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The Organization and Financing of School-Based Mental Health Services

The purpose of this chapter is to acquaint decision makers with the research that has been conducted on the organization and financing of school-based mental health services, what findings suggest, and where future research is necessary to promote SBMH service systems.

Research on Organization and Financing for SBMH

Little empirical knowledge exists about the organization and cost of providing mental health services in schools. It is estimated that the yearly cost of mental health services delivered in all settings to children and adolescents exceeds $11.68 billion or $172 per child (Ringel & Sturm, 2001). However, this estimate is based on an analysis of claims and survey data on mental health use for one year (1998) and generally excludes any costs from mental health support services delivered by school personnel. The purpose of this chapter is to acquaint decision-makers with the research that has been conducted on the organization and financing of school-based mental health services, what findings suggest, and where future research is necessary to promote SBMH service systems.

Organization of Mental Health Services in Schools

There have been two recent surveys reporting on the organization of school-based mental health services using a nationally representative sample of schools and districts or states. These two surveys include: The School Health Policies and Programs Study (SHPPS) 2000 (Brener, Martindale & Weist, 2001) and School Mental Health Services in the United States, 2002–2003 (Foster et al., 2005). Both of these surveys yield similar results and begin to document the immense efforts made by schools to supply mental health services to their students by using both school resources and contracting with community organizations such as mental health agencies. These efforts, however, differ by region of the country (Slade, 2003).

Both surveys document that the majority of schools offer some type of mental health or social service support to students, with 20% of all students receiving some type of school-supported mental health service. The most recent survey found that most schools provide individual counseling (76%), case management (71%), or group counseling (68%) to their students. The service most frequently reported as difficult to provide was family support,

and this has been documented in other studies as well (see Wagner et al., in press). For those schools delivering mental health services, most (96%) report that at least one school staff member is responsible for providing mental health services to students, while most schools have between two and five staff members delivering these services (Foster et al., 2005).

The most common administrative arrangement for the delivery of school mental health services is for schools to hire their own staff to provide mental health services and to augment these services through contracts with local community mental health providers. About half of all schools have a contract with a local provider to supply mental health services in the school (see Tables 6.1 and 6.2).

table 6.1

Results from the School Health Policies and Programs Study (SHPPS) 2000 Survey (Brener et al., 2001)

- 52% of states have a person who oversees or coordinates school mental health and social services while 63% of districts have a person who serves this role. More than three-fourths of schools (79%) have a person who oversees or coordinates mental health and social services at the school.
- 77% of schools have a part-time or full-time guidance counselor who provides mental health or social services to students at the school. In 66% of schools, a part-time or full-time school psychologist provides services to students.
- About one in ten schools (10.4%) and 25% of districts have a school-based health center (SBHC) that offers mental health and social services to students. Among the states (80%) with at least one SBHC, 87% have at least one that serves as a Medicaid Provider.
- 52% of schools (and 59% of districts) report having an arrangement with agencies or professionals independent of the school to supply mental health and social services to their students with most of these agencies (86%) being local mental health or social services agencies. Of the 59% of districts, 79% report these agencies provide identification or counseling services for mental or emotional disorders. Additionally, most districts offer case management (75%) for students with behavioral or social problems, family counseling (71%), and individual counseling (84%) under this arrangement.

table 6.2

How often various administrative arrangements for the delivery of mental health services are used in schools [a, b]

- School-financed student support services, in which school districts hire professional staff to provide traditional mental health services
  - 1/3 of school districts report that they exclusively use school- or district-based staff to provide mental health services
- Formal connections with community mental health services, in which formal agreements are made between schools and school districts and one or more community agency to provide mental health services and to enhance service coordination; the service can be co-located within the school or provided at the community agency
  - 1/4 of school districts only use outside agencies for the provision of mental health services
  - 49% of districts (55% of schools) have a contract with an outside agency to provide mental health services
- School-district mental health units or clinics, in which districts operate and finance their own mental health units or clinic that provides services, training, and/or consultation to schools, or districts organize multidisciplinary teams to provide a range of psychosocial and mental health services
  - 2% of school districts reported they operated their own mental health unit or clinic
  - 17% of schools reported having an agreement with a school-based center operated by a community-based organization to provide mental health services to their students
- Classroom-based curricula, which are activity-driven approaches aimed at optimizing learning by enhancing social and emotional growth. Interventions tend to be teacher-led and prevention-oriented
  - 59% of schools report using curriculum-based programs to enhance social and emotional functioning and reduce barriers to learning
  - 78% provide school-wide strategies to promote safe, drug free schools
- Comprehensive, multifaceted, and integrated approaches, in which districts bring multiple partners (e.g. community-based organizations) together to provide a full spectrum of services for children and youth with mental health needs. This approach would include such models as Systems of Care, in which an array of mental health and wraparound services are provided to children with mental health problems and their families via partnerships among various child-serving systems
  - 1/3 of schools rarely or never held interdisciplinary meetings among mental health staff or conducted joint planning sessions between mental health and other staff
  - 40% of schools held monthly or weekly interdisciplinary meetings and planning sessions

[a] The overarching categories and definitions for the administrative arrangement are from the Policy Leadership Cadre for Mental Health in Schools, 2001; and Weist, 1997;

[b] The data on the use of each administrative arrangement is supplied from Foster et al., 2005.

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Slade (2002) conducted an analysis of the effect on the use of community-based mental health services when mental health services are offered in the school. He concludes that "because few adolescents receive counseling in both school and non-school sectors in a given year, the data suggest that the school-based and community-based service sectors operate essentially as two parallel systems" (p. 163). This analysis provides evidence that the two systems do not compete with each other for clients or provide duplicate services for students.

Districts, rather than individual schools, have the authority to determine the types of mental health staff hired and the overall allocation of mental health resources in schools. Further, districts, rather than individual schools, have the authority and autonomy to determine the types of mental health services available for both general education and special education students. It is estimated that there are 358,000 staff at individual schools providing some type mental health service. The most common professional is a school counselor, where 52% of his or her time is spent in providing mental health services (Foster et al., 2005).

Funding of School-Based Mental Health Services

Little research has been produced on the financing of school-based mental health services. In their survey of districts and schools, Foster and her colleagues (2005) report that 58% of school district mental health budgets are designated for paying the salaries of mental health staff, while 26% are allocated to pay community-based organizations for the services they provide in schools. The remaining budget goes to providing technical assistance, professional development and training (8%), and various administrative expenses (8%).

Additionally, respondents to this survey reported that funding from the Individuals with Disabilities Education Act (IDEA) is the most frequently used federal source to finance mental health services (63%). Over half (55%) of respondents reported using state special education funds to pay for mental health services, 49% use local funds, 41% use State general funds, and 38% reported Medicaid reimbursement as a funding source.

Medicaid

It is estimated that Medicaid currently funds more than half of public mental health services administered by states. This increased use of Medicaid funding represents a major shift in the predominate model by which public mental health services are funded and delivered. In the past, the use of the mental health block grant and categorical grants such as the system of care grants were the dominate methods to pay for services (Buck, 2003; Mark et al., 2005).

Medicaid is based on the "3-E" principle of "Eligible Services for Eligible Clients by Eligible Providers" (Bundy & Wegener, 2000). To meet the requirements of Medicaid, all criteria must be met resulting in three areas that must be monitored in order to be in compliance with the mental health plans administered by each state's Medicaid office. In a project to document states' use of Medicaid and State Mental Health Authority funding to provide mental health services to children, researchers have documented extreme variations among states in both the number of children served and the funding of mental health services. Among states, there is a 14- to 17-fold difference between the lowest and highest measures of children served per thousand and an approximately 20-fold difference in average expenditure per child served (Dougherty Management Associates, 2005). These differences in number served and money spent demonstrate the impact of local policy on reaching the target population.

Three financing strategies have been used to maximize Medicaid to support health and mental health services for school-age children and youth (Bundy & Wegener, 2000). Under the "Fee for Service Claiming," Medicaid eligible services are reimbursed by the state Medicaid agency. Eligible services provided by school-based health clinics may be reimbursed by Medicaid using this mechanism. The second strategy is "Administrative Claiming" and many school staff activities that are related to student health and mental health are reimbursable through this mechanism. Activities can include Medicaid outreach, facilitating Medicaid enrollment, transportation and translation services, special education services and program planning, interagency collaboration, and administrative case management. The third strategy is for two or more agencies to create a partnership to "leverage" new and additional funding through Medicaid. An example of this strategy would be a partnership between a public school district and a mental health agency. Another leveraging strategy suggested by advocates is the greater integration of Medicaid and IDEA for youth who qualify for both (Bazelon Center for Mental Health Law, 2003). While it is generally believed that all of these strategies are being used to finance school-based mental health services, little national information on actual use is currently available.

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Summary

While there is only limited information on the financing and organization of school-based mental health services, the information that is available comes from surveys conducted with nationally representative samples of schools and therefore can be thought of as a valid description of the broad landscape. The results from these surveys support the notion that schools are a major provider of mental health services to children

and adolescents with most schools providing some type of mental health service. Staff supervised by the school system provide these mental health services most often. A significant number of schools, almost half, contract with local mental health providers to augment the mental health services provided by school staff.

Currently, schools are blending an array of federal, state, and local funds to support the delivery of mental health services in schools. The decision-making processes and magnitude to which each of these sources is used to fund different types of mental health services are currently unknown. There are, however, numerous descriptive examples of communities that have braided various funding streams to support school–based mental health (see Evans et al., 2003 and Robinson, Barrett, Tunkelrott, & Kim, 2000, for examples of descriptive case studies), and these descriptions of innovative financing mechanisms provide a foundation upon which to build future research.