Behavioral Health Services in School-Based Settings

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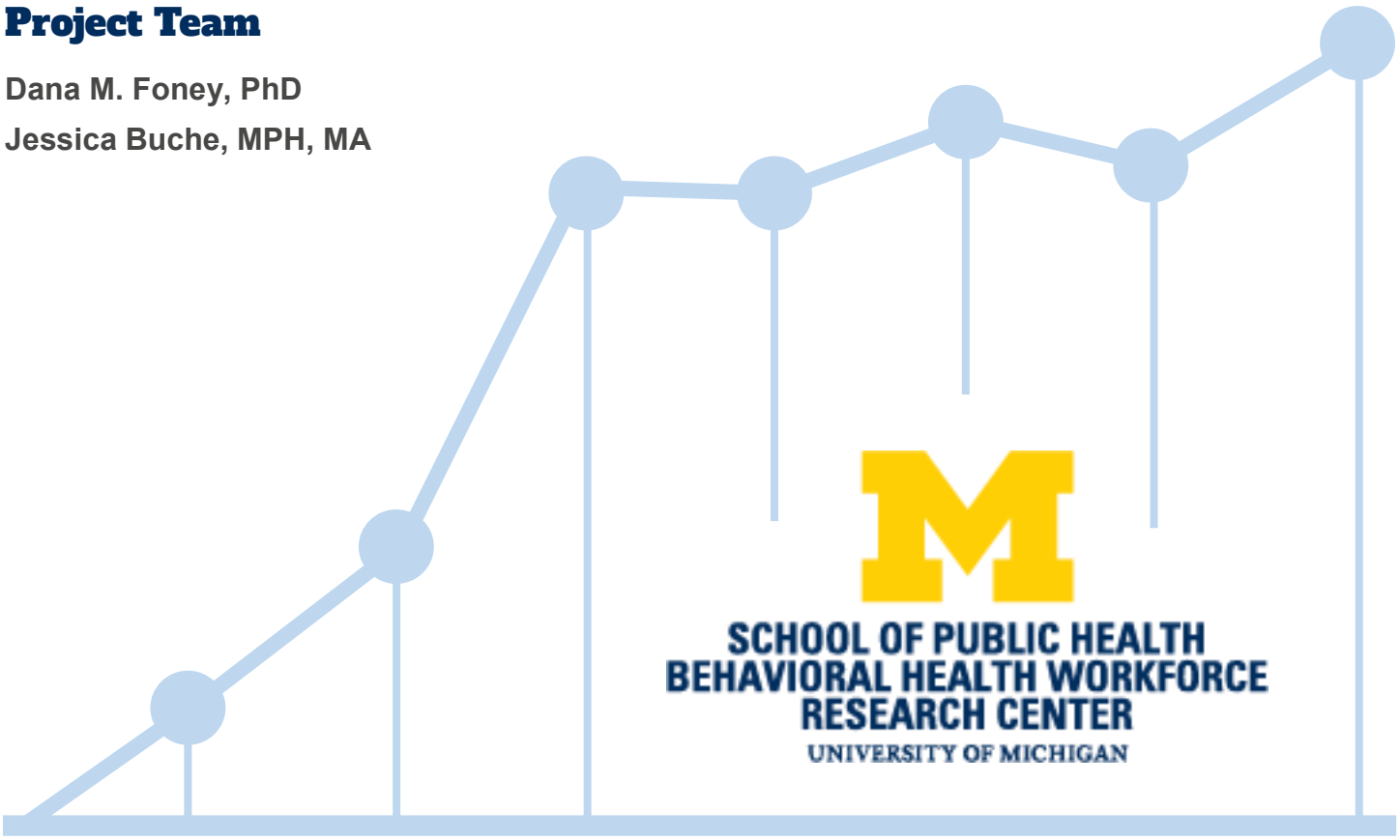

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Key Findings

Currently, there are over 2,000 school-based health centers (SBHCs) in the United States that provide accessible, effective, and integrated prevention and intervention supports to students and their families. Through SBHCs and their partnerships, students receive services such as physical health screenings and preventative interventions, behavioral health (mental health and substance use), oral health, health education, and case management. In addition to traditional SBHCs, non-traditional SBHCs also offer a range of behavioral health services to students. This descriptive study identified the range of school-based behavioral health services offered in designated *and* non-designated SBHCs. The National Council for Behavioral Health (National Council), in partnership with the Behavioral Health Workforce Research Center (BHWRC) at the University of Michigan, conducted the study to determine (1) characteristics of the behavioral health workforce practicing in school settings; (2) common characteristics of schools and populations served; (3) funding sources; (4) types of behavioral health services offered and common characteristics of the workforce; and (5) barriers to service delivery.

An online survey was completed by 295 school-based providers, with the majority of the sample identifying as a school nurse, school counselor, and/or marriage and family therapist. Most respondents worked in a traditional public school, and there was a fairly even distribution of respondents that serve elementary, middle, and high school aged students. Fifty-five percent of respondent worked in a traditional SBHC (45% did not). A comparison of these two groups indicated that state Medicaid agencies Medicaid Managed Care Organizations were the top funders of behavioral health services in both settings. Social/emotional well-being counseling was provided in over 75% of both types of settings and the two most common preventative services offered in both settings were: violence/bullying prevention and suicide prevention. In this sample, SBHCs and non-designated centers offered comparable rates of drug use prevention (32.4% vs. 32.5%, respectively), while SBHCs offered slightly higher rates of alcohol use prevention (28.8% vs. 25.6%, respectively) and tobacco prevention (25.2% vs. 19.7%, respectively) than non-designated centers. The top four barriers to service delivery in both settings included: insufficient funding for services, having too few behavioral health providers, lack of partnerships, and lack of clarity on staff roles.

The findings from this research indicate that SBHCs and non-designated centers fill a critical role in providing a range of behavioral health services for students of all ages. Regardless of the setting, a staffing structure that incorporates behavioral health providers strengthens the center and increases the value-add of including preventative mental health and substance use supports during a crucial age for developing problems in these areas. Also, building sustainable partnerships and leveraging existing funding mechanisms are critical for the success of these organizations. To improve the behavioral health services provided within SBHCs and non-designated centers, the following recommendations should be considered: (1) encourage states to leverage current state funding infrastructures, including 1115 waivers that support innovate practices to support the work of Medicaid; (2) focus on building partnerships with both school officials and behavioral health providers in the community and seek out funding that supports these partnerships such as the Delivery System Reform Incentive Payment (DSRIP) waivers; (3) continue to support and expand mental health awareness programs, such as Youth Mental Health First Aid, that support and foster readiness to learn for all students; and (4) collaborate and/or partner with a Certified Community Behavioral Health Clinic (CCBHC) to increase student access to mental health and addiction services and treatment.

Introduction

The School-Based Health Alliance (SBHA, 2016) describes school-based health centers (SBHCs) as those centers that “provide convenient, accessible, and comprehensive health care services for children and adolescents where they spend the majority of their time: in school.” SBHCs are expected to demonstrate the following seven core competencies when delivering care in a school setting: facilitate student access to health care and support services; offer relevant student-focused services; work to integrate within the school setting; employ quality standards; promote a culture of health/school wellness; foster systems coordination; and engage in sound management practices that ensure sustainability (2016).

Delivering behavioral health services within a school setting allows providers to combat barriers to care such as providing appointments on site for low or no cost, continuity of care, reduction of stigma, and, most importantly, allowing for a greater number of students in need of care to access it (Bains & Diallo, 2015).

Further, behavioral health issues largely manifest during school-age and providing support for youth in a school setting allows for a greater chance of behavioral health care usage for them where they spend much of their time (Forman, Ward & Fixsen, 2017). Including schools in the partnership to promote health development for children and adolescents simplifies the delivery of accessible, effective, integrated prevention and intervention supports to students who need them most (Price, 2016).

Schools may partner with other organizations to provide behavioral health services outside of the designation of a SBHC, as many SBHCs located in schools may not be fully integrated within that setting. Instead, they may be organized, funded, and staffed by a Community Behavioral Health Organization (CBHO)[1] or local health organization such as a local hospital, behavioral health agency, Federally Qualified Health Center (FQHC), Certified Community Behavioral Health Clinic (CCBHC)[2], and/or public health department (Olson, 2011; David, 2017). In turn, schools deliver on-site, accessible, available, inclusive health care services to pre-kindergarten through twelfth grade students (SBHA, 2016). Designated (i.e., traditional SBHC) and non-designated centers provide services such as physical health screenings and preventative interventions, behavioral health (mental health and substance use), oral health, health education, and case management (Levine, 2015). Assessments of SBHCs providing behavioral health services, including those from off-site partner organizations, indicate that they help to support mental, behavioral, and social-emotional health of students, promote success in learning, and improve attendance and behavior (Center for School Mental Health, 2014).

The SBHA conducted a census of SBHCs during the 2013-2014 school year and 2,315 SBHCs were identified in the United States, with 94 percent of them on school property, serving over two million students (2016). The 2013-2014 SBHA census revealed that SBHCs are employing multidisciplinary teams to provide behavioral health (e.g., depression screenings), physical health (e.g., influenza immunizations, fluoride treatments, reproductive health), as well as preventive services (e.g., individual counseling for substance use, group-based services for positive youth development). SBHC teams mainly include primary care providers (100%), nursing and clinical support staff (69%), and behavioral health providers (67%); with fewer SBHCs employing oral health providers (18%), nutritionists/dieticians (17%), health educators (12%), and vision service providers (1%). SBHCs serve pre-kindergarten/K-12 (28%), elementary school (15%), middle school (9%), high school (23%), or other age groups (25%).[3] The 2013-2014 SBHA census also reports that the majority of SBHCs rely on state Medicaid funds (89%) to support services with fee-for-service being the dominant payment method (78.3%).

This descriptive study expands on the information collected in the 2013-2014 SBHA census by identifying the range of school-based behavioral health services offered in designated and non-designated centers. We hypothesize that services provided through “designated” SBHCs will not vary greatly, but services provided in “non-designated” settings will have more variability. Additionally, this variability is hypothesized to carry over to types of providers engaged in service provision as well as funding mechanisms. The National Council for Behavioral Health (National Council), in partnership with the Behavioral Health Workforce Research Center (BHWRC) at the University of Michigan, conducted the study to determine (1) common characteristics of schools and populations served; (2) funding sources; (3) types of behavioral health services offered and common characteristics of the workforce; and (4) barriers to service delivery.

[1] CBHOs provide outpatient services, case management/community support, recovery/health coaching, medication-assisted treatment and crisis response for individuals with behavioral health needs.

[2] CCBHCs are directly responsible for providing nine required types of services with a focus on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care. Through the demonstration project CCBHCs receive an enhanced Medicaid reimbursement rate.

[3] Grade levels were defined as elementary school (pre-k or kindergarten to five or six), middle school (six or seven to eight or nine), high school (nine or ten to twelve), all grades (pre-k or k to 12), and any other ranges.

Methods

Researchers from the BHWRC and National Council administered an online survey via Qualtrics. Survey questions were developed from a comprehensive review of empirical literature and expanded upon the 2013-2014 SBHA census. The survey focused on identifying the range of behavioral health services provided in schools by exploring the following themes:

- Characteristics of the behavioral health workforce practicing in school settings
- Common characteristics of the schools and student and family populations served
- Funding sources for service provision
- Types of behavioral health services offered
- Barriers to behavioral health service delivery

Survey participants included school social workers, school counselors, school nurses, and marriage and family therapists practicing in school settings. Participants were recruited from four membership organizations: 1) the School Social Work Association of America (SSWAA), 2) the American School Counselor Association (ASCA), 3) the National Association of School Nurses (NASN), and 4) the American Association for Marriage and Family Therapy (AAMFT). The survey was first piloted with approximately 20 school counselors working within elementary (5), middle (7) and high schools (8).

Upon considering feedback from the pilot study, the research survey was disseminated via email in July and August, 2018 to 1,000 school counselors and 1,000 school nurses with membership at their respective organizations (ASCA and NASN). Survey participants were randomly selected and stratified equally by state and grade level (334 elementary, 333 middle, and 333 high schools) for both sub-populations. Follow-up emails were sent to these two sub-groups approximately two weeks after the initial recruitment message. Survey dissemination to school social workers and marriage and family therapists followed different methodology. Language used in email recruitment messages for school counselors and school nurses was included in monthly electronic newsletters sent to all school social workers and marriage and family therapists with membership in the SSWAA and the AAMFT, respectively. The survey was sent to both membership organizations in monthly electronic newsletters in July and August, 2018.

The recruitment email sent to school counselors and school nurses, and the message included in electronic newsletters sent to school social workers and marriage and family therapists included information about the BHWRC and the National Council, the purpose of the study, and an anonymous weblink to the survey. The first 200 respondents who completed the survey were offered a $20 MasterCard gift card to compensate the time needed to complete the survey.

Results

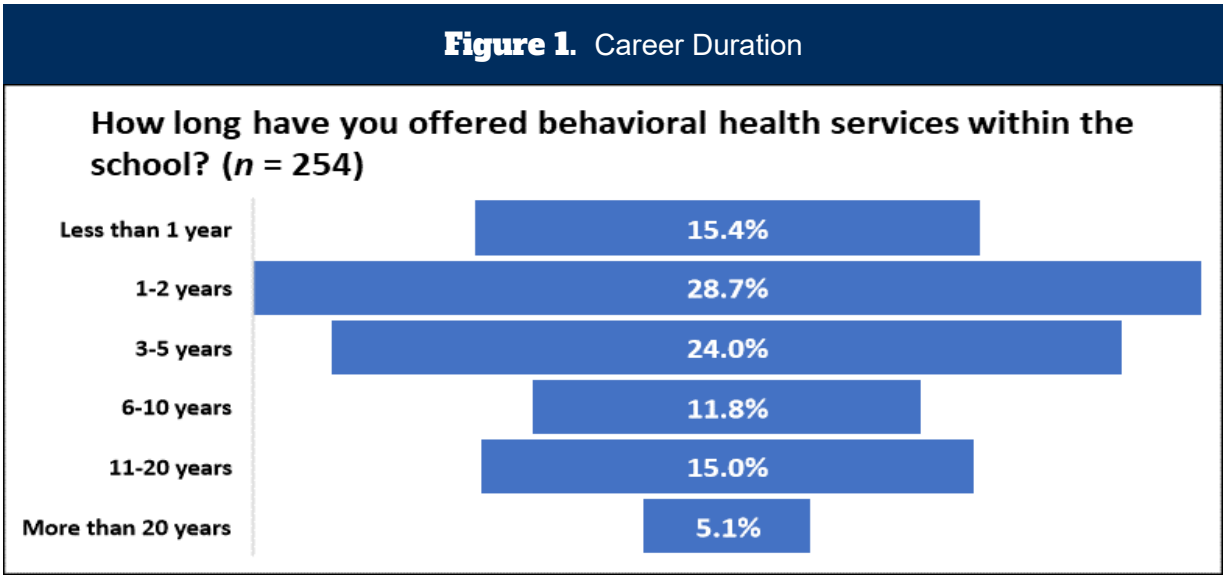
Common Characteristics of Schools and Populations Served

A total of 295 respondents were included in the sample. As shown in Table 1, the majority of the sample self-identified as being a school nurse (37%), school counselor (35%), or a marriage and family therapist (19%). Most participants had been offering school-based behavioral health services for 1-2 years (28.7%; see Figure 1).

Table 1: Professional Titles of Survey Respondents

Professional Title (select all that apply) (*n* = 259)	%
School nurse	**37.1%**
School counselor	**35.1%**
Marriage and Family Therapist (MFT)	**18.9%**
School social worker	**5.0%**
Other	**4.6%**
Licensed practical or vocational nurse or registered nurse	**2.7%**
Licensed Clinical Social Worker (LCSW)	**2.7%**
Health educator	**2.3%**
Licensed Mental Health Counselor (LMHC)	**1.5%**
In-training behavioral health provider	**1.2%**
Licensed Master Social Worker (LMSW)	**1.2%**
Psychologist	**0.8%**
Alcohol and drug counselor	**0.8%**

Figure 1. Career Duration

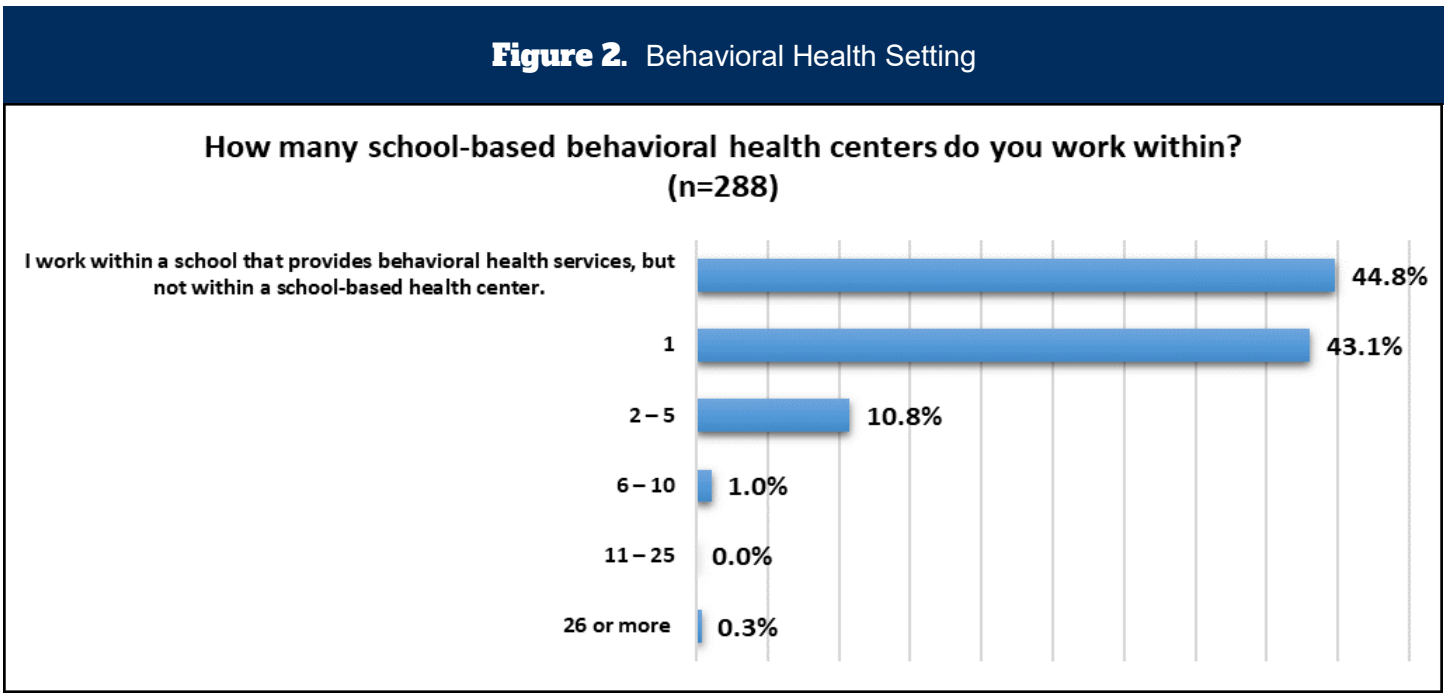


On average, almost half (49%) of survey respondents offer behavioral health services in schools between 0-10 hours per week, while 19% offer these services between 31-40 hours per week. The majority of respondents (77%) work in a traditional public school, and 40% of the sample worked in schools within suburban settings. Eighty-seven percent of respondents work in schools that serve greater than 500 students, and there was a fairly even distribution of respondents that serve elementary (52%), middle (39%), and high school (49%) aged students.

Sixty-four percent of respondents noted that they only serve students, with 36% serving some other population: families of students (29%), faculty/school personnel (16%), out-of-school youth (4%), and/or some other population (2%). According to the 2013-2014 SBHA census, 55.9% of census respondents report serving populations other than the students in school. Top populations are students from other schools (83.6%), family of student users (65.8%), out of school youth (61.4%), and faculty/school personnel (59.9%).

Figure 2 displays the proportions of survey respondents that work in a non-designated setting and those that work in a SBHC (45% and 55% respectively).

Figure 2. Behavioral Health Setting



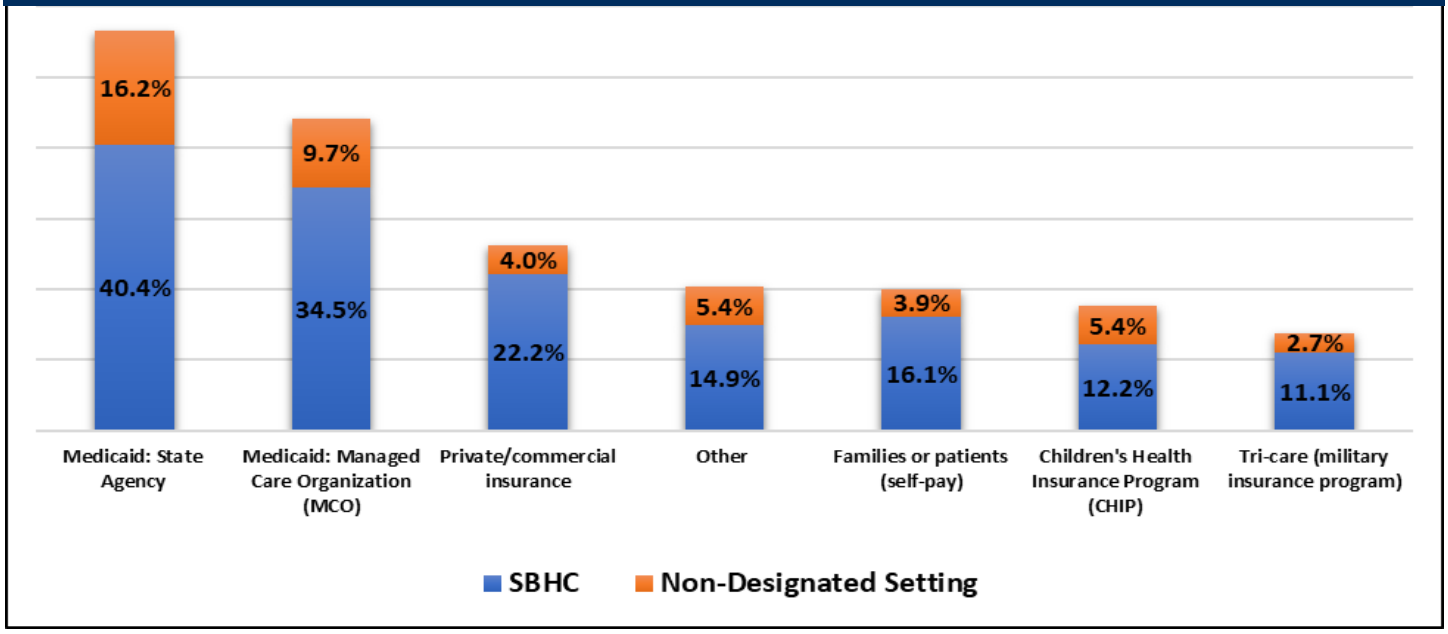
If respondents did not work in a traditional SBHC, subsequent survey responses were based on the one school where they provide behavioral health services for the most hours. If respondents did work in a SBHC, responses were based on the one school that they currently work within for the most hours.

Subsequent analyses compare respondents that work in a SBHC (*n* = 129) to those that do not (*n* = 159).

Funding Sources

When asked about sustainability and financing of behavioral health services, respondents noted that state Medicaid agencies and Medicaid Managed Care Organizations were the top funders of behavioral health services provided in both settings (see Figure 3). These findings align with findings from the 2013-2014 SBHA census that the majority of SBHCs (89%) rely on state Medicaid funds (89%) to support services with fee-for-service being the dominant payment method (78.3%).

Figure 3. Behavioral Health Funding Sources (*n* = 191)



Types of Behavioral Health Services Offered and Common Characteristics of the Workforce

Participants were asked to note which types of services they provide within the school setting. Table 2 displays the results of this investigation. Social/emotional well-being counseling was the most common behavioral health service provided within SBHCs (77.7%; 82.1% in non-designated centers). The most common behavioral health service provided within non-designated centers was crisis intervention (83.8%). The 2013-2014 SBHA census notes 59.6% of census respondents provide emotional health and well-being services. In terms of preventative services, the two most common services provided were: violence/bullying prevention and suicide prevention. These findings align with the 2013-2014 SBHA census data where violence prevention (75.8%) and suicide prevention (76.1%) were the topics most frequently covered.

Regarding substance use, national statistics indicate that almost 70 percent of high school seniors have tried alcohol, half have taken an illegal drug, nearly 40 percent have smoked a cigarette, and more than 20 percent have used a prescription drug for a nonmedical purpose (Johnston, et al., 2013). This points to a need for prevention services targeting youth. Results from the 2013-2014 SBHA census show that SBHCs are addressing these trends, as substance use was the most frequently covered topic by SBHC prevention and harm reduction counseling with individual students (79.7%). Findings from the current study, however, do not support these national statistics and school-based alcohol, drug, and tobacco prevention services are being offered at low rates, ranging from 19.7% to 32.5% of the time (Table 2).

Table 2: Type of Services Provided within Schools

Type of Services Provided within Schools (select all that apply)		
Behavioral Health Services		
	SBHC (*n*=139)	Non-designated center (*n*=117)
Social/Emotional well-being counseling	77.7%	82.1%
Crisis intervention	70.5%	83.8%
Classroom behavior/learning support	57.6%	76.1%
Individual counseling	61.9%	66.7%
Peer mediation / peer group counseling	42.4%	51.3%
Mental health screenings (e.g., depression, anxiety, ADHD, trauma)	42.4%	46.2%
Case management	44.6%	41%
Evaluation of need for individualized learning plans	37.4%	38.5%
Prescribing and managing mental health medications	12.2%	4.3%
Sexual assault counseling	10.1%	6%
Type of Service		
Prevention Services		
	SBHC (*n*=139)	Non-designated center (*n*=117)
Violence/bullying prevention (e.g., behavioral interventions)	54%	77.8%
Suicide prevention	46.8%	59%
Drug use prevention	32.4%	32.5%
Promote school safety and climate	23.7%	42.7%
Healthy eating / active living / weight management support	31.7%	23.9%
Alcohol use prevention	28.8%	25.6%
Tobacco prevention	25.2%	19.7%
Dropout prevention	16.5%	27.4%
Sexual orientation and gender diversity	19.4%	17.1%
Sexual and reproductive health (e.g., pregnancy testing, abstinence counseling, STD diagnosis and treatment, Papanicolaou [PAP] test)	13.7%	12.8%
Contraceptive Dispensing	2.9%	0.9%
Type of Service		
Additional Services		
	SBHC (*n*=139)	Non-designated center (*n*=117)
Career counseling	28.8%	33.3%
Education/secondary education counseling	20.9%	33.3%
Other	6.5%	4.3%

In this sample, SBHCs and non-designated centers offered comparable rates of drug use prevention (32.4% vs. 32.5%, respectively), while SBHCs offered slightly higher rates of alcohol use prevention (28.8% vs. 25.6%, respectively) and tobacco prevention (25.2% vs. 19.7%, respectively) than non-designated centers.

Most respondents utilize management information systems (MIS) or a practice management system (29.9%) in relation to the delivery of behavioral health services. This is followed by an electronic billing system (16.7%).

Barriers to Service Delivery

The top four barriers to service delivery (Table 3) reported by respondents included: insufficient funding (SBHCs: 56.5%, *n*=124; non-designated centers: 60.6%, *n*=104), having too few behavioral health providers (SBHCs: 47.6%; non-designated centers: 41.3%), lack of partnerships (SBHCs: 35.5%; non-designated centers: 47.1%), and lack of clarity on staff roles (SBHCs: 35.5%; non-designated centers: 45.2%). The 2013-2014 SBHA census did not include information on barriers but notes an increase in partnerships between schools and community health centers of FQHC look-alikes with an increase from 33% in 2011 to 43% in 2013. Although these partnerships benefit students, they may not provide comprehensive behavioral health services and schools would need to seek out other partnerships to fill this need.

Table 3: Barriers to Service Delivery

Type of Barriers Reported within Schools (select all that apply)		
	SBHC (*n*=124)	Non-designated center (*n*=104)
Insufficient funding	56.5%	60.6%
Too few behavioral health providers	47.6%	41.3%
Lack of available partnerships	35.5%	47.1%
Lack of clarity on staff roles	35.5%	45.2%
Administrative barriers	21.8%	26.0%
Inadequate communication between providers and teachers	16.9%	13.5%
Inadequate communication between providers and school administrators	12.1%	15.4%
Other	12.9%	11.5%
Inadequate communication between behavioral health providers at the school	12.2%	9.6%
Billing burdens	8.9%	4.8%

Administrative Barriers

Survey respondents were asked to provide comments on several categories of barriers. Many of the administrative barriers reported stemmed from the perceived lack of understanding by school administrators about the importance of providing behavioral health services in schools, or a lack of understanding about the role these behavioral health providers fill. Additionally, respondents noted the challenges of also having to complete administrative tasks in addition to providing counseling services. Respondents noted that communication between administrators and providers was greatly lacking, or non-existent.

Inadequate Communication Between Providers and Teachers, and Other Behavioral Health Providers

The time demands on both teachers and behavioral health providers was a common theme from the qualitative comments. Respondents noted that teachers do not have time to coordinate services, and they may not understand the role or how to access behavioral health providers. Privacy and Health Insurance Portability and Accountability Act (HIPAA) concerns were also noted both between providers, and between providers and teachers.

Resources and Support for More Efficient Service Delivery

Several key themes emerged from qualitative comments about additional resources or supports that would enhance behavioral health service delivery in school-based settings (Table 4). Overwhelmingly, the need for additional personnel and additional funding were noted as the top two needed resources. One respondent noted of the provider: student ratio: “Right now, we have two licenced marriage and family therapists for 9,000 general education students. One licenced marriage and family therapists and one licenced clinical social worker for Special Education students.” Another respondent noted that their current student: counselor ratio is 380:1.

Table 4: CPT Codes for Addiction Counselor Medicaid Reimbursement

Theme	Definition	Mentions
Additional Personnel	Comments on the need for additional staff, or varying levels of staff to provide behavioral health services	49
Additional Funding	Comments on the need for additional funding streams or more money to support service provision	31
Community Partnership	Comments on increasing, expanding, or exploring partnerships with other community-based organizations to facilitate transitions to varying levels of care	14
Administrative Support	Comments on the need for increased support from school administrators	12
Designated Space	Comments on the need for designated and private spaces to provide services	9
Stigma Reduction/Appreciation for Mental Health	Comments on decreasing stigma among service population and increasing the appreciation for behavioral health services at the administrator, teacher, and parent level	10
Time	Comments on the need for more staff time to provide services; related to additional personnel	6
Job Descriptions/Roles	Comments on the need for clear job descriptions and role delineation	5

In terms of community partnerships, common themes included generating partnerships to ensure that students have a service provider over the summer months or having more options for students that need different levels of care. Some less common comments touched on educational support and professional development for current providers and providing additional funding to ensure that current providers are paid competitive salaries.

Conclusions and Policy Recommendations

SBHCs provide behavioral health services for the children attending the host schools (Price, 2016). Although these centers have proven to offer necessary supports to students – services that may be essential but inaccessible to them outside of the school building – SBHCs are not available in every school (Olson, 2011). Findings from this descriptive study corroborate information available through the 2013-2014 SBHA census, with the exception of the provision of drug, alcohol, and tobacco use prevention. It should be noted that the survey sample populations for these two studies are distinctly different. This research targeted social workers, school counselors, school nurses, and marriage and family therapists while the SBHA disseminates their census and requests that the person who is most knowledgeable about care provided in the health center complete it. This may be the SBHC administrator, nurse practitioner, or clinical director.

The findings from this descriptive study indicate that the types of services offered within SBHCs and in non-designated centers were very similar to each other, and also similar to findings from the 2013-2014 SBHA census data. Specifically, social/emotional well-being counseling was the most common behavioral health service provided within SBHCs and non-designated centers, and the two most common preventative services provided were violence/bullying prevention and suicide prevention – findings that align with the 2013-2014 SBHA census data where violence prevention (75.8%) and suicide prevention (76.1%) were the topics most

frequently covered. Further, state Medicaid agencies and Medicaid Managed Care Organizations were the top funders of behavioral health services provided in designated and non-designated centers; a finding that was supported by 2013-2014 SBHA census data that the majority of SBHCs (89%) rely on state Medicaid funds to support services. Lastly, the barriers encountered in both settings were similar and each setting reported the same top four barriers to service delivery: insufficient funding, having too few behavioral health providers, the lack of partnerships, and a lack of clarity on staff roles.

This research targeted providers in school-based settings, and not administrators who may be more familiar with policy and procedures around service provision. Additionally, this sample is not as comprehensive as the sample through the 2013-2014 SBHA census and comparisons should be viewed with this in mind. The survey did not collect data on student engagement with substances; rather, this research focused on behavioral health services provided to students within school settings. Future research could explore if or how SBHCs are developing prevention programs on marijuana, e-cigarette use, and substance use screening.

The findings from this descriptive study indicate that SBHCs and non-designated centers fill a critical role in providing a range of behavioral health services for students of all ages. Regardless of the setting, a staffing structure that incorporates behavioral health providers strengthens the center and increases the value-add of including preventative mental health and substance use supports during a crucial age for developing problems in these areas (Cuellar, 2015; Forman, Ward & Fixsen, 2017). Also, building sustainable partnerships and leveraging existing funding mechanisms are critical for the success of these organizations. To improve the behavioral health services provided within SBHCs and non-designated centers, the following recommendations should be considered:

1. Encourage states to leverage current state funding infrastructures, including 1115 waivers that support innovate practices to support the work of Medicaid.
2. Focus on building partnerships with both school officials and behavioral health providers in the community and seek out funding that supports these partnerships such as the Delivery System Reform Incentive Payment (DSRIP) waivers.
3. Continue to support and expand mental health awareness programs, such as Youth Mental Health First Aid, that support and foster readiness to learn for all students.
4. Collaborate and/or partner with a Certified Community Behavioral Health Clinic (CCBHC) to increase student access to mental health and addiction services and treatment.

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