

POLICY BRIEF

Behavioral Health Services in School-Based Settings



Project Team

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Background

Academic problems are likely to arise for children with emotional disturbances, and teenagers who exhibit emotional disturbance have the highest rates of school dropout.¹ As behavioral health issues largely manifest during school age, 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.² The School-Based Health Alliance (SBHA) 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.”⁴ In their 2013–2014 school year census, the Alliance identified 2,315 SBHCs in the U.S., with 94% on school property, serving more than 2,000,000 students (2016). Additionally, schools may partner with other organizations to provide behavioral health services outside of the designation of an SBHC. 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 or local health organization such as a local hospital, behavioral health agency, Federally Qualified Health Center (FQHC), Certified Community Behavioral Health Clinic, or public health department.^{3,5} The resources that SBHCs provide increase students’ ability to access physical health and behavioral health care and improve their academic experience.

This descriptive study expands on the information collected in the 2013–2014 SBHA national census of SBHCs by identifying the range of school-based behavioral health services offered in designated and non-designated settings. The National Council for Behavioral Health, 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.

Methods

Researchers from BHWRC and the National Council for Behavioral Health administered an online survey using Qualtrics. Survey questions were developed from a comprehensive review of empirical literature and expanded upon the 2013–2014 census of SBHCs.

Survey participants included school social workers, school counselors, school nurses, and marriage and family therapists practicing in school settings, and were recruited from four membership organizations:

School Social Work Association of America (SSWAA); American School Counselor Association (ASCA); National Association of School Nurses (NASN); and American Association for Marriage and Family Therapy (AAMFT).

The survey was first piloted with approximately 20 school counselors from elementary (five), middle (seven), and high schools (eight). Upon considering feedback from the pilot study, the research survey was

disseminated via e-mail 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 subpopulations.

Survey dissemination to school social worker and marriage and family therapist populations followed different methodology. For these two subgroups, the same language used in e-mail 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 SSWAA and AAMFT membership, respectively.

Key Findings

Common Characteristics of Schools and Populations Served

A total of 295 respondents were included in the sample. The majority of the sample self-identified as being a school nurse (37%), school counsellor (35%), or a marriage and family therapist (19%). The majority of respondents (77%) work in a traditional public school, and 40% of schools are in suburban settings. Eighty-seven percent of respondents work in schools that serve more than 500 students, and there was a fairly even distribution of respondents that serve elementary (52%), middle (39%), and high school (49%) students. The majority of respondents (64.3%) noted that they only serve students, though families of students were also commonly served (28.7%). About 45% of respondents worked in a non-designated setting, and 55% worked in an SBHC.

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. These findings align with findings from the SBHA census that the majority of SBHCs (89%) rely on Medicaid funds to support services.

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

Participants were asked to note which types of services they provide within school setting. Table 1 summarizes the behavioral health services provided. Social/emotional well-being counseling was the most common behavioral health service provided within SBHCs and non-designated centers (77.7% and 82.1%, respectively). The SBHA notes 58% 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 are in line with the SBHA survey where violence prevention (64.7%) and suicide prevention (52.7%) were the topics covered most frequently. Additional services included prevention services and career/education counselling.

Table 1. 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, attention deficit hyperactivity disorder, 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%

Barriers to Service Delivery

The top four barriers to service delivery reported 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: 45.2%), and lack of clarity on staff roles (SBHCs: 35.5%; non-designated centers: 45.2%). The SBHA census did not include information on barriers but noted an increase in partnerships between schools and community health centers of FQHC look-alikes 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.

Conclusions & Policy Considerations

School-based health centers provide behavioral health services for the children attending the host schools.⁶ 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.⁵ Findings from this descriptive study corroborate information available through the SBHA census of SBHCs. 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, whereas the SBHA disseminates their census and requests that the person who is most knowledgeable about care provide 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 SBHA 2013–2014 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 SBHA survey where violence prevention (64.7%) and suicide prevention (52.7%) were the topics covered most frequently. Further, state Medicaid agencies and Medicaid Managed Care Organizations were the top funders of behavioral health services provided in both settings—a finding that was supported by SBHA census data that the majority of SBHCs (89%) rely on 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, a lack of partnerships, and a lack of clarity on staff roles.

Both SBHCs and non-designated centers fill a crucial 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.^{1,2} 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 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.

Acknowledgements

This project is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under the Cooperative Agreement for Regional Center for Health Workforce Studies #U81HP29300. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by SAMHSA, HRSA, HHS, or the U.S. Government.

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