19.0 percent of their time was spent on administrative and non-counselor duties. Four hundred and twenty-four of the 727 districts (58.3%) reported less than 20 percent of counselor time on administrative and non-counselor duties.

The Task Force also examined whether responses varied between districts that had completed the time analysis and those that had not, as those completing the analysis may have more concrete data for reporting. Overall, minimal differences were noted. While professional school counselors are the most widely available staffing within schools, they have duties unrelated to supporting student mental health and are currently spending less than half of their time on the MTSS for mental health.

Table 11. *District Reports of Estimated Counselor Time*

Counselor Activities	Mean (N=727)	Standard Deviation	Median	Minimum	Maximum
TIER 1 Student Mental Health Services	19.74%	16.00%	15%	0%	100%
TIER 2 Student Mental Health Services	11.74%	10.01%	10%	0%	75%
TIER 3 Student Mental Health Services	10.23%	11.31%	10%	0%	95%
Academic / Secondary Counseling	26.56%	19.52%	20%	0%	100%
Community Outreach	12.73%	12.25%	10%	0%	100%
Administrative Tasks	4.59%	5.18%	5%	0%	30%
Non-Counselor Duties	14.40%	18.71%	10%	0%	100%

Source: Collaborative Task Force for Public School Mental Health, District Survey results, 2022

School Counselor Feedback: **Support is Needed for School Counselors to Perform Counseling Services as outlined by TEA (e.g., mental health and academic).** In focus groups, school counselors reported a need to assign support personnel in the schools to complete tasks that they are currently responsible for but are not a part of their legislatively described roles, per the Texas Model Guide. This would allow them to focus more time on assisting students with support to promote wellness and academic success. Some persons in larger districts described having support personnel who assumed the responsibility for these non-counselor duties, such as testing and student monitoring. This allowed the counselors to focus on the four domains identified in the Texas Model Guide (i.e., Responsive Services, Guidance, Individual Planning, and System Support). Meeting this need would address the desperate shortage of time that many counselors described as necessary to accomplish their mandated work. The counselors welcomed the input of community mentors and others who reflect the student

> *[The] law may have changed but not I'm seeing anything changing in my district.*

population and can assist with school (clerical) tasks. School counselors also noted the shortage of mental health service providers statewide and in Texas schools.

5: Implementation of a Multi-tiered System of Support for Mental Health

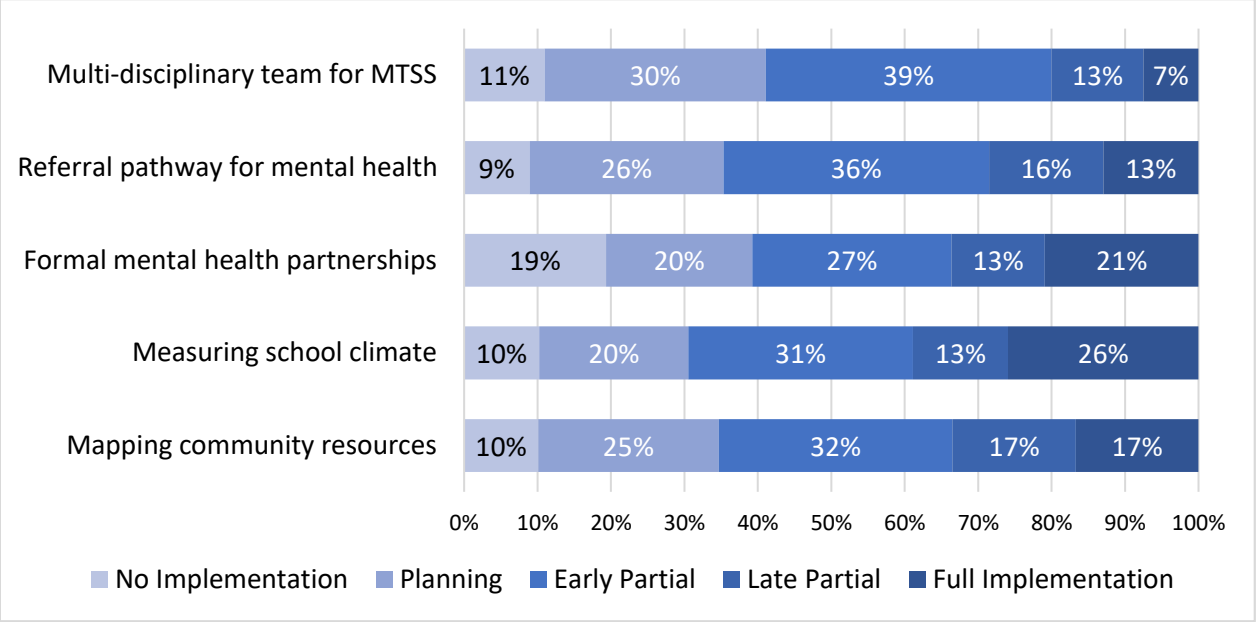
In its initial report, the Task Force recognized the importance of developing infrastructure to support a comprehensive school mental health system. The multi-tiered system of support (MTSS) for mental health provides structure and organization to school-based mental health services and supports, as well as coordination with academic, behavioral, and community-based student supports. The Task Force acknowledged that it could not evaluate state-funded school mental health by understanding the extent to which districts and campuses have implemented elements of an MTSS. Therefore, the Task Force set out to understand the degree to which districts and schools across the state had implemented different components of the MTSS into their frameworks (see Appendix B, Final District Survey for full completions). The Task Force acknowledged that implementation of best practices exists on a continuum; therefore, districts were asked to self-rate their level of implementation on the following scale:

- Not Implemented: Schools have not yet implemented this component of a multi-tiered system of support (MTSS).
- Planning for Implementation: Schools are currently planning for implementation, but active implementation has yet to begin.
- Early Partial Implementation: Schools have begun implementing this component of an MTSS, but it is not yet at the desired level of implementation. The activity may not happen as frequently as desired, is inadequate to meet the total need, or currently lacks the expected quality at full implementation.
- Late Partial Implementation: Schools have made substantial progress in implementing the component of an MTSS but are continuing to work towards expanding or strengthening the practice.
- Full Implementation: This mental health component of the MTSS has been implemented at the desired level and maintained over time. The focus is on ensuring the component is sustained and ongoing quality is monitored for opportunities for improvement.

While gathering self-report perceptions of the quality of a school's mental health system can introduce biases, the Task Force aimed to enhance the consistency of ratings by highlighting best practices to be considered when rating each element. District ratings were examined independently to understand the development of school mental health systems across the state; ratings were also averaged across the five indicators to create a summary score, ranging from 0 (no implementation on all indicators) to 4 (full implementation on all indicators).

Results are presented in Figure 4. Districts reported the most thorough implementation for conducting and using annual school climate data, with 69.5 percent reporting at least early partial implementation. Districts reported the least implementation for establishing one or more multi-disciplinary teams responsible for planning and overseeing the MTSS for mental health, with 58.9 percent reporting at least early partial implementation and 7.5 percent reporting full implementation. The development of formal mental health partnerships had the most significant variability, with a substantial proportion of districts in each level of implementation.

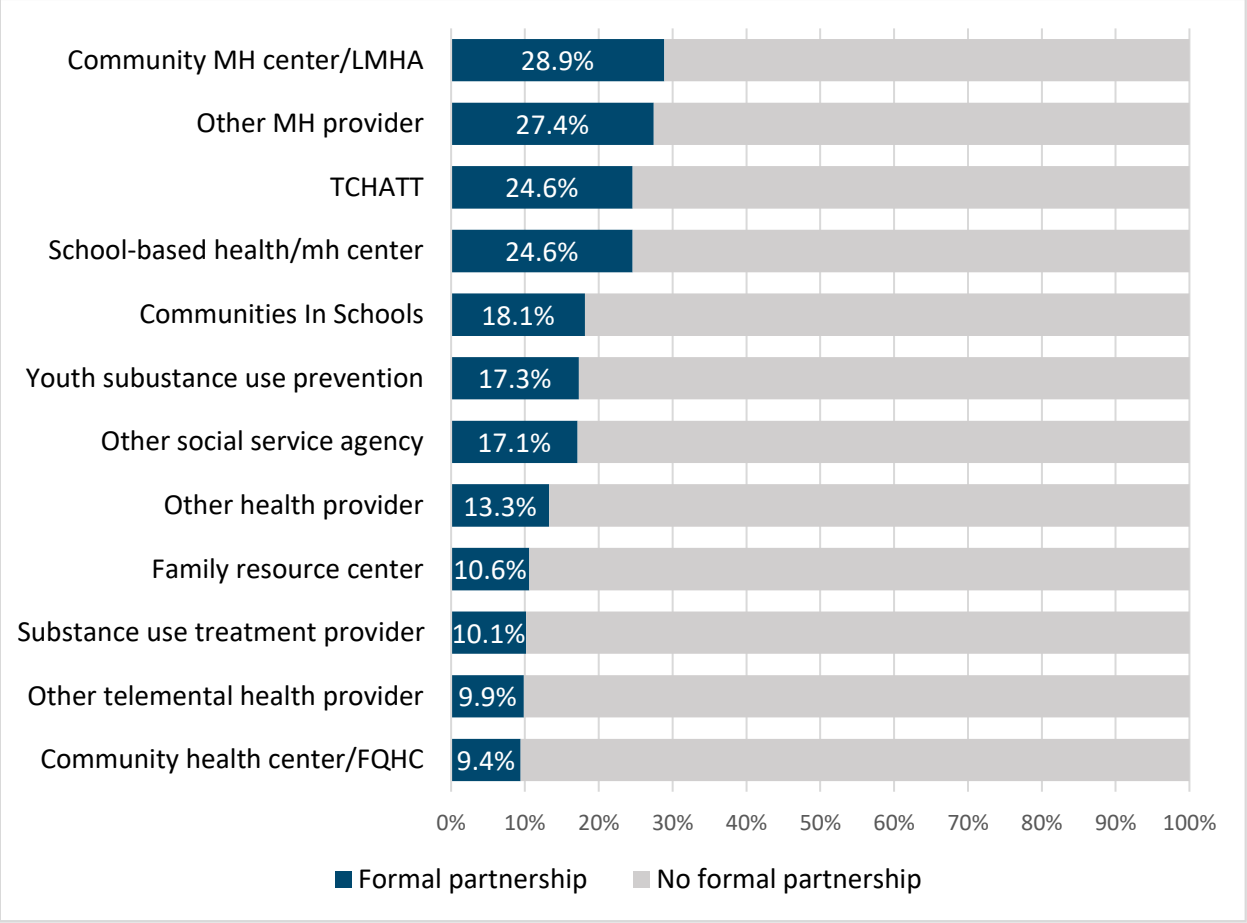
Figure 4. *Level of District Implementation of School Mental Health MTSS Practices*



Source: Collaborative Task Force for Public School Mental Health, District Survey results, 2022

School-Community Partnerships to Address Mental Health Needs. Districts were asked to identify the types of formal partnerships they had developed to address students' mental and behavioral health needs, and districts could identify more than one partnership. Responses are provided in Figure 5, presented from the most to the least common partnerships. The most common partnerships were reported with the LMHAs/LBHAs (28.9%), other mental health providers (27.4%), TCHATT (24.6%), and a school-based health or mental health centers (24.6%). Over half of districts reported at least one formal partnership (59.6%), with 26.4% of districts having one or two partners and 33.1% reporting three or more partners. Full data on the number of school-community partnerships are presented in Appendix D, Table 6.

Figure 5. *The Proportion of Districts Reporting Formal School-Community Partnerships*



Source: Collaborative Task Force for Public School Mental Health, District Survey results, 2022

District Implementation of School Mental Health Components. Districts are responsible for developing practices and procedures for each of the mental and behavioral health components outlined in TEC §38.351. TEA has provided program guidance in its School Mental Health Toolkit and Practice Guide on strategies for integrating these components within a MTSS for mental health. Districts were asked in the district survey to identify if the LEA provides student services or supports to address each component and whether the district has established policies and procedures related to the component. Specific practices and programs can address multiple components, so LEAs did not have to identify unique services for each component.

Results are presented in Table 12. Most districts report having services and support for each identified component, with mental health interventions (80.3%) and approaches to building skills to manage emotions, establish and maintain positive relationships, and make responsible decisions (80.0%) as the most commonly reported components. Fewer districts report having

policies and procedures in place for the different components. Positive youth development and grief-informed practices were the least commonly reported to have policies and procedures.

Table 12. *District Provision of Components of Mental Health System and District Policies*

Mental Health Components	District Provides Student Services/Supports		District Have Established Policies and Procedures	
	Number	Percent	Number	Percent
Early mental health promotion or prevention	517	72.4%	259	36.3%
Mental health intervention	573	80.3%	325	45.5%
Substance use prevention	480	67.2%	290	40.6%
Substance use intervention	433	60.6%	275	38.5%
Suicide prevention	545	76.3%	405	56.7%
Suicide intervention	533	74.7%	410	57.4%
Suicide postvention	439	61.5%	321	45.0%
Grief-informed practices	470	65.8%	196	27.5%
Trauma-informed practices	458	64.2%	226	31.7%
Positive behavior intervention and supports	538	75.4%	305	42.7%
Positive youth development	436	61.1%	187	26.2%
Approaches for safe, supportive, positive school climate	538	75.4%	366	51.3%
Approaches to building skills to manage emotions, establish and maintain positive relationships, and make responsible decisions	571	80.0%	260	36.4%

Source: Collaborative Task Force for Public School Mental Health, District Survey results, 2022

Funding for Mental Health. Finally, an effective MTSS for school mental health needs to have adequate funding, generally funding braided from different sources. Table 13 presents LEAs' report on the different funding sources they utilize to address student mental health. The most common funding sources are ESSER, local funds, Title 1, and foundation schools. While various funding sources are utilized to support school mental health, the most relied-upon source is time-limited federal funding.

Table 13. *District Use of Funding Sources to Address Student Mental Health*

Funding Source	Number of Districts Reporting Use	The proportion of Districts Reporting Use (N=714)	Funding Source	Number of Districts Reporting Use	The proportion of Districts Reporting Use (N=714)
ESSER	525	73.5%	Medicaid/ SHARS	140	19.6%
Local Funds	384	53.8%	Non-Financial Agreement	125	17.5%
Title I	343	48.0%	Title III	89	12.5%
Foundation School	323	45.2%	Philanthropy	69	9.7%
State Compensatory Education	300	42.0%	Other	55	7.7%
McKinney Vento	182	25.5%	Title IVB	23	3.2%
Title IVA	179	25.1%	Private Pay / Insurance	22	3.1%
School Safety Allotment	141	19.7%	VOCA	11	1.5%

Source: Collaborative Task Force for Public School Mental Health, District Survey results, 2022

Part 6. Partnerships through State Funded, School-Based Mental Health Services

Evaluation Question: To what extent do schools and students have access to state-funded, school-based mental health supports provided by external organizations partnering with schools?

Key Findings:

- The number of children served by the LMHA/LBHAs has remained stable over the past three years, but significantly fewer students were referred by schools in FY21 than previous years and there has been a 72.0% decrease in the number of sessions provided on school campuses between FY19 and FY21.
- CIS staff are available in 1,554 campuses across the state. The number of students targeted with Tier 2 or Tier 3 mental health services by CIS increased slightly over the two bienniums, but the total hours of services decreased by 28%.
- TCHATT is available to 44 percent of students in the state, with a goal of expanding statewide. TCHATT offers brief, problem-focused therapy and support for community-based referrals.
- School counselors report that there are barriers to families accessing community-based mental health services, including workforce shortages, long wait times, transportation challenges, and lack of health insurance. School counselors perceive these barriers to be greater in rural communities.

Recommendations:

- The TEA should continue to support formal collaboration (e.g., MOUs) with external agencies to provide components of the MTSS for student mental health/behavioral health (MH/BH) at no cost to LEAs to provide access to services beyond the professional role and competencies of school counselors.
- LEAs should consider hiring a care navigation role or social workers who can focus on resource connection and not reduce capacity for school-based interventions and services.
- TEA and ESCs should continue to maintain and grow the resource list of active providers in the regions so this task does not take up time from the counselor. ESCs should gather feedback from school counselors and district administrators to ensure the resource directory has the information that is needed and is easy to use.

At the time of this report, the state of Texas provides resources for youth mental health supports and related services to children and families through three core "funding streams" listed below. Appropriations across the past three biennia are presented in Table 14.

1. The Health and Human Service Commission receives funding for children's mental health services within the public mental health system, with an additional allotment to support a home and community-based waiver program. This funding is provided to Local Mental and Behavioral Health Authorities across the state. Services can be provided in the community, including on school campuses.
2. Appropriations are provided to TEA and passed through to Communities In Schools (CIS), which helps fund 27 CIS programs in the state. CIS services are intended to help students stay in school and succeed. While mental health services and supports are not mandated through the funding, many CIS programs provide services within the MTSS for mental health.
3. The 87th Texas Legislature funded the Texas Child Mental Health Care Consortium, which supports school-based telemental health services to children through the TCHATT program. State appropriations for these services are provided in Table 10.

Table 14. *State Appropriations for Mental Health and Related Services*

Funded Program	2018-2019 Biennium[1]	2020-2021 Biennium[1]	2022-2023 Biennium[1]
Children's Mental Health	$166,373,576	$184,635,596	$187,879,512
Communities In Schools	$31,043,630	$61,043,634	$61,043,632
Texas Child Health Care Access Through Telehealth (TCHATT)	$0	$37,166,834[2] (TCMHCC $99,000,000)	$49,904,679[2] (TCMHCC $118,508,272)

Sources: (1) Legislative Budget Board, 2022-2023 State Appropriations; (2) Presentation to the Senate Finance Committee, June 28, 2022

Community Mental Health Services. The Health and Human Services Commission contracts with 39 Local Mental or Behavioral Health Authorities (LMHA/LBHAs) to provide various community-based mental health services to children and adolescents. LMHAs/LBHAs are required to use state funding only to serve children within the state's priority population, which is defined as children aged 3 to 17 years diagnosed with a mental health disorder resulting in a serious functional impairment, risk of placement outside of the home or school, or who is served within the school's Special Education program for emotional disturbance. Services are provided in a variety of settings, including the clinic, home, and school. Some LMHAs/LBHAs

utilize non-state funding to provide additional services and supports on school campuses, including services to students who may not meet the criteria for the priority population.

The Task Force examined access to school-based mental health services through the LMHAs/LBHAs over time. Data on services was available for fiscal years 2019, 2020, and 2021. Data is presented in Table 15. Overall, the number of children served within the LMHAs/LBHAs increased between FY19 and FY20 and then decreased between FY20 and FY21. The number of total encounters provided to children enrolled in services decreased slightly over the three years. Most notably, the proportion of services provided on school campuses decreased dramatically in FY20, as the COVID-19 pandemic hit and schools experienced closures, and this trend continued into FY21. Many schools remained closed for portions of the school year and limited the presence of guests on campus as a part of public health protocols. Increased concerns around school safety and security may have also impacted access to school-based services.

Table 15. *Children Served by the Public Mental Health System*

Measure	FY19	FY20	FY21
Total youth served	67,785	68,590	67,974
Total child encounters (with time > 0)	1,061,011	1,050,426	978,315
The proportion of children referred by school (eliminating children with missing referral sources)	11.0%	9.5%	6.5%
Total child encounters in school (with time > 0)	189,006	68,285	53,000
Proportion of child encounters in school (eliminating encounters with missing locations)	17.8%	8.8%	5.4%

Source: HHSC CMBHS database; analysis by UT Austin

Communities In Schools. Communities In Schools (CIS) of Texas is a network of 27 CIS affiliates across the state. The mission of CIS is "to surround students with a community of support, empowering students to stay in school and achieve in life." CIS offers services and support across all three tiers of the MTSS, with six core components focused on: (a) health and human services (including mental health); (b) supportive guidance and counseling; (c) parental and family engagement; (d) academic enhancement and support; (e) college and career readiness; and (f) enrichment activities. CIS affiliates are funded through state and federal funds administered by TEA, corporate gifts, private foundations, local businesses, individuals, local fund-raising events, and community partnerships. The 27 CIS affiliates were embedded within

1,482 school campuses in 2021-2022, an increase from 1,193 school campuses in 2018-2019 (personal communication, CIS of Texas, April 22, 2022).

TEA regularly tracks the services and outcomes provided by CIS, including mental health services. Table 16 describes the mental health reach and outcomes reported by CIS for the fiscal years 2019 and 2021. CIS saw an increase in the number of students targeted for mental health needs between FY19 and FY21, with a reduction in service hours. Outcomes remained high across both years tracked by the Task Force.

Table 16. *Communities In Schools of Texas Mental Health Outcomes*

Measure	Fiscal Year 2018-2019	Fiscal Year 2020-2021
Students Targeted for Mental Health Needs — Tiers 2 and 3	52,652	54,650
Total Tier 2 and 3 Mental Health Service Hours Provided	513,401	369,587
Percent Case Managed Students with Mental Health Needs Promoted (grades K– 12th)	97%	98%
Percent Case Managed Students with Mental Health Needs Stayed in School (grades 7th–12th)	99%	100%
Percent Case Managed Students with Mental Health Needs Graduated (grade 12 only)	96%	96%
Total / Percent Case Managed Students with Mental Health Needs Targeted for Academic Needs that Improved in Academics	90% (26,913 of 29,881)	89.5% (19,573 of 21,869)
Total / Percent Case Managed Students with Mental Health Needs Targeted for Attendance Need that Improved in Attendance	77% (5,208 of 6,795)	74.1% (6,062 of 8,182)
Total / Percent Case Managed Students with Mental Health Needs Targeted for Behavior Need that Improved in Behavior	86% (45,519 of 52,652)	82.0% (44,818 of 54,650)

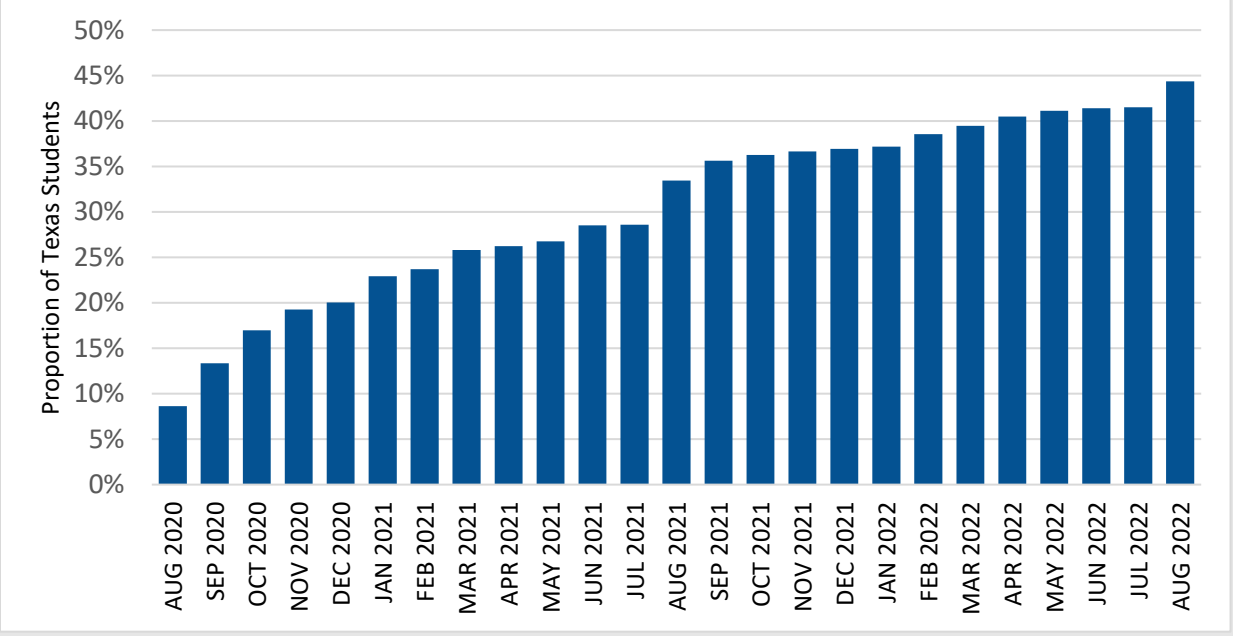
Sources: TEA, CIS Mental and Behavioral Health Services: 2018-2019 Data; TEA, CIS Mental and Behavioral Health Services: 2020-2021 Data

Texas Child Health Care Access Through Telehealth (TCHATT). The Texas Child Health Access Through Telehealth (TCHATT) Program is one component of the Texas Child Mental Health Care Consortium, established through SB11 in the 86th Legislative Session. The Consortium comprises 13 health-related institutions (HRI) of higher education. The legislation calls on the Consortium to "establish or expand telemedicine or telehealth programs for identifying and assessing behavioral health needs and providing access to mental health care services." TCHATT

consists of (a) educational and training materials for school staff in assessing, supporting, and referring children with mental health needs; (b) direct telepsychiatry or counseling to students within schools; (c) identification and referral support for students and families; and (d) a statewide data management system to track calls and responses.

TCHATT services were established in the latter period of FY20, with HRIs engaging with local school districts to establish memoranda of understanding (MOUs) to support student referrals and telehealth services. At the end of FY22, TCHATT had enrolled 407 districts and 3,615 school campuses. The reach of TCHATT can be measured by the number of students covered by TCHATT, meaning that the school campus can refer a student to TCHATT if the student's guardian provides consent. Figure 6 presents the proportion of students covered by TCHATT by August 31, 2022. At the end of the fiscal year 2022, TCHATT covered 2,391,070 students representing 44 percent of all Texas students. In June 2022, following the Uvalde school shooting, Texas leaders allocated an additional $5.8 million to expand TCHATT to all Texas schools that choose to participate in the program.

Figure 6. *Proportion of All Texas Students Covered Through TCHATT by Month, through April 2022*



Source: TCMHCC Report to the LBB, FYS 21-22; Internal Evaluation Report, FY 2022

Students can be referred to TCHATT by a school liaison, following parental consent to share information with the health-related Institution. TCHATT has been growing over the course of its two years of operation, as illustrated in Table 13. TCHATT has more than doubled the number

of students served in the second year of operation, with three additional months not yet reflected in the data. Similarly, TCHATT has almost tripled the number of service encounters provided. Since TCHATT was designed to be a brief, solution-focused intervention, it is noteworthy that almost half of the students are referred for further care. The types of referrals provided are illustrated in Figure 8. The most common referral was to an individual therapist. It is important to note that TCHATT is helping to identify students who may need more than a brief intervention, and those resources may not be available within the community or school system.

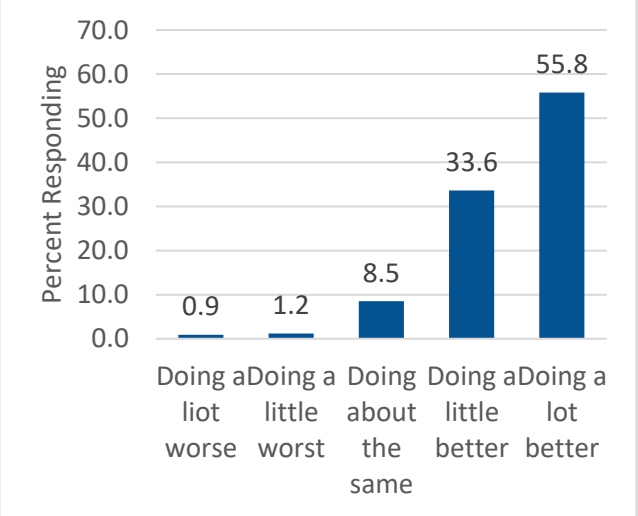
Table 13. *TCHATT Service Provision to Students and Families*

	FY21	FY22
Students Served	5,702	7,607
Number of Encounters	13,041	30,383
Number of Students Referred for further Supports		55.8%

Source: TCMHCC Internal Evaluation Report, FY21; TCMHCC Internal Evaluation Report, FY22

Families are surveyed at the end of TCHATT care to determine their satisfaction with services and perceived improvements because of those services. As illustrated in Figure 7, despite being a brief service, many families believe that TCHATT services have helped students improve their mental or behavioral health.

Figure 7. *Responses to Statement "As a result of TCHATT services, I (my child or family) am/is:"*



Source: TCMHCC Report to the LBB, FYS 21-22

Focus Group Theme: External Partnerships for Student Access to Mental and Behavioral Health Services. Professional school counselors indicated that referral pathways and access to care are challenges. The existing shortage of mental health service providers makes it challenging to provide continuity of care and to connect students to the help they need. They reflected that money provided is only sometimes helpful because there is no one to pay to provide services, and waiting lists are long, especially in rural districts where the wait time can be six to eight weeks. Additionally,

transportation may be a barrier for some families in rural communities, as the service provider may be in a neighboring city or town more than 100 miles away, causing parents to miss work and students to miss more time from school. Rural families may also need more access because of little or no insurance. For some districts, pathways are needed to refer students with deeper needs to a licensed mental health professional and reduce the need for school counselors to provide intensive supports for students with no other options.

Part 7. Initial Examination of Outcomes

Evaluation Question: What impacts or outcomes may be associated with the development of high-quality school mental health systems?

Key Findings: Analyses examined the relationship between lower school counselor-to-student ratios, greater implementation of school mental health systems, and the number of different types of community-based partners on select outcomes. Initial findings were:

- Exploratory analyses did not find a relationship between the three mental health indicators and school attendance rates.
- Analysis showed that as the ratio of school counselors to students increases, the district school dropout rate also increases.
- As the number of school mental health partner types increased, the student discipline rate at the district decreased.

The Task Force acknowledges that the data available for evaluation does not allow for an analysis of the causal relationship between services and educational or mental health outcomes. There are significant limitations to the available data. First, groups of students who do or do not have access to mental health services and supports are not randomly assigned, and differences between the groups of students are likely to reflect factors other than the services, preventing any conclusions to be drawn about differences in outcomes that may be observed. Second, the Task Force could only collect data at a district level, masking differences that occur at different campuses throughout the district. For example, a district may partner with CIS or TCHTT but only have services present on a fraction of campuses. The use of district-level data is likely to miss the variability in outcomes that are present at the campus level. Additionally, the Task Force is limited to a few relevant outcomes that may not adequately measure the impact of services and supports.

Despite these limitations preventing the Task Force from drawing conclusions based on exploratory analyses, the Task Force considered the relationships between three mental health indicators and three outcomes - revealing some promising evidence of impact on mental health indicators. Educational outcomes consisted of the following: (a) the district attendance rate (TAPR 2020-2021 report), the district dropout rate for 9-12 grade (TAPR, 2020-2021 report), and the rate of disciplinary records per 100 students (2020-2021 PEIMS report). Mental health indicators included (a) the district's school counselor-to-student ratio, (b) the average school mental health implementation score from the district survey, and (c) the number of different

types of school mental health partners reported by districts. Outliers for school counselor ratios over 1:4000 were removed from the analysis, as were outliers for dropout rates greater than 10%. Each removed less than 1 percent of the sample. Separate regression equations were estimated for each of the three outcomes of interest. The results of the analysis are presented in Table 14 and summarized below.

Attendance Rates. The analyses did not support the hypothesis of a linear relationship between the three mental health system indicators and district attendance rates. This lack of findings may indicate that there is not a relationship between these three indicators at a global level of district attendance. As noted, each of these indicators may vary at a campus level, especially in large districts, and other factors not measured in the analysis (e.g., quality of available services) may be critical to the relationship between mental health services/supports and attendance. It should also be noted that attendance is an outcome indicator with very little variability across districts. While attendance may vary greatly at a student level, the districts in the current analysis had a mean attendance of 98.0 with a standard deviation of 1.0 and a range of 89 to 99.

School Dropout Rates. The Task Force did find a small, positive relationship between the district's school counselor ratio and the outcome variable of school dropouts. This finding suggests that as the ratio of school counselors to students increases, the district dropout rate also increases. The data does not allow for a conclusion that the lower counselor ratios cause lower dropout rates, as there may be other factors that impact dropout rates that differ in a non-random manner with counselor ratios (e.g., parent involvement); however, this analysis indicates promising evidence of the impact of lower counselor ratios on school dropout rates. Future research should examine other variables that may help explain the relationship between school counselor ratios and district dropout rates noted here, as well as aim to replicate the finding with data in different years.

Disciplinary Rates. The third analysis examined the relationship between school mental health indicators and school discipline rates. The overall model was statistically significant and accounted for a small proportion of the variance noted in discipline rates. The only mental health indicator that served as a significant predictor was the number of mental health partners reported by a district. Results found that as the number of mental health partners increased, the student discipline rate in the district decreased. Similarly, this result cannot be interpreted as causal. Still, it may suggest that schools with more mental health partners have more options to address behavioral concerns outside of the disciplinary procedures – a promising indicator of the positive impact of mental health partnerships. These results should be considered exploratory until replicated in future research.

Table 14. *Results of Multiple Regression Analyses for Three Outcomes*

Outcome	t	p	β	F	df	p	adj. R^2
Attendance Rate				1.04	3, 599	0.372	0.0002
Counselor Ratio	0.87	0.387	0.000				
Implementation	0.65	0.515	0.036				
Number of Partners	-1.49	0.136	-0.028				
Dropout Rate				3.83	3, 570	0.010	0.015
Counselor Ratio	2.76	0.006	0.000				
Implementation	0.38	0.708	0.021				
Number of Partners	1.50	0.135	0.028				
Discipline Rate				6.44	3, 526	0.0004	0.028
Counselor Ratio	-1.57	0.117	-0.003				
Implementation	-1.65	0.101	-1.126				
Number of Partners	-2.15	0.032	-0.482				

Sources: Collaborative Task Force for Public School Mental Health, District Survey results, 2022; TEA District TAPR data, 2020-2021

References

[1] Krause KH, Verlenden JV, Szucs LE, et al. Disruptions to School and Home Life Among High School Students During the COVID-19 Pandemic — Adolescent Behaviors and Experiences Survey, United States, January–June 2021. MMWR Suppl 2022;71(Suppl-3):28–34. DOI: http://dx.doi.org/10.15585/mmwr.su7103a5external icon

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[3] Nirmita Panchal et al. (2021) Issue Brief: Mental Health and Substance Use Considerations Among Children During the COVID-19 Pandemic. https://www.kff.org/report-section/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic-issue-brief/

[4] Krause KH, Verlenden JV, Szucs LE, et al. Disruptions to School and Home Life Among High School Students During the COVID-19 Pandemic — Adolescent Behaviors and Experiences Survey, United States, January–June 2021. MMWR Suppl 2022;71(Suppl-3):28–34. DOI: http://dx.doi.org/10.15585/mmwr.su7103a5external icon

Appendix A: Full Logic Model

MISSION: TEA will develop and manage a statewide plan to ensure that all Texas students have adequate access to mental and behavioral health resources and research-based SMBH practices that are effectively coordinated with the SSSP to support learning for all students in a positive, safe, and supportive school climate.

ASSUMPTIONS

Whole Child Approach includes Mental Health
Childhood is a critical time-period for establishing healthy behaviors that set the stage for both academic success and quality of life. Integration of public health and education sectors, through a whole child approach, allows for the alignment of common goals.

Student Mental Health Impacts Learning
Students' emotional, behavioral, and social well-being impacts learning through a multitude of pathways. Enhancing student well-being is a critical strategy for supporting students in achieving their full potential.

Barriers Exist to Access to Mental Health Care
Families experience barriers that can impede access to MHBH services for their children and can lead to health and social inequities.

Children Have Better Access to MH Care in Schools
Children have greater access to and rates of completion of MHBH services within schools than other settings.

Communities have Varying Access to MH Resources & Providers
Many communities in the state do not have access to or awareness of MHBH providers or other critical resources.

Educator Professional Development
Professional development increases staff capacity to identify, intervene, and refer students for MHBH supports.

School Communities can Experience Collective Trauma and/or Grief
Members of the school community can be negatively impacted by natural disasters, school or community violence, death of a community member, or other traumatic events, which can increase MHBH risks.

INPUTS

SBH Legislative Policies
State legislative policies support access to an array of effective supports with flexibility for the diverse communities in Texas.

State Leadership
State leaders establish state vision and guidance for SMBH, monitor progress, and coordinate with relevant partners.

Mental Health First Aid
Educators are trained to identify early warning signs of MHBH and make appropriate referrals.

Educational Service Centers
ESCs provide training and implementation support for school MHBH system development.

Non-Physician MH Professionals in ESCs
Provide training and support school systems to implement policies and practices that enhances student access to SBMH promotion, prevention, early intervention, and targeted intervention.

Safe and Supportive School Program
Requires creation of a SSSP team, resource mapping, behavioral threat assessment, and the development of a MTSS. Outlines core components and provides school safety allotment.

Health Education
Schools plan for and implement curriculum to teach essential skills and knowledge (TEKS) related to mental health and wellness and related health education.

Communities In Schools
Partners with schools to provide individualized care management, MHBH services, and social supports to help students succeed in school.

TCMHCC/ TCHATT
Partners with schools to provide brief MHBH telehealth services to students and families.

Local MHBH Authorities
Provides safety net MHBH services to children with serious emotional disorders, including crisis response, and leads local MHBH network development.

School MH Task Force
Evaluates the outcomes and impact of state-funded school-based MHBH services and reports to Texas Legislature.

OUTPUTS

State Infrastructure
- Communication from leadership
- State MHBH plan
- State policy & guidance
- Policy implementation
- Communications
- Data & accountability

Best Practice List
- Training resources
- EBPs and BPs

State Training
- Access to Mental Health First Aid training
- Behavioral threat assessment training
- Safe & Supportive School Program training
- Project Restore
- TIER modules

Regional Training and Implementation Support through ESCs
- Expertise in school MHBH
- Training in EBPs & BPs
- ESCs increase staff capacity to support districts
- ESC increase skill capacity for system change coaching
- Capacity for practice coaching

Safe and Supportive School Program
- SSSP teams at district and/or campus level
- District policies
- MTSS structures
- Promoting positive climate
- Data-informed quality improvement

Health Education
- Teaching of essential knowledge and skills
- Integration of opportunities for practice, feedback, and reinforcement of skills

Communities In Schools
- MOUs/agreements
- Children/families served
- Referrals to services

TCHATT
- MOUs/agreements
- Children/families served
- Referrals to services

MH/BH Authorities
- MOUs/agreements
- Referrals from schools for outpatient care
- School-based services
- Mobile crisis response

Task Force
- Evaluation plan
- Data gathering & analysis
- Legislative reports

SHORT-TERM OUTCOMES

A shared vision and strategic direction is provided to guide state SMH activities.

State policies and rules align with the shared vision and support effective, efficient, and equitable SMH.

Districts and schools are aware, knowledgeable, and engaged with school MHBH resources and tools to support the development of school MHBH systems.

School district and/or campuses have policies, aligned with those of the state, that are equitable, fair, and support positive outcomes for all students.

Districts and schools have access to high-quality training and coaching on school MHBH practices.

Schools respond to crises in a way that reduces traumatic exposure, promotes community healing and fosters resilience.

Schools provide age-appropriate education on skills for social, emotional, behavioral and mental wellness.

The school community experiences school as safe, without bullying and victimization.

Students access school counselors or other school-based MHBH staff when needed.

Access to school school-based MHBH supports is equitable within campuses and the state.

Schools have formal partnerships with community-based organizations supporting positive youth development and MHBH.

School communities have caring, positive relationships (staff to staff, staff to student, student to student, staff to family).

Students and families are connected to specialized MHBH services when needed.

Students and families are satisfied with the supports and services available within their districts.

LONG-TERM OUTCOMES

- Effective, high quality school MHBH systems
- Cost effective service networks and partnerships
- Educators competent in core capacities (e.g., implementing MH promotion strategies, identifying MHBH and referral)
- Counselors and MHBH professionals competent in best practices
- Increase in educator mental wellness
- Reduced exposure to adverse childhood experiences or traumatic stress
- Positive school climates
- Increase in student social, emotional, and behavioral competencies
- Increased student resilience
- Reductions in disciplinary referrals
- Reduction in expulsion or placement in alternative education
- Decreased racial disparities in discipline practices
- Improved student mental health wellness
- Reduction in suicidal thoughts and behaviors
- Increased graduation rates
- Increased academic achievement scores

Notes:
- MHBH = mental health / behavioral health
- MTSS = multi-tiered system of support for mental health

Appendix B: District Survey Methodology

Methodology

A Task Force Survey Workgroup was developed to design surveys to gather key evaluation information from districts and campuses. The Workgroup was charged with identifying which elements of school-based mental health programming could only be measured through district and campus staff reporting and creating one or more surveys to measure these elements. With these parameters set, the Task Force developed two surveys, gathering specific information from school districts and campuses. The two surveys were intended to collect information across the following key areas:

a. professional development activities and resources, including the capacity to report on professional development metrics.
b. implementation of statutorily required components of school mental health.
c. implementation of school-based mental health infrastructure (e.g., mental health team, community partnerships, school-based services);
d. capacity to track and report on metrics specified in the statute.
e. initial data metrics for the 2021-2022 school year; and
f. mental and behavioral impacts related to COVID-19.

After finalizing the survey designs and related content, Task Force members shared the proposed surveys with a sample of school district administrators for feedback. Task Force members shared the proposed surveys with TEA on **November 2, 2021,** to obtain feedback and prepare for submission to the TEA's Data Governance Committee (DGC), with the survey presented to the DGC on **December 16, 2021**. Approval by the DGC is required for any surveys that involve TEA. TEA and the DGC provided additional feedback, and revisions were made and submitted to TEA Commissioner Morath's office on **December 21,** with the understanding that the surveys would be released on **January 10, 2022**.

The winter of 2021 was marked by increasing rates of COVID-19 and significant strains on school personnel due to staff absences from illness. As a result, TEA decided to delay the release of the surveys and later decided to minimize the burden by releasing only the district survey. This decision limited the data collected by the Task Force to questions that could reliably be collected at a district level and removed questions requesting the LEAs to report on specific data elements. After the survey was released through a To the Administrator Addressed (TAA) letter on **March 3, 2022**, the Task Force members collected questions from the districts and released a Question-and-Answer document on **April 3, 2022**. Districts were also provided

contact information for one of the Task Force's co-chairs to respond to any immediate questions. While the initial survey closure date was scheduled for **April 24, 2022**, the initial response rate was inadequate, so the Task Force requested help from ESC staff in encouraging the participation of LEAs. Additionally, reminder emails were sent to district contacts posted through the ASK TED list, and the final closure date was extended to **May 9, 2022**.

After the survey was closed for responses, data cleaning was conducted to ensure only one response per district (as instructed). The following steps were taken to ensure the best possible representation of district responses:

1. Districts with only one response were retained.
2. If districts had multiple responses, completed surveys were retained over partially completed surveys.
3. If districts had multiple responses, responses that incorporated multiple staff or stakeholders were retained over single respondents; and
4. If there were multiple individual responses, the responses reflecting district-level staff (e.g., superintendent, director of guidance and counseling) were selected over school-level staff (e.g., principal, teacher).

Final District Survey (as released)

Note: This version of the survey is provided to help organize data collection. The information will need to be submitted through the appropriate survey link on the TAA letter.

HB 906 Survey 2021-2022 - District

Background:
In Senate Bill 11 of the 86th Texas Legislature, ground-breaking state policies were adopted to advance safety, wellness, and resiliency in education. The Texas Education Agency (TEA), Local Education Agencies (LEAs,) and schools are charged with building multi-tiered systems of support (MTSS) that address mental and behavioral health as a pillar of safe and supportive schools programs in Texas. See additional background information from Texas Education Code Section 37.115 here.

Purpose:
House Bill 906, also in the 86th Texas Legislature, charged the Commissioner of Education to establish the Collaborative Task Force on Public School Mental Health to study and evaluate state-funded, school-based mental health services and training (Texas Education Code Section 38.301-38.312). The intent of this survey is to study our state's capacity towards establishing a MTSS that addresses mental and behavioral health in LEAs and schools. This is a baseline self-assessment only. The Task Force seeks a 100% response rate to this survey. The results of this survey will not be shared publicly, except in aggregate, on the state and regional levels of reporting results. The results will not be used in any way to evaluate any school district. TEA will store all data in accordance with the agency's information security plan, Records Retention Schedule, Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and any applicable state statutes. While it is a statutory requirement for an LEA to respond to the Task Force's request for information, the Task Force is grateful for your thoughtful and honest self-assessment in this study.

Survey Response Strategy:
It is recommended that multi-disciplinary team members will convene and engage to collaboratively respond in each LEA, consistent with MTSS teaming best practices. LEAs should also include campus administrators as part of this district-level MTSS team. Team members should self-assess baseline capacity on each question section by section on the paper version during the multi-disciplinary team meeting. Then, one team member should be assigned the responsibility to enter your LEA capacity self-assessment into the survey link.

Please review the survey by March 24th and submit any questions through this form. The Task Force

will collect questions received by **March 24th** and post responses to those questions by **April 3rd** at this link: https://schoolmentalhealthtx.org/hb-906-task-force/.

Survey responses must be submitted using the survey link by **April 24, 2022**. If you have any questions while working on the survey, please email or call the School Mental Health Task Force Co-Chair Tracy Spinner directly: ts@goodsidehealth.com or 512-848-7139. The Task Force appreciates your efforts to support student mental health and wellness. Thank you in advance for your attention to this survey.

Resources: For more information on the Task Force and MTSS-MH, please access these resources:
TEA Statewide Plan for Student Mental Health
The Collaborative Task Force on Public School Mental Health Services- Year 1 Report
Texas School Mental Health Practice Guide and Toolkit

1. Please identify your educational region and district.

   Education Service Center: _____

   District Name: _____

2. Please identify the role or roles represented by the individual(s) contributing to the completion of the survey:

   - ☐ Superintendent
   - ☐ Assistant Superintendent
   - ☐ Director/representative for guidance and counseling
   - ☐ Director/representative for special education
   - ☐ Director/representative for mental health/social and emotional wellness
   - ☐ Director/representative for nursing and health
   - ☐ Director/representative for federal programs
   - ☐ Director/representative for at-risk students
   - ☐ Director/representative for alternative education
   - ☐ Director/representative for curriculum and instruction
   - ☐ Chief/representative of law enforcement personnel (SRO, security, local PD, etc.)
   - ☐ Operational departments (e.g., business, food services, transportation)
   - ☐ Other _____

COVID-19 has impacted schools in different ways. In the following questions, please indicate ways in which the pandemic has affected your district mental health services.

3. Select the student needs that have increased in frequency or intensity during the pandemic?

- ☐ Distress related to trauma or grief
- ☐ Anxiety or stress-related concerns
- ☐ Sadness or depressed mood
- ☐ Withdrawal or shyness
- ☐ Acting out / tantrums / outbursts
- ☐ Regression in behaviors
- ☐ Leaving school or elopement
- ☐ Health concerns, illness, hygiene
- ☐ Substance use, including vaping
- ☐ Suspected child abuse
- ☐ Non-suicidal self-injury (cutting, self-harm)
- ☐ Suicidal ideation or behaviors
- ☐ Attendance problems
- ☐ Student tardiness to classes
- ☐ Disengagement/lack of participation
- ☐ Underachievement
- ☐ Study skills
- ☐ Scholastic failure
- ☐ None of the above

4. Select the components of school mental health to which your district has made changes in response to the pandemic.

   - ☐ Early mental health prevention and intervention practices
   - ☐ Grief-informed and trauma-informed practices
   - ☐ Positive behavior interventions and supports
   - ☐ Positive youth development practices
   - ☐ Safe, supportive, and positive school climate practices
   - ☐ Practices related to building skills related to managing emotions, establishing and maintaining positive relationships, and responsible decision-making.
   - ☐ Substance use prevention and intervention practices
   - ☐ Suicide prevention, intervention, and postvention practices
   - ☐ Educator professional development activities
   - ☐ None of the above

5. Has your district implemented changes to any of the following in response to increased mental health needs among students, families, or staff? (Check all that apply)

   - ☐ New policies
   - ☐ New Tier 1 supports (for all students)
   - ☐ New Tier 2/3 supports or services (for some students)
   - ☐ New educator or staff wellness supports
   - ☐ Hired new staff focused on social-emotional interventions
   - ☐ Hired new staff focused on academic interventions
   - ☐ Developed new partnerships with community-based providers focused on social, emotional, or mental health supports
   - ☐ None of the above

Please rate the following statement:

6. Our district has sufficient staffing or campus-based community partners to provide mental health services to meet the current mental health needs of our students.
   - ○ Strongly agree
   - ○ Agree
   - ○ Neither agree nor disagree
   - ○ Disagree
   - ○ Strongly disagree

7. Please select the most significant barriers to having adequate capacity to provide mental health services based on the current mental health needs of students (select up to three).
   - ☐ Insufficient sustainable funding for professional school counselors
   - ☐ Insufficient number of professional school counselors available in the area
   - ☐ Insufficient sustainable funding for school-based mental health staff
   - ☐ Insufficient number of school-based mental health staff available in the area
   - ☐ Insufficient sustainable funding to support community-based mental health partner providers
   - ☐ Insufficient number of community-based mental health partners in the area
   - ☐ Insufficient capacity of current staff to plan for or oversee school-based mental health staff/partnerships
   - ☐ Other priority areas need to come before a focus on student mental health
   - ☐ Community stakeholder feedback that student mental health should not be a priority
   - ☐ Other _____

8. To what extent has your district conducted a time analysis of professional school counselors in response to recently enacted legislation (SB 179 of 87R)?
   - ○ No time analysis has been conducted
   - ○ Planning is underway for a time analysis
   - ○ Time analysis is in progress
   - ○ Time analysis is completed
   - ○ Unsure

9. Please identify the percentage of time school counselors in your district spend on the following activities. If the time analysis is not complete, please include an estimate. (Should total 100)

Tier 1 student mental health services: _____
Tier 2 student mental health services: _____
Tier 3 student mental health services: _____
Academic / secondary counseling: _____
Community outreach: _____
Administrative tasks: _____
Non-counselor duties: _____

Total: _____

10. Does your district needs assessment include the results of a mental health needs assessment to identify the mental health services to provide?

- Yes
- No
- Unsure

11. The following lists components of the school mental and behavioral health system outlined in TEC § 38.351. Please check all the ways your district has implemented the component.

	Provide professional development	Provide student services or supports	Have established policies and procedures	None	Unsure
Early mental health promotion or prevention	☐	☐	☐	☐	☐
Mental health intervention	☐	☐	☐	☐	☐
Substance use prevention	☐	☐	☐	☐	☐
Substance use intervention	☐	☐	☐	☐	☐
Suicide prevention	☐	☐	☐	☐	☐
Suicide intervention	☐	☐	☐	☐	☐
Suicide postvention	☐	☐	☐	☐	☐
Grief-informed practices	☐	☐	☐	☐	☐
Trauma-informed practices	☐	☐	☐	☐	☐
Positive behavior interventions and supports	☐	☐	☐	☐	☐
Positive youth development	☐	☐	☐	☐	☐
Approaches for safe, supportive, positive school climate	☐	☐	☐	☐	☐

Building skills to manage emotions, establish and maintain positive relationships, and make responsible decisions	☐	☐	☐	☐	☐

12. What funding sources are currently used to fund one or more components of the school and behavioral health systems outlined in TEC § 38.351? (Check all that apply)

- ☐ Foundation School Program
- ☐ State Compensatory Education (to reduce disparities in achievement or completion)
- ☐ Title I (supporting education of economically disadvantaged students)
- ☐ Title III (supporting education of English learners)
- ☐ Title IVA (Student Support and Academic Enrichment)
- ☐ Title IVB (21st Century Community Learning Centers)
- ☐ ESSER grants (COVID-19 federal funding)
- ☐ McKinney Vento (supporting education of students experiencing homelessness)
- ☐ School Safety Allotment
- ☐ Victims of Crime Act (VOCA) grants (through the Office of the Governor)
- ☐ Medicaid / SHARS
- ☐ Private pay or insurance
- ☐ Philanthropy (e.g., foundations, donations)
- ☐ Local funds
- ☐ Non-financial agreements with partner agencies
- ☐ Other _____

13. Does your district have a data system or platform that is used by schools to monitor student progress across mental and behavioral health outcomes?

- ○ Yes
- ○ No
- ○ Unsure

14. What data system or platform does your school use to monitor student progress (indicate "LOCAL" if locally developed)?

    _____

The Task Force is charged with collecting data on mental health service delivery and outcomes of services. The data elements below were included in the charge to the Task Force through HB 906 and codified in TEC Section 38.301-38.312. To better understand the data that is collected at LEAs, we want to ask about data that the district tracks on student mental and behavioral health and the ways in which the district is able to report this data.

15. For each of the following data elements, please indicate whether the district collects the data on individual students (school/district collects data), whether the district analyzes or creates reports on the data (district and schools use data), and whether the data can be reported separately by race,

ethnicity, gender, special education status, and economically disadvantaged status (data is broken down or disaggregated).

For the three items marked with an asterisk (available in PEIMS), please complete only the "District team uses data" box to reflect if the available data is used.

	District collects data	District team uses data	Data is disaggregated	Unsure
Number of violent incidents that occur at school	☐	☐	☐	☐
Student out-of-school suspensions*	■	☐	■	■
Student expulsions*	■	☐	■	■
Student referral to disciplinary alternative education programs*	■	☐	■	■
Student referral to law enforcement	☐	☐	☐	☐
Involvement of SRO in disciplinary event	☐	☐	☐	☐
Length of time (days) of disciplinary actions	☐	☐	☐	☐
Number of bullying allegations	☐	☐	☐	☐
Number of students reporting discrimination-related concerns	☐	☐	☐	☐
Number of students receiving mental health services on campus (by school or non-school providers)	☐	☐	☐	☐

Number of students referred to off-campus outpatient mental health provider or counselor.	☐	☐	☐	☐
Number of students referred to an inpatient mental health provider.	☐	☐	☐	☐
Number of students identified with risk of suicide	☐	☐	☐	☐
Number of students known to have died by suicide	☐	☐	☐	☐
Number of students referred to child welfare for investigation and reason for referral (excluding anonymous reports)	☐	☐	☐	☐
Number of students experiencing a mental health crisis transported for emergency detention by medical or law enforcement personnel	☐	☐	☐	☐

16. Does your district have a research or accountability department or access to an evaluation partner, such as a local university, to support data collection, analysis, and use?

- ○ Yes
- ○ No
- ○ Unsure

Next, we would like to ask some questions about staff professional development related to mental and behavioral health.

17. Does the district have a system to track staff professional development?

- ○ Yes, at the district level
- ○ Yes, at the campus level
- ○ No
- ○ Unsure

18. Which mental health-related topic areas has your district offered professional development for in the last 12 months?

	Offered to counselors or mental health staff	Offered to educators	Offered to other staff	None	Unsure
Youth Mental Health First Aid	☐	☐	☐	☐	☐
Psychological First Aid	☐	☐	☐	☐	☐
Recognizing warning signs of suicide	☐	☐	☐	☐	☐
Classroom positive behavior management	☐	☐	☐	☐	☐
Restorative practices	☐	☐	☐	☐	☐
Behavioral threat assessment	☐	☐	☐	☐	☐
Impact of trauma	☐	☐	☐	☐	☐
Trauma-informed practices	☐	☐	☐	☐	☐
Impact of grief	☐	☐	☐	☐	☐
Grief-informed practices	☐	☐	☐	☐	☐
Specific universal program for all students	☐	☐	☐	☐	☐
Specific mental health program for selected students	☐	☐	☐	☐	☐
Evidence-based therapies	☐	☐	☐	☐	☐

19. Which two sources of professional development do you use most frequently for training on mental health topics (select only two)?

- ☐ Internal district or school staff
- ☐ Education service centers
- ☐ Online training system
- ☐ Texas School Safety Center
- ☐ Community partner agency(ies)
- ☐ Contracted external trainers
- ☐ Other _____
- ☐ None

Please indicate the extent to which the following elements of a comprehensive school mental health system have been implemented in your LEA using the following stage of the implementation scale:

Not Implemented: The school has not yet implemented this component of a multi-tiered system of support (MTSS).	**Planning for Implementation:** The school is currently planning for implementation, but active implementation has not yet begun.	**Early Partial Implementation:** The school has begun implementation of this component of an MTSS, but it is not yet at the desired level of implementation. The activity may not be happening as frequently as desired, is inadequate to meet the full need, or currently lacks the quality that is expected at full implementation.	**Late Partial Implementation:** The school has made substantial progress to implement the component of an MTSS but is continuing to work towards expanding or strengthening the practice.	**Full Implementation:** This mental health component of the MTSS has been implemented at the desired level and is being maintained over time. The focus is on ensuring the component is sustained and ongoing quality is monitored for opportunities for improvement.

20. To what extent do schools in your district have a multi-disciplinary team or teams (e.g., student support team, school mental health team) tasked with planning and overseeing the implementation of the school mental health component of a multi-tiered system of support (MTSS)?

Some best practices to consider:

- Team is multidisciplinary
- Team meaningfully involves parents and students
- Team or teams address each tier of MTSS
- Team or teams makes referral linkages to school or community-based services
- Team or teams conducts regular, efficient meetings
- Team or teams uses data to determine student needs

Check LEA self-assessment rating:

- ○ No implementation
- ○ Planning for implementation
- ○ Early partial implementation
- ○ Late partial implementation
- ○ Full implementation

21. To what extent has your LEA developed and documented a referral pathway (e.g., decision points and processes) for school or community-based mental or behavioral health services?

Best practices to consider:

- Schools use a current resource directory or map
- Schools conduct family meetings to review needs, options, and release of information for care coordination
- Schools provide clear information for families and students to self-refer to services
- Schools provide clear referral instructions and confirm service availability
- Schools discuss potential barriers to accessing mental or behavioral health services and plan for how to overcome them
- Schools use referral meetings with service providers or feedback forms, or a process for ongoing communication

Check LEA self-assessment rating:

- ○ No implementation
- ○ Planning for implementation
- ○ Early partial implementation
- ○ Late partial implementation
- ○ Full implementation

22. Part A: To what extent does your LEA have formal partnerships (MOUs, agreements) with mental or behavioral health providers to serve students and/or families?

Best practices to consider:

- Schools establish ongoing communication mechanisms with community-based providers
- Schools establish data-sharing agreements
- Schools understand the populations served by the provider and any limitations
- Schools understand the targeted outcomes of services and the impact

Check LEA self-assessment rating:

- ○ No implementation
- ○ Planning for implementation
- ○ Early partial implementation
- ○ Late partial implementation
- ○ Full implementation

23. What types of providers do you have formal partnerships with (check all that apply)?

- ☐ School-based health/mental health center
- ☐ Communities In Schools
- ☐ Community mental health center or Local Mental Health Authority (LMHA)
- ☐ Texas Child Health Access Through Telehealth (TCHATT)
- ☐ Family resource center
- ☐ Community health centers or Federally Qualified Health Centers
- ☐ Youth substance use prevention provider or program
- ☐ Substance use treatment provider
- ☐ Other mental health provider
- ☐ Other health provider
- ☐ Other social service organizations
- ☐ Other telemental health service provider

24. To what extent do schools in your LEA conduct and review data annually from a school climate survey of students, family members, and staff?

Best practices to consider:

- Schools assess multiple dimensions of climate
- Schools use an evidence-based assessment
- Schools assess the perspectives of staff, students, and families
- Schools align with other school improvement efforts
- Schools use data to select priority areas

Check LEA self-assessment rating:

- ○ No implementation
- ○ Planning for implementation
- ○ Early partial implementation
- ○ Late partial implementation
- ○ Full implementation

25. To what extent have schools in your LEA documented the available community-based mental health resources?

Best practices to consider:

- Schools foster school-community partnerships with community providers
- Schools use multiple sources to identify existing resources
- Schools include who the resource is intended for, how to access it
- Schools include target outcomes and evidence of impact
- Schools make resource lists available to all
- Schools have a process for regularly updating the resources list

Check LEA self-assessment rating:

- ○ No implementation
- ○ Planning for implementation
- ○ Early partial implementation
- ○ Late partial implementation
- ○ Full implementation

Initial Campus Survey

Note: This version of the survey is provided to help organize data collection. The information will need to be submitted through the appropriate survey link on the TAA letter.

HB906 Survey 2021-2022 – Campus Version

Background:
In Senate Bill 11 of the 86th Texas Legislature, ground-breaking state policies were adopted to advance safety, wellness, and resiliency in education. The Texas Education Agency (TEA), Local Education Agencies (LEAs), and schools are charged with building multi-tiered systems of support (MTSS) that address mental and behavioral health as a pillar of safe and supportive schools in Texas. See additional background information here.

Purpose:
House Bill 906, also in the 86th Texas Legislature, charged the Commissioner of Education to establish the Collaborative Task Force on Public School Mental Health to study and evaluate state-funded, school-based mental health services and training (Texas Education Code Section 38.301-38.312). The intent of this survey is to study our state's capacity towards establishing a MTSS that addresses mental and behavioral health in LEAs and schools. This is a baseline self-assessment only. The Task Force seeks a 100% response rate to this survey. The results of this survey will not be shared publicly, except in aggregate, on the state and regional levels of reporting results. The results will not be used in any way to evaluate any school district or campus. TEA will store all data in accordance with the agency's information security plan, Records Retention Schedule, Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and any applicable state statutes. While it is a statutory requirement for an LEA and campus to respond to the Task Force's request for information, the Task Force is grateful for your thoughtful and honest self-assessment in this study.

Survey Response Strategy:
There is an LEA version and a school version of this survey. It is requested that LEA and school administrators ensure that independent responses are provided at both the school level and the LEA level. It is recommended that multi-disciplinary team members will convene and engage to collaboratively respond in each LEA and each school, consistent with MTSS teaming best practices. Before the MTSS team meeting, administrators should assign at least one team member to gather any available data on the ten requested metrics in the final survey section. Team members should self-assess baseline capacity on each question section by section on the paper version during an

MTSS meeting. Then, one team member should be assigned the responsibility of entering your school MTSS capacity self-assessment into the survey link.

Please review the survey by February 7th and submit any questions through this form. The Task Force will collect questions received by **February 7th** and post responses to those questions **by February 14th** at this link: https://schoolmentalhealthtx.org/hb-906-task-force/. If you have any questions while working on the survey, please email or call the School Mental Health Task Force Co-Chair Tracy Spinner directly: ts@goodsidehealth.com or 512-848-7139.

Resources:

For more information on the Task Force and MTSS-MH, please access these resources:

TAA Letter

TEA Statewide Plan for Student Mental Health

The Collaborative Task Force on Public School Mental Health Services- Year 1 Report

Texas School Mental Health Practice Guide and Toolkit

1. What is the Education Service Center for your school district?
   - ○ Regions 1 - 5
   - ○ Regions 6 - 10
   - ○ Regions 11 - 15
   - ○ Regions 16 - 20

2. Please provide information on the campus you represent.
   a. Education Service Center:
   b. District name:
   c. Campus name:

3. Please identify the role or roles represented by the individual(s) contributing to the completion of the survey:
   - ☐ School administrator (principal/assistant principal)
   - ☐ School counselor
   - ☐ School social worker
   - ☐ School mental health staff (e.g., licensed professional counselor)
   - ☐ A nurse or other health staff
   - ☐ Family specialist or liaison
   - ☐ Teacher or instructional specialists
   - ☐ Paraprofessional
   - ☐ Other _____

COVID-19 has impacted schools in different ways. In the following questions, please indicate ways in which the pandemic has affected your school's mental health practices.

4. Select the student needs that have increased in frequency or intensity during the pandemic?

- ☐ Distress related to trauma or grief
- ☐ Anxiety or stress-related concerns
- ☐ Sadness or depressed mood
- ☐ Withdrawal or shyness
- ☐ Acting out / tantrums / outbursts
- ☐ Regression in behaviors
- ☐ Leaving school or elopement
- ☐ Health concerns, illness, hygiene
- ☐ Substance use, including vaping
- ☐ Suspected child abuse
- ☐ Non-suicidal self-injury (cutting, self-harm)
- ☐ Suicidal ideation or behaviors
- ☐ Attendance and/or tardies
- ☐ Disengagement / lack of participation
- ☐ Underachievement
- ☐ Study skills
- ☐ Scholastic failure
- ☐ None of the above

5. Select the components of school mental health to which your campus has made changes in response to the pandemic.

   - ☐ Early mental health prevention and intervention practices
   - ☐ Grief-informed and trauma-informed practices
   - ☐ Positive behavior interventions and supports
   - ☐ Positive youth development practices
   - ☐ Safe, supportive, and positive school climate practices
   - ☐ Practices related to building skills related to managing emotions, establishing and maintaining positive relationships, and responsible decision-making
   - ☐ Substance use prevention and intervention practices
   - ☐ Suicide prevention, intervention, and postvention practices
   - ☐ Educator professional development activities
   - ☐ None of the above

6. Has your school implemented changes to any of the following in response to increased mental health needs among students, families, or staff? (check all that apply)

   - ☐ New policies
   - ☐ New Tier 1 supports (for all students)
   - ☐ New Tier 2/3 supports or services (for some students)
   - ☐ New educator or staff wellness supports
   - ☐ Hired new staff focused on social-emotional interventions
   - ☐ Hired new staff focused on academic interventions
   - ☐ Developed new partnerships with community-based providers focused on social, emotional, or mental health supports
   - ☐ None of the above

Please rate the following statement:

7. Our campus has sufficient staffing or campus-based community partners to meet the current mental health needs of our students.
   - ○ Strongly agree
   - ○ Agree
   - ○ Neither agree nor disagree
   - ○ Disagree
   - ○ Strongly disagree

8. Please select the most significant barriers to having adequate capacity to meet the current mental health needs of students (select up to three).
   - ☐ Insufficient sustainable funding for professional school counselors
   - ☐ Insufficient number of professional school counselors available in the area
   - ☐ Insufficient sustainable funding for school-based mental health staff
   - ☐ Insufficient number of school-based mental health staff available in the area
   - ☐ Insufficient sustainable funding to support community-based mental health partner providers
   - ☐ Insufficient number of community-based mental health partners in the area
   - ☐ Insufficient capacity of current staff to plan for or oversee school-based mental health staff/partnerships
   - ☐ Other priority areas need to come before a focus on student mental health
   - ☐ Community stakeholder feedback that student mental health should not be a priority
   - ☐ Other _____

Please indicate the extent to which the following elements of a comprehensive school mental health system have been implemented using the following stage of the implementation scale:

- Not Implemented: The school has not yet implemented this component of a multi-tiered system of support (MTSS).
- Planning for Implementation: The school is currently planning for implementation, but active implementation has not yet begun.
- Early Partial Implementation: The school has begun implementation of this component of an MTSS, but it is not yet at the desired level of implementation. The activity may not be

happening as frequently as desired, is inadequate to meet the full need, or currently lacks the quality that is expected at full implementation.

- Late Partial Implementation: The school has made substantial progress to implement the component of an MTSS but is continuing to work towards expanding or strengthening the practice.
- Full Implementation: This mental health component of the MTSS has been implemented at the desired level and is being maintained over time. The focus is on ensuring the component is sustained and ongoing quality is monitored for opportunities for improvement.

9. To what extent does your school have a multi-disciplinary team or teams (e.g., student support team, school mental health team) tasked with planning and overseeing the implementation of the school mental health component of a multi-tiered system of support (MTSS)?

   Some best practices to consider:
   - Team is multidisciplinary
   - Team meaningfully involves parents and students
   - Team or teams address each tier of MTSS
   - Team or teams makes referrals to school or community-based services
   - Team or teams conducts regular, efficient meetings
   - Team or teams uses data to determine student needs

   ○ No implementation

   ○ Planning for implementation

   ○ Early partial implementation

   ○ Late partial implementation

   ○ Full implementation

10. Please check all roles represented on your school mental health team(s).

- ☐ Campus administrator
- ☐ School counselor
- ☐ School mental health staff
- ☐ School social worker
- ☐ Teacher
- ☐ School nurse
- ☐ Special education lead
- ☐ Family specialist or liaison
- ☐ Military family liaison
- ☐ School-based law enforcement officer (SBLE) or School resource officer (SRO)
- ☐ Family member
- ☐ Student
- ☐ Community mental health representative
- ☐ Community member (non-mental health)
- ☐ Other _____

11. To what extent does your school conduct and review data annually from a school climate survey of students, family members, and staff?

Best practices to consider:

- School assesses multiple dimensions of climate
- School uses an evidence-based assessment
- School assesses perspectives of staff, students, and families
- School aligns with other school improvement efforts
- School uses data to select priority areas

- ○ No implementation
- ○ Planning for implementation
- ○ Early partial implementation
- ○ Late partial implementation
- ○ Full implementation

12. What climate survey is used (add the term "LOCAL" if locally developed)?

    _____

13. If your school uses a curriculum-based approach to building skills to manage emotions, establish positive relationships, and make responsible decisions (sometimes known as Social and Emotional Learning/SEL), please share the name of the program(s).

    _____

14. To what extent does your school review local data on mental and behavioral health strengths and needs and develop a needs assessment for your campus?

    Best practices to consider:

    - School convenes a mental health needs assessment team
    - School assesses student mental health strengths
    - School assesses student mental health needs
    - School uses needs assessment to inform decisions on services/supports

    ○ No implementation

    ○ Planning for implementation

    ○ Early partial implementation

    ○ Late partial implementation

    ○ Full implementation

15. Are the mental health needs assessment results incorporated into the district needs assessment?

    ○ Yes

    ○ No

    ○ Unsure

16. Does the district needs assessment include the results of a mental health needs assessment?

    ○ Yes

    ○ No

    ○ Unsure

17. To what extent has your school documented the available school-based mental health resources?

    Best practices to consider:
    - School uses multiple sources to identify existing resources
    - School includes who the resource is intended for and how to access it.
    - School includes target outcomes and evidence of impact
    - School makes resource list available to all
    - School has process for regularly updating the resource list

    ○ No implementation

    ○ Planning for implementation

    ○ Early partial implementation

    ○ Late partial implementation

    ○ Full implementation

18. To what extent has your school documented the available community-based mental health resources?

    Best practices to consider:
    - School fosters school-community partnerships with community providers
    - School uses multiple sources to identify existing resources
    - School includes who the resource is intended for, how to access it
    - School includes target outcomes and evidence of impact
    - School makes resource list available to all
    - School has process for regularly updating the resources list

    ○ No implementation

    ○ Planning for implementation

    ○ Early partial implementation

    ○ Late partial implementation

    ○ Full implementation

19. Is the school- and community-based mental health resource map or guide available on the school website?

    - ○ Yes
    - ○ No
    - ○ Unsure

20. To what extent has your school developed and documented a referral pathway (e.g., decision points and processes) for school or community-based mental or behavioral health supports?

    Best practices to consider:
    - School uses a current resource directory or map
    - School conducts a family meeting to review needs, options, and release of information.
    - School provides clear information for families and students to self-refer.
    - School provides clear referral instructions and confirms service availability
    - School discusses potential barriers and how to overcome
    - School uses referral meetings or feedback forms for ongoing communication

    - ○ No implementation
    - ○ Planning for implementation
    - ○ Early partial implementation
    - ○ Late partial implementation
    - ○ Full implementation

21. Has your school communicated procedures for families to self-refer a student to receive school-based mental or behavioral health supports?

    - ○ Yes
    - ○ No
    - ○ Unsure

22. To what extent does your school conduct mental health screenings of all students (in accordance with local consent procedures) to identify students needing potential mental or behavioral health supports?

Best practices to consider:

- School involves students and families in planning the screening process
- School identifies a screening tool or process
- School selects a tool that assesses social and emotional strengths, as well as risk for mental health concerns
- School engages students and families in a consent process and offers opportunities to consent opt-out
- School has a defined and timely process to assess results and triage students further to assess the need for Tier 2 or 3 supports

○ No implementation

○ Planning for implementation

○ Early partial implementation

○ Late partial implementation

○ Full implementation

23. What mental/behavioral health screening tool(s) is used? (Indicate "LOCAL" if locally developed.)

_____

24. What type of parental notification and/or parental consent is obtained for universal screening? (check all that apply)

☐ None / teacher observation only

☐ Parental and student notification

☐ Passive parental consent (opt-out)

☐ Active parental consent (opt-in)

☐ Unsure

25. To what extent does your school have formal partnerships (MOUs, agreements) with mental or behavioral health providers to serve students and/or families?

Best practices to consider:

- School establishes ongoing communication mechanisms with community-based providers
- School establishes data-sharing agreements
- School understands the populations served by the provider and any limitations
- School understands the targeted outcomes of services and their impact

○ No implementation

○ Planning for implementation

○ Early partial implementation

○ Late partial implementation

○ Full implementation

26. What types of providers do you have formal partnerships with (check all that apply)?

☐ School-based health/mental health center

☐ Communities In Schools

☐ Community mental health center or Local Mental Health Authority

☐ Texas Child Health Access Through Telehealth (TCHATT)

☐ Family resource center

☐ Community health centers or Federally Qualified Health Centers

☐ Youth substance use prevention provider or program

☐ Substance use treatment provider

☐ Other mental health provider

☐ Other health provider

☐ Other social service organization

☐ Other telemental health provider

27. To what extent does your school use multiple funding sources to support financially, including staff training and coaching, the services and supports within the MTSS for mental health?

Best practices to consider:

- School uses multiple and diverse funding sources
- School ensures funding and resource align to support a full continuum of services and supports School establishes and uses a process to regularly evaluate and update your financing plan
- School regularly seeks diverse partners who may have funding or non-financial resources
- School has strategies in place to retain staff and minimize turnover

- ○ No implementation
- ○ Planning for implementation
- ○ Early partial implementation
- ○ Late partial implementation
- ○ Full implementation

28. What funding sources are currently used to fund one or more components of your MTSS for mental and behavioral health?

- ☐ Foundation School Program
- ☐ State Compensatory Education (to reduce disparities in achievement or completion)
- ☐ Title I (supporting education of economically disadvantaged students)
- ☐ Title III (supporting education of English learners)
- ☐ Title IVA (Student Support and Academic Enrichment)
- ☐ Title IVB (21st Century Community Learning Centers)
- ☐ ESSER grants (COVID-19 federal funding)
- ☐ McKinney Vento (supporting education of students experiencing homelessness)
- ☐ School Safety Allotment
- ☐ Victims of Crime Act (VOCA) grants (through the Office of the Governor)
- ☐ Medicaid / SHARS
- ☐ Private pay or insurance
- ☐ Philanthropy (e.g., foundations, donations)
- ☐ Local funds
- ☐ Non-financial agreements with partner agencies
- ☐ Other _____

29. To what extent does your school use data to monitor the progress of individual students receiving supports through the school mental health component of the MTSS?

Best practices to consider:

- School identifies existing and potential educational outcome data (e.g., grades, attendance, discipline referrals)
- School identifies existing and potential social, emotional, and behavioral outcome data (e.g., mental health screenings, behavioral observations, crisis incidents)
- School establishes data infrastructure that allows for easy collection, analysis, and reporting
- School examines educational data to understand student progress and service impact
- School examines social, emotional, and behavioral data to understand student progress and service impact

○ No implementation

○ Planning for implementation

○ Early partial implementation

○ Late partial implementation

○ Full implementation

30. For whom is data used to monitor individual student progress? (check all that apply)

☐ Students receiving a behavioral threat assessment

☐ Students receiving early intervention (Tier 2) mental health supports

☐ Students receiving intensive intervention (Tier 3) mental health supports

☐ Students receiving services/supports from external providers

☐ Students involved in select, limited programs (e.g., grant programs)

☐ None

☐ Unsure

31. To what extent does your school use aggregate/group data to understand the quality and outcomes of the services and supports?

Best practices to consider:

- School develops a theory of change about how specific services impact educational or mental health outcomes
- School identifies existing and potential outcome data
- School establishes data tools and processes that allow for easy collection, analysis, and reporting. School examines student outcome data based on demographic characteristics (e.g., age, disability, ethnicity, race, gender, language, socioeconomic status)
- School reports the impact of services and supports to a broad and diverse group of stakeholders

- ○ No implementation
- ○ Planning for implementation
- ○ Early partial implementation
- ○ Late partial implementation
- ○ Full implementation

32. What data system or platform does your school use to monitor student progress (indicate "LOCAL" if locally developed)?

_____

The Task Force is charged with collecting data on mental health service delivery and outcomes of services. The data elements below were included in the charge to the Task Force through HB 906 and codified in TEC Section 38.301-38.312. To better understand the data collected in schools, we want to ask about data that the campus tracks on student mental and behavioral health and how the school can report this data.

33. For each of the following data elements, please indicate whether the campus collects the data on individual students (school collects data), whether the school analyzes or creates reports on the data (school uses data), and whether the data can be reported separately by race, ethnicity,

gender, special education status, and economically disadvantaged status (data is broken down or disaggregated).

For the three items marked with an asterisk (available in PEIMS), please complete only the "School team uses data" box to reflect if the available data is used.

	School collects data	The school team uses data	Data is disaggregated	Unsure
Number of violent incidents that occur at school	☐	☐	☐	☐
Student out-of-school suspensions*	☐	☐	☐	☐
Student expulsions*	☐	☐	☐	☐
Student referral to disciplinary alternative education programs*	☐	☐	☐	☐
Student referral to law enforcement	☐	☐	☐	☐
Involvement of SRO in disciplinary event	☐	☐	☐	☐
Length of time (days) of disciplinary actions	☐	☐	☐	☐
Number of bullying allegations	☐	☐	☐	☐
Number of students reporting race-or discrimination-related concerns	☐	☐	☐	☐
Number of students receiving mental health services on campus (by school or non-school providers)	☐	☐	☐	☐
Number of students referred to off-campus outpatient mental health provider or counselor	☐	☐	☐	☐

Number of students referred to an inpatient mental health provider	☐	☐	☐	☐
Number of students identified with risk of suicide	☐	☐	☐	☐
Number of students known to have died by suicide	☐	☐	☐	☐
Number of students referred to child welfare for investigation and reason for referral (excluding anonymous reports)	☐	☐	☐	☐
Number of students experiencing a mental health crisis transported for emergency detention by medical or law enforcement personnel	☐	☐	☐	☐

34. Does your school have access to a district research or accountability department or access to an evaluation partner, such as a local university, to support data collection, analysis, and use?

- ○ Yes
- ○ No
- ○ Unsure

While the Task Force recognizes that the information may not be available on all data elements, the members prioritized data that is most important to achieving the Task Force's charge for collection in

the current year. Please provide the following data elements for your school campus for the period ending in December 2021. The Task Force also plans to request this data at the end of the 2021-2022 school year, at which time we hope other schools will have the capacity to report on the measures. Another survey will be administered in June 2022, requesting data on the 10 elements below to cover the period of January - June 2022.

35. Identification of Mental or Behavioral Health Needs (ALL needs):

1. Number of students identified with early warning signs and the possible need for early mental health, mental health, or substance abuse intervention (warning signs may include declining academic performance, depression, anxiety, isolation, anger outbursts, hyperactivity, unexplained changes in sleep or eating habits, destructive behavior toward to self or others):

Enter -9 if data is not available

_____

2. Number of students whose parents/guardians were notified of a recommendation for early mental health or substance abuse intervention after early warning signs were identified in #1

Enter -9 if data is not available

_____

3. # served at school: Of those referred in #2, the number of students who received mental health services and supports at school after notification of early warning signs were identified

Enter -9 if data is not available

_____

4. # served in the community: Of those referred in #2, the number of students known to have received mental health services and supports in the community after early warning signs were identified

Enter -9 if data is not available

_____

36. Identification of Suicide-Focused Needs:

5. Number of known student outcries/expressions of suicidal thoughts, plans, or behaviors (either on or off campus)

Enter -9 if data is not available

_____

6. Number of students whose parents/guardians were notified of a student identified as potentially at risk for suicide after identification of early warning signs in #5

Enter -9 if data is not available

_____

7. Number of known (confirmed with reasonable certainty) student suicide attempts (either on or off campus)

Enter -9 if data is not available

_____

8. Number of known (confirmed with reasonable certainty) student deaths by suicide (either on or off campus)

Enter -9 if data is not available

_____

37. School Transitions following Mental Health Services:

9. Number of students returning to the campus following intensive mental health treatment, such as in a psychiatric hospital or residential treatment program

Enter -9 if data is not available

_____

10. Number of students provided transition supports by the school following intensive mental health treatment, such as a coordinated student support plan that outlines strategies to address academic, behavioral, emotional, and social needs upon return to the home campus

Enter -9 if data is not available

Next, we would like to ask some questions about staff professional development related to mental and behavioral health.

38. Which mental health-related topic areas has your school offered professional development for in the last 12 months?

	Offered to counselors or mental health staff	Offered to educators	Offered to other staff	None	Unsure
Youth Mental Health First Aid	☐	☐	☐	☐	☐
Psychological First Aid	☐	☐	☐	☐	☐
Recognizing warning signs of suicide	☐	☐	☐	☐	☐
Classroom positive behavior management	☐	☐	☐	☐	☐
Restorative practices	☐	☐	☐	☐	☐
Behavioral threat assessment	☐	☐	☐	☐	☐
Impact of trauma	☐	☐	☐	☐	☐
Trauma-informed practices	☐	☐	☐	☐	☐
Impact of grief	☐	☐	☐	☐	☐
Grief-informed practices	☐	☐	☐	☐	☐
Specific universal program for all students	☐	☐	☐	☐	☐

Specific mental health program for selected students	☐	☐	☐	☐	☐
Evidence-based therapies	☐	☐	☐	☐	☐

39. Which two sources of professional development do you use most frequently for training on mental health topics (select only two)?

- ☐ Internal district or school staff
- ☐ Education service centers
- ☐ Online training system
- ☐ Texas School Safety Center
- ☐ Community partner agency(ies)
- ☐ Contracted external trainers
- ☐ Other _____
- ☐ None

Initial District Survey

Note: This version of the survey is provided to help organize data collection. The information will need to be submitted through the appropriate survey link on the TAA letter.

HB 906 Survey 2021-2022 - District

Background:
In Senate Bill 11 of the 86th Texas Legislature, ground-breaking state policies were adopted to advance safety, wellness, and resiliency in education. The Texas Education Agency (TEA), Local Education Agencies (LEAs,) and schools are charged with building multi-tiered systems of support (MTSS) that address mental and behavioral health as a pillar of safe and supportive schools in Texas. See additional background information here.

Purpose:
House Bill 906, also in the 86th Texas Legislature, charged the Commissioner of Education to establish the Collaborative Task Force on Public School Mental Health to study and evaluate state-funded, school-based mental health services and training (Texas Education Code Section 38.301-38.312). The intent of this survey is to study our state's capacity towards establishing a MTSS that addresses mental and behavioral health in LEAs and schools. This is a baseline self-assessment only. The Task Force seeks a 100% response rate to this survey. The results of this survey will not be shared publicly, except in aggregate, on the state and regional levels of reporting results. The results will not be used in any way to evaluate any school district or campus. TEA will store all data in accordance with the agency's information security plan, Records Retention Schedule, Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and any applicable state statutes. While it is a statutory requirement for an LEA and campus to respond to the Task Force's request for information, the Task Force is grateful for your thoughtful and honest self-assessment in this study.

Survey Response Strategy:
There is an LEA version and a school version of this survey. It is requested that LEA and school administrators ensure that independent responses are provided at both the school level and the LEA level. It is recommended that multi-disciplinary team members will convene and engage to collaboratively respond in each LEA and each school, consistent with MTSS teaming best practices. Team members should self-assess baseline capacity on each question section by section on the paper version during an MTSS meeting. Then, one team member should be assigned the responsibility to enter your LEA capacity self-assessment into the survey link.

Please review the survey by February 7th and submit any questions through this form. The Task Force will collect questions received by **February 7th** and post responses to those questions **by February**

14th at this link: https://schoolmentalhealthtx.org/hb-906-task-force/. If you have any questions while working on the survey, please email or call the School Mental Health Task Force Co-Chair Tracy Spinner directly: ts@goodsidehealth.com or 512-848-7139.

The Task Force appreciates your efforts to support student mental health and wellness. Thank you in advance for your attention to this survey.

Resources: For more information on the Task Force and MTSS-MH, please access these resources:
TAA Letter
TEA Statewide Plan for Student Mental Health
The Collaborative Task Force on Public School Mental Health Services- Year 1 Report
Texas School Mental Health Practice Guide and Toolkit

6. Please identify your educational region and district.

   Education Service Center: _____

   District Name: _____

7. Please identify the role or roles represented by the individual(s) contributing to the completion of the survey:

   ☐ Superintendent

   ☐ Assistant Superintendent

   ☐ Director/representative for guidance and counseling

   ☐ Director/representative for special education

   ☐ Director/representative for mental health/social and emotional wellness

   ☐ Director/representative for nursing and health

   ☐ Director/representative for federal programs

   ☐ Director/representative for at-risk students

   ☐ Director/representative for alternative education

   ☐ Director/representative for curriculum and instruction

   ☐ Chief/representative of law enforcement personnel (SRO, security, local PD, etc.)

   ☐ Operational departments (e.g., business, food services, transportation)

   ☐ Other _____

COVID-19 has impacted schools in different ways. In the following questions, please indicate ways in which the pandemic has affected your district mental health practices.

8. Select the student needs that have increased in frequency or intensity during the pandemic?

- ☐ Distress related to trauma or grief
- ☐ Anxiety or stress-related concerns
- ☐ Sadness or depressed mood
- ☐ Withdrawal or shyness
- ☐ Acting out / tantrums / outbursts
- ☐ Regression in behaviors
- ☐ Leaving school or elopement
- ☐ Health concerns, illness, hygiene
- ☐ Substance use, including vaping
- ☐ Suspected child abuse
- ☐ Non-suicidal self-injury (cutting, self-harm)
- ☐ Suicidal ideation or behaviors
- ☐ Attendance and/or tardies
- ☐ Disengagement / lack of participation
- ☐ Underachievement
- ☐ Study skills
- ☐ Scholastic failure
- ☐ None of the above

9. Select the components of school mental health to which your district has made changes in response to the pandemic.

   ☐ Early mental health prevention and intervention practices

   ☐ Grief-informed and trauma-informed practices

   ☐ Positive behavior interventions and supports

   ☐ Positive youth development practices

   ☐ Safe, supportive, and positive school climate practices

   ☐ Practices related to building skills related to managing emotions, establishing and maintaining positive relationships, and responsible decision-making

   ☐ Substance use prevention and intervention practices

   ☐ Suicide prevention, intervention, and postvention practices

   ☐ Educator professional development activities

   ☐ None of the above

10. Has your district implemented changes to any of the following in response to increased mental health needs among students, families, or staff? (check all that apply)

   ☐ New policies

   ☐ New Tier 1 supports (for all students)

   ☐ New Tier 2/3 supports or services (for some students)

   ☐ New educator or staff wellness supports

   ☐ Hired new staff focused on social-emotional interventions

   ☐ Hired new staff focused on academic interventions

   ☐ Developed new partnerships with community-based providers focused on social, emotional, or mental health supports

   ☐ None of the above

Please rate the following statement:

6. Our campus has sufficient staffing or campus-based community partners to meet the current mental health needs of our students.
   - ○ Strongly agree
   - ○ Agree
   - ○ Neither agree nor disagree
   - ○ Disagree
   - ○ Strongly disagree

26. Please select the most significant barriers to having adequate capacity to meet the current mental health needs of students (select up to three).
   - ☐ Insufficient sustainable funding for professional school counselors
   - ☐ Insufficient number of professional school counselors available in the area
   - ☐ Insufficient sustainable funding for school-based mental health staff
   - ☐ Insufficient number of school-based mental health staff available in the ‘?area
   - ☐ Insufficient sustainable funding to support community-based mental health partner providers
   - ☐ Insufficient number of community-based mental health partners in the area
   - ☐ Insufficient capacity of current staff to plan for or oversee school-based mental health staff/partnerships
   - ☐ Other priority areas need to come before a focus on student mental health
   - ☐ Community stakeholder feedback that student mental health should not be a priority
   - ☐ Other _____

27. To what extent has your district conducted a time analysis of professional school counselors in response to recently enacted legislation (SB 179 of 87R)?

- ○ No time analysis has been conducted
- ○ Planning is underway for a time analysis
- ○ Time analysis is in progress
- ○ Time analysis is completed
- ○ Unsure

28. Please identify the percentage of time school counselors in your district spend on the following activities. If the time analysis is not complete, please include an estimate. (should total 100)

Tier 1 student mental health supports: _____
Tier 2 student mental health supports: _____
Tier 3 student mental health supports: _____
Academic / secondary counseling: _____
Community outreach: _____
Administrative tasks: _____
Non-counselor duties: _____

Total: _____

29. Does your district needs assessment include the results of a mental health needs assessment?

- ○ Yes
- ○ No
- ○ Unsure

30. The following lists components of the school mental and behavioral health system outlined in TEC § 38.351. Please check all of the ways your district has implemented the component.

	Provide professional development	Provide student services or supports	Have established policies and procedures	None	Unsure
Early mental health promotion or prevention	☐	☐	☐	☐	☐
Mental health intervention	☐	☐	☐	☐	☐
Substance use prevention	☐	☐	☐	☐	☐
Substance use intervention	☐	☐	☐	☐	☐
Suicide prevention	☐	☐	☐	☐	☐
Suicide intervention	☐	☐	☐	☐	☐
Suicide postvention	☐	☐	☐	☐	☐
Grief-informed practices	☐	☐	☐	☐	☐
Trauma-informed practices	☐	☐	☐	☐	☐
Positive behavior interventions and supports	☐	☐	☐	☐	☐
Positive youth development	☐	☐	☐	☐	☐
Approaches for safe, supportive, positive school climate	☐	☐	☐	☐	☐

Building skills to manage emotions, establish and maintain positive relationships, and make responsible decisions	☐	☐	☐	☐	☐

31. What funding sources are currently used to fund one or more components of the MTSS for mental health?

- ☐ Foundation School Program
- ☐ State Compensatory Education (to reduce disparities in achievement or completion)
- ☐ Title I (supporting education of economically disadvantaged students)
- ☐ Title III (supporting education of English learners)
- ☐ Title IVA (Student Support and Academic Enrichment)
- ☐ Title IVB (21st Century Community Learning Centers)
- ☐ ESSER grants (COVID-19 federal funding)
- ☐ McKinney Vento (supporting education of students experiencing homelessness)
- ☐ School Safety Allotment
- ☐ Victims of Crime Act (VOCA) grants (through the Office of the Governor)
- ☐ Medicaid / SHARS
- ☐ Private pay or insurance
- ☐ Philanthropy (e.g., foundations, donations)
- ☐ Local funds
- ☐ Non-financial agreements with partner agencies
- ☐ Other _____

32. Does your district have a data system or platform that is used by schools to monitor student progress across mental and behavioral health outcomes?

- ○ Yes
- ○ No
- ○ Unsure

33. What data system or platform does your school use to monitor student progress (indicate "LOCAL" if locally developed)?

_____

The Task Force is charged with collecting data on mental health service delivery and outcomes of services. The data elements below were included in the charge to the Task Force through HB 906 and codified in TEC Section 38.301-38.312. To better understand the data that is collected at LEAs, we want to ask about data that the district tracks on student mental and behavioral health and the ways in which the district is able to report this data. We are seeking some of the most important data elements from schools in the current campus survey, if available, and plan to seek these elements again at the end of the school year.

34. For each of the following data elements, please indicate whether the district collects the data on individual students (school/district collects data), whether the district analyzes or creates reports on the data (district and schools use data), and whether the data can be reported separately by

race, ethnicity, gender, special education status, and economically disadvantaged status (data is broken down or disaggregated).

For the three items marked with an asterisk (available in PEIMS), please complete only the "District team uses data" box to reflect if the available data is used.

	District collects data	District team uses data	Data is disaggregated	Unsure
Number of violent incidents that occur at school	☐	☐	☐	☐
Student out-of-school suspensions*	☐	☐	☐	☐
Student expulsions*	☐	☐	☐	☐
Student referral to disciplinary alternative education programs*	☐	☐	☐	☐
Student referral to law enforcement	☐	☐	☐	☐
Involvement of SRO in disciplinary event	☐	☐	☐	☐
Length of time (days) of disciplinary actions	☐	☐	☐	☐
Number of bullying allegations	☐	☐	☐	☐
Number of students reporting race- or discrimination-related concerns	☐	☐	☐	☐
Number of students receiving mental health services on campus (by school or non-school providers)	☐	☐	☐	☐

Number of students referred to off-campus outpatient mental health provider or counselor	☐	☐	☐	☐
Number of students referred to an inpatient mental health provider	☐	☐	☐	☐
Number of students identified with risk of suicide	☐	☐	☐	☐
Number of students known to have died by suicide	☐	☐	☐	☐
Number of students referred to child welfare for investigation and reason for referral (excluding anonymous reports)	☐	☐	☐	☐
Number of students experiencing a mental health crisis transported for emergency detention by medical or law enforcement personnel	☐	☐	☐	☐

35. Does your district have a research or accountability department or access to an evaluation partner, such as a local university, to support data collection, analysis, and use?

- ○ Yes
- ○ No
- ○ Unsure

Next, we would like to ask some questions about staff professional development related to mental and behavioral health.

36. Does the district have a system to track staff professional development?

- ○ Yes, at the district level
- ○ Yes, at the campus level
- ○ No
- ○ Unsure

37. Which mental health-related topic areas has your district offered professional development for in the last 12 months?

	Offered to counselors or mental health staff	Offered to educators	Offered to other staff	None	Unsure
Youth Mental Health First Aid	☐	☐	☐	☐	☐
Psychological First Aid	☐	☐	☐	☐	☐
Recognizing warning signs of suicide	☐	☐	☐	☐	☐
Classroom positive behavior management	☐	☐	☐	☐	☐
Restorative practices	☐	☐	☐	☐	☐
Behavioral threat assessment	☐	☐	☐	☐	☐
Impact of trauma	☐	☐	☐	☐	☐
Trauma-informed practices	☐	☐	☐	☐	☐
Impact of grief	☐	☐	☐	☐	☐
Grief-informed practices	☐	☐	☐	☐	☐
Specific universal program for all students	☐	☐	☐	☐	☐

Specific mental health program for selected students	☐	☐	☐	☐	☐
Evidence-based therapies	☐	☐	☐	☐	☐

38. Which two sources of professional development do you use most frequently for training on mental health topics (select only two)?

- ☐ Internal district or school staff
- ☐ Education service centers
- ☐ Online training system
- ☐ Texas School Safety Center
- ☐ Community partner agency(ies)
- ☐ Contracted external trainers
- ☐ Other _____
- ☐ None

Appendix C: Counselor Focus Group Methodology

The Task Force identified that an evaluation of school-based mental health would require measuring the extent and types of school mental health programming happening in districts and campuses across the state. Therefore, the Task Force opted to conduct focus group interviews with a sample of school counselors across Texas. The Task Force developed questions to collect data on the counselors' experiences and perspectives.

Focus Groups Data Collection

The focus group data collection template reflected two major categories. The first had questions on Multi-Tiered Support Systems (MTSS) to support student mental health and improve outcomes. The sub-categories queried whether available training aligned with the counselors' roles, the presence of any additional support and the effects of counselors on academic outcomes. The second major category of questions focused on the Texas Comprehensive Guidance and Counseling Model[1]. The related questions asked whether the American School Counselor Association[1] (ASCA) or Texas Model was being utilized, the model's effect on academic outcomes, and whether the time for counseling was adequate. In all, the data collection template had eight sub-categories of questions that addressed successes, challenges, and recommendations.

The groups were conducted virtually and online during two Texas counselor conferences. School Counselors participating in the Focus Groups were from districts varying in size from the 1A to 6A scale according to UIL designation. The following regions in Texas were chosen for a diverse representation in varying geographic and demographic areas, including ESC 2 (Corpus Christi), ESC 4 (Houston), ESC 5 (Beaumont), ESC 10 (Dallas), ESC 11 (Fort Worth), ESC 14 (Abilene), ESC 16 (Amarillo), and ESC 19 (El Paso)." Participants ranged from elementary to secondary school experience, rural and urban. The focus group data collection occurred in February 2022. There were nine groups (three in-person and six online). Groups varied from 4 to 15 per group in each in-person and online session (maximum participation was capped at 15 per session). Overall, 104 Texas counselors participated in the Counselor Focus Groups. The focus groups lasted approximately an hour and a half, as scheduled.

Participants

All in-person participants were from districts 2A to 6A and were full-time counselors. Over 80% of them had 6 or more years of counseling experience. There was representation from those serving elementary, middle, and high school levels. This group self-reported a counselor-to-student ratio of 225 to 1:980, with modal reports at or close to a 1:500 ratio. The ASCA Model for counselor-to-student ratios is 1:250. This ratio is based on empirical data indicating what is necessary to see increases in success indicators.

Demographic Information for In-Person Counseling Focus Groups:

Total Number of Participants: 24
Number of Counselors identifying as “full-time” counselors: 87%
UIL School Size: 1A=0, 2A=4%, 3A=4%, 4A=13%, 5A=26%, 6A=52%
Least ratio of counselors to students; 1:225
Highest ratio of counselors to students; 1:980

Demographic Information for Online Counseling Focus Groups:

Total Number of Participants: 81
Number of Counselors identifying as “full time” counselors: 73%
UIL School Size: 1A=15%, 2A=4%, 3A=20%, 4A=25%, 5A=30%, 6A=15%
Least ratio of counselors to students; 1:100
Highest ratio of counselors to students; 1:2,600

Appendix D: Additional Data Analyses

Table 1. *Types of Respondents Participating in the District Survey*

Please identify the role or roles represented by the individual(s) contributing to the completion of the survey:	Number	Percent (N=756)
Superintendent	317	41.93%
Assistant Superintendent	120	15.87%
Director/Representative for Guidance and Counseling	346	45.77%
Director/Representative for Special Education	145	19.18%
Director/Representative for Mental Health/Social Emotional	238	31.48%
Director/Representative for Nursing and Health	99	13.10%
Director/Representative for Federal Programs	131	17.33%
Director/Representative for At-Risk Students	138	18.25%
Director/Representative for Alternative Education	46	6.08%
Director/Representative for Curriculum and Instruction	128	16.93%
Chief/Representative of Law Enforcement Personnel	46	6.08%
Operational Departments (e.g., Business, Food Services)	42	5.56%
Other: MTSS/Student Services	17	2.25%
Other: School Safety, Risk, or Emergency	9	1.19%
Other: Campus Representative	47	6.22%
Other: Varied/No Clear Category	11	1.46%

Source: Collaborative Task Force for Public School Mental Health, District Survey results, 2022

Table 2. *Response Rate to Survey by Education Region*

Education Region	LEAs Respond-ing	Total LEAs in Region	Response Rate	Education Region	LEAs Respond-ing	Total LEAs in Region	Response Rate
ESC 1	30	46	65.2%	ESC 11	55	93	59.1%
ESC 2	22	43	51.2%	ESC 12	48	84	57.1%
ESC 3	27	39	69.2%	ESC 13	56	78	71.8%
ESC 4	62	93	66.7%	ESC 14	28	43	65.1%
ESC 5	22	39	56.4%	ESC 15	32	44	72.7%
ESC 6	31	60	51.7%	ESC 16	40	61	65.6%
ESC 7	51	100	51.0%	ESC 17	34	61	55.7%
ESC 8	24	46	52.2%	ESC 18	26	34	76.5%

ESC 9	27	37	73.0%	ESC 19	8	17	47.1%
ESC 10	69	115	60.0%	ESC 20	64	84	76.2%

Source: Collaborative Task Force for Public School Mental Health, District Survey results, 2022

Table 3. *District-Reported Data Systems to Track Student Mental Health*

Response	Number	Percent (N=167)
Locally Developed Tool	77	46.11%
Rhithm	19	11.38%
Panorama	16	9.58%
Skyward	13	7.78%
DMAC	9	5.39%
Frontline	9	5.39%
PASS	7	4.19%
Eduphoria	7	4.19%
Ascender	6	3.59%
E-School	5	2.99%
Emergent Tree	5	2.99%
Success Ed	5	2.99%

Source: Collaborative Task Force for Public School Mental Health, District Survey results, 2022
Note: 167 of 708 districts identified one or more data systems used, with most districts reporting a locally developed tool.

Table 4. *Top Sources of Professional Development on Mental Health*

Sources of Professional Development	The proportion of LEAs Reporting as Top Two Sources of Professional Development
Education Service Centers	62.96%
Online training system	44.59%
Internal district/school staff	41.88%
Texas School Safety Center	18.23%
Community partner agencies	14.10%
Contracted external trainers	9.12%
Other	1.57%

Source: Collaborative Task Force for Public School Mental Health, District Survey results, 2022

Table 5. *District Survey Responses Reflecting to What Extent the District Has Conducted a Time Analysis of Professional School Counselors (per SB 179)*

Response	Number	Percent
No time analysis has been conducted	183	25.31%
Planning is underway for a time analysis	177	24.48%
Time analysis is completed	65	8.99%
Time analysis is in progress	206	28.49%
Unsure	92	12.72%

Source: Collaborative Task Force for Public School Mental Health, District Survey results, 2022

Table 6. *Formal Partnerships to Support Student Mental/Behavioral Health Reported by LEAs*

Response	Number	Percent (N=700)
School-based Health/Mental health Center	172	24.57%
Communities In Schools	127	18.14%
Community Mental Health Center/LMHA	202	28.86%
TCHATT	172	24.57%
Family Resource Center	74	10.57%
Community Health Center/FQHC	66	9.43%
Youth Substance Use Prevention Provider	121	17.29%
Substance Use Treatment Provider	71	10.14%
Other Mental Health Providers	192	27.43%
Other Health Provider	93	13.29%
Other Social Service Agency	120	17.14%
Other Telemental Health Providers	69	9.86%

Source: Collaborative Task Force for Public School Mental Health, District Survey results, 2022

Appendix E: Full Recommendations List

Recommendations Related to the Availability of School Mental Health Data Metrics

1. The Task Force acknowledges that the data available for the previous two years does not reflect school-based mental health services outside of the COVID-19 pandemic, which is reflected in the available data. Additionally, concerns about the added burden of data collection during the pandemic limited the Task Force's ability to collect the data needed to fulfill its charge.

The Task Force recommends that data collection in the next biennium focus on ensuring that trends related to increased student mental health needs begin to normalize and that mental health services, including those provided by partner organizations on campuses, begin to return to the level seen prior to the pandemic, if not increase.

2. To begin to address the evaluation at the level of mental health programming, the Task Force will need to collect information at a campus level, as variability in student needs and programming is likely to occur across the district.

The Task Force recommends collecting additional data related to mental health programming and outcomes at a campus level in the next period as the state moves to implement further data collection at a student level.

3. A critical set of data should be collected at a student level through the PEIMS system, with full protections for the confidentiality of the data. TEA will need legislative authority to require data collection of critical elements and funding to prepare a complete evaluation of mental health services. Currently, data collection on the most critical elements is needed to study and evaluate services only if required for tracking data related to services due to a behavioral threat assessment. Most mental health services provided in the MTSS in schools are to address needs early and early, with parental consent. Mental health needs are not always connected to the behavioral threat assessment process. This data should include the following:
    1. Information on behavioral threat assessments conducted, including coding of the cause of the assessment, the determination of the assessment, and the outcome
    2. Referrals for school-based services in Tier 2 or Tier 3 of the MTSS, both as an outcome of a behavioral threat assessment and to meet the identified need. This includes the need for early mental health intervention/services not connected to a behavioral threat assessment. Authority, as necessary, should be provided to TEA to require and collect referral to services and access to school-based mental health services with parental consent for a student that receives school-based services as appropriate to the law
    3. Referral for mental health providers external to the school or through a school partner, noting that TEA should not collect specific information on whether a child or family

accesses services outside of the school, as this is confidential information protected through federal laws. Authority should be provided to TEA as needed to require and collect the referral of a parent to community partner mental health services data (not school-based) on behalf of a minor student or for a student referred, as appropriate to the law.

4. The legislature should require school districts to report the use of positive behavioral interventions and alternatives to exclusionary discipline in PEIMS. Current requirements focus solely on exclusionary discipline and do not allow for an examination of the array of responses available to LEAs. Positive behavioral interventions may include strategies such as PBIS, classroom de-escalation strategies, counseling, skill-building interventions, student-family conferencing, restorative practices, wrap-around services, providing and connecting families with mental health services, etc.

5. The Task Force recommends that data collection processes for the Safe and Supportive School Program (SSSP) be amended to ensure regular data reporting to evaluate school mental health in compliance with HB 906. This includes mental health services provided for an identified need (early intervention services) that are in recommendation number 3 above. These data points can be collected as part of the SSSP data collection, align with the SSSP MTSS for mental and behavioral health, and help support and coordination for districts. In addition, the following recommendations are based on responses to the district survey reported in 2020-2021 and 2021-2022.
    a. All elements of the SSSP data collection should continue to be mandatory for completion by districts (or excluded from the survey).
    b. The data collection tool should be formatted to ensure consistent formatting of responses (e.g., only numbers allowed) and parameters that limit the opportunity to enter inaccurate data.
    c. Clear definitions should be provided by TEA for any data elements to ensure consistency in data tracking and reporting.
    d. With funding and support to create the system to collect and track additional data items, future SSSP data collection should include the following data elements, with each including the total and broken down by gender, race, ethnicity, special education status, and educationally disadvantaged status:
        i. The school-based mental health supports or services available at Tiers 1, 2, and 3 of the MTSS for mental health, the number of students who can be served by each support/service, and any referral criteria.
        ii. The number of referrals because of behavioral threat assessments related to the risk of the arm to self and those related to the risk of harm to others, total and broken down by gender, race, ethnicity, special education status, and educationally disadvantaged status.
        iii. The number of school-based mental health referrals to Tier 2 or Tier 3 services/supports, the number resulting from a behavioral threat assessment, and

the number of students who received the support/service. If the student did not receive the recommended support/service, the data collection should include the reason the service was not received (e.g., parent declined, lack of provider capacity).

iv. The number of mental health referrals to CIS, TCHATT, LMHAs, or another partner or community-based provider, the number that w the result of a behavioral threat assessment, and the number of students who received the support/service.

v. The number of mental health referrals to a psychiatric hospital, acute care hospital, or emergency room to address acute mental health risk, the number that resulted from a behavioral threat assessment, and the number of students who received the support/service.

3. The following recommendations are specific to the measures identified in Establishment Sec. 38.302(3):
   a. Number of Violent Incidents: The PEIMS system should be modified to include an indicator of whether a threat assessment had been conducted before and during the school year in which violent incidents are reported, as well as the outcome of that threat assessment. Violent incidents include terroristic threat (Code 26), assault (Codes 27-32), arson (Code 16), murder (Code 17), manslaughter (Code 47), and criminally negligent homicide (Code 48).
   b. Suicide Rates of Individuals Receiving Mental Health Services: Reporting data on deaths by suicide is sensitive and should only be collected if it provides actionable information that can support the health and well-being of district staff and students. The Task Force recommends that TEA develop a critical incident reporting system that would include the unexpected death of any student (such as by suicide, homicide, or accident), including whether the incident occurred on the school campus or at a school-sponsored event. TEA should use the reporting of critical incidents to assess needs, connect with LEAs and ESCs to offer support, provide technical assistance, help plan and guide training that reduces the traumatic stress experienced by impacted individuals, and puts in place evidence-based suicide postvention practices.
   c. Number of Students Referred to Outside Counselors: The Task Force recommends that the legislature authorize TEA to establish a standard definition of this data element and a mechanism for districts to report the number of students referred for mental health care. The Task Force also recommends expanding this element to include referrals to all outside providers (counselors, physicians, and agencies) to obtain mental health care.
   d. Individuals to Whom Mental Health Services are Provided: The Task Force recommends that the legislature authorize TEA to establish a standard definition of this data element and a mechanism for districts to report the number of students referred for school-based mental health care at the early intervention (Tier 2) or intensive levels (Tier 3), as well as the number of students receiving these services or supports. In addition, the Task Force

recommends that TEA gather data on specific school-based mental health programs or practices available within the school campus. This service delivery plan should be updated annually to reflect available services on the campus.

e. Number of Individuals for Whom the District Has Adequate Mental Health Resources: The measurement of the adequacy of available mental health resources could be better assessed through an anonymous campus-based health survey that would allow for estimates of mental health conditions at the school level. These estimates of mental health needs could be examined, along with data tracking community- and school-based referrals to provide estimates of the extent to which student mental health needs have been met. This data would provide a mechanism to document mental health needs at a campus level and support district and campus needs assessments.

f. Number of Individuals for Whom the School Provides Mental Health Services who are Referred to an Inpatient or Outpatient Mental Health Provider: The Task Force recommends that the legislature authorize TEA to establish a standard definition of these data elements and a mechanism for districts to report the number of students referred to inpatient or outpatient mental health care after or while receiving school-based mental health services. To provide additional context, the Task Force recommends that TEA establish a standard definition and collect information on the number of students referred to an inpatient or outpatient mental health care facility for whom no school-based mental health services or supports have been provided.

g. The Task Force recommends that the following elements be removed from the charge and not utilized in the evaluation of school-based mental health services:

    i. The number of public-school students referred to the Department of Family and Protective Services for investigation services and the reasons for those referrals: This data is available at a county level and could be utilized by the Task Force. Despite its availability, the indicator is not currently included in the Task Force's logic model. It is unclear if increases in referrals to DFPS would be a positive indicator (e.g., earlier identification of trauma experiences) or a negative indicator (e.g., an increase in inappropriate referrals for neglect if failing to act on mental health referrals).

    ii. The number of individuals transported from each school district or open-enrollment charter school for emergency detention under Chapter 573, Health and Safety Code: The Task Force recommends that this element be removed from the charge, but information about school referrals for psychiatric hospitalization be documented. This would include referrals in which a child is transported under an emergency detention order or those in which a guardian transports the student.

Recommendations Related to Strategic Direction and Resources

1. The Task Force recommends that the Texas Legislature fund a state center on school mental health or a consortium of higher education institutes to collaborate on supporting school-based mental health across the state. The state center could serve in one or more of the following roles:
    a. Collaborate with TEA, ESCs, and HHSC to identify a core menu of mental health trainings that are offered in every region, providing consistent and equitable access to district and campus staff
    b. Provide train-the-trainer workshops to support the availability of core mental health trainings by ESC or district staff and monitor for quality and outcomes of training activities
    c. Develop guidance documents, tools, and resources to support the implementation of mental health best practices selected by districts, reducing the overall cost of implementation
    d. Provide direct technical assistance through structures such as learning communities around best practices and their implementation
    e. Support job-embedded coaching with specific practices to support implementation – counselors or other staff trained so that they can support/translate to teachers of
    f. Develop low-burden, effective programs that prevent or address mental health challenges and meet the specific needs of Texas schools and

Enhance the coordination between community-based organizations and schools to support students and families efficiently, using models appropriate to the community context (e.g., family resource centers, telehealth, school-based clinics).

2. The Task Force recommends the Texas Legislature direct The Texas School Safety Center (TxSSC), in partnership with TEA, to develop appropriate criteria - and corresponding metrics – to evaluate the effectiveness of a school district's Safe and Supportive Schools Program (SSSP) plan and MTSS framework pertaining to the use of practical mental and behavioral health safety strategies for implementation. For this recommendation to be successful, the legislature must attach funding to its directive.

    Once this evaluation framework has been clearly established and approved by the legislature, the TxSSC, in cooperation with TEA, should conduct annual reviews of a sample of SSSP plans and MTSS frameworks for mental and behavioral health among a randomized sample of school districts, as well as others that are selected due to "at-risk" indicators, such as high ratios for counselors to students, high disciplinary actions, or lack of reporting on the SSSP data collection system. The external reviews could inform changes to SSSP training activities and technical assistance to districts on SSSP development.

3. The Task Force recommends that the legislature to direct TEA to support the development of an electronic platform that school districts can use to conduct annual school climate surveys. The platform should allow districts to customize the surveys to meet district needs while maintaining a core set of items required of all districts. The platform should include real-time access to data visualizations following the closure of the survey, as well as disaggregation by informant characteristics (e.g., grade and gender). The platform should include anonymous surveys that are completed by staff, students, and families. The platform should allow schools to benchmark their results against the average of Texas schools with similar characteristics as we track climates over time. Additionally, after school climate surveys are launched on the platform, TEA should consider adding optional survey modules allowing report data regarding health and wellness and student social, emotional, and behavioral competencies.

   This directive must be attached to a funding mechanism to succeed.

Recommendations Related to Professional Development

1. The SBEC, through their goal to "seek the tools and resources to ensure the education, safety, and welfare of Texas school children," should expand upon the current information shared with LEAs and ESCs to provide additional guidance for school boards in the development of local professional development policies. The guidance documents should clarify for school boards the purpose of specific trainings supporting social, emotional, and behavioral wellness or early identification of concerns, as well as the expected outcomes of specific trainings, so that boards can make informed decisions about professional development opportunities for educators.

2. TEA and ESCs should provide school mental health training for school and district administrators that covers multi-tiered systems of support (MTSS); school mental health; social, emotional, and behavioral skills; discipline practices, and codes of conduct. Training should increase understanding of what mental health support looks like in schools and demonstrate how administrators can advocate and support mental and behavioral health programs and services. Training should help administrators clearly connect mental health and emotional wellness to positive academic outcomes.

3. ESCs and LEAs should provide school mental health training for teachers that covers student mental health and social-emotional skills development, increases understanding of what mental health support looks like in classrooms, covers their role as teachers in supporting emotional wellness, and demonstrates how teachers can advocate for and support mental and behavioral health programs and services and advise on changes to discipline practices and codes of conduct.

4. TEA, ESCs, and LEAs should provide more effective training for school counselors through the following:
    a. Update existing training and open access to more relevant training material.
    b. Improve the quality of training by including more application-based and advanced trainings that build on foundational knowledge and offers successful skills and practices in populations like those served the school. Additionally, training modalities should have methods to acknowledge the competence level and use that as a guide to select training.
    c. Seek more programmatic and MTSS implementation-based training on each tier level for counselors focusing on the application of MTSS and not the definition of MTSS. Include Tier 1 implementation systems, techniques, and responses for the whole school, as well as restorative circle training for Tier 2 and 3 needed but are not offered.
    d. Strengthen district partnership with the Regional Service Centers to continue to access training, obtain guidance and mentorship, assist with identifying community and clinical partnerships, and to access training and speaker resources to remove the time and research of counselors identifying their speakers and training programs.
    e. Make a deliberate effort to organize counselor training and offer ongoing support for properly implementing approaches. This should facilitate establishing adequate time for counselors to 1) attend an orientation to the school for new counselors, 2) attend trainings, 3) cover travel costs to minimize the distance to training/events as a barrier, and 4) ensure school leadership allows time for counselors to attend off-campus trainings. LEAs should consider a designated "onboarding" process for counselors new to the campus (or the profession), which could reduce stress and build workforce retention.
    f. Offer (licensed counselor) training courses to increase abilities/skills/expand the role of counselor, i.e., therapy for those in communities with a shortage of mental health professionals.
    g. Increase opportunities for counselors to convene throughout the school year to exchange information, express needs and concerns, offer solutions, and provide the mental and emotional support necessary to do the job and reduce burnout.

4. HHSC should present the results of their biannual survey of MHFA/YMHFA respondents disaggregated by participant type (e.g., K-12 school, college or university, community setting). This would provide additional information to determine the impact of the training on public school personnel and students. Data should also be presented disaggregated by the training format to allow for an exploration of the equivalency of virtual versus in-person formats.

5. The addition of the virtual workshop format for MHFA/YMHFA creates an opportunity for new models of delivery, perhaps creating greater efficiency and access. The Task Force recommends

that the legislature allocate funds to TEA / HHSC to maintain the capacity for in-person trainings within each LMHA/LBHA while also increasing the capacity for virtual training in Texas. The Task Force recommends offering virtual trainings at regular intervals (e.g., bi-weekly), aligning with professional development days when possible. These training events could be listed on the HHSC website (and linked on the TEA website), allowing eligible participants to register at convenient LMHA/LBHA facilities. In addition, trainers could offer the trainings on a rotating basis. This format could increase the ability for educators/staff to access the training, as individual staff can participate without the district/campus coordinating the workshop. Additionally, the training could be offered as a pre-conference workshop or other strategies to enhance educator access and flexibility.

6. The legislature should direct HHSC to track attendance/participation in YMHFA and MHFA to include information on the number of staff members participating at each district and whether the Youth or Adult version is completed. NPMHPs could provide outreach and engagement targeted to districts with minimal participation in YMHFA/MHFA.
7. To ensure the availability of high-quality professional development opportunities, TEA, in partnership with the ESCs and HHSC, should identify a core menu of mental health trainings offered in every region. HHSC should utilize centralized training resources to ensure NPMHPs have access to professional development to access the menu of professional development opportunities. Additional funding would likely be necessary to support access to the training.

Recommendations Related to Adequate Staffing for a Multi-tiered System of Support for Mental Health

1. Texas schools should receive targeted funding to reduce counselor-to-student ratios to 1 counselor for every 350 students. In addition, the legislature should direct TEA to support school districts to meet the following recommendation: The Task Force recommends that the legislature authorizes TEA to require all school district campuses have access to a school counselor. TEA should have the capacity to monitor district capacity to achieve this minimum ratio.

2. The Task Force recommends that the legislature clarify language in SB 179 to clarify elements that are mandated (versus recommended), the role of TEA in oversight, and mechanisms for accountability. School counselors interviewed believe that LEAs should remove 504 coordinator and testing duties from the counselor role and allow other staff to share the role of referrals for resources and supports. This would them to “see their kids individually and more regularly,” which is a preferred use of counseling time.

3. The state should address critical workforce shortages by increasing the number of people choosing a counselor career by offering student loan forgiveness, incentives, and scholarships for individuals to obtain the training needed for this profession and work in the field. Current concerns include staffing shortages with teachers and their effect on the teacher/student ratio, not having enough substitutes, and competing with teachers for staff positions.

4. Due to the regional shortages within the licensed mental health workforce, the Legislature should consider allowing HB 19 NPMHP positions to filled by non-licensed mental health professionals with appropriate competencies and experience with mental health and substance use prevention and intervention.

Recommendations Related to Implementation of a Multi-tiered System of Support for Mental Health

1. The Texas Legislature should establish a Mental Health Allotment to provide districts with a consistent and dedicated funding stream to support schoolwide strategies that address the mental health needs of all students.
2. In accordance with Medicaid #14-006, HHSC should be directed to amend the state Medicaid Plan to allow school districts who are Medicaid providers to be reimbursed for behavioral health services provided to students enrolled in Medicaid, beyond those provided to students with disabilities with an Individualized Education Plan (IEP). Additional guidance on leveraging Medicaid to support access to school-based services is found in this informational bulletin.
3. The TEA should establish a discretionary grant program for LEAs to support the development and implementation of a comprehensive MTSS, including access to enhanced training, technical assistance, and coaching. Priority for grant support should be based on identified need, readiness, and plan.

Recommendations Related to Partnerships through State Funded, School-Based Mental Health Services

1. The TEA should continue to support formal collaboration (e.g., MOUs) with external agencies to provide components of the MTSS for student mental health/behavioral health at no cost to LEAs to provide access to services beyond the professional role and competencies of school counselors.
2. LEAs should hire adequate district personnel to assist with obtaining required Memorandum of Understanding (MOUs) with external providers.

3. LEAs should consider hiring a care navigator or social workers who can focus on resource connection, thereby increasing the capacity for other school-based interventions and services.
4. TEA and ESCs should continue to maintain and grow the resource list of active providers in the regions so this task does not take up time from the counselor. ESCs should gather feedback from school counselors and district administrators to ensure the resource directory has the information that is needed and is easy to use.

Task Force Membership list

Required Role	Name/Position	District/Agency
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Parent	Faith Colson	Parent
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MH Provider	Tracy Spinner, M.Ed., SVP of Education and Strategic Initiatives | Task Force Co-Chair	Goodside Health
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Other - MH Representative	Greg Hansch, LMSW, Executive Director	NAMI Texas
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Task Force Workgroup Membership & Roles

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