A SCHOOL BASED MENTAL HEALTH SERVICES (SBMHS) WHITE PAPER

BEHAVIORAL HEALTH CONSIDERATIONS FOR SCHOOL-BASED MENTAL HEALTH SERVICES (SBMHS): A CALL FOR INTEGRATION AND INFRASTRUCTURE

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RECOMMENDED ACTION PLAN

- *EXAMINE THE OPPORTUNITIES FOR SCHOOL COMMUNITY PARTNERSHIPS IN THE DELIVERY OF SCHOOL BASED MENTAL HEALTH SERVICES THAT ULTIMATELY SUPPORT A TIERED APPROACH TO BEHAVIORAL HEALTH CARE FOR SCHOOL AGED YOUTH AND FAMILIES*
- *INCORPORATE STRATEGIES FOR FUNDING FOR SCHOOL BASED MENTAL HEALTH SERVICES IN ALIGNMENT WITH LOCAL, STATE, AND NATIONAL INITIATIVES THAT ADDRESS BUILDING A QUALIFIED BEHAVIORAL HEALTH WORKFORCE*
- *IMPLEMENT INCREASED ACCESS TO EVIDENCE-BASED TREATMENTS FOR YOUTH AND FAMILIES, PARTICULARLY IN UNDERSERVED COMMUNITIES*

ACKNOWLEDGMENT:

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To hear Executive Summary

EXECUTIVE SUMMARY

- *Behavioral health climate*
- *Research supports a tiered, systemic and collaborative approach to SBMHS*
- *Alignment with national strategic initiatives*
- *Advancing specialized treatment and access to research based interventions*

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EXECUTIVE SUMMARY AND INTRODUCTION

EXECUTIVE SUMMARY

Rising behavioral health symptoms and subsequent lack of access to behavioral health care is a significant problem affecting our school aged youth and their families. In response to startling behavioral health indicators and continued acts of school violence, legislators are increasingly urged to fund more school-based mental health professionals. However, the school system as a primary point of intervention warrants further examination as a strategic investment in improving behavioral health outcomes and in response to school violence.

While there is abundant research suggesting more school-based behavioral health professionals are the answer (e.g., National Association of School Psychologists, 2013; Teasley, 2018), there is little to connect the dots from the addition of behavioral health staffing to improved behavioral health outcomes and access to care from this investment alone. Michigan's 31(n) legislation, while indicative of a swift and timely solution to support school based mental health services (SBMHS), overlooks the complexity of the solutions and community collaborations that can support behavioral health outcomes for school aged youth and families. Moreover, tackling this problem is an intricate and systemic undertaking (Cohen, 2021) that should consider supports for the youth and family unit together, behavioral health workforce shortages and distributions, and already established national initiatives to improve youth and family access to evidence-based care, such as recommended by the Substance Abuse and Mental Health Services Administration, National Alliance on Mental Illness, and Centers for Medicare and Medicaid.

This white paper highlights three main points addressing why complementary strategies for 31(n) legislation that do more than add behavioral health providers directly to the school system are needed.

THREE MAIN POINTS:

First, the best research available on SBMHS includes implementing tiered, systemic approaches that partner and collaborate with families and communities to support the full range of needs for school aged youth and families. This involves sharing funding and community resources that include the behavioral health workforce itself. In this way, each partners' expertise and resources can be maximized to best meet the needs of youth and families.

Second, legislators and policy makers should consider investing in infrastructure and collaborative partnerships that engage school systems and community partners around behavioral health capacity. These strategies not only align strategically with national health workforce initiatives, but they also support minimizing the maldistribution of behavioral health providers. Investments in partnership and capacity building can ultimately help communities develop a capable, well-supported behavioral health workforce that can deliver the very tiered system approach most recommended in the research.

Third, improving specialized behavioral healthcare through access to evidence-based treatment remains a national imperative. Bringing evidenced-based practices to communities has been a longstanding aim of community mental health providers, as has been their commitment to building the infrastructure for delivering specialized care. Encouraging partnerships between schools and community mental health service providers can not only support evidence-based practice implementation efforts; it can also build collaboration with schools to share the responsibility for training and supporting practitioners.

These points, considered together, ultimately call for investment that can improve community-wide access to specialized care for youth and families. To target the dismal rates of access to care reflected in the prevalence data, collaborative solutions need to be implemented. This paper recommends that the call to invest in SBMHS be just that – a requirement at the community level to a system of care supporting school age youth and their families that includes access to specialized behavioral healthcare. At the forefront, 31(n) efforts should require meaningful collaborative partnerships with families and community providers that promote the stability of a behavioral health workforce able to support youth and families. The following points are expanded upon to support these assertions and conclude with specific recommendations.

INTRODUCTION

Behavioral Health Climate for School Age Youth

Prevalence data on behavioral health

Millions of school age youth experience mental health concerns that significantly impact their overall health and their ability to take part in their learning environments (Rafa et al., 2021). National prevalence data estimate almost eight million youth met criteria for at least one diagnosable behavioral health disorder (Whitney & Peterson, 2019) and that as many as 44% of youth felt persistently sad or hopeless in the past year (Centers for Disease Control and Prevention [CDC], 2021). Half of all mental health disorders initiate by age 14 (National Alliance on Mental Illness [NAMI], n.d.). This estimate includes disorders such as anxiety, depression, drug addiction, alcohol use, and exposure to bullying behavior (Pew Research Center, 2019), in addition to behavioral and developmental problems such as attention-deficit/hyperactivity disorder, oppositional defiance, and conduct problems (CDC, 2018). Our school age youth remain at high risk for early death, as suicide continues to be the second leading cause of death for youth ages 12-17 (CDC, 2018). Further, we know that youth living in poverty are at a disproportionate risk for developing behavioral or developmental disorders (CDC, n.d.). Currently in Michigan this impacts 18% of our youth (Kids Count, 2019).

Global estimates during the COVID-19 pandemic suggest behavioral health disorders in youth have doubled since the last decade, putting increased pressure on sustainable efforts to address these health disparities in youth and their families (Racine et al., 2021). In Michigan, community mental health providers are reporting increased requests for services for youth and families. For example, screenings for youth psychiatric hospitalization have risen 344% post-COVID (C. Conklin, personal communication, June 16, 2022).

School violence data indicate at least one incident of theft or other crime in over 70% of schools (Wang et al., 2020). Devastatingly, occurrences of multiple victim homicides are increasing in our school systems (Frederique, 2020). To address these alarming data and trends, bold solutions must be enacted that offer school aged youth and family access to prevention programming, behavioral health supports, and specialized interventions.

INTRODUCTION

Access to behavioral health care

Legislative efforts and task forces designed to address supports to school aged youth are prevalent at the national, state, and local levels. These efforts consistently identify the need to build infrastructure that can support early identification of needs and access to specialized care for not just youth, but their families (i.e., Michigan Department of Health and Human Services [MDHHS], National Alliance on Mental Illness [NAMI]; Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). Yet, despite these calls for action, regrettably less than half of youth identified with behavioral health disorders receive needed treatment from a mental health care professional (Whitney & Peterson, 2019).

Lack of access to behavioral healthcare is attributed not only to a lack of behavioral health care providers, but also to inefficiencies in behavioral healthcare provider distribution among communities (Kepley & Streeter, 2018; United States Department of Health and Human Services [USDHHS], 2017). Particularly at risk are youth who have more significant mental health symptoms that impair their functioning in their home, school, or community (serious emotional disturbance [SED]). Sadly, four out of five youth with SED symptoms do not receive needed services, and less than 17% of youth have access to substance use disorder treatment (SAMSHA & CMS, 2019). Further, the unavailability of child psychiatric placements remain a known issue, with youth waiting upwards of 30 days for placement in some situations (C. Conklin, personal communication, June 16, 2022).

Data consistently show over time that the most promising long-term outcomes for treating behavioral health problems in youth comes from treatment models that engage the family system in behavioral health care (e.g., Robbins et al., 2016; Szapocznik & Hervis, 2020). Moving evidence-based treatments into community care has been a long-standing priority for federal and state agencies who understand it as a complex undertaking (e.g., American Psychological Association [APA], 2018; NAMI, n.d.; SAMSHA, 2020). Continued emphasis on specialized behavioral healthcare that engages youth with their families in treatment and infrastructure that can support access to mental health treatment is crucial toward the aim of improving behavioral health outcomes.

INTRODUCTION

School climate and violence

Fifty-three million school age youth are enrolled in the public school system in the United States (United States Census, 2019). While public school continues to be the primary education setting for United States youth, recent prevalence data affirms the rate of homeschooled youth has tripled since 2019 to about five million (United States Census, 2021). Reasons for transition to homeschooling have included not only the pandemic, but issues of distress and relational problems between families and schools around the treatment of youth with disabilities (Green-Hennessy & Mariotti, 2021). Trends for homeschooling are also rationalized by parents as a safer option; one way to protect youth from bullying behavior and school shootings (Brewer, 2021). These trends are particularly concerning for youth and families who may benefit from formalized supports that can be offered in the public-school setting.

While violence in the schools is on the decline since the early 2000's, incidences of homicidal school violence is not (Frederique, 2020). In addition to many other states in the US, Michigan schools have suffered greatly with school homicide (e.g., Associated Press, 2022). The profile of a school shooter is complex. Typically, this is a youth who has experienced bullying or social isolation themselves, is revenge seeking, has access to guns at home, has exposure to aggressive media, i.e., video games, and has likely suffered a loss (Paolini, 2015; Teasley, 2018). If taking psychotropic medication, they are likely not compliant with it (Paolini, 2015). This profile suggests many factors contributing to school homicide. The CDC (n.d.) calls for schools to enact comprehensive best practices for violence prevention that incorporates relationship building and community assets e.g., psychoeducational training around social media use.

Schools represent not only an important developmental milieu, but a vital community institution that can partner to deliver much needed behavioral support to youth and families. It is no surprise that increased attention on school systems as a place for behavioral health intervention has been suggested following more recent school shootings and significant behavioral health indicators (Cammack et al., 2014; Michigan Department of Health and Human Services [MDHHS], 2021; SAMHSA, n.d.). This attention is logical when considering that support to school age youth and their families in

their home and school environments is essential to impacting their health outcomes and influences social determinants of health domains, i.e., education access and quality, health care access and quality, and neighborhood/built environment (Alegria et al., 2018; Healthy People, n.d.).

Since fiscal year 2018-2019, Michigan has designated funds to add licensed behavioral health providers in the schools (Michigan Department of Health and Human Services [MDHHS], 2021). Referred to as 31(n) legislation (State School Aid Act, 1979), the stated overall intent is to increase provision of mental health and support services in the school for general education students throughout Michigan. 31(n) funding includes dollars for placing licensed master's level behavioral health providers in schools that do not have services available for general education students, and dollars to intermediate school districts for mental health support services and administration around the intent of the legislation. However, the call to invest in school based mental health services (SBMHS) is recommended to be a collaborative and systemic approach; one that incorporates entirety of systems supporting the school age youth and promotes meaningful partnerships with family and community partners (Cohen, 2021).

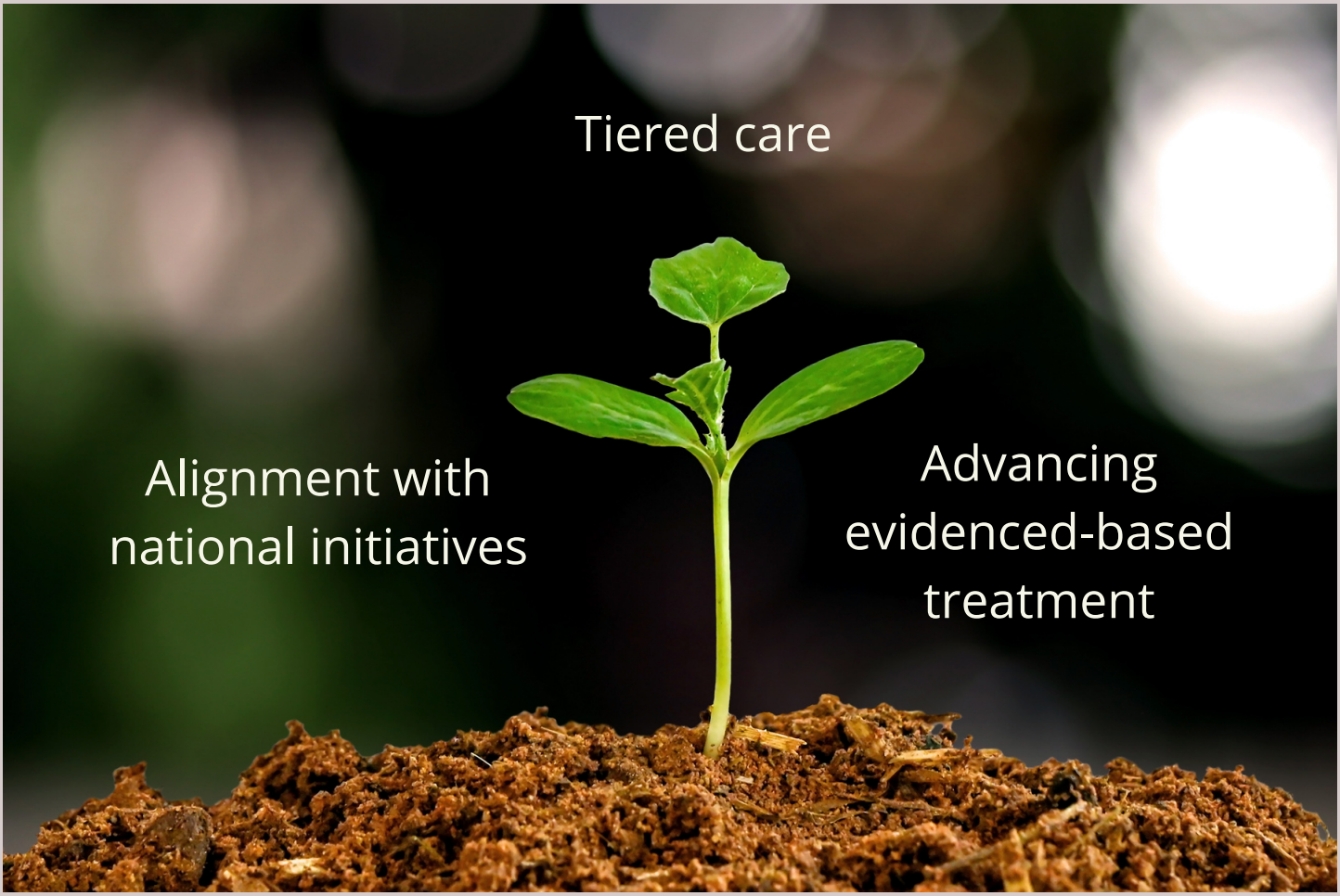
A call to action for a coordinated response

Rising behavioral health symptoms and violence in our schools calls for immediate action. In response, current research points to a need for more school-based mental health professionals (Teasley et al., 2018). Yet, the addition of more school-based mental health professionals is a short-sighted response when considering prevalence data alongside the many national and state calls to action that highlight strategy that can improve access to care (e.g., SAMHSA, NAMI, CMS). Behavioral health workforce shortages, lack of access to specialized, evidenced-based behavioral healthcare, and the commitment to supporting youth and families are all concurrent needs.

Community behavioral healthcare providers and schools share responsibility for addressing the behavioral health needs of youth and families. Building infrastructure to support this shared responsibility is critical. Equally critical are funding strategies that bond partnerships and address community level approaches to care as complex as the data itself.

INTRODUCTION

This white paper is organized in a three-point format which highlights and supports: 1) best practice research on SBMHS, including a collaborative tiered system of care, 2) infrastructure and partnerships that can maximize access to and reach of behavioral health providers, and 3) improved access to specialized care – bringing research informed practices to communities. These points together highlight why developing and implementing complementary strategies for 31(n) legislation that 1) mandate innovative community partnerships, and 2) promote synergy when adding behavioral health providers are necessary. In the end, this provides the best opportunity to improve community-wide access to specialized care and improve outcomes for youth and families.



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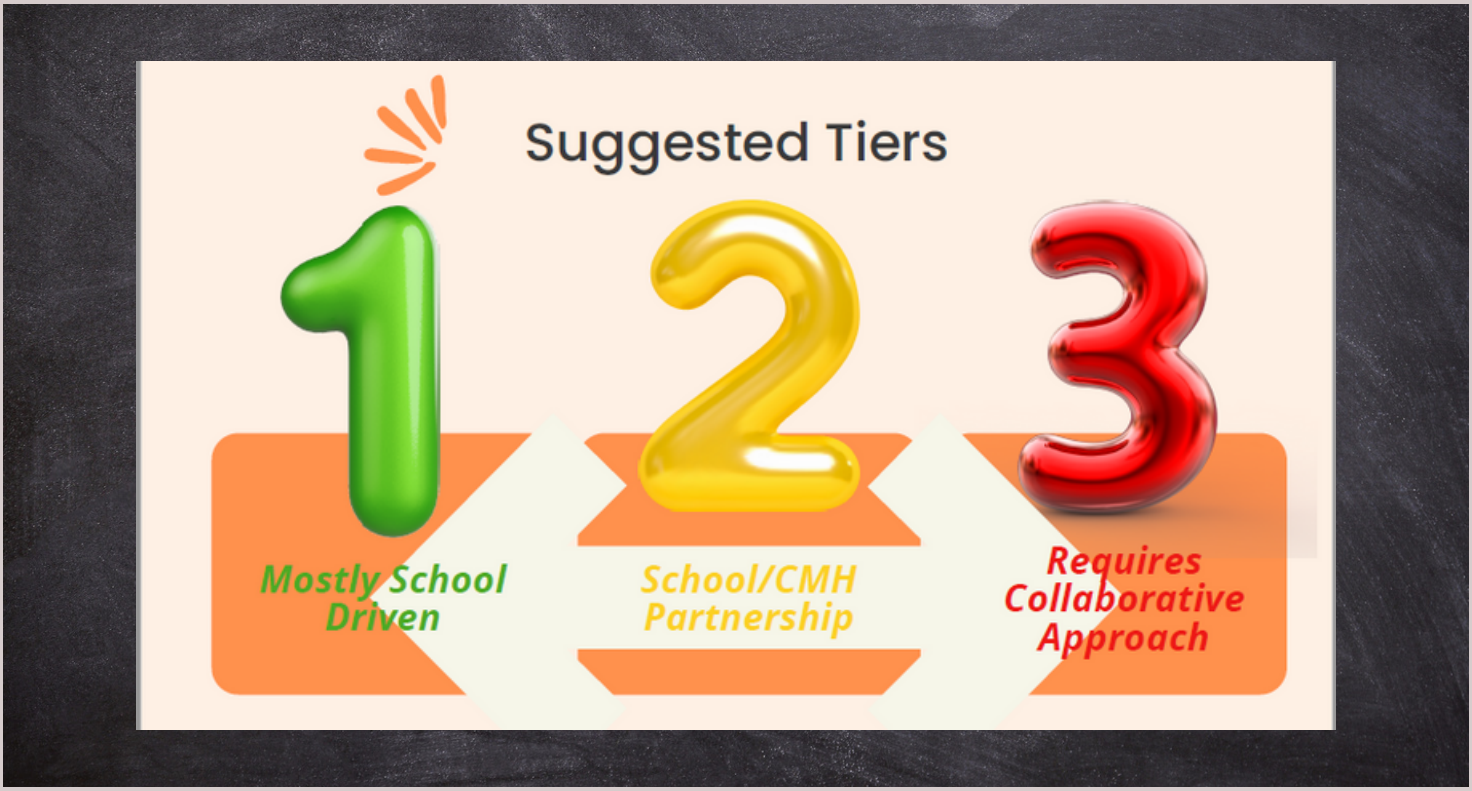
SECTION

POINT 1: TIERED SYTEM OF SUPPORT



POINT 1: RESEARCH SUPPORTS SYSTEMIC AND COLLABORATIVE APPROACHES TO IMPLEMENTING SCHOOL-BASED MENTAL HEALTH SERVICES (SBMHS), THROUGH A TIERED SYSTEM OF CARE.

Best practices for SBMHS includes implementing tiered, systemic approaches that partner and collaborate with families and communities to support school aged youth. While data are clear that school systems offer many benefits to support behavioral healthcare efforts, overall, the research is somewhat limited on the provision of and outcomes from those services. Currently in Michigan, spending for more mental health services for K-12 students is proposed to increase by $361 million (Bridge Michigan, 2022). This signals a significant investment in behavioral healthcare for school age youth and families. At the same time increased 31(n) dollars are being earmarked for SBMHS, there is little to suggest that increased dollars for more behavioral health staff in the school settings is the answer. How this investment ties to the best practices known for addressing behavioral health for school age youth and families is of the utmost importance to consider. 31(n) legislation and funding that can leverage access to school age youth and strengthen partnerships to support a tiered approach to SBMHS is needed.

Perhaps the best guidance on considering a tiered system of support come from the Guidance to States Bulletin (SAMHSA & CMS, 2019) and the Handbook of School Mental Health (Weist et al., 2014). Both endorse SBMHS that include universal assessment and prevention strategies through access to specialized care for students based on medical necessity. The tiered approach aligns with best practice research and supports a collaborative aim to providing behavioral healthcare. Tiers 1-3 are elaborated on below and organized as 1) mostly school driven, 2) school and community mental health partnerships, and 3) required collaborative approach (specialized care).

POINT 1: TIER 1

SAMHSA & CMS (2019) explain Tier 1 supports to include activities such as screening/assessment, social-emotional curriculum, and prevention activities geared toward healthy functioning in a school climate (p.3). While these supports may or may not include partnerships with community providers, the overarching premise is that interventions in this tier are largely based in prevention and driven by the school setting (Weist et al., 2014). Further, strategies in Tier 1 consider comprehensive, universal approaches to a healthy school environment, positive behavior, and general mental health programming (Weist et al., 2014).

Tier 1 strategies build on the assets of school systems, namely that they are well-established community institutions that can serve as a central point of contact for youth and sometimes families (Jensen & Mendenhall, 2018). They also can facilitate the delivery of social-emotional curriculum to all students. In Michigan, one example of a Tier 1 effort would be the Capturing Kids' Hearts program. This is a district wide effort aimed at strengthening support skills for teachers and school administrators, and promoting a healthy learning environment (Bridge Michigan, 2022).

Best practices such as curriculum development and restorative justice programming are promising in a tiered approach (Katic et al., 2020). Equally promising are strategies that parents and teachers can implement to improving youths' sense of safety and belonging in learning environments (e.g., National Association of State Boards of Education, 2020), implementing social emotional learning and character development curriculum (SEL4US, 2020), and supporting behavior control and discipline both in the classroom and at home (Cohen, 2021; Weist et al., 2014). Other prevention programs unique to Michigan such as OKAY2SAY and Handle with Care offer options for reporting bullying activity and alert school professionals when a youth might need extra support (State of Michigan, n.d.). Further, the implementation of well-established assessment and self-report tools, e.g., Behavior and Symptom Identification Scale (BASIS; Eisen et al., 2004) offer opportunities for reliable and valid behavior inventories that can identify symptoms in youth populations.

POINT 1: TIER 1

Finally, Tier 1 interventions target school aged youth broadly. Schools are a natural choice for universal mental health promotion interventions because of the large amount of time youth spend in this environment (O'Reilly et al., 2018). In fact, increased participation by schools in early identification of behavioral health concerns is significantly associated with behavioral health service delivery for adolescents as it facilitates access to support (Green et al., 2013; Hoovey et al., 2019). Furthering the importance of schools promoting Tier 1 activities, large effects were found with the integration of mental health into academic instruction or other spaces where support could fit into students' natural school routines (Sanchez et al., 2018). Elementary children's mental health outcomes are shown to be significantly impacted by SBMHS that incorporate contingency management (behavioral) programs to address behavior in the school milieu (Sanchez et al., 2018).

Tier 1 strategies require resource and infrastructure to implement. Teachers and other school professionals should be supported in their ability to administer these important interventions. Although not shown in the research to be unequivocal in addressing mental health concerns, smaller classrooms for example support teachers in curriculum delivery and managing student outcomes (Blatchford & Webster, 2018). Prevention efforts include shared responsibilities among all school personnel and can be enhanced by working with community partners in delivering evidence-based models of prevention and early intervention. Models such as Mental Health First Aid (Kitchener & Jorm, 2006), TRAILS [Transforming Research into Action to Improve the Lives of Students] (Rodriguez-Quintana et al., 2021) are commonly adopted by community mental health practitioners and offered to school and community partners free of charge. Tier 2 activities build off Tier 1 by enhancing school curriculum and working with parents and other community partners to implement strategies that extend beyond the borders of the public-school buildings.

POINT 1: TIER 2

Tier 2 services include provision of targeted support for youth who are at risk and would benefit from early intervention. In this tier, problems have started to manifest but are not fully specialized treatment intervention issues (SAMSHA & CMS, 2019). The basis for this tier relies on school systems being or becoming a key partner in a multisystem effort to increase access to behavioral health care and decrease behavioral health problems in youth (Cammack et al., 2014; Sanchez et al., 2018). Research establishes that while a variety of behavioral health supports offered in school settings have lasting impact on youth success in school and beyond (Sanchez et al., 2018), these need to be operationalized through school-community partnerships that assure effective continuums of care (SAMHSA & CMS, 2019; p.3). Tier 2 supports build on existing school programs, services, and supports by leveraging partnerships between schools and community mental health providers (Rider & Freeman, 2016).

Research highlights the importance of partnership approaches that build off the assets of the communities in which school aged youth live. There is significant evidence in Michigan to show these partnerships are working. A recent 31(n) technical assistance audit for youth intervention programming developed in a rural school-community mental health collaboration earned a “top echelon of programs” accolade (S. Miceli-Sorenson, personal communication, May 29, 2022). This system focuses on screening and brief intervention with opportunity for service linkage and family engagement. Praise such as this only further highlights the significant opportunity before us to promote collaboration and partnerships in the SBMHS spectrum and assure youth and families have continued access to a full array of behavioral health resources. Tier 2 ideology is that early identification and support can reduce or ameliorate future problems (Hoover et al., 2019).

POINT 1: TIER 2

Of most importance and rarely referenced in the SBMHS literature is the ability to engage families in the behavioral health care of their youth. This in and of itself is a critical strategy that supports youth wellness and provides protective factors from a host of behavioral health and conduct problems (Haine-Schlagel & Walsh, 2015). While some research supports schools as natural conveners for youth and families in communities, other research reminds us that parents do not always have the best relationships with schools (Green-Hennessy & Mariotti, 2021) and that student/caregiver/school partnerships need to be built and nurtured. Families may or may not feel comfortable engaging in treatment in a setting that is not designed for behavioral healthcare. This is in part attributable to youth who report feeling stigmatized by peers for receiving mental health intervention, and the perception that the school setting offers less confidentiality with which to explore their needs and experiences (Gronholm et al., 2018). Even without this concern, it is noted that while youth can be accessed in school for screening and treatment purposes, families do not share the same kind of access for treatment. This is concerning as family is not only a social determinant of health, but is also one of the strongest impacts on mental health outcomes for youth (Alegria et al., 2018). Partnerships between schools and community mental health providers may provide additional opportunities for family engagement. Some districts host education and support programs for parents led by community mental health agency experts on important topics such as effects of social media and violent media images on mental health (J. Obermesik, personal communication, June 7, 2022).

The urgency of school-community partnerships is highlighted even more in the wake of COVID-19 and considered to be essential to the well-being of school aged youth (Hertz et al., 2021). Tier 2 increases the level of support and intervention with an emphasis on engaging parents/caregivers as partners, coordinating referral and resources for youth and families, and ultimately seeking to mitigate the need for more intensive services whenever possible (Hoover et al., 2019).

POINT 1: TIER 3

In their joint informational bulletin (2019), SAMHSA and the Centers for Medicare and Medicaid (CMS) summarize the best practice models for facilitating the implementation of quality, evidence-based behavioral health and substance use services to school age youth. This bulletin delineates the critical role schools play in connecting school age youth and families to treatment and services and highlight their lack of capacity to identify and adequately treat behavioral health disorders and substance use disorders alone. They guide the use of multidisciplinary approaches and collaboration with community providers as key strategies to expand needed behavioral health services. Further, Tier 3 supports acknowledge that while the school system plays a vital role in behavioral healthcare, a comprehensive community approach is essential to implementing SBMHS (SAMSHA & CMS, 2019). Collaborations and partnerships that provide innovation in addressing the behavioral healthcare of school age youth are hallmarks of Tier 3 activities (Rider & Freeman, 2016).

In a tiered approach, universal screenings done in school settings can serve as a point of surveillance and brief intervention, facilitating referrals and coordination for continued care and, when needed, treatment from specialized providers. Tier 3 comprehensive community approaches not only consider community behavioral health providers, but other professionals with expertise that can be partners in supporting SBMHS, e.g., police or threat teams for safety, child advocacy centers, faith communities, government agencies, etc. (SAMHSA & CMS, 2019). This strategy builds from community assets and prevents duplication of effort. For example, evidence suggests schools are excellent places for screening and brief interventions, but not the place for comprehensive treatment (Jensen & Mendenhall, 2018). Working with community partners, coordinated care efforts can assure the transition from brief intervention to specialized care.

It is important for youth and their families to have the opportunity for service coordination and access to specialized care. There are significant, negative consequences to the lack of availability for youth and their families to access family therapy and team-based care approaches, i.e., wraparound services (Weist et al., 2014). Weist and colleagues further advocate that it is the responsibility

of policy experts along with school and mental health professionals to design collaborations that can assure these aims are met. Further, they assert that schools also need to assure that they can maintain their main goal of supporting academic achievement. Finally, Tier 3 services need to be accessible to students identified as experiencing behavioral health or substance use disorders and require treatment or intervention to address the illness (SAMSHA & CMS, 2019).

As legislation continues to support the provision of mental health services in non-specialty settings such as schools, data should be considered regarding more recent trends indicating where youth and families typically receive care and what kinds of supports are appropriate for each setting. Utilization of care studies highlight that schools and outpatient settings are now almost equal when tracking where access to behavioral health care happens. It is important to remember that this is not a competition, rather, a significant call for these two systems to strengthen linkages. Collaborative frameworks suggest that schools are a good fit for surveillance, early identification, and initial entry to services (SAMHSA & CMS, 2019), but that meaningful connections must be built across a range of settings and offer access to more intensive and/or specialty treatment for youth and families (Duong et al., 2021).

In further support of this point, Duong et al. (2021) highlight that behavioral health support for highly symptomatic youth is accessed in settings such as primary health care, juvenile justice programs, and child welfare agencies at less than half that of outpatient or school settings. This points to a need for more proactive and preventative mechanisms for ensuring youth receive access to mental health services and that partnerships are considered beyond schools and outpatient community mental health providers. As community mental health providers continue to build collaboration with primary care providers through initiatives such as MC3 (provides psychiatry support to primary care providers), establish themselves as child-placing agencies, and expand community behavioral health clinic initiatives (CCBHC), it is more important than ever to assure school system collaborations are built and sustained. Collaborative efforts and integration of behavioral care within varied community settings is necessary to improve access to care (Duong et al., 2021).

POINT 1: TIER 3

School settings offer an important choice of setting for behavioral healthcare treatment. Noted for their ability to be trusted institutions in communities, schools can be natural conveners (Jensen & Mendenhall, 2018). However, guidance is needed for successful implementation of psychological interventions and mental health treatment in educational settings. There are significant logistical and community-level factors that should be considered with implementing mental health care in school settings that take into consideration important interventions such as intensive home-based services, scheduling treatment with working families (i.e., after school/work times), treatment during seasonal breaks, space for adequate treatment, and access to space and materials for evidence-based practice. Meeting space that is private and infrastructure for on-site supervision and consultation is necessary. Subsequently, health and education policy should reflect an approach aimed to accurately treat and impact emotional health of school age children across multiple sectors (Gee et al., 2021). Further, family choice is an important value of treatment and a guiding principle of youth behavioral health care (MDHHS, n.d.).

School settings may not be the most promising for engaging families in more serious conditions requiring longer term interventions. While school systems are an asset in accessing youth, there is no research to support successful engagement in a youth's family in SBMHS. This is concerning as family approaches to treating behavioral health symptoms in youth are well-documented as able to produce the best, longest lasting outcomes for families (e.g., Cunningham & Henggeler, 1999; Robbins et al., 2016; Szapocznik & Hervis, 2020) and involve strategic, culturally sensitive methods of engaging family members for the purpose of treating a youth's symptom in context (Szapocznik & Hervis, 2020). Specialized, evidenced-based family approaches to treating behavioral health recognize school systems as important contextual partners and facilitates treatment that meets the family where they are at, supporting the entirety of the family system. Family centered care is a hallmark of Medicaid services to youth and families (MDHHS.gov, n.d.) and is a specialty of community mental health providers who provide services to youth and families. Community mental health providers have extensive experience with mobilizing teams supportive of youth and families (e.g., Wraparound, SED Waiver, HCBS, and other Medicaid services for youth). Support to families can be addressed with schools as a partner in the process, but not

when they are exclusively a provider. Therefore, a systemic look at SBMHS requires a comprehensive, collaborative, approach to mental health treatment that involves specialized care for families to sustain treatment gains. Expanding behavioral health providers in the school system without ensuring the complementary community resources necessary to provide collaborative specialized care risks assuring the best possible outcomes for youth and their families. In a highly competitive and thin market for mental health professionals, doubling down on SBMHS can weaken community resources necessary to treat the whole family.

Finally, schools are not well suited for targeted approaches to fully address mental health in youth (O'Reilly et al., 2018). While participation by schools in early identification of behavioral health concerns is significantly associated with behavioral health service delivery for adolescents (Tier 1), effect sizes are smaller in decreasing mental health problems (Green et al., 2013). This is to say that a tiered approach to SBMHS, particularly one that supports early or emerging identification of behavioral health problems, could be key in facilitating a comprehensive assessment of severity (Tier 2) and the subsequent use of community based mental health services that can treat the youth and family (Tier 3). This furthers the importance of a coordinated system of care built on increasing opportunity for partnership and collaboration. Tier 3 requires collaboration to be successful in achieving a comprehensive package of SBMHS. Funding the strategies that build capacity and partnerships is a more promising solution than shifting dollars to one system that will inevitably promote maldistribution and migration of mental health professionals from one setting to another.

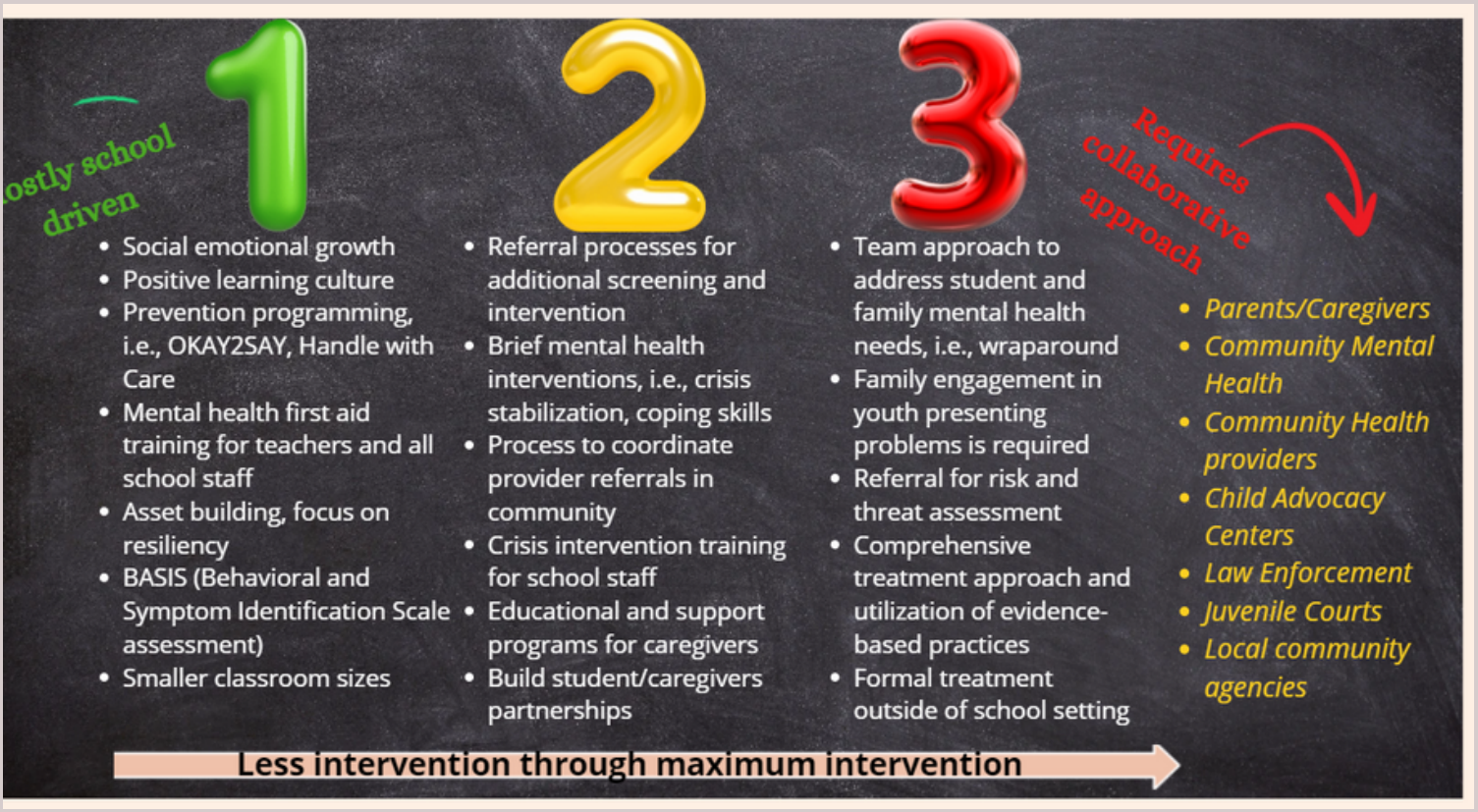
POINT 1: TIER 3

Summary of Point 1 and Recommendations:

School systems are educational institutions, not specialized behavioral health providers. The expansion of Michigan's existing school-based services has created an important pathway for assuring general education youth have access to behavioral health care and that school aged youth and families are better resourced with needed supports. Clearly, this path is part of the answer. However, just as school systems are counted on to be the experts in education, community behavioral health holds vital expertise in solutions rooted in collaboration and partnership that can be capitalized on and adopted.

A tiered system of care offers a well-established framework for considering further implementation of SBMHS. Instead of a linear approach of adding behavioral health staff to schools, in a tiered system there is significant opportunity to systemically build on each other's strengths and address the increasing and overwhelming behavioral health needs that school aged youth and families face. To the degree that behavioral health needs are viewed as a problem for schools to address outside of a continuum of care, the school system will be siloed in owning those problems. Instead, sharing the responsibility of comprehensive, specialized care among multiple systems is a more promising approach. School systems can normalize social-emotional health through curriculum and experiential learning, provide universal screening and brief intervention, and leverage specialized, evidenced-based family-centered care through partnership with community behavioral health providers.

While early estimations of effort are that more behavioral health staff in the schools have created more contacts with youth (MDHHS, 2021), whether this has leant itself to better outcomes is unknown. However, best practices for SBMHS are well-documented and can be adhered to. Funding the strategies that build capacity and partnerships along a tiered system of care is a more promising solution. A framework for school-community collaboration is needed that can be fluid, responsive to individual communities, and sustainable. This involves sharing funding and community resources including peer consultation for the ongoing oversight and development of a specialty behavioral health workforce. In this way, each partners expertise and resource to best meet the needs of youth and families can be maximized.


ostly school driven
1
• Social emotional growth
• Positive learning culture
• Prevention programming, i.e., OKAY2SAY, Handle with Care
• Mental health first aid training for teachers and all school staff
• Asset building, focus on resiliency
• BASIS (Behavioral and Symptom Identification Scale assessment)
• Smaller classroom sizes
2
• Referral processes for additional screening and intervention
• Brief mental health interventions, i.e., crisis stabilization, coping skills
• Process to coordinate provider referrals in community
• Crisis intervention training for school staff
• Educational and support programs for caregivers
• Build student/caregivers partnerships
3
• Team approach to address student and family mental health needs, i.e., wraparound
• Family engagement in youth presenting problems is required
• Referral for risk and threat assessment
• Comprehensive treatment approach and utilization of evidence-based practices
• Formal treatment outside of school setting
Requires collaborative approach
• Parents/Caregivers
• Community Mental Health
• Community Health providers
• Child Advocacy Centers
• Law Enforcement
• Juvenile Courts
• Local community agencies
Less intervention through maximum intervention

SECTION 3

POINT 2: ALIGNMENT WITH NATIONAL STRATEGIC BEHAVIORAL HEALTH INTIATIVES

POINT 2 – ALIGNMENT WITH NATIONAL STRATEGIC INITIATIVES

Increased attention to SBMHS should consider how funding school-based mental health positions in the schools aligns with other strategic initiatives, such as national calls for partnerships that can address behavioral health disparities and leveraging access to behavioral health providers. Sadly, almost 2/3 of our communities lack essential behavioral health providers (United States Department of Health and Human Services, 2017). This disproportionately impacts rural and impoverished communities which in turn negatively impacts social determinants of health and access to care (Alegria et al., 2018; SAMSHA, 2020). Optimizing care resources by creating community level partnerships and collaborations is a highly valued practice for addressing the workforce shortage, especially considering the estimated 80,000 openings for behavioral health therapists projected each year for the next decade (United States Bureau of Labor Statistics, 2022).

It is not just shortage, but workforce planning and distribution, that impact access to care (Kepley & Streeter, 2018). Legislation such as 31(n) has a significant impact on the setting in which behavioral healthcare personnel will be prioritized. Schools alone may not be the single best distribution strategy to meet individual community needs. Prior to funding decisions for adding behavioral health staff in schools, there should be an examination of the resources and assets in communities. This point builds off Point 1, in which SAMHSA and CMS guide us to consider comprehensive school mental health systems that maximize community-school partnerships to deliver SBMHS.

Two key subpoints include: 1) addressing mental health workforce shortage, and 2) strategically aligning with state and national initiatives that are already addressing behavioral health needs for youth and families.

POINT 2: WORFORCE SHORTAGE

1. There is a significant mental health workforce shortage.

Many national strategic efforts call for communities to integrate resources to address the workforce shortage. At the same time, 31(n) policies are incentivizing highly qualified behavioral healthcare providers to work in school systems with the allure of partial year employment, educational incentives, and less complex documentation requirements. This taxes an already limited community-based behavioral health workforce, which is even more disproportionately affected in rural settings (US Department of Health and Human Services, 2017). Simultaneously, state level policies and practices influence behavioral healthcare resources (Black & Schiller, 2016). Increasing funding for positions without regard for local workforce infrastructure is not only illogical but creates workforce competition within the same communities of interest to serve the same youth and families.

Workforce shortages and national initiatives to improve access to evidenced-based care for school age youth and families cannot be ignored when considering how continued school-based mental health funding continues. Positions created in the school system run the risk of creating siloed care unique to that system. Further, they pull from the pool of providers available in the community to serve youth in specialized care settings. When considering national initiatives for guidance, suggestions are to improve access to care through investing in practitioner training and creating community plans of care that intentionally distribute behavioral health expertise within community settings. These kinds of systemic solutions call for funding that can be flexible, collaborative, and uniquely depend on the assets and needs of each community. In addition, they should include memorandums of understanding about collaborations and agreements to not recruit staff from each other to underscore their shared purpose.

POINT 2: WORFORCE SHORTAGE

Increased funding allocations to schools to hire qualified behavioral healthcare staff take from the existing pool and talent base of behavioral health providers. The resulting workforce shift does not allow an opportunity to coordinate behavioral health response, and instead takes resources from one silo and puts it in another silo. Unfortunately, this leaves many community mental health provider agencies in the position of having invested significant training dollars in clinicians learning how to deliver evidence-based practices in the community only to have them leave to work in a school setting that is lacking the ongoing infrastructure necessary to support specialized behavioral health treatment methods. Said another way, new position funding puts communities in a space to compete for practitioners instead of developing and using mutual assets to work together. In the end, the risk is losing the community asset of providers who could be delivering specialized, evidence-based treatments to our youth and families. Without strategic partnerships that emphasize building infrastructure, the clinical sustainability of specialized care is endangered.

Provider shortages and the unequal distribution of behavioral health providers across communities are responsible for constraining access to essential behavioral health care (Kepley & Streeter, 2018). This is to say the solutions for improving access to behavioral health providers is not a school issue but a community issue and suggests solutions come from a systemic instead of siloed lens. For example, SAMHSA released a recent report outlining strategies for communities to understand their behavioral health prevalence data and respond with staffing models that address both provider capacity and settings of care. This kind of scoping guidance suggests schools equip themselves with behavioral health staff that can provide assessment and in acute instances triage to appropriate specialty services. At the same time, staffing models assure communities have other supports in place to receive that youth and family for services, i.e., intensive outpatient or in-home services, with a goal to integrate existing behavioral health supports in the school system (SAMHSA, 2022).

POINT 2: WORFORCE SHORTAGE

To address the national behavioral health workforce shortages, the Health Resources and Services Administration (HRSA) has created the Behavioral Health Workforce Education and Training (BHWET) program, which is designed to support the development and expansion of the behavioral health workforce. This effort recognizes the significant shortages and uneven distributions of psychiatrists, psychologists, social workers, school counselors, and marriage and family therapists (Kepley & Streeter, 2018). BHWET programs support the training of new behavioral health providers, both professionals and paraprofessionals, where significant behavioral health disparities are present and access to care is needed. BHWET emphasizes training in primary care and behavioral health integrated settings as they are seen as most equipped to provide universal access to behavioral health care.

Improving access to treatment in integrated and sustainable ways is not only necessary, but a challenge considering the almost 80,000 openings for behavioral health therapists projected each year (United States Bureau of Labor Statistics, 2022). Assessing behavioral health access and needed workforce from the lens of community needs instead of from a specific siloed system is a strategy endorsed nationally and seeks to provide a more systemic solution to behavioral healthcare access and workforce crisis. Funding the strategies that build capacity and partnerships is a more promising solution than shifting dollars to one system that will inevitably promote migration of mental health professionals from one setting to another.

POINT 2: CREATING COMMUNITY LEVEL PARTNERSHIPS AND COLLABORATIONS

2. Creating community level partnerships and collaborations

As evidenced by the call from SAMSHA and CMS (2018), many state and national organizations urge communities to address behavioral healthcare needs in their communities in alignment with already established (and funded) initiatives working to enhance access to behavioral healthcare, research-based treatments, and behavioral health workforce shortages. School-community partnerships have been known to increase the types of mental health services available in schools, by providing a full range of mental health supports and intervention services to youth and their families (Cammack et al., 2013). In fact, regardless of where SBMHS are provided, their main intention is to be a resource in their communities when those supports are not available in the community and to design policy that involves parents and links youth to services when necessary (Shelton & Owens, 2021). Partnerships are needed to support policy and practice that links youth and families to community resources. Bridging parents as a key piece of school-community partnership is critical to success of SBMHS (Shelton & Owen, 2021). Without established partnerships and collaborations, struggle within community systems of care ensues.

While there is much attention on behavioral health shortages, schools are hemorrhaging with shortages in almost every category of staff. More than half of educators plan to leave the profession sooner than planned, with 90% noting burnout is a serious problem (Connecticut Education Association, 2022). Adequately staffing schools is an important piece to consider in any conversation on improving behavioral health for youth, as teachers and other school staff play a significant role in supporting any SBMHS. Funding that supports educators and other key school personnel as well as community behavioral health providers offers a much needed opportunity for community collaboration and support.

POINT 2: CREATING COMMUNITY LEVEL PARTNERSHIPS AND COLLABORATIONS

The need for infrastructure that creates partnerships is evident when considering not only workforce shortages but strict definitions of who can and cannot be served. National advocacy groups such as the National Alliance on Mental Illness (NAMI) advocate for early identification and treatment for youth mental health concerns by convening key community partners to collaboratively eliminate barriers to accessing care. As schools commit to providing services to school age youth in both general and special education designations (MDHHS, 2021), community mental health providers also need to assure provision to youth and families that do not meet serious emotional disturbance designations. In years past, cuts to general funding not only tightened eligibility for community mental health care, but it also left many rural communities without access to specialized behavioral health services (J. Obermesik, personal communication; Larrison et al., 2011). This history is relevant to building community partnerships and considering policies and agreements for tiered systems of care that rely on each other serving all youth and families in communities.

The SAMHSA model for Certified Community Behavioral Health Clinics (CCBHC) is a national, strategic effort to expand access to and quality of care for mental health and substance abuse services (Everett, 2020). Although CCBHC demonstration projects vary by communities, hallmarks of these efforts include integration with primary health care, creating outreach and access points for care that align with community cultural values, delivering evidence-based services to the community, including school systems, and addressing anticipated behavioral health workforce shortages (Foney et al., 2019). Aligning SBMHS with CCBHC efforts is a critical piece of infrastructure for building access to care in communities. SAMHSA has also maintained a consistent commitment to funding training initiatives for supporting practitioners in delivering evidence-based practices, an important piece of building a community's capacity for delivering specialized care.

POINT 2: CREATING COMMUNITY LEVEL PARTNERSHIPS AND COLLABORATIONS

Partnerships are key in promoting SBMHS and in the end can promote greater access to care. Without legislative emphasis to build community partnerships in line with the best guidance from national behavioral health initiatives, siloed care or struggle within systems can persist. Partnerships should incorporate building memorandums of understanding among partners that seek to overcome past issues of access to care, particularly when considering school-community mental health partnerships. The third point will briefly focus on the importance of advancing specialized treatment and access to evidenced-based care.

Summary of Point 2 and Recommendations:

A strong focus for building SBMHS should consider not only the tiered system discussed in Point 1, but whether funding school-based mental health positions in the schools aligns with other strategic initiatives best able to meet a communities' needs. Only in this way can behavioral health disparities, workforce shortages, and access to behavioral health providers that work with and not against the behavioral health assets in the community be leveraged. This point considers strategy that can improve overall access to care for youth and families. Legislation such as 31(n) can support developing a behavioral healthcare distribution strategy instead of considering siloed positions, so that behavioral healthcare assets are best positioned to meet community needs.

POINT 3: ADVANCING SPECIALIZED TREATMENT AND EVIDENCED-BASED PRACTICES

POINT 3: ADVANCING SPECIALIZED TREATMENT AND ACCESS TO RESEARCH BASED INTERVENTIONS

Finally, there has been a consistent call to improve access to evidenced-based behavioral health interventions over the past several decades (SAMSHA, 2020). To advance access to evidence-based care and continue to close the research to practice gap, investment in systems that can support ongoing implementation, conduct research on effectiveness, and understand how best to support implementations in community settings are necessary. Much like school systems have long established and respected specialty in education and student learning, community mental health providers have long standing success with implementing specialty behavioral health and substance use disorder treatment. It is important to remember that our community mental health providers are not only well-equipped to provide the kind of clinical supervision, team-based care, family engagement strategy, and implementation support necessary to provide evidence-based specialty behavioral health care to youth and families, but that they possess a skillset that has been honed over years of practice and would take major effort to recreate. Point 3 elaborates on why attention to specialized care should be agreed upon in partnership and left to community providers that can assure the entirety of the evidence-based care package be delivered, i.e., family engagement through measuring family outcomes.

1. **Collaboration that supports access to specialized care**

While touched on in earlier points, here it is further asserted that behavioral health care treatment is complex and not the primary aim of school settings. Estimates of 10-20% of students meet criteria for serious emotional disturbance (SED; SAMSHA, 2020). SED defines youth who have a diagnosable mental, behavioral, or emotional disorder that results in impairment of their role in family, school, or community (Center for Behavioral Health Statistics and Quality, 2016; SAMHSA, 2020).

POINT 3: ADVANCING SPECIALIZED TREATMENT AND ACCESS TO RESEARCH BASED INTERVENTIONS

SED treatment calls for comprehensive, evidence-based care delivered in specialized mental health settings (2020). This is not to undermine the importance of partnerships, but instead to once again highlight that tiered systems of care can be effective solutions toward the aim of delivering specialized behavioral healthcare (SAMHSA & CMS, 2019). Through partnerships, pathways for accessing care can be designed in such a way to eliminate barriers to receiving supports and facilitate access from one point of intervention to another. Continuing to advance access to evidence-based, specialized treatments is in fact a national priority (SAMHSA, 2020). Further, integrating evidenced based care has been a longstanding aim for community mental health providers and requires a significant commitment to investing in and maintaining an organizational structure for ongoing fidelity and commitment to evidence-based practice. This includes an implementation network that can support the supervision, consultation, and training of practitioners, and assure successful implementation of the model to fidelity (Miller, 2021).

When considering the array of specialized mental health treatments and infrastructure already in place throughout the statewide community mental health system, it is difficult to consider what the benefits might be of creating new systems for Medicaid specialty behavioral health services. Specialists exist in the community mental health system for understanding and adhering to best practice for programs such as Wraparound, SED waiver programs, intensive home-based services, and even pre-primary supports just out of the reach of K-12 school systems, i.e., infant mental health care and evidence-based parenting programs (MDHHS, n.d.). Community mental health providers have long been working to engage our school partners in these efforts to support families highest at risk in our communities.

POINT 3: ADVANCING SPECIALIZED TREATMENT AND ACCESS TO RESEARCH BASED INTERVENTIONS

Data from the FY20-21 31(n) legislative report demonstrates that schools recognized community mental health service providers as highly qualified and accessible community resources in Michigan, as evidenced by a 286% increase in contracts for behavioral health support. Unfortunately, many of these contracts have turned instead to direct hires by the schools, or districts have seen community mental health staff as a resource for recruiting staff (J. Obermesik, personal communication). It is reasonable to consider that collaborative efforts between schools and community mental health providers could instead change this script to ensuring the best possible care coverage regardless of which entity holds the funds for the positions. In this way, the entity with the ability to deliver specialized care could deliver those supports in service to the community. Collaborative efforts should ensure funding for CMHs for recruitment, training, and supervision in the more intensive evidence-based practices. This logic is supportive of the MDE Whole Child policy and can reach not only youth and families enrolled in public schools, but youth referred to services in charter or home school networks.

Qualitative feedback from intermediate school districts on their continued needs and concerns about 31(n) funding includes a wish list for continued training and collaboration, in addition to supporting Tier 1 social emotional learning and behavioral health prevention. Many of the examples on the wish list already exist when looking at the community for partnerships, i.e., hiring bachelor level heath providers and training in specialized care approaches. While school districts are asking for more collaboration, the advisory council's response is to offer collaboration opportunities only among 31(n) implementers. Collaborations that identify assets and opportunities within the community need to be considered. Further, while school districts asked for flexibility in spending 31(n) dollars beyond adding Master's behavioral health providers, the response from the Council allocated 240 million to increase the number of masters level behavioral health providers (i.e., psychologists, social workers, counselors, and school nurses). Continued funding to one system to support the advancement of specialized care not only hamstrings opportunity for partnership, but it recreates systems in the community that already exist.

POINT 3: ADVANCING SPECIALIZED TREATMENT AND ACCESS TO RESEARCH BASED INTERVENTIONS

2. Partner to build infrastructure to support a specialized behavioral health workforce, i.e., specialized EBP training, implementation support, and supervision

Evidence-based treatments require expertise in implementation science to succeed, something that CMH settings have been developing over time. As discussed in Point 2, 31(n) funding to increase providers in the school system finds many community behavioral health providers having invested significant training dollars and licensure supervision only to have providers shift to work in a school setting. CMH settings are losing specialized behavioral health treatment providers who have received extensive evidence-based practice training and will not likely be able to practice it in the school setting as the infrastructure for evidence-based practice implementation and fidelity does not exist there. However, partnerships as advocated for in the literature to address comprehensive mental health needs for youth (Jensen & Mendenhall, 2018), can be built around sharing responsibility of delivering evidenced-based care to youth and families. Legislative support and funding to build infrastructure with the aim of high-quality evidenced-based care at the forefront could push partners toward innovative solutions, agreements, and memorandums of understanding between schools and community mental health providers to provide peer consultation, training, supervision, and collaboration around evidence-based practice.

Summary of Point 3 and Recommendations:

The call to improve access in communities to evidenced-based behavioral health interventions has been consistent over the past several decades (SAMSHA, 2020). To improve access to quality care, investment in infrastructure capable of supporting ongoing implementation efforts is required. Community mental health providers in Michigan have longstanding success in this area given large statewide initiatives for evidence-based care e.g., Statewide Trauma Initiative, Parent Management Training, Wraparound, Parent Support) that involve training, fidelity, supervision structures, etc. (MDHHS, n.d.). The significance of this investment and the opportunity to build upon this structure through partnership and collaboration is critical to the ongoing success of access to research-based care in communities.

SECTION 5

CONCLUSION, FINAL RECOMMENDATIONS, AND REFERENCES

CONCLUSION

The purpose of this paper is to assure funding for SBMHS can be earmarked for advanced partnerships and collaborations between community mental health providers and schools to build upon existing expertise and improve access to care. ***Funding allocated for school-based behavioral healthcare efforts should: 1) support teacher resources and curriculum development that enhances social-emotional learning, 2) focus on building youth assets, and 3) assure that schools have all necessary safety measures in place. Considering a tiered system approach as advocated for in Point 1, funding should also be allocated for 1) collaborations and partnerships that can be effective in assuring both schools and community partners play an integral role in developing a behavioral health care response, 2) improve the safety net for all youth and families in the community, and 3) continue to enhance access to specialized behavioral healthcare.***

As a partner in the provision of SBMHS, community mental health providers have a long history of being the safety net for behavioral health needs. Community mental health assets include fulfillment of the mental health code, working with Medicaid funds for specialized care, building infrastructure for evidenced based treatments, and engaging families and other important systems in the whole picture of a person's care. Community mental health providers have key consultative, supervision and training roles in Tier 1 supports to schools with expertise in screening, crisis intervention, psychoeducational skill curriculum, mental health first aid, and supporting school staff with their high workloads. Service provision to mild-moderate behavioral health conditions, particularly in communities where shortages mean school age youth and families do not have other choices for behavioral healthcare, are being addressed by many local community mental health providers. This aligns with strategic workforce initiatives such as CCBHCs, SAMSHA commitment to evidence-based practice dissemination, and the call from NAMI to coordinate intervention for youth (Tier 2 and 3 activities). In addition, community mental health service providers have been building a solid foundation of partnerships with youth interventionists in the schools. However, even considering all these assets, community mental health providers and schools are often competing for the same behavioral health staff. This risks not only creating a siloed system of care but runs the risk of re-creating systems of support that already exist in communities. To address these points, the final recommendations are supported.

FINAL RECOMMENDATIONS

- ***Align the Michigan Department of Education Whole Child policy which emphasizes community-based mental health collaboration with the tiered services model as recommended by SAMHSA and CMS, and the Certified Community Behavioral Health Clinic Initiatives [CCBHC] (National Council for Mental Wellbeing, n.d.).***

- ***Incentivize School-CMH partnerships that emphasize a community-level strategy for addressing access to care. Provide technical assistance and support on benchmarking access to care, workforce needs, and acceptability of care provided in communities.***

- ***Maintain a commitment to family-centered care in addressing youth behavior symptoms with access points throughout communities.***

- ***Address the maldistribution of the behavioral health workforce budget allocations by incentivizing and funding collaborative community-level staffing strategies. Provide technical assistance and support toward building memorandums of understanding and measuring impact of partnerships on workforce trends.***

- ***Ensure resources to support local evidence-based treatment capacity and competency. This includes provisions for appropriate supervision, model fidelity, ongoing training, and peer consultation. This can be built in partnership with schools utilizing existing resource and infrastructure established through the Michigan Department of Education, Michigan Department of Health and Human Services and local community mental health providers.***

- ***Adopt psychoeducational curriculum to include prevention of school violence and continue to build on youth and family assets in communities.***

- ***Align recommendations with professional continuing education for behavioral health providers.***

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