School-Based Mental Health and Crisis Care for Students

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KEYWORDS

• School-based mental health • Crisis intervention • Multi-tiered system

KEY POINTS

- Local schools serve as a vital platform for mental health intervention by reaching students where they spend the majority of their time and mitigating traditional barriers like transportation or delayed crisis detection.
- Current consensus recommends a comprehensive multi-tiered framework that provides a continuum of care ranging from universal mental health literacy to intensive, specialized crisis intervention for high-risk students.
- At Northwell Health in New York, an innovative Hub-and-spoke model utilizes a centralized virtual triage unit to facilitate same-day access to community-based outpatient Behavioral Health Centers staffed by child psychiatrists for crisis stabilization and bridging of care, while supporting and educating parents and school staff with a robust mental health literacy curriculum.
- This integrated, multi-tiered, collaborative approach has significantly diverted crisis cases from emergency departments (ED), reduced ED over-utilization while providing significant cost containment for school districts.

CASE VIGNETTE

"Maya," a 15 year old girl and 10th grade student within a local partnering school district, presented to her school counselor exhibiting acute emotional distress. Her presentation was characterized by concerns related to academic pressures, recent peer relationship challenges, and family system stressors. She endorsed exacerbated depressive symptoms and intensifying suicidal ideation. The school counselor promptly initiated contact with the Crisis Hub team. Through immediate phone consultation, the Crisis Hub clinicians provided support for crisis triage and facilitated Maya's prompt referral to their local, outpatient Behavioral Health Center (BHC). At the BHC, Maya underwent a comprehensive same-day crisis evaluation, conducted by a Child

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Abbreviations	
BHC	Behavioral Health Center
BOCES	Boards of Cooperative Educational Services
CDC	Centers for Disease Control and Prevention
CEU	Continuing Education Unit
CTLE	Continuing Teacher and Leader Education
ED	emergency departments
IEPs	Individualized Education Programs
LMHC	Licensed Mental Health Counselor
MTSS	Multi-Tiered System of Supports
SAMHSA	Substance Abuse and Mental Health Services Administration
SHAPE	School Health Assessment and Performance Evaluation

and Adolescent Psychiatrist and a Licensed Mental Health Counselor (LMHC). This evaluation encompassed diagnostic assessment, psychoeducation on coping skills, collaborative safety planning, and communication with the school.

Next, the clinical team looped back to the school counselor to coordinate specific academic and therapeutic accommodations, ensuring that her educational environment supported her recovery by alleviating the scholastic pressures contributing to her distress.

Over the subsequent week, Maya engaged in sequential follow-up sessions with the BHC's interdisciplinary treatment team for ongoing safety assessment and diagnostic refinement. This process led to the initiation of psychopharmacological intervention targeting her depressive and anxiety symptomatology. Concurrently, Maya's dedicated care coordinator identified appropriate community-based resources for ongoing psychopharmacological management and individual psychotherapy. She received 2 additional sessions at the BHC, constituting a "bridging care" phase, which ensured a seamless and supported transition to long-term outpatient services including seeing a psychiatrist and a therapist.

This collaborative care network and coordinated continuum of care, effectively facilitated through the school mental health partnership, successfully transitioned Maya from a point of acute crisis stabilization to sustained engagement in outpatient support.

Background and Introduction

The public health emergency of youth mental health demands an innovative solution: deep integration and collaboration with local school districts to reach students where they are. Data from the Centers for Disease Control and Prevention (CDC) emphasizes the critical nature of this problem: suicide accounts for more deaths among youth and young adults aged 10 to 24 than all medically related causes combined.[1] Furthermore, mental health concerns, including anxiety and depression, are higher than ever in children ages 3 to 17 years.[2] Alarmingly, the prevalence of poor mental health and suicidal thoughts has worsened, particularly among female students and those identifying as LGBTQ+.[3] The latest CDC data from 2024 reveal that significant vulnerabilities persist among youth, with nearly 20% of students in grades 6 to 12 experiencing bullying and 11% of high schoolers reporting sexual violence.[4,5]

Given the pervasiveness of these challenges, schools are increasingly recognized as the most vital venue for intervention, as most youth spend the majority of their day within the school setting. This makes school-based care an efficient and effective method to improve access by mitigating traditional barriers like the detection of a psychiatric crisis, timeliness of intervention, and collaborating between the family and

school.[6] However, in the absence of adequate same-day or next day outpatient capacity, most systems default to using the ED as the primary care location for youth in crisis. This approach can be suboptimal; school referrals constitute a significant driver of avoidable pediatric ED visits (30%–40% of total behavioral health volume). This reliance on the ED is often suboptimal and inefficient. Data indicate that schools initiate 44% of psychiatric ED evaluations, yet only 7.8% of these referrals result in hospitalization, highlighting a significant volume of avoidable visits.[7] EDs often lack specialized staff and care coordination, resulting in 47.7% of school-referred students being discharged without any arranged follow-up.[7] Most concerningly, students presenting with "suicidality" were even more likely to be discharged without follow-up compared to other complaints (56.0% vs 41.0%).[7] The ED environment is highly variable and dependent on each hospital's available resources, often lacking specialized staff and provides limited care coordination or timely follow-up, potentially delaying critical treatment.[8]

To overcome these structural deficits and move beyond tertiary care models, our field should embrace upstream, comprehensive, multi-tiered systems of support that address the child holistically in their eco-system, integrating universal prevention with timely, evidence-based treatment.[9] Wang and colleagues advocate for integrating clinical and educational programs to enhance competencies in prevention and systems-based practice, while addressing the workforce shortage in child mental health. This integrated approach can be key because mental well-being is intrinsically linked to the academic achievement and is influenced by a complex interplay of interpersonal relationships, classroom experiences, and the overall school climate.[6]

The Northwell School Mental Health Program represents an emerging, growing model responding directly to this need, positioning itself within the crisis care continuum. The program operates under core goals that emphasize community education, staff training, prevention, early recognition, immediate crisis assessment, timely psychiatric evaluations, and care coordination to longitudinal treatment.[10] The program implements a multi-tiered model of mental health, with universal interventions for all students, their family, and schools (Tier 1), at-risk students (Tier 2), and immediate crisis needs (Tier 3).[10] The Virtual Crisis Hub serves as the central unit for triage and coordination.[11] This approach ensures immediate availability of triage, clinical guidance and support for school staff and families, as well as crisis services, offering essential rapid access to care such as same day appointments at one of our BHCs or virtual crisis visits.[11] The Northwell School Mental Health Partnership Program demonstrates promising scalability since inception in 2020, serving an expanding geographic area that currently covers 417 schools and over 277,000 students across Long Island and Westchester County. This operation is facilitated by five dedicated outpatient BHCs. These ambulatory centers are physically located in the community near the school districts they serve, which also allows families with transportation barriers to access this much needed care. Each BHC is staffed by a multidisciplinary team, including board-certified child and adolescent psychiatrists, nurse practitioners, clinical social workers, LMHCs and care coordinators to effectively address the needs of the student population.

Various school-based mental health programs currently operate across the country, utilizing different structural frameworks to address the growing needs of students. The University of Maryland School Mental Health Program—housed at the very institution that hosts the National Center for School Mental Health—for instance, focuses on a 3 tier prevention model in Baltimore City, offering a full continuum of care and a growing telepsychiatry initiative serving 25 schools.[12] Despite being the first well-established school-based mental health program in the nation, founded in 1989, the program

does not offer robust same day urgent crisis appointments. Instead, students are recommended to call the local city crisis hotline.[12]

In Texas, the Texas Child Health Access Through Telemedicine program provides telemedicine services to help school districts identify and assess behavioral health needs, connecting families to the next steps of care through a virtual portal. This program covers 4.5 million students across the entire state and offers telepsychiatry psychiatric evaluations and crisis evaluations.[13]

The US Army School Behavioral Health program integrates mental health professionals, psychologists and social workers, into 60 on-post schools to deliver care ranging from prevention to treatment. These schools primarily serve the children of active-duty service members and are physically located on military installations.[14]

The Los Angeles Unified School District integrates mental health support through school-based social workers who provide a continuum of care ranging from prevention to acute intervention, while certain on-campus clinics and wellness centers offer broader medical and mental health access to students and families. This direct support is bolstered by crisis counseling and intervention services, which deliver immediate stabilization and recovery assistance following critical incidents and is further strengthened by training staff in trauma-informed practices, suicide prevention, and threat assessment.[15]

Compared with these beneficial initiatives, the Northwell School Mental Health Program is unique in that no other current programs feature dedicated ambulatory centers, staffed by child and adolescent psychiatrists and their team, specifically designed to provide rapid, same day, crisis evaluation, stabilization, and a swift, reliable bridging of care. Traditional school mental health models face significant limitations, primarily the lack of board-certified psychiatrists required to manage medications and diagnose complex cases with specialized medical oversight, often resulting in escalating care to the hospital system, leading to significant gaps and fragmentation of care.

The Multi-Tiered Systems of Support, a Public Health Model for School Mental Health

The worsening crisis of youth mental health in the United States has necessitated a fundamental shift in how care is delivered, moving away from reactive, ED visit-based framework toward a proactive, community-integrated approach.[16] Data from the CDC reveal a staggering level of distress: 4 in 10 students report persistent feelings of sadness or hopelessness, and 2 in 10 have seriously considered attempting suicide.[5] In response to these alarming trends, the Multi-Tiered System of Supports (MTSS), guided by Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services, has emerged as the gold standard in the public health model of school-based mental health activities.[17] By integrating mental health supports directly into the environments where students spend most of their time, MTSS addresses a child's case holistically, blending universal wellness with intensive crisis intervention.[17,18] A unique and sophisticated example of this framework in practice is the Northwell School Mental Health Partnership Program in New York, which utilizes an upstream centralized Hub-spoke model to bridge the gap between education, the academic hospital system, and the community.

The Public Health Framework

The MTSS framework is rooted in a public health approach that organizes interventions by levels of acuity.[17] This model is exemplified by federal initiatives like Project

AWARE (Advancing Wellness and Resilience in Education), a large grant program administered by SAMHSA that supports activities to increase mental health awareness, train school personnel, and connect students to treatment.[17] Project AWARE mandates the use of the three-tiered public health model, ensuring a continuum of care that affects the entire school culture while offering specific interventions for individual needs.[17]

To evaluate the effectiveness and quality of these tiered systems, schools can utilize the SHAPE (School Health Assessment and Performance Evaluation) System. SHAPE is a free, interactive tool that allows districts to map their services, assess system quality against national standards, and access a library of evidence-based screening and assessment measures.[19] Through the SHAPE Quality Guides, schools can advance their performance in critical domains such as funding, sustainability, and trauma-responsiveness.[19] Together, AWARE and SHAPE provide the policy and assessment infrastructure recommended to maintain a robust MTSS, which Northwell Health has operationalized through its innovative partnership program with over 400 schools.

The Expansion of the Northwell School Mental Health Partnerships

The Northwell School Mental Health Partnerships were born out of a widespread local need for timely psychiatric intervention and crisis support. Historically, schools have been the largest referral source for pediatric behavioral health ED visits, contributing to 30% to 40% of the total behavioral health volume, much of which was avoidable.[8] The program was developed to provide a "middle ground" for students who required urgent, thorough, psychiatric assessment but did not necessarily need an emergency department (ED) or hospital level stay.[8,10]

The program has demonstrated rapid expansion since inception in 2017, beginning with the CCMC Pediatric Behavioral Health Urgent Care Center and South Oaks Hospital's in-district consultation program that started as a pilot in 2018, adding 12 school districts in 2019, the first dedicated BHC opening in Rockville Centre in January 2020,[20] successfully weathering the pandemic by temporarily pivoting to virtual care before returning to in-person services in September 2020. Growth accelerated with the opening of the Mineola BHC (July 2021) in Nassau County and the Commack BHC (September 2022) in Suffolk County. This effectively covered a broad catchment area, as Suffolk and Nassau rank as the 26th and 29th most populous counties in the U.S., placing both in the top 1% nationally.[21] With the opening of Mount Kisco and Riverhead locations in July 2025, the program now serves over 277,000 students across 65 districts and 417 schools. As of December 2025, 16,700 appointments have been completed over 6 years at our BHCs, helping 12,000 children and families. Furthermore, we have completed 2500 in-school comprehensive psychiatric evaluations (**Fig. 1**).

Tier 1: Universal Prevention and Mental Health Literacy

Tier 1 of the MTSS is defined as the universal level of care, focusing on primary prevention and the promotion of mental well-being for all students. This approach aims to create a positive school climate and create a supportive culture where mental health literacy is integrated into the daily educational experience. By building students' self-regulation, coping, and social skills before symptoms appear, Tier 1 improves the mental health literacy of the entire student body.[6,17,22]

The Northwell School Mental Health Program implements a robust Tier 1 strategy that focuses on 3 primary pillars: staff professional development, community/parent empowerment, and student advocacy—involving the entire community.[10]

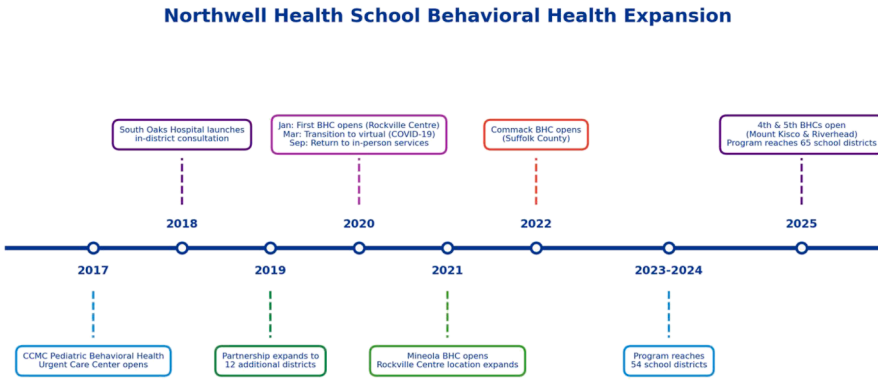

Fig. 1. Timeline of program expansion. (*Image Courtesy* Northwell School Mental Health.)

Staff and professional development

To ensure school personnel are equipped as frontline mental health observers, the program provides extensive training that aligns with New York State requirements, such as the 100 Continuing Teacher and Leader Education (CTLE) hours every 5 years for teachers and 36 Continuing Education Unit (CEU) hours every 3 years for school clinical staff.[23] These trainings utilize various formats, including virtual professional development sessions, the "Ask the Expert" series, Project ECHO case conferences, and informational newsletters.[23]

The program's educational reach has been extensive. Each academic year, the initiative conducts approximately 30 Professional Development sessions, 10 "Ask the Expert" forums, and 10 ECHO case conferences, engaging an audience of over 2000 school professionals comprised social workers (53%) and psychologists (37%), followed by School Counselors (8%), Educators, and Administrators. These efforts, led by 50 different mental health clinicians such as psychiatrists, psychologists, and LMHCs, over the past 5 years have resulted in the issuance of 509 Social Work certificates, 308 Psychology certificates, and 57 LMHC certificates. Feedback from school professionals has been highly positive, with the program reporting a 97% satisfaction rate on its professional development sessions. Additionally, the Northwell School Mental Health Program has facilitated an increasing number of customized in-district events, last year reaching more than 1800 attendees across 102 sessions, addressing major topic areas such as wellness, stress first aid, anxiety, suicide prevention, ADHD, screen time/social media, and emotional resiliency.[23]

Mental health literacy and student wellness

Tier 1 also involves direct health education for students to reduce stigma and normalize help-seeking behavior.[6,22] Northwell's direct-to-student education covers relevant wellness topics such as healthy relationships, body image, bullying prevention, substance use and vaping, mindfulness, LGBTQ/Gender issues, and stress management. This is further supported by youth advocacy initiatives, including Teen Mental Health First Aid trainings, youth mental health conferences, an Erase the Stigma Art Contest, and active student engagement through social media platforms like @nyteenstalkmentalhealth. By embedding these resources within the school environment, the program mitigates barriers such as transportation and stigma, ensuring that mental wellness becomes a visible, universal, and accepted aspect of the school culture.[23]

Community and digital resources

For parents and caregivers, the program offers virtual 6 week parent support groups and community education webinars addressing relevant topics such as supporting your anxious child, school avoidance, electronic use, meaningful conversations at home, navigating difficult emotions, academic burnout, sleep, and stress management. A helpful resource for this universal support is the Resiliency Toolkit, a comprehensive digital resource toolkit providing expert-created, evidence-based materials that are tailored to specific family needs and includes various topics such as ADHD, bullying, and depression that has been accessed over 17,000 times since its launch in August 2024. Reflecting the program's commitment to promoting equity, the toolkit provides critical resources in Spanish and Mandarin to support the diverse student populations in partnering districts, where enrollment can range from 20% to 70% Hispanic/Latino and 20% to 70% Asian American and Pacific Islander.[24] Furthermore, in the 2025 academic year, the community education webinars have also added 6 talks in Spanish and Mandarin Chinese.[23]

Tier 2: Targeted Early Recognition and Consultation

Tier 2 of the MTSS serves as a secondary prevention layer designed for students exhibiting risk factors or moderate behavioral health needs. Unlike the universal focus of Tier 1, Tier 2 targets students with early-onset distress to mitigate risks and prevent the development of functional impairments like academic failure or school avoidance.[22]

In the Northwell model, this tier emphasizes early recognition and consultative services, including outpatient neuropsychology evaluations and in-school psychiatric evaluations. This allows board-certified psychiatrists to provide immediate diagnostic clarification and treatment plans for complex issues such as school avoidance, or severe emotional or behavioral dysregulation.[23] By aligning mental health resources with educational strategies, this approach assists the Committee on Special Education in creating informative Individualized Education Programs (IEPs) or 504 Plans. Furthermore, these clinical recommendations guide critical placement decisions, whether referring a student to Boards of Cooperative Educational Services (BOCES) for specialized instructional and vocational programs or escalating to higher levels of care such as day-treatment or partial hospitalization.[25]

Following these in-school psychiatric evaluations, the Northwell model emphasizes care coordination and linkage to care as the vital bridge to long-term stability, which is needed for 95% of our patients. Because the health care system can often be daunting for families to navigate, designated care coordinators are integrated into the program to assist families in making appropriate referrals for subsequent longitudinal treatment. The care coordinators refer students to community providers based on insurance, accessibility, and availability. Furthermore, the care coordinators facilitate handoff between the school-based evaluation and long-term outpatient care, ensuring that no information is lost in the transition.[23] This intensive, integrated support has yielded consistent results. We recommend long-term follow-up care for 95% of families; of those, 70% respond to our outreach efforts to facilitate ongoing care. Initial appointment adherence is equally strong, with 60% successfully attending their first visit within 30 days—a figure that rises to 87% by the 2 month mark. These outcomes significantly outperform standard Emergency Room connection rates, which typically range from 30% to 50%.[26]

In addition to the services above, the Virtual Crisis Hub serves as a vital Tier 2 service that functions as a centralized "triage to care" engine for schools and families.[11] Staffed by licensed behavioral health clinicians, the Hub receives calls regarding

students who may be experiencing suicidal ideation or a mental health crisis. These Hub clinicians gather information on precipitating events and available outpatient supports to determine the appropriate level of care. By providing clinical guidance and triage support, the Crisis Hub allows school staff and parents to manage acute, emerging concerns effectively before they escalate into high-risk situations or emergency room visits.[11]

Moreover, the Crisis Hub acts as the bridge that connects Tier 2 early recognition to intensive Tier 3 treatment services.[23] When a Hub clinician identifies a student whose current risk factors outweigh their protective factors, they facilitate an immediate transition to Tier 3 interventions, such as same-day crisis appointments at a nearby BHC. This Hub-spoke model streamlines the referral process through clinician consultation and provisional appointments, ensuring a swift handoff to dedicated psychiatric care. This is described in the following section.

Tier 3: Treatment and Crisis Intervention

Tier 3 of the MTSS framework represents the most specialized level of support, targeting high-risk students whose severe behavioral health needs require immediate clinical intervention.[17,22] Within the Northwell School Mental Health Program, Tier 3 offers a vital alternative to traditional crisis pathways, which frequently default to the ED.[23] By intervening promptly, the program stabilizes students whose symptoms might otherwise escalate to a level requiring emergency care. Through a practical Hub-and-spoke model, the program ensures that students in active crisis—defined as those at risk of harming themselves or others—receive high-level psychiatric care in the least restrictive and most appropriate environment.[10,11]

The facilitator of this intensive tier is the virtual Crisis Hub, a novel rapid-response call center that facilitates timely triage and psychiatric assessment. Staffed by a multidisciplinary team including behavioral health counselors and psychiatrists, the unit receives calls from school professionals and parents to determine the necessary level of care based on a structured triage tool that includes elements of evaluating risk and protective factors, psychosocial stressors, and available resources. To qualify for a same-day crisis appointment at a Tier 3 level, students present with acute symptoms such as suicidal ideation, homicidal ideation, non-suicidal self-injury, command auditory hallucinations, or an acute or subacute significant decline in baseline functioning. This centralized triage process is essential for streamlining referrals to the program's physical "spokes," the 5 BHCs,[23] and away from the ED.

The implementation of the physical BHCs—located in Mineola, Rockville Centre, Commack, Riverhead, and Mount Kisco—is a major differentiator of the Northwell model, as they provide rapid access to child and adolescent psychiatrists and LMHCs.[23] These centers are designed as specialized ambulatory settings where families can avoid inconveniences and barriers associated with pediatric EDs. Traditionally, the ED serves as the default for immediate psychiatric access, yet it can often be a traumatizing environment that subjects youth and families to excessive wait times, sensory overload, and a sometimes lack of specialized mental health focus.[27,28] Unlike the specialized Northwell model, the medicalized ED setting, depending on resources, frequently fails to provide seamless care transitions or necessary diagnostic clarification, potentially magnifying stigma and leaving vulnerable children feeling penalized rather than supported.

The impact of these Tier 3 services has been far-reaching, with data from the Crisis Hub demonstrating the model's ability to effectively differentiate risk. While 43% of consultations result in urgent referrals to outpatient BHCs, another 41% are resolved immediately through clinical guidance, care coordination, or connection to local

resources. Consequently, the Hub successfully diverted the vast majority of students from hospital settings, with only 6% of cases requiring an ED referral.[11] This effective diversion prevents the over-utilization of resource-intensive hospital settings and ensures that acute care resources are preserved for the most critical medical cases and crucial handoffs from school are provided to hospital staff. By offering urgent or same-day evaluations, BHCs allow students to be professionally assessed sooner, facilitating bridging care that stabilizes the child while the care coordination team secures long-term community placement. By working with the student's school staff, this program also helps transition the child strategically and smoothly back into the school setting.[23]

Within the framework of Tier 3 intensive supports, Northwell's BHCs can also perform psychiatric assessments to provide much-needed diagnostic clarification and develop comprehensive treatment plans for complex cases, given referrals from partnering schools and families.[23] Beyond immediate stabilization, the BHCs provide short-term bridging of care, offering follow-up appointments with psychotherapy and pharmacotherapy treatment for students while the care coordination team secures a long-term outpatient provider in the community.[23] This logical transition is an important component of tertiary prevention, as early and effective intervention has been shown to improve long-term outcomes and prevent the progression of more serious, impairing symptoms.[6] By ensuring students are evaluated sooner and supported through this critical bridging period, the model effectively prevents future functional deterioration and reduces the likelihood that a child's condition will worsen to the point of requiring an ED, higher level of care such as inpatient hospitalization.

In addition, the BHCs facilitate collaboration of care with access to the extensive specialty services at Cohen Children's Medical Center, ensuring that even the most complex pediatric cases receive expert, integrated care.[29] This interdisciplinary model allows for timely referrals to medical services such as pediatric neurology, developmental pediatrics, or adolescent medicine. This allows for blending health and educational resources to address the specific needs of the whole child—whether they are neurodevelopmental conditions such as ADHD, autism, or eating disorders.

Another feature of Tier 3 intensive treatment is the inclusion of specialized, short-term treatment tracks, most notably the School Avoidance Program, social skills, and parent groups. The need for these targeted treatment programs was significantly exacerbated by the COVID-19 pandemic, which more than doubled rates of chronic absenteeism to approximately 30% of the student population and increased the rate of social anxiety due to isolation and remote learning.[30] These tracks utilize a strategic, evidence-based approach to identify and mitigate school-refusal behaviors and improve social communication skills through a 4 to 6 week curriculum.

The success of these Tier 3 interventions is evidenced by their clinical outcomes. For example, the School Avoidance Program shows an overall 77% decrease in school days missed and a 57.6% decrease in days arriving late.[30] Furthermore, the program fosters a collaborative and hands-on approach by building parental capacity and school clinical support alongside the student's own motivation. By providing this level of comprehensive, short-term psychiatric care and specialized intervention, the Northwell model bridges the gap between acute crisis and long-term stability, ensuring that high-risk students are not lost in the complexities and scarcities of the health care system.

Program Strengths and Challenges

The integration of mental health support within the education system, exemplified by the Northwell School Mental Health Crisis Program, has demonstrated significant

success in improving both clinical and educational outcomes. By utilizing the MTSS framework, these programs transition from traditional reactive models to a comprehensive public health approach that balances universal wellness with intensive intervention.[22]

The Northwell School Mental Health Partnerships operate on a break-even model, primarily funded by school contracts (roughly 75%) and philanthropic grants (approximately 5%). Because these contracts are managed through the BOCES, schools receive New York State financial reimbursement the following year to cover a portion of the costs.

The remaining revenue is generated through clinical billing, though this varies significantly by role. Physicians, who make up 26% of the team, are 100% billable. In contrast, Master's-level clinicians (29% of the team) are only 20% billable, and care-coordination or support staff (35% of the team) are currently non-billable. Any operational surplus is reinvested into the program to fund resource expansion (Fig. 2).

PROGRAM STRENGTHS AND OUTCOMES

Accessibility and Integrated Support

The biggest strength of the Northwell model is its ability to reduce barriers to care by offering rapid access services in collaboration with schools, near the patient's home district, in a family-centric ambulatory environment. By embedding BHCs in the community near partnering districts and facilitating crisis visits through the centralized Crisis Hub, the program ensures that families with transportation barriers, scheduling conflicts, and financial barriers can also access same-day or rapid access dedicated care.[10] This collaborative model allows clinicians to become part of the school treatment team rather than mere visitors, facilitating smooth transitions between medical and educational systems (Fig. 3).

De-stigmatization and Mental Health Literacy

SBMH programs play a critical role in normalizing help-seeking behavior. By integrating mental health topics directly into the school curriculum and increasing the visibility of professionals on campus, the program dispels negative stereotypes of children and families seeking professional help.[6] Northwell's Tier 1 initiatives, such

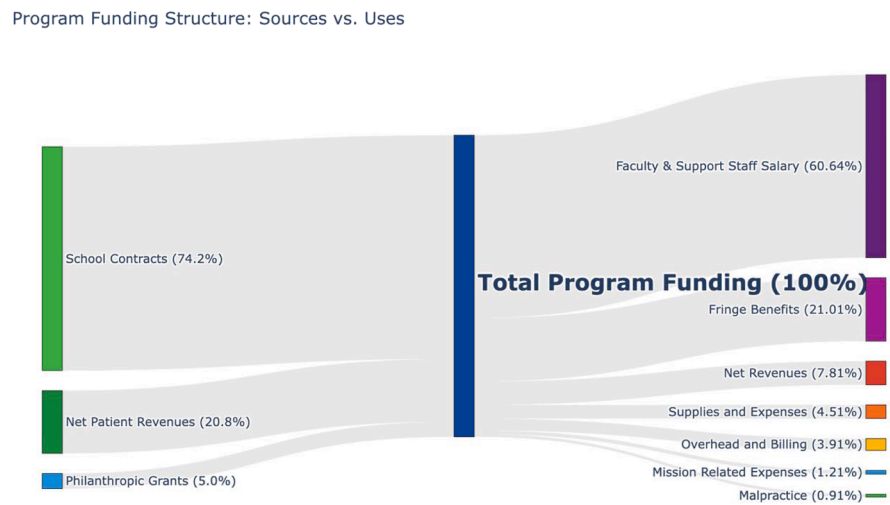

Fig. 2. Program function and expenses. (*Image Courtesy* Northwell School Mental Health.)

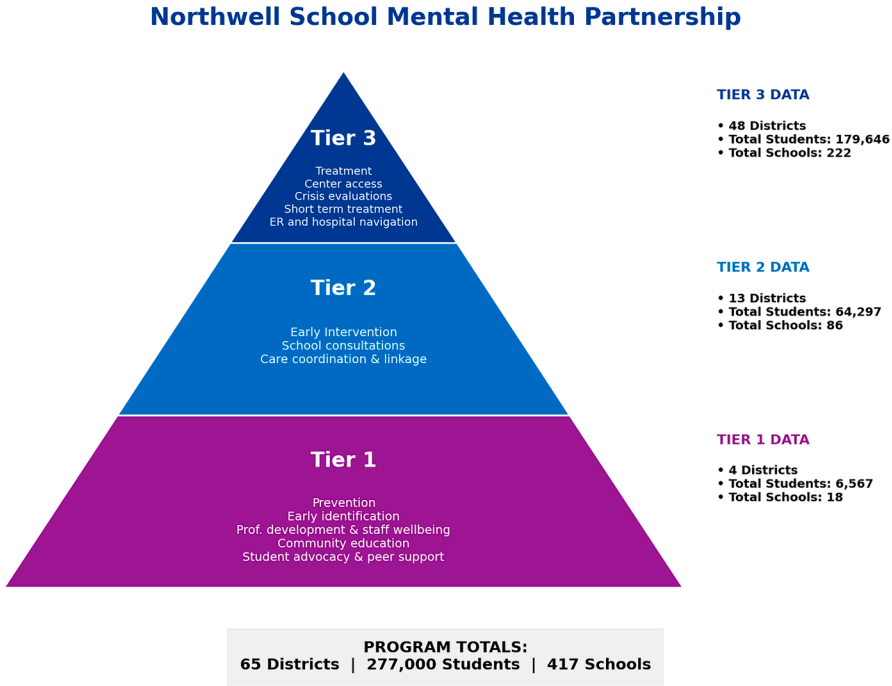

Fig. 3. Services by tiers with corresponding participating schools. (*Image Courtesy* Northwell School Mental Health.)

as direct-to-student education on body image, social media, and stress management, normalize these discussions as a standard part of student wellness.[23]

Professional Development and Community Presence

The program provides robust Professional Development sessions, following New York State guidelines and offering CEU/CTLE credits. With a 97% satisfaction rate among school professionals, these trainings equip staff as more competent frontline observers who can recognize signs of distress early. Furthermore, the program empowers families through its Resiliency Toolkit, a digital resource hub available in English, Spanish, and Mandarin, and virtual parent support groups that offer practical, evidence-based treatment strategies.[23]

Clinical and Educational Outcomes

The impact of these services is reflected in the positive data across both clinical and educational domains. The initiation of the program resulted in an initial 60% decrease in ER referrals from participating schools. The Crisis Hub also supports this mission and effectively prevents ED over-utilization, resulting in only 6% of consultations requiring an ED referral; this high diversion rate successfully prevents inefficient and at times traumatizing ED visits while preserving hospital resources for critical medical cases.[11] This preventative approach is further reinforced by bridging care at BHCs, which targets symptom progression and prevents future functional deterioration. These clinical successes are mirrored by significant academic improvements, where specialized interventions like the school avoidance workshops have led to a significant overall decrease in missed school days as well as a reduction in late arrivals to classes.[30]

In summary, the Northwell School Mental Health Program stands as an exemplary model addressing the escalating youth mental health crisis through a comprehensive MTSS. By integrating services directly into schools via a unique Hub-and-spoke framework, the program significantly enhances accessibility, de-stigmatizes mental health care, and provides rapid access to assessments by board-certified child and adolescent psychiatrists. This innovative approach effectively diverts crisis cases from EDs, fosters critical bridging care, and delivers demonstrably improved clinical and educational outcomes, ultimately reshaping the landscape of school-based behavioral health with a proactive, community-integrated public health perspective.

CLINICS CARE POINTS

School Professionals and Educational Leaders (Administrators, Counselors, and Social Workers)

- Pearls:
  - If resource allows, adopt a Multi-Tiered Framework—Implement an MTSS that blends universal wellness and mental health literacy (Tier 1) with targeted early recognition (Tier 2) and intensive crisis intervention (Tier 3).
  - Utilize centralized triage units (eg, a Virtual Crisis Hub) to provide school staff and parents with immediate clinical guidance, helping to de-escalate situations and appropriately route care.
  - Enhance Mental Health Literacy—Invest in universal prevention through robust staff professional development (eg, CEUs, case conferences) and parent empowerment tools (eg, translated digital Resiliency Toolkits) to normalize help-seeking behavior.
  - Collaborate on Accommodations—Actively use clinical recommendations from partnered psychiatric evaluations to inform IEPs, 504 Plans, or special education placements, ensuring the academic environment supports clinical treatment.
- Pitfalls:
  - Defaulting to the ED—Relying on the ED as the primary care location for youth in crisis often subjects students to extended wait times, sensory overload, and a lack of specialized mental health focus while depleting community hospital resources.
  - Fragmented Handoffs—Attempting to manage high-risk students without a formalized communication loop with the health care system could lead to vital psychosocial information being lost in transition.

Clinicians (Child & Adolescent Psychiatrists, Pediatricians, and Emergency Providers)

- Pearls:
  - Establish "Bridging of Care"—Utilize community-based ambulatory BHCs to provide same-day crisis evaluations and short-term bridging care (psychotherapy and pharmacotherapy) to stabilize youth while long-term care is secured.
  - Integrate Care Coordination—Embed dedicated care coordinators into the clinical team to navigate insurance, availability, and community placements. Supported linkage to care yields up to an 87% retention rate at 2 months.
  - Address School-Specific Impairments—Develop specialized, short-term treatment tracks targeting prominent functional impairments, such as school avoidance/refusal programs, which have shown significant efficacy in reducing school days missed.
  - Psychiatric Expertise—Ensure school-based mental health initiatives include access to board-certified child and adolescent psychiatrists who can manage complex diagnostics and psychopharmacological interventions, reducing the need to escalate to higher levels of care.
- Pitfalls:
  - Discharging Without Follow-up—Discharging school-referred pediatric patients from the ED without secured outpatient follow-up—a systemic issue that currently affects nearly half of all school referrals, particularly those presenting with suicidality.
  - Operating in Silos—Treating the pediatric patient without considering their primary ecosystem (the school). Failing to coordinate with school counselors regarding a patient's safety plan or scholastic pressures can stall overall prognosis.

- Overlooking Accessibility Barriers—Setting up clinical interventions that do not account for traditional barriers such as family transportation, financial constraints, and stigma. Embedding care pathways directly within or adjacent to the school district mitigates these challenges.

DECLARATION OF AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

During the preparation of this work, the authors used Gen AI. After using this tool/service, the authors reviewed and edited the content as needed and takes full responsibility for the content of the publication.

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