

SUPPLEMENT ARTICLE

Funding a Full Continuum of Mental Health Promotion and Intervention Programs in the Schools

MARK D. WEIST, Ph.D., JULIE GOLDSTEIN, Ph.D., STEVEN W. EVANS, Ph.D.,
NANCY A. LEVER, Ph.D., JENNIFER AXELROD, Ph.D., ROBERT SCHRETERS, M.D., AND
DAVID PRUITT, M.D.

Purpose: To assess the availability of public and private financing sources to support comprehensive school mental health programs. The paper focuses on “expanded school mental health” (ESMH) programs, which provide a full array of mental health promotion and intervention services to youth in general and special education through school–community partnerships.

Methods: A range of strategies to fund ESMH services are reviewed, including fee-for-service funding, as well as grants, contracts, and other mechanisms from federal, state, local, and private sources.

Results: An objective national study of the characteristics and financing of ESMH programs has yet to be conducted. Existing evidence suggests that funding for these programs is patchy and tenuous. Many programs are being funded through fee-for-service programs, which generally only support the provision of more intensive services (e.g., assessment, therapy) and are associated with significant bureaucracy and other concerns (e.g., the need to diagnose students). As programs move to enhance funding for preventive and mental health–promoting activities and services, there is an increasing need for grants, contracts, and other sources of support.

Conclusion: Progress in the national movement toward ESMH will be promoted through an interconnected agenda of quality improvement, evaluation of program

effectiveness, and the advancement of advocacy. These developments will facilitate policy improvements and increased funding for the full continuum of mental health promotion and intervention in the schools. © Society for Adolescent Medicine, 2003

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As reviewed by Flaherty and Osher [1], school-based mental health services began in the Progressive Era, a period of local, state, and national reforms that lasted from 1890 through the 1920s. Through the 20th century, the emphasis on school mental health waxed and waned. For example, activity decreased in the 1930s and 1940s related to the Depression and World War II, followed by renewed attention in the 1950s and 1960s related to the Child Guidance and Community Mental Health Center movements. The passage of the Individuals with Disabilities Education Act (IDEA) in 1975 was a major event that launched an array of supportive service, including mental health services for youth with disabilities. The 1980s and 1990s saw the development and increasing influence of the Child and Adolescent Service System Program, which promoted a system-of-care approach to address emotional and behavioral needs of youth with more severe disturbances.

From the Center for School Mental Health Assistance, Department of Psychiatry, University of Maryland School of Medicine, Baltimore, Maryland (M.D.W., J.G., N.A.L., J.A., R.S., D.P.); and James Madison University, Harrisonburg, Virginia (S.W.E.).

Address correspondence to: Dr. Mark D. Weist, Ph.D., Center for School Mental Health Assistance, Department of Psychiatry, University of Maryland School of Medicine, 680 West Lexington Street, 10th Floor, Baltimore, MD 21201. E-mail: mweist@psych.umaryland.edu.

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The 1980s and 1990s also saw the development and expansion of school-based health centers (SBHCs), which provide comprehensive primary care to youth in schools [2]. As they began to develop, SBHCs became flooded with mental health referrals, propelling efforts to expand school-based mental health services both within the centers and in schools without them [3–6].

These developments helped to promote the articulation and advancement of the expanded school mental health (ESMH) framework. In this framework, education systems join with community programs such as community mental health centers, health departments, hospitals, and universities to broaden mental health promotion and intervention activities and services [3]. Expanded school mental health programs offer services to youth in both regular and general education and commonly provide assessment and treatment (e.g., individual, group, family therapy) services, with more programs focusing on whole school mental health promotion activities, as well as prevention and early intervention services [7]. These programs build on and complement the work of school-employed mental health professionals such as school counselors, social workers, and psychologists [3,7]. In this new decade and century, ESMH programs are growing progressively throughout the United States, related to their documented abilities to improve access to mental health care, while removing barriers to student learning [8,9]. In addition, evaluation and early research findings are documenting that they are leading to outcomes valued by families, schools, and communities (e.g., improved grades, attendance, and school behavior, as well as decreased referrals to special education) [10–13].

Unfortunately, no systematic research has been conducted to enable assessment of the percentage of schools in the United States that have ESMH programs, but estimates indicate that less than 10% of schools contain them [14,15]. Instead, a more common arrangement is for limited mental health services (assessment, consultation) for youth in or being referred into special education, with major voids in the areas of prevention, treatment, and services for youth in regular education [3,16,17].

Any discussion of school mental health funding should begin with a discussion of strategies for increasing mental health programs that are developed and staffed by systems of education. Departments of education are often the largest child-serving system in a community, and failure to focus on increasing and improving mental health services

provided by this system will promote a piecemeal and fragmented strategy. Here the reader is referred to the important work of Adelman and Taylor [18–20] through their School Mental Health Project and Center for Mental Health in Schools at the University of Los Angeles.

This article focuses on funding expanded school mental health programs. Although the literature is limited, a broadly accepted conclusion is that funding for these programs has been patchy and tenuous [21]. Programs have been funded through a mix of sources. In general, the fee-for-service approach is used to support more intensive services such as assessment and therapy for youth with diagnoses. Because this mechanism can usually not be used to support more preventive services, other sources of revenue, such as grants and contracts, and other forms of support must be obtained for programs to provide a full continuum of mental health promotion and intervention services. In this article, we first review issues related to fee-for-service funding and then turn to issues related to federal, state, local, and private sources of funding. Each of these funding mechanisms is discussed, and the challenges and ideas for overcoming them are presented. The article concludes with a discussion of important opportunities to enhance funding for expanded school mental health programs.

Fee-For-Service Funding

For ESMH programs to obtain fee-for-service revenue, students must have active health insurance and must have a clinical diagnosis typically recorded using nomenclature from the American Psychiatric Association's *Diagnostic and Statistical Manual, Fourth Edition* [22]. Some insurers insist that the clinical diagnosis be more serious (e.g., major depression, oppositional defiant disorder), excluding diagnoses that could be deemed less serious (e.g., the various adjustment disorders). There are increasing concerns about mental health diagnosis of children and adolescents related to the questionable reliability of these diagnoses and the negative effects they could have on the children and adolescents (e.g., denied future employment or military service) [15,23]. Given this concern, many ESMH programs evince an appropriately cautious attitude, enrolling youth in the fee-for-service component of their program only when more serious and legitimate mental health diagnoses present (i.e., justifying the need for formal entry into the community's mental health system). Alterna-

tively, there is a clear trend for programs to use less severe diagnoses (such as the adjustment disorders) when reimbursement is available for these diagnoses. Efforts to obtain reimbursement for V-Codes (issues that are a focus of treatment, but not reflective of formal “disorders”) have, for the most part, failed.

Typically, programs need to be connected to a licensed community mental health center to obtain fee-for-service revenue. In many ways this connection can be beneficial to schools and to SBHCs, as the community mental health center brings the structure and experience with the regulations to enable the rapid introduction of fee-for-service funding, as well as expansion of services to meet the needs of students with established problems [24]. However, the school-based program must abide by all paperwork and administrative requirements necessary for reimbursement (e.g., completing treatment plans, requesting approval for services, meeting licensing and compliance requirements, completing service tickets, clinical evaluations, progress notes, etc.). These bureaucratic requirements are often quite intensive, placing a considerable burden on ESMH clinicians that competes with their time and ability to provide more preventive services. This is a significant issue for advocacy because in many states the regulations for providing licensed outpatient mental health services have not been changed since the 1970s and could be complex and burdensome related to the regulations’ initial focus on caring for people with severe emotional and behavioral disturbances [25]. It is also worth noting that owing to the administrative demands of conducting fee-for-service activities, it can be difficult for the revenue that is received to even match the costs associated with providing services and negotiating fee-for-service bureaucracies [26].

An additional obstacle to relying on fee-for-service billing to fund school-based mental health is the financial incentive to rely on services listed on the fee schedule. Fee schedules are a list of services that the insurance company will pay for with corresponding codes. Typically, these services are established to support traditional clinic-based mental health services such as the 50-minute treatment session. Some managed care organizations (MCOs) can have limited lists, whereas others can go beyond those services typically found on fee schedules. One of the primary advantages of ESMH is the ability to flexibly provide services in the context of the environment in which the child is demonstrating problems. These services can take many different forms, including observations, interventions in the classroom or on

the playground, participation in interdisciplinary team meetings, and brief meetings with individuals or with groups of children. Programs that take advantage of this clinical flexibility are likely to have difficulty fitting its services to the fee schedule.

Methods exist for overcoming this financial disincentive through negotiations with MCOs. One method is to negotiate additional services that can be added to the fee schedule to support the effective use of school-based clinicians. For example, Community Care Behavioral Health in Pittsburgh, Pennsylvania, added consultation with teachers to their fee schedule to support ESMH services. In Maryland, a community support and prevention mechanism allows clinicians to bill through the Medicaid MCO for preventive services, including classroom presentations, teacher consultation, and skill training groups. Other fee schedule items may be pursued, or expanded definitions of the current items may be proposed. It can be useful to bring evidence documenting the positive outcomes, quality assurance procedures, and satisfaction with services to the negotiations.

Medicaid Funding

Children’s enrollment in Medicaid for health and mental health care coverage accounts for a large portion of health care insurance. Of low-income children, private insurance covers approximately 34%, 25% are uninsured, and 41% are covered by Medicaid [27]. At present, Medicaid is the largest funding source of school-aged children’s health care. For example, in 1997, Medicaid funded 25% of care for children aged younger than 18 years [28]. The role of Medicaid and managed care on improving sustainability of programs is highlighted through an analysis of funding of SBHCs. Smith [28] reported that funding for SBHCs comes from five main sources: state schools and related agencies, county or city schools and related agencies, federal schools and related agencies, private sources, and patient revenue, of which Medicaid was the primary source of revenue within this category of funding.

There are little published data on Medicaid funding of SBHCs, with even less related to expanded school mental health. Percentages of Medicaid revenue vary, with programs reporting amounts that range from 10% to 33% [28,29]. Most SBHCs (80%) report billing Medicaid or Medicaid health plans [30]; however, only a small percentage (3%-10%) of the SBHCs’ budgets in most states actually comes from Medicaid reimbursements [26]. In fact, some

SBHCs lose money when trying to collect from Medicaid, because the revenue recovered from it frequently does not cover the cost of billing [26]. In response to these challenges, some states have attempted to simplify Medicaid reimbursement processes. In Illinois and North Carolina, for example, centers that meet standards set by the Health Department, School Health Office, and Office of Medical Assistance do not have to receive prior approval to bill Medicaid for services [31].

Significant barriers exist that affect the success of the Medicaid-SBHC partnership and that influence the numbers and types of services provided [32]. An important issue is that SBHCs are often not licensed outpatient mental health centers, meaning that, in most states, they cannot access fee-for-service funding through Medicaid (or other indemnity insurance) to pay for mental health care. This situation means that the SBHCs will need to formally connect to such centers in order for fees to support mental health care. There are exceptions to this pattern. For example, in North Carolina and New Mexico, Medicaid reimbursement is available for preventive mental health services in SBHCs [33].

Some states provide Medicaid funding to SBHCs through less traditional channels. For example, SBHCs can receive Medicaid funds by providing "related health services" intended for special education under IDEA [26]. In Vermont, the schools provide administrative functions on behalf of Medicaid to ensure comprehensive and preventive health services to enrolled students as part of the state's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) plan. In other states, SBHCs have obtained the designation of "essential care providers," which provides a legal mandate for Medicaid MCOs to contract with them [26].

State Children's Health Insurance Program

The state Children's Health Insurance Program (SCHIP) is a state-driven, federally funded initiative designed to provide insurance coverage for children from low-income families who do not qualify for Medicaid. In some states this program is operating like an extension of Medicaid, with higher income limits for eligibility. There is considerable variability in how states are using SCHIP, but most use managed care delivery systems to implement the program [26]. One report underscored concern that this federal resource is being grossly underused to improve health care for children and adolescents because of, to a large extent, poor enrollment [34].

As mentioned, these fee-for-service mechanisms are primarily being used to support assessment and treatment services in schools for youth with established problems. A trend is beginning for some fee-for-service support for more preventive services, but here experiences and the literature are limited. Next, strategies for ESMH programs to fund broader mental health promotion, prevention, and early intervention activities through federal, state, local, and private funding streams are presented.

Federal and State Funding

The federal government has become a significant funding resource of school-based mental health programs, with two mechanisms that are the most prominent. The first mechanism, the Safe Schools/Healthy Students initiative, was established in the late 1990s as a national response to school violence, particularly school shootings. In an unprecedented collaboration between the U.S. Departments of Education, Health and Human Services, and Justice (as the three primary federal agencies involved), grants through this initiative helped to establish ESMH programs, with particular emphases on violence prevention, healthy childhood development, and resilience. Initially \$98.7 million was provided to fund 54 sites. To date, the federal government has invested more than \$600 million in the Safe Schools/Healthy Students program and provides funding to 97 communities [35].

The second prominent mechanism, the Healthy Schools, Healthy Communities program is administered by the Health Resources and Services Administration. Healthy Schools, Healthy Communities was established in 1994, via the Bureau of Primary Health Care, to encourage the development of new, comprehensive, full-time, school-based primary care programs that serve high-risk children. It is the first federal program to support the creation of school-based health centers and now is a primary source of support for SBHCs, with \$17 million allocated to support the centers in 2001 [36]. Around 60% of SBHCs offer mental health services, so support for SBHCs will often support the development of these services [37]. Funding is used to support prevention-oriented topics such as fitness programs, as well as violence prevention, wellness promotion, parenting groups, and self-esteem enhancement.

Other sources of federal support for school mental health programs include the Title V Maternal and Child Health Block grant, Title XI funds for disad-

vantaged youth, the Title XX Social Services block grant, and the Preventive Health and Health Services block grant [6,26,38]. In general, these federal block grants are provided to states, which then have some discretion as to how funds are actually allocated within relatively broad categories indicating appropriate uses [6]. This level of discretion points to the importance of state level advocacy to ensure that school mental health has a voice in the context of the many other voices heard as diverse programs scramble for funding.

In addition to federal funding, some states include school-based health and mental health services in their budgets. State general funds contributed almost \$32 million to SBHCs in 18 different states during 1999–2000 [38]. Specific health initiatives also provide opportunities for funding SBHCs. For example, North Carolina increased funding in its adolescent health initiative to assist in the support of SBHCs [26]. As an example of significant advocacy at local and state levels, Maryland has allocated \$2 million as a line item in the state budget to support the expansion of school-based mental health and violence prevention programs.

State taxes also provide substantial support for SBHCs. In particular, tobacco taxes, money from tobacco settlements, or both in Arizona, Massachusetts, Florida, and Louisiana provided funding for SBHCs [38]. Other states have used a supplemental sales tax to help support SBHCs [39].

Local Funding

An important potential source of funding for expanded school mental health programs is schools and school districts themselves. For example, since 1997, the Baltimore City Public School System has allocated \$1.6 million per year for contracts to community-based providers for the development of expanded school mental health programs. Revenue for these contracts was generated by developing and improving a system to capture Medicaid reimbursements for services delivered to students receiving special education [21]. In addition, in most communities, related to site-based management, school principals can allocate money from their budgets to expand the school's mental health program. This money can be for staff members to become employees of the school or in the form of contracts to hire community providers. However, such arrangements should be based on an explicit policy of the schools

and community programs that no school funding will be used to hire community providers if doing so results in a reduction of school-employed mental health staff. If such assurance is not provided, there is significant potential for resentment and "turf" issues [40].

All other child-serving programs in the community represent potential funding sources of school mental health, such as departments of child welfare, juvenile justice, and health. In addition, local governments often have pools of discretionary dollars that can be used to support the programs [41].

Private Funding

The most significant private funding source of school mental health programs has been foundations, with a number of these making significant contributions. The Annenberg Foundation gave a large grant to the Coalition of Essential School and LEARN through the Los Angeles Unified School Districts [42]. In North Carolina, the Duke Endowment has financed planning and start-up costs for SBHCs [42]. Another private foundation that has been a significant supporter in establishing and developing SBHCs is the Robert Wood Johnson (RWJ) Foundation. The RWJ Foundation developed a program called "Making the Grade," which focused on assisting states to develop financial and other strategies to foster replication of SBHCs [26]. For most states involved in the Making the Grade program, approximately 10% of their budget was provided through contributions from private donors and foundations [26]. Although the Making the Grade project is no longer in formal operation, many of its functions are continuing through RWJ Foundation funding for the recently established Center for Health and Health Care in Schools. The Kellogg Foundation has also provided significant support to SBHCs through its support of the National Assembly on School-Based Health Care, a membership association that is leading advocacy, training, and technical assistance to advance school-based health care.

Although these sources of foundation support for school-based health care have been important for the field, they remain isolated examples. In general, foundation funding is limited to initial seed funding to demonstrate the potential of an idea or approach, with other sources required for project sustainability [21].

Concluding Comments and Future Directions

Efforts to expand mental health programs in schools should begin with advocacy, policy improvement, and resource and program enhancement for programs owned by school systems. But the work should not end there, because doing so will result in overburdened schools and lost opportunities for interdisciplinary collaboration and movement toward a true system of care. Bringing in community providers to work in schools through expanded school mental health programs requires mechanisms to fund them. Fee-for-service is the dominant approach to fund child and adolescent mental health care in general and has led to a bias toward using this approach to fund ESMH programs. However, if this is the only mechanism in place, then the programs will be mainly clinics in schools, helping to bring care to underserved youth with disorders, but failing to assist in the building of preventive and health-promoting approaches. For these programs to do the latter, then other financial support, through grants, contract, and other sources (e.g., state line-item support, capitated strategies), will need to be pursued, and here the picture is much more variable and tenuous.

This picture leads us to two pressing needs to advance the field, as reviewed by Evans and colleagues [21] in a recent publication. The first need is to enhance communication mechanisms to enable the sharing of lessons learned and funding strategies among and between programs, communities, and states. National technical assistance centers for mental health in schools [43] are currently engaged in sharing information about school mental health funding, as are other groups. There would be considerable benefit to integrating this information into "one evolving guide that reviews the full panoply of school mental health funding opportunities and strategies, with this information broadly shared with diverse constituents (e.g., through list-serves, websites, conferences" (pp. 84–85). The second need reflects a primary theme in this article, which is to build advocacy for mental health in schools. "While current advocacy efforts resound with passion, testimonials, and some data and experience; they are lacking the real ammunition that will secure widespread stable funding. Outcome, satisfaction, and economic data demonstrating the value to children and families are needed to achieve this goal. Once obtained, large companies will expect insurance companies to fund ESMH, employees will consider ESMH when selecting coverage, and communities

will insist that ESMH services are a part of the schools" (p. 85).

Efforts to enhance both communication and advocacy should focus on solidifying existing funding mechanisms and working out problems, and on expanding funding options to include new mechanisms. A number of efforts hold promise.

EPSDT and Medicaid

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program of Medicaid is meant to ensure that Medicaid-eligible children receive appropriate health screening to ensure the early and timely delivery of services [44]. These regulations should include screening for early emotional and behavioral health problems in students. However, EPSDT functions are often housed within primary care sites such as pediatrician's offices, where emotional and behavioral health screening is limited and a population-focused approach is not possible. Thus, advocacy in a community or state to move the program into the schools and to focus on behavioral health (as done in Vermont) could assist in expanding Medicaid funding both for the screening and for services to address problems identified in the screening. The topic of screening for early emotional and behavioral problems is receiving increased attention related to a number of developments (e.g., the Surgeon General's report and call to action to prevent suicide [45], the growing amount of literature on the personal and economic effects of untreated depression [46]). Thus, connecting these agendas to expanding the role of EPSDT in school mental health would be strategic.

Transitional Assistance for Needy Families

The Welfare Reform Act enacted in 1996 created the Transitional Assistance for Needy Families (TANF) program to replace the Aid to Families with Dependent Children and the Job Opportunities and Basic Skills Training programs [47]. TANF is designed to aid families through the provision of employment opportunities and assistance through federally allocated funds to be dispersed at the state level. In one example of the flexible use of the application of TANF funds, the city of Philadelphia has launched a major initiative (\$4 million per year) using TANF funds to support preventive mental health services in schools. A range of preventive services, as well as quality assurance and evaluation mechanisms for the services, has been established. These programs have

been developed to ensure close collaboration between these services and more intensive school-based services funded through a fee-for-service mechanism. On the basis of the success of this experience, other communities have begun planning efforts to explore TANF funding for preventive school mental health.

No Child Left Behind Legislation

On January 8, 2002, President Bush signed into law legislation that is designed to reform, augment, and improve public education in the United States. This broad reform effort builds on the Elementary and Secondary Education Act with a particular emphasis on accountability [48]. The No Child Left Behind Act of 2001 has a particular emphasis on basing activities on "principles of effectiveness" (i.e., must be implemented to address specific school needs, be based on scientific research when appropriate, and be evaluated using on-going performance measures). In addition, initiatives targeted at improving educational outcomes through child and family enrichment activities, improvement of services at low-performing or poor schools, and the development of enhanced accountability measures are included. This law legitimizes and mandates that resources be allocated to ensure partnerships between school and community programs to use evidence-based programs to reduce barriers to student learning. Discussions about the law and how its implementation can better support mental health promotion and intervention efforts in schools are increasing [49]. The complete law and related summaries are available at the U.S. Department of Education's No Child Left Behind website (www.nochildleftbehind.gov).

Safe and Drug-Free Schools Funding

Safe and Drug-Free Schools (SDFS) funds through the U.S. Department of Education have been available to support health and mental health programs in schools for more than a decade. However, in many communities these funds have not visibly supported such programs. Recently, through a reorganization in the U.S. Department of Education, the Office of Safe and Drug-Free Schools was given increased prominence and formally connected to Homeland Security. The office has a specific charge to address issues of school safety, crisis responses, drug and alcohol prevention, and the health and well-being of students. There is hope that, through this organiza-

tion, the SDFS program will become more involved in providing leadership to and resources for school-based mental health programs (See www.ed.gov/PressReleases/09-2002/09172002.html).

The Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration is currently supporting a significant effort titled Characteristics and Funding of School Mental Health Services. This is a large-scale research project that involves surveying 2,000 elementary, middle, and high schools and their district offices on the characteristics of services being provided, staffing patterns, and methods and sources of funding. Surveys are being conducted in the 2002–2003 school year, with initial reports planned for release by fall 2003. Findings from this study will represent the first objective evaluation of financing of school mental health services, a major step forward for this emerging field.

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