

The Federal Case for School-Based Mental Health Services and Supports

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By all indicators, the need for mental health services has been more not less. Not everybody is in agreement that schools should be doing this. The long and short of it is there is some confusion about what constitutes mental health.—U.S. Department of Education official, 2006

Provision of health care in schools is a logical component of an advanced industrial society; however, health care providers have struggled to make universal school health and mental health a reality. Despite the President's New Freedom Commission Report that stressed the need for school-based mental health in the context of a wider public health agenda, school mental health services and supports continue to be fragmented.¹ Instead of riding a wave of new resources, knowledge, and a quality focus, the school-based mental health movement struggles to answer basic questions about identity. Is school mental health the provision of services similar to those found in a community mental health center? Is it psychosocial services? Or is it a cluster of prevention strategies that engage the entire school?

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These questions remain largely unanswered. Federal and state health policy is not only a necessary component of any strategy to advance mental health for children and youth but also requires consideration of issues central to the identity of school-based programs: what is at stake, how services are integrated, and who pays.

CHILDREN AND YOUTHS WITH BEHAVIORAL PROBLEMS FAIL IN U.S. SCHOOLS

We know what is at stake. Children and youth with emotional and behavioral problems have poorer academic outcomes than children with other disabilities.^{2,3} They experience lower levels of social adjustment and are more likely to be the subject of bullying and disciplinary actions.^{3,4} Yet, research shows a clear connection between social and emotional learning and academic achievement.^{5,6} Social and emotional learning in schools facilitated academic learning in later grades.^{7,8} When combined with a strong parent component, it also improved family and youth engagement and youth outcomes.⁹

Despite this evidence in support of school-based mental health services and supports, many schools still do not have access to prevention and intervention strategies. Of those schools that do, there is little evidence of the quality or effectiveness of the services provided.¹⁰ Indeed, some data suggest that the quality of the care provided is highly variable.^{11,12} As Lucille Eber, a longtime mental health intervention specialist notes, "A lot of people [are] just planting clinicians in buildings and hanging a shingle with no intention of changing the culture of schools" (Lucille Eber, Ed.D., Statewide Coordinator, Illinois EBD/PBIS Network, oral communication, February 1, 2006).

GREATER POLICY SUPPORT FOR SCHOOL-BASED HEALTH SERVICES AND SUPPORTS IS NEEDED

A comprehensive school-based mental health strategy requires federal and state agencies, but federal and state policies do not ordinarily support applying our best knowledge of effective mental health practice in school settings. Use of prevention science is patchy, and those who try to push a research-based agenda appear to be working against the political grain. The present incremental approach draws resources away from a public-health, evidence-based focus to mental health in schools.¹³

Some states have legislatively mandated support to promote social emotional health in schools (e.g., Indiana, Illinois, and New York).¹⁴⁻¹⁶ Initial findings from the Unclaimed Children Revisited State Children's Mental Health Directors' Survey suggest a substantial state-based foundation. Figure 1 shows that state children's mental health authorities are engaged in a variety of strategies to support mental health initiatives in schools. Nearly 43% of states report statewide implementation (not shown; Fig. 1).

Developing the empirical support for these initiatives is essential. Funded in a number of communities through the federal Safe Schools Healthy Students Initiative (e.g., Garfield Heights and Cleveland Heights in Ohio, New York City, and Los Angeles), whole-school strategies that include evidence-based mental health care and supports demonstrate early successes. These range from promotion of social and emotional

learning and skills development (e.g., PATHS curriculum in Chicago, Collaborative for Academic, Social, and Emotional Learning supported initiatives), to prevention and early intervention (e.g., positive behavioral interventions and supports [PBIS]) and school-based treatment models. Evidence-based substance use disorder prevention and treatment in schools is also gaining traction (e.g., Olympia, WA). To move beyond demonstrations, these initiatives must be backed by federal and state policies.

Whole-school initiatives are not without their detractors. Critics point to poor family engagement components and weak links to community-based mental health services; however, some communities are addressing these shortcomings. Several initiatives link whole-school strategies like PBIS to community-based mental health care (e.g., Bridgeport, CT, Worcester, MA). In a few states, policymakers and practitioners also are strengthening the family- and youth-engagement components of school-based mental health.¹⁷ For example, a Minnesota statute requires teacher training on the early signs of mental health problems as a criteria for certification. The Minnesota Association for Children's Mental Health, a family advocacy organization, conducts this training. New York's Parent Empowerment Program trains parents to better access mental health services and supports in schools. Last, several state efforts link a model of school, family, and community partnerships and whole-schools strategies.¹⁸

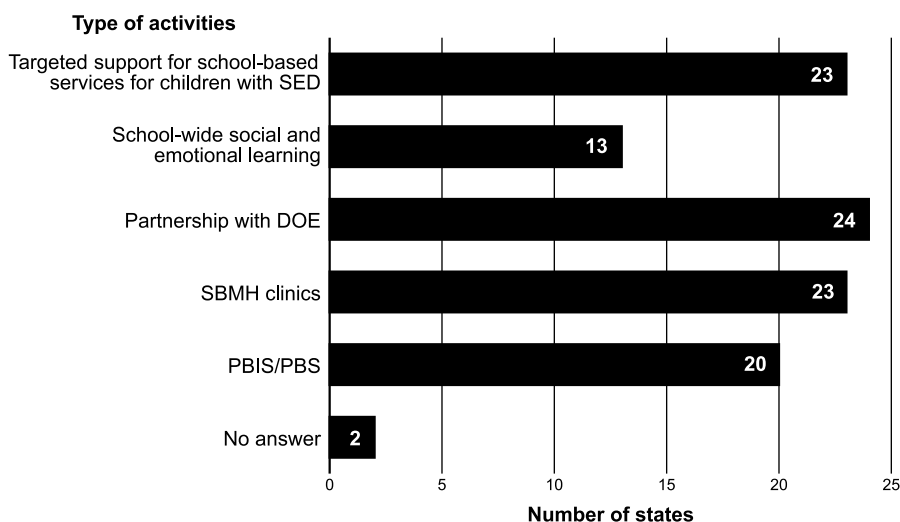


Fig. 1 Types of mental health services and strategies that children's mental health authorities' support. DOE = Department of Education; PBIS/PBS = positive behavioral interventions and supports; SBMH = school-based mental health; SED = serious emotional disturbance.

SUPPORTIVE FISCAL POLICY IS SORELY LACKING

Seriously considering the nature of school-based mental health services necessarily involves examination of fiscal policies that support them. In a recent study, most of the schools surveyed reported funding barriers to providing mental health services and supports, with half reporting restrictions on funding.¹³ In addition, almost three fourths noted decreased or flat levels of funding.¹³ The net effect of budgetary pressures was more outside referrals (reported by 60% of schools) at a time of increased needs but unchanged levels of service capacity.¹³ Resources are also required to support improvements in quality. Throughout the United States, school-based mental health professionals are expected to deliver high-quality care, but often lack appropriate skills and tools to assess and treat.¹⁹ They often work in suboptimal physical and social conditions.²⁰

To make school-based mental health services integral to the health care delivery system, its financing needs to be part of the mainstream of health care financing. This requires that proponents of school-based mental health care articulate why these strategies collectively form an essential component of any serious health policy discussion. Urgently needed, then, is a comprehensive proposal to improve access to mental health for children and youths through the schools that goes beyond the current tinkering for marginal effect. Instead, it requires a three-pronged approach that clarifies the case for federal funding. Proponents must first garner support to address geographic inequities by illuminating the state differences in school-based mental health financing.²¹ Second, they must highlight and support those elements of newly proposed Medicaid rules that reinforce a critical role for school-based mental health services.²² Other related language, without modification, threatens to undermine community mental health capacity, particularly Medicaid funding for services deemed “integral” to nonmedical programs, such as case management. A third strategy involves identifying alternative ways to address collaborative financing. Historically low federal contributions to local education funding (<10%), tough state and local struggles to fund noninstructional services and supports, and arduous and politically charged efforts to raise revenues through property taxes (particularly where the tax base is low) cries out for a re-examination of education’s role in

mental health financing.²³ Finally, proponents must advance an agenda that links funding and shared outcomes, including academic outcomes.

BOLD FEDERAL ACTION CAN DISMANTLE APPARENT INCOMPATIBLE POLICIES AND CULTURES

Advancing the school-based mental health agenda requires more than money. Equally important is bold federal action bolstered by the tenacity to wade through an avalanche of legislative processes, eliminate interest group-driven political stalemate, and overcome philosophical disagreements. At least 11 Congressional committees and their corresponding subcommittees and required hearings stand between a bill and a legally mandated comprehensive national school mental health strategy. Numerous stakeholders with competing agendas need to weigh in. Legislative procedures and politics aside, education and health often value policy choices that in implementation may lead to conflict and stymie progress. For example, is the education policy that seeks to perpetually raise the academic achievement bar for students always consistent with their optimal mental health? Yet, the mental health community recognizes that schools often rank as a critical linchpin for students’ resilience.²⁴ Similarly, is a health and mental health perspective in which the school is simply a different care delivery venue the most beneficial for the student? From an educator’s perspective in which the presence of health care provider enables schools to “unburden” their “problem” students with no supportive cultural changes may be of limited value. Working together to articulate and achieve shared goals can potentially thwart resistance to change and encourage collaboration.

Education and mental health also face other common implementation challenges related to quality and privacy. As in child mental health, widespread adoption of evidence-based practices in education is slow, particularly those supportive of students’ diverse learning needs.²⁵ Furthermore, field-specific privacy protections can hamper information sharing that is critical to an integrated model. The Health Insurance Portability and Accountability Act (HIPAA), health care’s privacy regulation, permits the sharing of medical information only with parental consent or youth consent in states where minors can consent to care.²⁶ The Family Educational Rights and Privacy Act

(FERPA), education's privacy mandate, requires parental consent to share education records and allows parental access to educational records.²⁷ Data shared by mental health personnel with schools are subject to FERPA. Both laws support a transparent information disclosure process. In the school setting, they can be a potential barrier to collaboration.

These confidentiality-related obligations engender deep concerns and even disagreements particularly regarding litigation. Schools must tell parents when staff learn information that potentially endangers students.²⁸ Both HIPAA and FERPA permit disclosures without consent to protect the health and safety of others. Therein rests the implementation conundrum. One administrator's proactive request for information may be perceived as overreaching and risk adverse. In general, information-sharing barriers can be resolved by obtaining parental consent. Comprehensive integrated school-based mental health programs must commit to obtaining consent and to educating and training all personnel, families, and students in the parameters of confidentiality.

In school-based mental health, two major reforms occupy the policy landscape. The President's New Freedom Commission report highlighted screening as a centerpiece of its public health approach. In some schools, it fomented significant controversy. It surfaced deep-seated cultural clashes, featuring contestations about mental illness, parental autonomy and the school's role, and stigma. In education, No Child Left Behind (NCLB) promised to radically improve educational outcomes.²⁹ It requires schools to attend to factors that impede student achievement. It also creates an obligation, through Title V, to address the social and emotional health of students. In implementation, these promises fall short. More than 70% of school psychologists surveyed report negative effects associated with NCLB, such as overstretched school personnel and students.³⁰ In addition, more than 30% of them also report acting as building or district test coordinators. Districts report that NCLB-related spending increases tax already stretched mental health funding and that they sometimes shift funds and staff earmarked for mental health to support NCLB programs or testing.¹³ Fortunately, these policy and legal touchstones afford families and youths wide latitude for input and choice. Proponents of school-based mental health would be well served by enlisting them as partners.

PROGRESS EMBEDDED IN A FRAMEWORK BASED ON SHARED ACCOUNTABILITY

To move forward, school mental health supporters must recognize schools as equal partners with mental health. With crucially needed federal support, they must confront three challenges: how to help teachers better work with students with serious behavioral problems, how to build a framework of shared responsibility between schools and mental health, and how to hold leaders of health and education jointly accountable for improved mental health outcomes for children and youths.

Policymakers at all levels should promote a compact between education and mental health based on clear expectations, agreed-on outcomes, and joint periodic public reporting of progress toward those outcomes. At a minimum, schools should be able to expect from mental health authorities and providers onsite mental health consultation and treatment, coordination with off-site mental health specialists, expertise in trauma and crisis, and participation in whole school prevention strategies. Mental health authorities and specialists must be able to rely on schools to support social emotional learning in consultation with mental health experts, to consult on individual child and family service planning and supports, and to create and maintain safe, caring, cooperative, and well-managed learning environments for children, youths, and their families.

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