Research Article

Journal of Trauma Studies in Education
Volume 5, Issue 1 (2026), pp. 1-14
ISSN: 2832-1723 (Print), 2832-1731 (Online)
http://doi.org/10.70085/jtse.v5i1.128

Advancing Culturally Responsive, Trauma-Informed School Mental Health Systems through a National Learning Collaborative

Jerica Knox
University of Maryland School of Medicine

Taneisha A. Carter
University of Maryland School of Medicine

Sharon A. Hoover
University of Maryland School of Medicine

Ayla Novruz
University of Maryland Baltimore County

Sarah Clark
Alliance for Inclusion & Prevention

Tali Raviv
Northwestern University

Tiffany Beason
University of Maryland

Saadia Elahi
Northwestern University

ABSTRACT

Multi-site learning collaboratives have improved school mental health systems by offering pragmatic guidance for engaging in evidence-based practices. However, minimal research to date has examined the use of learning collaboratives to inform culturally responsive, trauma-informed school mental health systems. This pilot study illustrates the first national learning collaborative to advance comprehensive school mental health systems with specific attention to culturally responsive, trauma-informed care. Thirteen school districts in 14 states participated in the 2-year learning collaborative, representing urban, rural, and suburban communities. Descriptive statistics and paired-sample T-tests were used to examine school districts' acceptability of the learning collaborative and progress in their school mental health systems. Findings support using learning collaboratives that provide professional development in trauma-informed and culturally responsive care to advance school mental health systems.

Keywords: school mental health, trauma-informed care, culturally responsive practice, learning collaborative, professional development

A trauma-informed school recognizes the prevalence of trauma, promotes a culture of safety, and employs universal, early intervention, and intensive interventions to support the healing and well-being of students affected by trauma (National Child Traumatic Stress Network, 2017). The evidence base for these approaches is growing, with studies indicating that universal programmatic elements, such as teacher professional development, have not only improved teacher knowledge and self-efficacy in supporting students exposed to trauma but also positively influenced the overall perceptions of the school climate (Cafaro et al., 2023; Garcia et al., 2023). However, most existing research describes programming at a single intervention tier rather than integrated, multi-tiered and whole-school approaches (Berger, 2019; Fondren et al., 2020). Multi-tiered approaches have shown improvements in educator knowledge about trauma and in preparedness to support students experiencing trauma, reductions in student trauma symptoms, and reductions in disciplinary infractions (Dorado et al., 2016; Perry & Daniels, 2016). Taken together, this emerging body of research highlights the potential for trauma-informed schools to optimize learning outcomes and support the holistic development of students. Overlaying and integrating key aspects of trauma-informed schools with existing multi-tiered frameworks, such as comprehensive school mental health (SMH) programming, may help schools move beyond piecemeal programs and implementation to a more schoolwide, integrative, and multi-tiered approach to trauma responsiveness.

In addition to integrating trauma-informed approaches into comprehensive SMH programming, practitioners and researchers must consider the integration of cultural responsiveness into trauma-informed care. Cultural responsiveness involves intentionally acknowledging and including diverse student cultural identities, values, and experiences in school culture and supports, including academic lessons, disciplinary practices, and mental health supports (Gay, 2013). Culturally responsive practices address long-standing issues of systemic racism and cultural exclusion of students of color that contribute to adverse academic, socioemotional, and disciplinary outcomes (Ladson-Billings, 1995). In addition to addressing systemic oppression in schools, culturally responsive practices promote positive mental health and well-being, acknowledge cultural differences and assets, help students leverage their cultural knowledge, and mediate power imbalances based on identity or cultural background (Ladson-Billings, 1995). Cultural responsiveness is central to a trauma-informed approach because disproportionate rates of trauma exposure exist among youth of color due to systemic inequities, and children and families conceptualize and cope with trauma differently (Alvarez, 2020; Knox et al., 2025; Knox & Sturdivant, 2026). Overall, educators who engage in culturally responsive, trauma-informed care prevent and respond to trauma exposure through practices that incorporate the unique needs and lived experiences of students. However, limited research exists examining professional learning opportunities for schools that combine the two.

Learning collaboratives have emerged as effective models for enhancing SMH and promoting trauma-informed practices in schools. These collaboratives bring together schools, districts, and child-serving agencies to share best practices, learn from each other, and implement evidence-based strategies (Gotham et al., 2023). Key components of learning collaboratives include professional development, data

collection, feedback, peer support, and networking (Orenstein et al., 2023). Multiple studies have suggested a positive impact of learning collaboratives on SMH and trauma-informed services. Connors and colleagues (2020) found that learning collaborative engagement improved the quality of SMH services through enhanced screening and assessment processes, increased use of evidence-based practices, improved coordination of services, and better integration of mental health support within schools. Similarly, the New Orleans Trauma-Informed Schools Learning Collaborative enhanced educators' understanding and acceptability of trauma-informed approaches that can be utilized in the classroom (McIntyre et al., 2019). Learning collaboratives have shown promise in extending reach and accessibility to school programs, ensuring that schools even in remote or underserved areas can benefit from shared expertise and resources.

CURRENT STUDY

This preliminary study describes a national learning collaborative—National Center for Safe Supportive Schools (S3-LC)—which builds school and district capacity to implement culturally responsive, trauma-informed policies and practices in comprehensive SMH systems nationwide. We provide preliminary results in this study, including school districts' acceptability of the S3-LC and progress on their comprehensive SMH systems. We hypothesized that all elements of the S3-LC would be acceptable for participating districts and that they would show improvement in their SMH systems. This work is particularly critical as students and schools continue to grapple with the widespread impacts of the COVID-19 pandemic, which heightened mental health needs and exacerbated existing inequities. By integrating culturally responsive and trauma-informed practices, schools can create safer, more inclusive environments that promote healing and resilience while addressing systemic barriers that disproportionately affect marginalized students. This study addresses current gaps in the literature by demonstrating how learning collaboratives can equip schools to implement these practices at a systemic level, contributing to both immediate needs and long-term improvements in school mental health systems.

METHODS

The S3-LC includes four components: virtual learning sessions, school training, ongoing consultation from a SMH expert, and clinician training. The nineteen 90-minute virtual learning sessions (VLSs) for school district teams include didactic instruction and cross-district and within-district collaboration (Table 2). Twelve hours of asynchronous and synchronous school training are made available for school staff to complete together (Table 2). School districts are paired with an S3-LC faculty lead who provides monthly supportive consultation, including goal setting related to S3-LC topics and progress monitoring. Finally, up to eight school clinicians per year from each district are invited to participate in tier II intervention training, including Supporting Transition Resilience of Newcomer Groups (Crooks et al., 2020), Bounce Back (Langley et al., 2015), or Cognitive Behavioral Intervention for Trauma in Schools (Jaycox, 2018).

Table 2: Virtual Learning Session and School Training Content

Virtual Learning Session	School Training Module	Content
1	1	Foundations of comprehensive school mental health
2	2	Understanding trauma and adversity
3	3	Defining cultural responsiveness, anti-racism, and equity
4	4	Cultural humility and awareness
5	5	Engaging students, families, and communities as partners
6	6	Educator well-being
7		Building effective teams to advance cultural responsiveness
8		Conducting needs assessments and resource mapping
9		Mental health screening
10	7	Promoting the well-being of all students
11	8	Trauma-informed, healing centered schools
12	8	Supporting BIPOC and newcomer youth
13	9	Recognizing and referring students experiencing adversity and distress
14	10	Classroom strategies to support students experiencing health concerns and distress
15	11	Best practices for tiers 2/3 mental health services and supports in schools
16	11	School-based early intervention and treatment for trauma
17	12	Supporting BIPOC, newcomer, and LGBTQ+ youth at tiers 2/3
18		Funding and policies to advance safe, supportive schools
19		End-of-cohort celebration and sustaining progress

Participants

The S3-LC began with 15 school districts representing 14 states (see Table 1). Two districts withdrew at the beginning of the collaborative due to competing demands during the COVID-19 pandemic. Thus, the current study focuses on 13 school districts from 12 states. District teams consisted of 12 team members on average. These teams included at least one representative from each of the following groups: (1) school district administrator, (2) community mental health provider, (3) youth or family advocate, and (4) school leaders from two of the district's schools.

Measures

Acceptability of the four S3-LC components (i.e., VLSs, school training, tier II clinician training, and faculty lead consultations) was measured via surveys at the mid-point (Time 2) of the S3-LC and at the end of the S3-LC (Time 3). District teams were asked how helpful each component was on a Likert scale of 1 to 7 (1 = Not helpful at all to 7 = Extremely helpful).

Comprehensive SMH progress was measured via the School Mental Health Quality Assessment (SMHQA; Hoover et al., 2015). The SMHQA (Hoover et al., 2015) was developed by the National Center for School Mental Health to assess culturally responsive, trauma-informed comprehensive SMH system quality at the district and school levels based on seven domains: Teaming (i.e., the extent to which the district has multidisciplinary and effective SMH teams); Needs Assessment/Resource Mapping (i.e., the extent to which the district identifies mental health needs/strengths); Mental Health Screening (i.e., the extent to which the district uses best practices for mental health screening, planning, and implementation); Mental Health Promotion Services and Support (i.e., the extent to which the district promotes universal mental health support); Early Intervention and Treatment Services and Supports (i.e., the extent to which the district addresses students' mental health concerns); Funding and Sustainability (i.e., the extent to which the district optimizes financial and non-financial assets to maintain SMH supports); and Impact (i.e., the extent to which the district monitors changes in SMH based on programming). Importantly, the SMHQA was designed to assess policies and practices that are culturally responsive (e.g., Mental Health Promotion Services and Supports assesses the extent to which Tier 1 evidence-based practices are culturally relevant) and trauma-informed (e.g., Screening assesses districts' use of trauma screeners). Districts received an aggregate score between 1 and 6 for each domain where 1.0-2.9 is considered emerging, 3.0-4.9 is considered progressing, and 5.0-6.0 is considered mastery. The SMHQA is available via The SHAPE System (theshapesystem.com). S3-LC districts were required to submit the SMHQA at the beginning of each school year (Time 1: 2021, Time 2: 2022) and at the end of the cohort (Time 3: June 2023).

Procedure

S3-LC recruited school districts from across the U.S. via the National Center for School Mental Health listserv. Each district was also asked to select two schools that

Table 1: Participating District Characteristics

District	State	Schools in District	% Black/African American Students	% Hispanic/ Latinx Students	% Asian/Pacific Islander Students	% American Indian/Alaska Native Students	% White Students	% Students on Free/Reduced Lunch	Urbanicity
A	AZ	14	4.9	63.0	0.7	4.7	21.8	51.8	Urban
B	CA	26	2.2	80.5	6.9	0.2	6.7	47.0	Urban
C	DE	28	22.5	29.3	4.8	0.3	39.3	28.4	Suburban
D	GA	9	18.5	5.6	4.2	0.2	62.9	13.3	Suburban
E	IL	3	45.1	42.9	0.1	0.3	6.7	80.1	Suburban
F	MD	14	5.5	11.5	1.0	0.1	75.6	17.3	Rural
G	MA	8	11.1	14.4	9.4	0.4	59.1	28.7	Suburban
H	MN	97	30.6	17.3	3.8	3.1	38.5	32.5	Urban
I	MN	28	30.5	16.9	6.1	0.6	35.0	31.1	Suburban
J	NH	21	10.7	24.9	4.1	0.2	51.0	32.8	Suburban
K	NJ	1	24.5	15.0	4.7	0.2	48.2	21.3	Suburban
L	NC	17	34.9	22.7	0.5	0.2	36.3	34.2	Suburban
M	ND	18	6.8	9.6	3.5	3.7	66.0	16.1	Suburban
N*	NY	4	18.2	14.5	0.8	0.1	56.2	40.5	Urban
O*	PA	9	15.9	29.4	5.5	0.3	43.6	47.8	Suburban

Note: S3-LC refers to the National Center for Safe Supportive Schools Learning Collaborative
*Indicates districts that disengaged completely.

would participate in the S3-LC as part of the district team. The recruitment resulted in 96 applications. Districts were selected based on a review and scoring of applications according to established review criteria. Criteria included capacity and commitment of the district team, clear identification of district strengths and challenges in S3-LC priority areas, and explanation of how participation would advance their goals. Consideration was also given to demographic and geographic diversity. Thirteen selected districts and their participating schools engaged in the S3-LC components from August 2021 to June 2023.

Data Analysis

Quantitative data were cleaned and checked for accuracy. Descriptive statistics were calculated for acceptability at the mid-point and end of the S3-LC. Two-tailed paired sample t-tests were conducted to assess comprehensive SMH changes via SMHQA domains. Notably, the S3-LC was conducted during the COVID-19 pandemic, and school districts struggled to complete the SMHQA. As a result, we employed three paired-sample T-tests across the three time points (i.e., Time 1 and Time 2, Time 1 and Time 3, and Time 2 and Time 3) to account for the missing data across all time points.

RESULTS

Acceptability

All 13 school districts completed both time points for acceptability (Time 2 and Time 3). The mean score for the acceptability of VLSs was 6.03 (SD = 0.79) at the mid-point and 5.77 (SD = 0.75) at the end of the S3-LC. Districts rated faculty lead consultations acceptability 6.40 (SD = 0.70) at mid-point and 6.27 (SD = 1.10) at the end of the S3-LC. The mean score for acceptability of clinician training was 6.37 (SD = 0.56) at the mid-point and 5.90 (SD = 0.71) at the end of the S3-LC. Finally, districts rated school training acceptability 3.79 (SD = 1.29) at the mid-point and 6.06 (SD = 1.02) at the end of the S3-LC.

Progress

Table 3 provides mean scores on all SMHQA domains across the three time points. Overall, before participating in the S3-LC, participating districts' scores on the SMHQA were within the emerging category (M = 2.66, SD = 0.57, n = 12). At the midpoint of the S3-LC and the end of the S3-LC, participating districts' scores on the SMHQA were within the progressing category (M = 3.07, SD = 0.58, n = 9) and (M = 3.29, SD = 0.51, n = 7), respectively. Paired sample t-tests revealed that school districts significantly improved in 5/7 SMHQA domains from Time 1 to Time 2: Teaming ($t(8) = -3.60$, $p = .007$), Needs Assessment/Resource Mapping ($t(8) = -4.20$,

p = .003), Mental Health Promotion (t(7) = -4.12, p = .004), Screening (t(7) = -3.87, p = .006), and Early Intervention (t(7) = -4.50, p = .003). School districts improved in 1/7 SMHQA domain from Time 2 to Time 3: Teaming (t(3) = -3.16, p = .036).

Finally, across the entire S3-LC (Time 1 to Time 3), school districts improved in 5/7 comprehensive SMH domains: Teaming (t(5) = -6.93, p < .001), Needs Assessment/Resource Mapping (t(5) = -3.47, p = .018), Mental Health Promotion (t(5) = -3.58, p = .016), Early Intervention (t(5) = -5.56, p = .003), and Impact (t(5) = -4.39, p = .007).

Table 3: S3-LC SMHQA Domain Descriptives

SMHQA Domains	Time 1 *M*(*SD*)	Time 2 *M*(*SD*)	Time 3 *M*(*SD*)
Teaming	2.68(0.63)	$3.27(0.62)_a$	$3.65(0.48)_b$
Needs Assessment/ Resource Mapping	2.23(0.81)	$3.05(0.91)_a$	$3.50(0.47)_b$
Screening	1.85(0.87)	$2.75(1.08)_a$	3.12(1.43)
Mental Health Promotion	2.70(0.66)	$3.41(0.53)_a$	$3.79(0.43)_b$
Early Intervention	2.75(0.65)	$3.53(0.68)_a$	$3.51(0.46)_b$
Funding	2.93(0.44)	3.19(0.57)	3.62(0.65)
Impact	2.19(0.53)	2.46(0.47)	$3.11(0.60)_b$

Note. S3-LC = National Center for Safe Supportive Schools Learning Collaborative. SMHQA = School Mental Health Quality Assessment. Time 1 *n* = 12, Time 2 *n* = 9, Time 3 *n* = 7. Subscript $_a$ indicates a significant improvement from Time 1 to Time 2. Subscript $_b$ indicates a significant improvement from Time 2 to Time 3.

DISCUSSION

This study evaluated the impact of a national learning collaborative to advance trauma-informed, culturally responsive SMH systems. Generally, the findings underscore a growing demand for training and technical assistance to support districts in these critical practice areas. This is evidenced by the nearly 100 applications from districts across the country, even during the challenging circumstances of the COVID-19 pandemic. The study also revealed a pressing need for district training and consultation; even the successful applicants to the S3-LC were, on average, in the "emerging" stages of implementing all seven domains of comprehensive trauma-informed and culturally responsive SMH systems at the start of the learning collaborative. This underscores not only the demand for training but also the necessity for ongoing support in this area.

Overall, the 13 school districts rated the S3-LC components as moderately to highly acceptable. Notably, the school training initially received the lowest ratings in

terms of helpfulness in the first year relative to the other S3-LC components—likely due to the impact and disruptions of the COVID-19 pandemic. District teams, while able to prioritize training for VLSs, faced difficulties in gathering staff within specific schools for training due to pandemic-related restrictions and concerns. However, as the pandemic eased and districts adapted, the ratings for the training improved significantly by the end of the second year. Districts may also require support not only in accessing quality professional development for their schools but also in designing their professional development calendars to allot time for these critical topics. Additionally, state policies vary in the degree to which such training is required, and recent trends have shown some states limiting the content of professional learning in these areas (Alexander et al., 2023). This may cause uncertainty among schools and districts regarding their ability to fully participate in the content of the S3-LC.

Districts demonstrated significant growth in five out of the seven comprehensive SMH domains—Teaming, Needs Assessment/Resource Mapping, Mental Health Promotion, Early Intervention, and Impact. This finding provides support for the S3-LC in advancing quality SMH systems. Much of this improvement was made during the first year of the S3-LC, with districts improving significantly in five out of seven domains from Time 1 to Time 2, but only one out of seven domains from Time 2 to Time 3. This finding could illustrate the monumental levels of mental health needs during the start of the pandemic and the openness and need for support in SMH at the time. Importantly, despite the lack of improvements from Time 2 to Time 3, school districts still maintained their growth from Time 1 at the end of the S3-LC (Time 3), indicating that the changes made were sustainable. Interestingly, the Impact domain showed significant improvement across the entire S3-LC, but not from Time 1 to Time 2 nor Time 2 to Time 3. Impact refers to the long-term effects of practices and policies implemented, which may indicate that more time is necessary to achieve significant growth in this domain. Similarly, even at the end of the two-year S3-LC, overall scores on the SMHQA were still only in the "progressing" range on average, showing that this work may potentially take more time and/or resources to reach "mastery." Additionally, there was no significant improvement in Funding and Sustainability across the two years of the S3-LC. This could be due to the lack of goal prioritization in this area for districts or lack of available funding support.

Several implications can be drawn from our findings. First, the findings suggest that learning collaboratives like the S3-LC provide a replicable framework for school systems aiming to strengthen their mental health infrastructure. The structured nature of the learning collaborative, combining professional development, consultation, and cross-district collaboration, can serve as a model for other districts seeking to address both immediate needs and systemic gaps. School leaders can use the results to justify allocating time and resources to multi-component learning collaboratives, which offer a structured approach to systemic improvement. Schools in underserved areas, in particular, can use these findings to justify participation in initiatives that emphasize tailored training and capacity-building. For policymakers, these results highlight the importance of sustained funding and legislative support to ensure the scalability and sustainability of collaborative approaches.

Second, depending on the specific goals of school districts—whether proficiency in specific SMH domains or overall improvement in SMH—engagement in a learning collaborative may need to extend over a longer timeframe. This is particularly crucial as changes in certain SMH domains may require more time to materialize compared to others. One-year learning collaboratives may be helpful for school districts as a quick "boost" to their SMH systems. However, investing in longer-term collaboratives may be the key to moving from emerging to mastery.

School districts should prioritize multi-level training in trauma-informed care and cultural responsiveness to effectively enhance their SMH systems. This includes embedding these principles into district policies, professional development plans, and day-to-day practices to ensure their integration into the broader school culture. Such training should address not only immediate needs but also provide strategies for sustained systemic change, equipping educators and mental health professionals with the tools to create inclusive, healing-centered environments.

Additionally, building local capacity is critical to sustaining improvements in school mental health systems. Similar to the S3-LC, districts can prioritize training a core team of educators, administrators, and mental health professionals who can serve as internal champions of culturally responsive, trauma-informed practices. These individuals can act as trainers and advocates within their schools, ensuring the continuation of these practices even after the conclusion of external support, such as learning collaboratives. This approach not only fosters sustainability but also empowers school communities to take ownership of their mental health initiatives, reducing reliance on external consultants and promoting systemic, long-term change. By cultivating internal expertise, districts can create a ripple effect, gradually embedding these principles into the broader school culture and ensuring that students benefit from consistent, high-quality support.

Finally, our findings suggest that school training may be a particular area for improvement in learning collaboratives. S3-LC districts were able to pick two schools to engage in professional development, and their reasons for selecting schools varied (e.g., high need for professional development, high interest in cultural responsiveness). It is possible that the context of the COVID-19 pandemic presented significant challenges for schools, with school personnel reporting higher levels of stress as they managed changing public health guidance, navigated the return to school after remote learning, and responded to increased mental health needs for students (Baker et al., 2021). This may have made it difficult to prioritize school training effectively. Alternatively, they may have found certain modules more immediately beneficial for addressing their pressing needs, while others focused on longer-term practices may not have seemed as relevant. Consequently, a more tailored approach to school training, considering the specific needs and capacities of each school, may be necessary to ensure optimal uptake of the training. Additionally, S3-LC faculty leads can assist districts in identifying and prioritizing two schools that would be most suitable for the types of training offered.

Limitations and Future Directions

The preliminary findings in this study did not examine the mechanisms underlying improvement in SMH quality. Some areas of growth were directly related to the components of the S3-LC (e.g., the school training is directly related to the Mental Health Promotion domain); however, domains not directly related to each component also improved, showing that the comprehensive nature of the S3-LC may have driven overall improvement. Future studies are needed to further examine specific mechanisms that lead to school improvement. Another limitation of this study is the absence of a control or comparison group, which makes it challenging to ascertain whether the improvements observed were solely attributable to participation in the S3-LC. For example, it is possible that the observed growth in SMHQA domain scores occurred nationwide, driven by heightened attention to student mental health and an influx of funds through COVID relief efforts. Also, the analysis included missing data, which limited the ability to fully assess the impact of the S3-LC. Future studies should employ a more robust approach, including a waitlist comparison group and greater resources for data collection. Finally, while the SMHQA was developed to undergird cultural responsiveness and trauma-informed care, we did not directly measure each area. Future studies should use separate measurement tools to assess both independently. This additional separation would allow researchers to better understand the unique contributions of each construct to overall school mental health practices and outcomes, identify specific areas of strength or need within schools, and explore how these constructs interact with one another to inform targeted interventions and policy development.

CONCLUSION

This study revealed preliminary findings of a national learning collaborative initiative to improve SMH systems with specific attention to trauma-informed and culturally responsive care. S3-LC districts improved in several domains of SMH across the 2-year learning collaborative, demonstrating the usefulness of multi-site, multi-component training. Findings also support the high need and demand for such training across the nation. Continued research and evaluation are essential to further understand the mechanisms underlying school improvement and to enhance the effectiveness of learning collaboratives like the S3-LC.

REFERENCES

Alexander, T., Baldwin, C. L., Reinhardt, K., & Zatz, N. (2023). *CRT Forward: Tracking the Attack on Critical Race Theory.* University of California School of Law.

Alvarez, A. (2020). Seeing race in the research on youth trauma and education: A critical review. *Review of Educational Research*, *90*(5), 583–626. https://doi.org/10.3102/0034654320938131.

Baker, C. N., Peele, H., Daniels, M., Saybe, M., Whalen, K., Overstreet, S., & Trauma-Informed Schools Learning Collaborative The New Orleans. (2021). The experience of COVID-19 and its impact on teachers' mental health,

coping, and teaching. *School Psychology Review, 50*(4), 499-504, https://doi.org/10.1080/2372966X.2020.1855473

Berger, Emily. (2019). "Multi-tiered approaches to trauma-informed care in schools: A systematic review." *School Mental Health*, *11*(4), 650–664. https://doi.org/10.1007/s12310-019-09326-0

Cafaro, C . L., Gonzalez Molina, E., Patton, E., McMahon, S. D., & Brown, M. (2023). Meta-analyses of teacher-delivered trauma-based and trauma-informed care interventions. *Psychological Trauma: Theory, Research, Practice, and Policy, 15*(7). https://doi.org/10.1037/tra0001515

Connors, E. H., Smith-Millman, M., Bohnenkamp, J. H., Carter, T., Lever, N., & Hoover, S. A. (2020). Can we move the needle on school mental health quality through systematic quality improvement collaboratives? *School Mental Health*, *12*(3), 478-492. https://doi.org/10.1007/s12310-020-09374-x

Crooks, C. V., Hoover, S., & Smith, A. C. (2020). Feasibility trial of the school-based STRONG intervention to promote resilience among newcomer youth. *Psychology in the Schools, 57*(12), 1815-1829. https://doi.org/10.1002/pits.22366

Fondren, K., Lawson, M., Speidel, R., McDonnell, C. G., & Valentino, K. (2020). Buffering the effects of childhood trauma within the school setting: A systematic review of trauma-informed and trauma-responsive interventions among trauma-affected youth. *Children and Youth Services Review,* 109. https://doi.org/10.1016/j.childyouth.2019.104691

Garcia, Sprang, G., & Clemans, T. (2023). The role of school leaders in cultivating a trauma-informed school climate. *Children and Youth Services Review*, *146*. https://doi.org/10.1016/j.childyouth.2023.106816

Gay, G. (2013). Teaching to and through cultural diversity. *Curriculum Inquiry, 43*(1), 48-70. https://doi.org/10.1111/curi.12002

Gotham, H. J., Paris Jr, M., & Hoge, M. A. (2023). Learning collaboratives: A strategy for quality improvement and implementation in behavioral health. *The Journal of Behavioral Health Services & Research*, *50*(2), 263-278. https://doi.org/10.1007/s11414-022

Jaycox, L. H., Langley, A. K., & Hoover, S. A. (2018). Cognitive behavioral intervention for trauma in schools (CBITS) (2nd ed.). RAND Corporation.

Knox, J., Lawson, T., Gaona, M., & Casella, J. (2025). Examining trauma-informed professional development in schools: A systematic narrative review highlighting culturally responsive, anti-racist, and equitable content. School Psychology. https://doi.org/10.1037/spq0000714

Knox, J., & Sturdivant, B. (2026). Applying a CARE framework to trauma-informed schools: Introduction to the special issue. *Journal of Trauma Studies in Education, 4*(3), i-viii. https://doi.org/10.70085/jtse.v4i3.396

Ladson-Billings, G. (1995). But that's just good teaching! The case for culturally relevant pedagogy. *Theory into Practice, 34*(3), 159-165. https://doi.org/10.1080/00405849509543675

Langley, A. K., Gonzalez, A., Sugar, C. A., Solis, D., & Jaycox, L. (2015). Bounce back: Effectiveness of an elementary school-based intervention for

multicultural children exposed to traumatic events. *Journal of Consulting and Clinical Psychology, 83*(5), 853–865. https://doi.org/10.1037/ccp0000051.

Orenstein, S., Connors, E., Fields, P., Cushing, K., Yarnell, J., Bohnenkamp, J., Hoover, S., & Lever, N. (2023). Advancing School Mental Health Quality Through National Learning Communities. *Handbook of School Mental Health - Innovations in Science and Practice* (pp. 215-231). Springer.

Perry, D. L., & Daniels, M. L. (2016). Implementing trauma-informed practices in the school setting: A pilot study. *School Mental Health, 8*, 177-188. https://doi.org/10.1007/s12310-016-9182-3

Hoover, S., Lever N., Connors, E., & Bohnenkamp, J. (2015). School mental health quality assessment-Version 1. University of Maryland, National Center for School Mental Health. https://theshapesystem.com

JERICA KNOX, PhD, is an Assistant Professor at the University of Maryland School of Medicine and faculty member at the National Center for School Mental Health. Her major research interests lie in the area of school mental health, with an emphasis on trauma-informed and culturally responsive practices. Email: Jerica.knox@som.umaryland.edu

TANEISHA A. CARTER, MS is a lead Clinical Research Specialist in the Division of Child and Adolescent Psychiatry, Department of Psychiatry, at the University of Maryland School of Medicine. Her research interests lie in the area of comprehensive school mental health systems, using learning communities as a continuous quality improvement strategy to improve service quality, and elevating youth voice to inform effective mental health practice. Email: tacarter@som.umaryland.edu

SHARON A. HOOVER, PhD, is Professor Emeritus in the Division of Child and Adolescent Psychiatry, Department of Psychiatry, at the University of Maryland School of Medicine. Her major research and practice interests lie in the area of comprehensive school mental health systems, trauma-informed and resilience-oriented practices, implementation science, and workforce development to advance equitable access to mental health services for children and adolescents. Email: shoover@som.umaryland.edu

AYLA NOVRUZ, MA, is a clinical psychology and behavioral medicine doctoral student at the University of Maryland, Baltimore County. Her research interests include early life adversity, social determinants of health, and their impact on psychological and functional outcomes across the lifespan. Email: novruz1@umbc.edu.

SARAH CLARK, MPG, is a Research Project Manager at the Alliance for Inclusion and Prevention in Boston, MA. Her major research interests lie in the area of mental health as a critical public health issue, with particular emphasis on youth mental health and perinatal mental health, and on advancing equitable, prevention-focused strategies within school and healthcare systems to address disparities in access, quality of care, and outcomes. Email: sclark@aipinc.org

TALI RAVIV, PhD, is a clinical psychologist at Ann & Robert H. Lurie Children's Hospital of Chicago and Associate Professor at Northwestern University, Feinberg School of Medicine. Her research focuses on the effectiveness, implementation, and dissemination of school-based mental health programs and interventions. Email: traviv@luriechildrens.org

TIFFANY BEASON, PhD, is an Assistant Professor in the Department of Psychiatry at University of Maryland, Baltimore. Her major research interests lie in the areas of school mental health, positive youth development, culturally responsive practices, and trauma-informed care. Email: tbeason@som.umaryland.edu

SAADIA ELAHI, MS is a Doctoral Candidate in Clinical Psychology in the Department of Psychiatry and Behavioral Sciences at Northwestern University Feinberg School of Medicine. Her major research interests include implementation science and evaluation of school-based mental health interventions as a means to increase service access for traditionally underserved youth. Email: saadia.elahi@northwestern.edu.