ISSUE BRIEF

The Promise and Challenge of School-Based Mental Health Care for Girls of Color

Kimberlyn Leary, Ph.D.

Chloe Greenbaum, Ph.D.*

*   Cambridge Health Alliance/Harvard Medical School

Why School-Based Health Care?

The majority of youth who need mental health services don't receive care — a trend that has persisted over time.[1] The gap between the need for care and access to care is accentuated for youth of color.[2] Because young people between the ages of 5 and 19 spend most of their waking hours in school settings, school-based health centers are particularly suited to close that gap. School-based health programs serve as entry points to primary care, while also being part of a larger care system or a "medical home," especially for children who otherwise lack consistent access to care.[3] Services are available through "push technology" (always offered through the school year) rather than obligating students and parents to "pull" resources by initiating or activating contact independently.

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1   *Access to Adolescent Mental Health Care*, Off. of Adolescent Health, U.S. Dep't of Health & Hum. Serv., https://www.hhs.gov/ash/oah/adolescent-development/mental-health/access-adolescent-mental-health-care/index.html (last visited June 5, 2019); Sheryl H. Kataoka, Lily Zhang & Kenneth B. Wells, *Unmet Need For Mental Health Care Among U.S. Children: Variation By Ethnicity and Insurance Status*, 159 Am. J. Psychiatry 1548 (2002).

2   Khusdeep Malhotra, Ruth Shim, Peter Baltrus, Harry J. Heiman, Oluwatoyosi Adekeye & George Rust, *Racial/Ethnic Disparities in Mental Health Service Utilization Among Youth Participating in Negative Externalizing Behaviors*, 25 Ethnicity & Disease 123 (2015); Jeanne S. Ringel & Roland Sturm, *National Estimates of Mental Health Utilization and Expenditures for Children in 1998*, 28 J. Behav. Health Serv. & Res. 319 (2015); John F. "Fred" Thomas, Jeff R. Temple, Noe Perez & Richard Rupp, *Ethnic and Gender Disparities in Needed Adolescent Mental Health Care*, 22 J. Health Care Poor & Underserved 101 (2011); Stevenson Fergus & Marc A. Zimmerman, *Adolescent Resilience: A Framework for Understanding Healthy Development in the Face of Risk*, 26 Ann. Rev. Pub. Health 399 (2005).

3   *See* Victoria Keeton, Samira Soleimanpour & Claire D. Brindis, *School-Based Health Centers in an Era of Health Care Reform: Building on History*, 42 Current Probs. Pediatric & Adolescent Health Care 132-158 (2012).

Evaluating School-Based Health Care

School-based health care began in the realm of public health policy and practice. In the early 1900s, the New York City Board of Health established a "rule of exclusion" which allowed officials to exclude students with contagious illness from public schools. However, neither the school nor parents were obliged to provide care for ill children — and, in fact, healthy children continued to engage, play, and spend time with excluded youth, resulting in the ongoing spread of illness. In 1902, Lina Rogers, who would later be known as the nation's first "school nurse," began initiating home visits and providing families with health and hygiene information. Within a year, school absenteeism rates had substantially decreased as families learned to better manage sick children and thus reduce the spread of disease.[4]

School-based health centers have been successful in key ways. Studies indicate that "adolescents are 10 to 21 times more likely to prefer visiting a school-based health center over a community health center for mental health care" because of the greater availability and convenience of care.[5] Other studies suggest that many school-based health care centers attract and retain both white and minority youth at higher rates than do community-based health care settings.[6] This may be so because school-based clinics enable access by reducing temporal, transportation-related, and financial constraints and decrease stigma by normalizing mental health problems and mental health care.

4   *Id.*

5   *Id., see also* Linda Juszczak, Paul Melinkovich & David Kaplan, *Use of Health and Mental Health Services by Adolescents Across Multiple Delivery Sites*, 32 J. ADOLESCENT HEALTH 108 (2003).

6   Janet R. Cummings, Ninez A. Ponce & Vickie M. Mays, *Comparing Racial/Ethnic Differences in Mental Health Service Use Among High-Need Subpopulations Across Clinical and School Based Settings*, 46 J. ADOLESCENT HEALTH 603 (2010).

Case Study:
Mount Sinai's Adolescent Health Center

Since 1984, New York City's Mount Sinai Hospital's Adolescent Health Center has offered "head to toe" care for youth. The Center serves 24 schools and over 12,000 young people. It deploys a diverse staff through which young people can access a full suite of services from mental health care, to academic tutoring, to primary care in a developmentally sensitive context that recognizes how the preferences and needs of adolescents differ from those of adult patients. "We are able to reach kids," says Center Director Dr. Angela Diaz, "because we think about the culture of adolescence and the community and culture from which our students come. We understand their journey, the impact of poverty and trauma, and the complex lives they must navigate. That comes first."[7]

Overall, the available evidence suggests that school-based mental health programs yield positive outcomes for students, families, and communities. School-based health centers are associated with aggregate improvements in attendance and academic performance, enhanced school climate, fewer discipline referrals, and reduction in mental health stigma.[8] Providing mental services in elementary schools can facilitate the early detection, referral, and treatment of symptoms; in middle and high school settings, they can also support adolescents and emerging adults in making adaptive choices and consolidating socio-emotional and relational skills.[9]

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7   Interview with Dr. Angela Diaz, Jean C. and James W. Crystal Professor in Adolescent Health, Dep't of Pediatrics and Dep't of Envtl. Med. & Pub. Health at the Icahn Sch. of Med. (Nov. 20, 2018).

8   Ctr. of Excellence for Children's Behavioral Health, Ga. Health Policy Ctr., School-based Mental Health Brief (2015), https://www.cartercenter.org/resources/pdfs/health/mental_health/school-based/school-based-mental-health-issue-brief.pdf.

9   Keeton et al., *supra* note 3.

School-Based Health and Mental Health Care in the U.S.

Mapping tools like that designed by the School-Based Health Alliance aggregate data voluntarily submitted by school districts about school-based health centers to create a snapshot of the nation's investment in school-based health and mental health.[10] According to the Alliance, there are approximately 2,500 school-based health centers in the United States, a number that has steadily increased over time.[11] Yet despite the centers' promise, with well over 98,000 public schools in the United States, school-based health care currently reaches only 2 percent of U.S. public schools.[12]
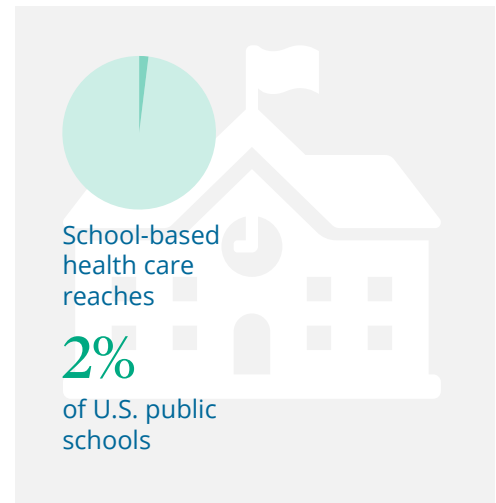
According to the 2016-2017 census, the number of school-based health centers ranges from a single center in each state (for example, New Hampshire and Wyoming) to close to 200 centers (for example, in Texas, California, and New York).[13] Most school-based health centers are located on school property, with 65 percent of school-based health centers pairing a primary care provider with a behavioral health provider.[14]

Utilizing school-based health centers is not without its challenges. In many communities with school-based health centers, for example, staffing levels and care panels (i.e., the number of students to whom a health professional provides care) vary. School-based health professionals might provide services at one or multiple schools. Given that different schools have different cultures and different in-school teams managing triage and referral processes, school-based health professionals working across different schools or jurisdictions experience distinct challenges that may not be recognized by those employing them, with potential adverse effects on the students they treat.[15]

School-based health care reaches

2%

of U.S. public schools

10 *National School-Based Health Care Census*, Sch. Based Health Alliance, https://www.sbh4all.org/school-health-care/national-census-of-school-based-health-centers/ (last visited June 5, 2019).

11 *Id.*

12 Note: Because the census is voluntary, it is likely that that these figures represent an undercount.

13 Hayley E. Love, Samira Soleimanpour, Nirmita Panchal, John Schlitt, Caroline Behr & Matt Even, 2016-2017 National School-Based Health Care Census Report, School-Based Health Alliance (2018), https://www.sbh4all.org/wp-content/uploads/2019/05/2016-17-Census-Report-Final.pdf.

14 Hayley Lofink Love, Erin Schelar, Kyle Taylor, John Schlitt, Matt Even, Anna Burns, Suzanne Mackey, Megan Couillard, Jessica Danaux, Anna Mizzi, Dela Surti, and Daisha Windham, 2013-2014 Digital Census Report, School-Based Health Alliance, https://censusreport.sbh4all.org.

15 Interview with Michelle Grier, Director of Social Work, Girls for Gender Equity (Apr. 19, 2019).

Funding can also present a hurdle to sustainability. There is considerable variability in how school-based health centers are funded. Grant- or philanthropy-funded school-based health and mental health services may be provided at no or little direct cost to the student or her family. Other school-based centers or partnerships bill families who have private or public insurance for covered services. However, some centers experience challenges in obtaining reimbursement; some plans, for example, may not reimburse school-based health care service providers because they are not the students' designated primary care providers. Even when reimbursement is feasible, few schools have the resources to hire billing staff with requisite knowledge of billing codes or sufficient capacity to pursue outstanding payments. Further, many of the services that school-based health centers provide to enhance student capacity and wellness may fall outside of the scope of "procedure codes" for medical intervention and therefore not reimbursable.[16]

The Affordable Care Act (ACA) offered a promising solution in the form of two provisions for school-based health centers: "a one-time-only mandatory appropriation of $200 [million] to construct, expand, and equip [school-based health centers], and a first-ever authorization for a federal initiative that would help finance clinical services."[17] However, the latter initiative

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16   Keeton et al., *supra* note 3 at 136, 148-149.

17   *School-Based Health Centers and the Affordable Care Act*, HEALTHY SCH CAMPAIGN (Oct. 24, 2013), https://healthyschoolscampaign.org/policy/school-based-health-centers-and-the-affordable-care-act-5879/.

remained an unfunded mandate.[18] Thus, school-based health centers often rely on sponsorship, soft funding in the form of federal and state grants and philanthropy, or customized solutions that leverage local or state-specific opportunities. For example, in 2009 California's Alameda County "launched a School-Based Behavioral Health Initiative, bringing together two divisions within the Alameda County Health Care Services Agency to create a shared model for building and financing school-based behavioral health systems" among all 18 of its school districts.[19] Key components included an annual investment of $25 million, coordination strategies at the district level, ongoing assessment, trauma-informed care, and cultivating cultural responsiveness and school-wide responsibility for its success.[20] Georgia developed the APEX program, funded by the state's Department of Behavioral Health and Developmental Disabilities, which "creates partnerships between community-based mental health providers and local schools to provide school-based mental health services."[21] The APEX model also uses a tiered system, distributing interventions across universal prevention (e.g., parent education and mental health education), early intervention (e.g., individual treatment options for at-risk students), and intensive intervention (for students in crisis and at substantial levels of risk).[22] For over 30 years, Florida's PACE Center for Girls has offered gender-specific diversion programming (Students Making A Right Turn, or SMARTGIRLS!) to provide at-risk girls with alternatives to the juvenile justice system. Girls attend PACE classes for six hours a day, four or five days each week, and engage in counseling, group therapy, and community-service projects. Students also serve as peer counselors to teach others about self-esteem, decision-making skills, and building positive relationships.[23] PACE programming is funded by a line item in the Florida state budget.[24]

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18 *Id.*

19 Ctr. For Healthy Schs. & Cmtys., Alameda County School-Based Behavioral Health Model: Creating Nurturing School Environments (2015), http://achealthyschools.org/assets/116_alameda_county_school-based_behavioral_health_model.pdf.

20 *Id.*

21 The Georgia Apex Program: School-Based Mental Health Services, The Center of Excellence for Children's Behavioral Health (2019), https://gacoeonline.gsu.edu/download/apex-school-based-mental-health-year-3-years-1-3-summary-brief/.

22 Interview with Dr. Veda Johnson, Professor in Gen. Acads. and Pediatrics & Dir. of PARTNERS for Equity in Child & Adolescent Health for the Dep't of Pediatrics, Emory Univ. (Apr. 1, 2019).

23 Office Of Juvenile Justice & Delinquency Prevention, U.S. Dep't Of Justice, *App. PACE Center for Girls, in* Guiding Principles for Promising Female Programming: An Inventory of Best Practices (1998), https://files.eric.ed.gov/fulltext/ED439191.pdf.

24 Mary Lett, *$2.1M to help girls at PACE centers*, Pensacola News Journal, July 25, 2015, https://www.pnj.com/story/news/education/2015/07/29/pace-center-girls-receives-extra-funds/30826849/; PACE Center for Girls, Inc. and Affiliates, Consolidated Financial Statements, Reports Required by Government Auditing Standards, the Uniform Guidance, the Florida Single Audit Act, and Schedule of Expenditures of Financial Awards, https://www.pacecenter.org/files/resources/annual_reports_990s/PACE_Center_for_Girls_2018_Financial_Statements.pdf.

Meeting the Needs of Diverse Youth

School-based health centers are positioned to play an important role in meeting the needs of diverse youth by expanding the accessibility of the continuum of care to those at the greatest risk of being left behind.[25] More than 70 percent of the students in schools offering school-based health care are ethnic minorities.[26]

Economically disadvantaged minority families face many barriers to seeking care even when they have insurance, including identifying providers willing to accept Medicaid despite the program's limited reimbursement rate. Health care and mental health care delivered in schools interrupt this cycle by bringing the care to them. In addition, school-based health and mental health care mitigate some of the "taxes" of seeking health services, reducing temporal, transportation-related, and financial constraints. School-based care may also reduce at least some of the stigma commonly associated with mental health care, especially in communities of color, by normalizing mental health challenges and help-seeking. For example, when mental health is integrated across co-curricular activities, mental health services became normalized and seeking care for oneself or suggesting that friends seek services becomes de-stigmatized.

Some school-based programs are also evolving best practices to address cultural responsiveness. Alameda County's School-Based Behavioral Health Initiative, for example, has adopted the Standards for Cultural Competence in Social Work Practice as a framework to ensure that cultural and linguistic empathy is embedded in all programming.[27]

However, most outcome measurements are not disaggregated by race and gender, making it difficult to know much about the particular impact of school-based care for girls of color.

> **Health care and mental health care delivered in schools interrupt this cycle by bringing the care to them.**

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25 Keeton et al., *supra* note 3.

26 *Id.*

27 CTR. FOR HEALTHY SCHS. & CMTYS., *supra* note 18.

The perceptions of practitioners as to the effectiveness of culturally responsive school-based health services are also important indicators. One study found that low-income African-American girls reported to practitioners high rates of "exposure to violence, limited trusting relationships, depression, and low self-esteem."[28] Significantly, the practitioners in the study also identified these girls as resilient despite their lack of access to mental health supports.[29] In the face of disproportionate exclusionary school discipline and under-recognition of girls of color as psychological subjects, schools remain complicated sites for girls of color. Interventions aimed at reducing negative or skeptical attitudes among providers as they pertain to girls of color may be an important component of ensuring that girls of color benefit from available resources.

28   Erin Harper, Ann Cale Kruger, Chela Hamilton, Joel Meyers, Stephen D. Truscott & Kris Varjas, *Practitioners' Perceptions of Culturally Responsive School-Based Mental Health Services for Low-Income African American Girls*, 10 Sch. Psychol. F. 16 (2016).

29   *Id.*

There's No One Model of School-Based Health Centers

The moniker of school-based health care can refer to a multitude of different models. The core services provided through school-based health programs range from traditional primary care, to mental health screening, to specialized behavioral health, to oral health, health education, and wellness programs. In addition to primary care visits, in schools offering comprehensive programs, students visited school health centers most often for reproductive health or mental health concerns.[30] School-based health centers also play an educational role by offering health information programming, serving in an advisory role to faculty, school staff, and student groups, or offering teacher training.

In some counties, school-based services are provided through mental health professionals, some employed as independent contractors, while others may be employed directly by schools or districts.[31] In other models of school-based care, schools partner with health care entities (e.g., a hospital, federally qualified health center, community health and/or specialized mental health agency, or local health department) to provide services for students and families.[32] In many communities, school-based health centers also provide services to individuals beyond students, including family members of students. Partnerships with health care entities like these enable schools to offer a comprehensive range of services to a broader range of community members, but the partnerships themselves also require management resources to ensure effective collaboration and coordination to meet the needs of schools.[33]

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30   Keeton et al., *supra* note 3.
31   Ctr. of Excellence for Children's Behavioral Health, *supra* note 8.
32   Keeton et al., *supra* note 3.
33   Interview with Michelle Grier, *supra* note 15.

The School-Based Health Care Ecosystem

Many school-based health initiatives rely on a conceptual framework that includes stepped care and tiered services. Some programming is structured to be universal and generalizable to the whole school community (e.g., socio-emotional learning, behavioral supports, and mental health first aid). Other tiers focus on students who are at risk of developing mental health concerns (e.g., social skills training) and intensive services are offered for students with demonstrated high risk (including personalized behavior plans).

As Heather D. Boonstra and Elizabeth Nash of the Guttmacher Institute have recognized,

> States have traditionally recognized the right of parents to make health care decisions on their children's behalf, on the presumption that before reaching the age of majority (age 18 in all but four states), young people lack the experience and judgment to make fully informed decisions …. [C]ourts in some states have adopted the so-called mature minor rule, which allows a minor who is sufficiently intelligent and mature to understand the nature and consequences of a proposed treatment to consent to medical treatment without consulting his or her parents or obtaining their permission."[34]

In addition, many state law provisions give minors the right to consent to health care in certain contexts, ranging from reproductive health care to substance abuse treatment and mental health care.[35] Some states apply this provision to minors as young as 12 years old.[36] Other states give doctors discretion to inform parents that their child is seeking services.[37]

In other jurisdictions, statutes limit which services a minor child may receive. In Georgia, for example, state law prohibits school-based health centers from providing reproductive health care, except in those communities where local laws have been designed to supersede state mandates.[38]

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34   Heather D. Boonstra & Elizabeth Nash, *Minors and the Right to Consent to Health Care*, 3 Guttmacher Pol'y Rev. 4 (2000), https://www.guttmacher.org/sites/default/files/pdfs/pubs/tgr/03/4/gr030404.pdf.

35   *Id.*

36   Ann McNary, *Consent to Treatment of Minors*, 11 Innovations Clinical Neurosciences 43 (2014).

37   Boonstra & Nash, *supra* note 34.

38   Interview with Dr. Veda Johnson, *supra* note 21.

Referrals for care are typically initiated by teachers, counselors, or other school personnel, often in collaboration with the student's parents or guardian, and the student herself. At-risk students become eligible for mental health or other support services in the context of failing to educationally thrive. Under the federal statute the Individuals with Disabilities Education Act (IDEA), an individualized education plan (IEP) is required for children who demonstrate disabilities that interfere with their learning, including "emotional disturbance," a non-specific category that may encompass a broad range of socio-emotional challenges and significant forms of diagnosable mental illness.[39] Public schools are required by federal law to provide students with special education and related services (including counseling and mental health resources), enabling them to benefit from the general education program.[40]

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39   Interview with Michelle Grier, *supra* note 15.

40   *About IDEA*, U.S. Department of Education, https://sites.ed.gov/idea/about-idea/ (last visited Nov. 5, 2019).

Recommendations to Improve the Potential of School-Based Health Centers to Serve All Students

Conduct targeted research on mental health and girls of color. Research is urgently needed on the mental health needs and treatment preferences of girls of color. Additionally, research must focus on which evidence-based treatment packages best meet the needs of girls of color. Although the value proposition of school-based health care includes attention to cultural responsiveness, there is a dearth of research on the impact of school-based health care on mental health outcomes for girls of color. Without additional research, we don't yet know the most effective ways to leverage school-based health care to address and mitigate the risk factors associated with being a girl of color or how to design school-based mental health care so that programs may be maximally responsive to the needs of girls of color. Mapping tools like those designed by the School-Based Health Alliance can be leveraged to identify needed synergies between high-need areas (e.g., as determined by rates of school discipline) and the availability of school-based health resources.[41]

Improving the Potential of School-Based Health Centers to Serve All Students

- ✓ Conduct targeted research on mental health and girls of color

- ✓ Identify exemplars of school-based health center expansion and principles that enabled successful scale-up and create toolkits

- ✓ Build capacity of school-based health centers through strategic partnerships

- ✓ Expand the continuum of care through technology

- ✓ Build proactive readiness to leverage funding and policy opportunities

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41   *National School-Based Health Care Census, supra* note 10.

Identify exemplars of school-based health center expansion and principles that enabled successful scale-up and create toolkits. To facilitate growth in communities of color, promising practices and their core components should be elevated. In Georgia, for example, a concerted investment in school-based health centers led to an exponential expansion — from 2 centers to 48 centers in 10 years. Key elements in Georgia's effort included planning grants to support year-long planning processes with all potential stakeholders in a given community; designing services commensurate with locally perceived need; delivering services through evidence-based models; identifying minimum criteria for outcomes and benchmarks; and reporting out metrics that measured whether the services provided addressed local and system needs (e.g., improved health and well-being and reduced costs).[42] Developing toolkits based on exemplar efforts enables communities to leverage learning from parallel efforts.

Build capacity of school-based health centers through strategic partnerships. Under the ACA, hospitals are obliged to conduct a community-needs assessment to identify key health needs in a community and devise targeted solutions for implementation.[43] Additionally, many health systems engage in philanthropic activities supporting public health initiatives. School-based health centers should identify opportunities to partner with health systems to improve their business and management operations. For example, few school-based health centers have the resources to hire billing staff with requisite knowledge of billing codes or sufficient capacity to pursue outstanding payments.[44] Since health systems excel at financial back-office operations, building partnerships between health care entities and school-based health centers may enable those centers to capture funding with more effective billing practices.

42   Interview with Dr. Veda Johnson, *supra* note 22.

43   Community Health Needs Assessments, The Network for Public Health Law, https://www. networkforphl.org/resources/topics__resources/health_reform/community_health_needs_ assessments/, (last visited Nov. 5, 2019).

44   Keeton et al., *supra* note 3.

Expand the continuum of care through technology.[45] Although school-based health care represents an expansion of the continuum of care for students, there needs to be greater continuity of engagement, especially through the use of technology.

Technology plays a critical and mediating role in the lives of most young people. It has also changed student expectations about what counts as responsible and responsive health care. As Jeannette Pai-Espinosa, President of National Crittenton, noted:

> For many youths with well-founded distrust in systems, expecting them to feel comfortable seeking care for sensitive personal concerns, let alone to disclose trauma or violence they have experienced, seems unrealistic. Girls of color, for example, may not be willing to ask certain questions of a provider if they expect to feel blamed or shamed rather than understood. Technology may expand access to care for students who are not comfortable with traditional access points and those for whom direct contact with a mental health professional is stigmatizing.[46]

For example, rather than expecting a girl to walk in to request help, schools could provide stepped care through curated internet resources and provider access via chat, texts, or a video call before she seeks direct care in more traditional ways. A continuum of access offers a lower threshold for girls to gain needed information or learn about resources that honor the understandable distrust some young people have with respect to systems.

Technology may also be utilized to extend clinical resources. For example, tele-psychiatry may allow more school-based health care centers to expand their ability for clinical consultation, given a critical workforce shortage of child and adolescent psychiatrists.

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45   This framing of the role of technology and clinical care was suggested by Jeannette Pai-Espinosa. Interview with Jeannette Pai-Espinosa, President of Nat'l Crittenton (Apr. 6, 2019).

46   *Id.*

Schools should also train referring and treating staff to sensitively respond to culturally unique risk factors.[47] Technology platforms can be used to support and nurture communities of practice to sharpen their capacity for cultural awareness. Technology can be leveraged to provide technical assistance. For example, innovation that focuses on helping girls of color give voice to their treatment preferences and needs could be incorporated into Khan Academy-type content delivered through professional organizations and networks, such as the National Child Traumatic Stress Network.[48]

Build proactive readiness to leverage funding and policy opportunities. By developing model language and creating a portfolio of evidence-based interventions, community-based agencies can proactively develop readiness to respond to federal and state invitations for public comment or granting opportunities. For example, the Family First Prevention Act modifies federal child welfare financing to provide services ("mental health and substance abuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator services") to families who are at risk of entering the child welfare system. School safety legislation like Florida's "Marjory Stoneman Douglas High School Public Safety Act" funds school guardians and requires them to complete a certification program in diversity training.[49] Both opportunities offer the possibility of introducing interventions and language relevant to the needs of girls of color in school settings. Unless relevant advocacy and policy agencies achieve readiness, opportunities to interject interventions relevant to the needs of girls of color may be lost.[50]

47   Yolanda Anyon, Seow Ling Ong & Kelly Whitaker, *School-Based Mental Health Prevention for Asian American Adolescents: Risk Behaviors, Protective Factors, and Service Use*, 5 Asian Am. J. Psychol. 134 (2014).

48   *Who We Are*, The Nat'l Child Traumatic Stress Network, https://www.nctsn.org/about-us/who-we-are (last visited June 5, 2019).

49   Family First Prevention Services Act of 2017, H.R. 253, 115th Cong. (2017).

50   Fla. Stat. § 30.15(1)(K) (2018).