ALIGNING THE EDUCATION AND HEALTHCARE SECTORS

The Role of Integrated Behavioral Health

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make health whole
INTEGRATING CARE. IMPROVING LIVES.

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Key Messages

Adolescent behavioral health concerns are pervasive and impact academic achievement – students with positive behavioral health are more equipped to learn and excel academically

Promoting adolescent behavioral health is an integral and critical mission shared by teachers, school administrators, and clinicians that bridges the school and healthcare sectors

- **Schools are strategically poised to deliver** both universal and tiered adolescent behavioral health services; these opportunities are **augmented by leveraging resources** from the healthcare sector
- Multi-Tiered Systems of Support (MTSS) is a framework applicable to education and healthcare sectors that could **align efforts and instill policy for strengthening partnerships** and leveraging resources to sustain and expand adolescent behavioral health services in schools

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Overview

Integrating behavioral health resources between the healthcare and education sectors offers compelling and strategic opportunities to prepare youth for academic success through promotion of positive behavioral health. The primary mission of schools is education, and achieving academic excellence is most promising when youths experience stable emotional, behavioral, and physical health. However, adolescent behavioral health concerns are common, and access to services and treatment is limited.[1-4] Minimizing the negative consequences of behavioral health problems will require fostering sustainable and responsive collaboration across the education and the healthcare sectors. This issue brief presents best practices and policy recommendations for establishing operative partnerships between schools and healthcare systems to optimize adolescent behavioral health and wellbeing. Utilizing a common framework to align mission and vision, ensuring clear communication that complies with Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA), and establishing diverse funding streams will build systems to support whole health of our youth.

Behavioral Health Integration

Behavioral health and primary care integration has been defined as patient-centered care that addresses mental health and substance use conditions, health behaviors, life stressors, and stress-related physical symptoms, provided by a team of primary care and behavioral health clinicians.[7]

Addressing whole person health requires applying integration both within and outside of the traditional healthcare system. Therefore, behavioral health integration pertains to (1) the healthcare sector; and (2) cross sector collaborations between the healthcare sector and social services, employers, schools, and communities.

Ultimately, the underlying principle of behavioral health integration is that physical, behavioral, and social health are inextricably intertwined. Fragmented systems of care create barriers to achieving optimal whole person health. Integration of care is a solution to fragmentation. Understanding the physical, behavioral, and social determinants of health, and their relationship to one another, exposes the root causes of many health disparities. Policies advancing integration support sustainable change to achieve more equitable health outcomes.

This issue brief was developed following a rapid review to summarize evidence, a methodology that streamlines the usual processes for systematic reviews to synthesize relevant evidence in a timely manner for decision-makers in healthcare and policy. Detailed methods are available in an online appendix.

NEARLY HALF OF ALL LIFETIME MENTAL HEALTH DISORDERS START BY THE MID-TEENAGE YEARS[2,3]

1 in 5 youth

have a diagnosable mental health condition[1]

75 - 80%

of youth with mental health needs do not receive needed behavioral health services[4]

70 - 80%

of youth who obtain behavioral health services do so in the school setting[5,6]

Purpose

Fostering positive behavioral health and wellbeing during adolescence has critical long-term impacts for youth to develop into healthy and productive adults. Nearly 1 in 5 adolescents meet criteria for a diagnosable mental health condition[1] yet, fewer than one third receive evaluation or treatment for these conditions.[4,8] Teens experiencing emotional and behavioral difficulties struggle with peer and family relationships and are at risk for academic problems such as chronic absenteeism, school failure, and dropping out.[9-11] When emotional and behavioral conditions are not prevented or addressed, the problems may worsen with devastating and costly long-term outcomes such as incarceration, unemployment, substance abuse, and early death.[10,11] Identifying teens with and at risk for behavioral health conditions is critical to improving whole health and achieving life-long gains. Innovative and effective strategies for prevention and treatment must be realized.

Expanded behavioral health integration in schools promotes preventive behavioral health, early identification for youth at risk for behavioral health concerns, and treatment for those with behavioral health conditions. Currently, 70-80% of youth who obtain behavioral health services do so in school.[5,6,12,13] Meeting youth where they spend most of their daily time removes common barriers to obtaining behavioral health care by eliminating transportation needs, reducing challenges related to stigma, and improving access to care for racial/ethnic minority youth.[14-16] Furthermore, incorporating social and emotional curricula in schools to reach all students not only improves youth emotional skills[17] but also improves academic outcomes.[18] A recent meta-analysis of 213 universal school-based social-emotional learning programs demonstrates that participating youth had an 11 percentage point gain in academic performance, as well as improvements in social and emotional skills, attitudes, and behavior.[19] Still, many barriers remain to fully integrate behavioral health curricula and services in schools.

While there is a longstanding history of informal collaboration between schools and the healthcare system, the process of integrating youth behavioral health is often cursory, ad hoc, and not routine.[20] Difficulties sustaining supportive collaborative processes are often driven by time constraints, logistical challenges of communications, and financial pressures.[20,21] These challenges are perpetuated by both sectors developing and continuing to operate in different silos.[20,21] In the wake of many school tragedies, there is increased emphasis, energy, and funding for promoting youth behavioral health in schools.[22] Embracing this momentum requires mechanistic guidance for productive alignment of the education and health systems. This issue brief seeks to address these challenges by offering mechanisms for the education and healthcare sectors to forge opportunities together through shared missions, enabling pathways of communication, and establishing sustainable funding for services.

Shared Framework: The Multi-Tiered System of Support

School teams and healthcare partners each have expertise in providing behavioral health supports and share a common interest in promoting positive adolescent behavioral health. To achieve whole adolescent health, coordinated efforts must bridge the differing perspectives of the healthcare and school systems. Using a shared framework facilitates this work, starting with identifying shared missions, visions, and values. Adopting a shared framework provides a common language for clarifying specific roles and strategies for each group to work, strategically leveraging and augmenting available resources. Subsequently, policies can be targeted to address systemic barriers, align values, and define actions for relevant stakeholders.

An established framework exists in the education sector that is ideal for adopting and applying to advance integrated behavioral health in schools and healthcare. This framework, the Multi-Tiered Systems of Support (MTSS), is a whole school prevention-based framework that incorporates behavioral supports into every day schooling to improve learning for every student through a layered continuum of evidence-based practices and systems.[23] The MTSS extends from a federal mandate and incorporates both academic and behavioral supports for students.[9,24] This nationwide, school-based framework starts with the foundation of family-school-community partnerships and extends to three tiers that are layered to align systems necessary for every student's academic, behavioral, and social success. The tiered approach spans from universal screening (tier 1) to targeted intervention (tier 3) with evidence-based practices as well as opportunities for partnering with healthcare and community groups throughout the tiers.

The MTSS framework draws heavily from components of the public health model of primary, secondary, and tertiary prevention.[9] Because the MTSS closely mirrors a well-known model in medicine, the familiarity encourages a common language for members of the healthcare team to discuss behavioral health programming and interventions with the education team.[9] Furthermore, the MTSS is widely used by school districts nationwide. These reasons support promoting the MTSS as a shared framework with high likelihood of broad acceptance and buy-in among schools and partners in healthcare to use the MTSS as the common language when establishing partnerships. Within each tier of the MTSS framework exists actionable policy levers to integrate behavioral health in the schools.

State and District Policy and Program Levers

Integrating behavioral health in schools most commonly occurs informally with ad hoc partnerships creating unique policies specific to one school, or district, and their community healthcare partner. However, state-level agenda setting and policy making can guide district and local programmatic strategies to strategically integrate and streamline youth behavioral health programs and services across sectors and across the MTSS. This work necessitates engaging diverse, policy-focused, state-level leaders and stakeholders—representing education, health, mental health, and child advocates—to set realistic and flexible goals that encourage collaboration across sectors. Representative stakeholders will ensure the proposed processes are aligned with the areas of expertise for each group. Sustainability can be accomplished by establishing a state-level work group, such as a coalition, task force, or committee, as part of an executive or legislative order.[26,28]

MTSS Tiers defined

The Foundation of MTSS establishes a culture of collaboration between family-school-community and healthcare partners. This premise strives to reduce stigma around behavioral health, emphasize data-driven decisions, and establish a respectful and culturally-responsive climate amongst partners.

Tier 1 is universal for all students. This tier focuses on positive behavior supports for all youth. Services address the entire student body and include programming such as universal screening, evidence-based social and emotional learning curricula, and an established referral process for identified concerns.

Tier 2 is targeted intervention for some students. Students in need of additional behavioral health support services gain this through either individual or small-group interventions.

Tier 3 is intensive intervention for few students. Students with high-risk behaviors are the target population for tier 3 and receive individualized treatment. Critical components include counseling or therapy during the school day and re-entry assistance for students transitioning back from hospitalization or residental treatment.[25]

At the state level, leaders support cross-sector partnership development by drafting statewide guidance documents detailing standard policies and procedures.[27] Early tools must focus on guidance for establishing Memorandums of Understanding (MOU) that address the unique roles and responsibility between education and healthcare partners. While MOUs do establish a legal agreement, the language can also be written to highlight a culture of integration supportive of the differing and complementary benefits of cross-sector collaboration. Additional guidance documents can lay out the information important to be shared once the partnership is in process. This includes standardized tools for reporting services delivered and measuring outcomes considered important for schools and healthcare partners. Linking outcomes to items embedded in the grant-making and contracting processes creates a foundation for sustainability.

Across all tiers of MTSS, school districts can utilize nationally available and evidence-supported programmatic interventions for integrating behavioral health in schools. In situations where an evidence-based program does not yet exist, data-informed programs with data-driven outcomes should be considered best available evidence. Resource repositories for these supported interventions are curated by:

- SAMHSA's National Registry of Evidence-Based Programs and Practices,[28]
- Institute for Education Science's What Works Clearing House,[29] and
- Blueprints for Healthy Youth Development.[30]

These resources are useful in creating social-emotional learning curricula for all students or more specific interventions for youth with targeted behavioral health needs. Community health partners may be part of the team with the schools in providing these curricula.

Similarly, at the district level, experts from community mental health organizations can educate teachers and youth-serving adults at the school to identify students' strengths and classroom challenges. This process can incorporate the philosophy that children exposed to trauma and adversity are often more likely to act out at school and be at higher risk for behavioral health concerns.[31] Likewise, trainings can teach school personnel about the impact of trauma on youth behavior and provide guidance for teachers and school staff to respond in a sensitive and supportive manner.[31] Educating and encouraging this trauma-informed approach in schools is critical to form a foundation promoting positive social-emotional health of all students. Additionally, this training engages teachers and other school personnel in understanding how to identify concerning youth behavior and next steps for action, such as referral either in the schools or the community.[27]

Effective Communication and Data Sharing

Fostering partnerships between schools and healthcare, for universal services such as training or curricula, or high-level tiered care such as individual student treatment, requires a mutual level of interest and investment. Often, successful school-community health partnerships begin locally when a school's leadership determines student behavioral health to be a top priority and actively reaches out to engage community health partners.[32] This process is akin to pediatric primary care providers and psychiatrists having specific concerns about youth and desiring collateral information from schools for optimal treatment. In this way, it is clear to see how schools and healthcare partners share a similar mission of whole adolescent health. Building systemic channels for communication between school and healthcare encourages collaboration, that when strengthened, can lead to a reciprocal cross-disciplinary conversation and more consistent communication beyond individual cases to address greater needs.

Promoting collaboration often begins with Memorandums of Understanding (MOU) and training for teachers and school personnel to identify and screen students at risk for behavioral health concerns and in need of early intervention. Next steps for integration include formalizing the process for referring students needing additional behavioral supports in the school and community healthcare setting. A clear and targeted Release of Information (ROI) signed by parents authorizes sharing of their child's health and academic information promotes appropriate and timely referrals and permits bidirectional flow of information. Prioritizing communication means that schools may receive information about management plans to be implemented in the school setting and feedback can flow back to the mental health provider regarding success or challenges with implementation of the plans.

STATE SPOTLIGHT

Maryland

For nearly two decades, Maryland has prioritized school behavioral health services by creating policy frameworks for expanding school mental health. In 2014, the School Behavioral Health Coalition worked with the Maryland General Assembly to develop and introduce House Bill 639: Task Force on Community-Partnered School Based Mental Health.[27] While the coalition fell short of successful bill passage, the heightened awareness resulted in the Behavioral Health Administration being tasked with guiding development of a Community-Partnered School-based Behavioral Health (CP-SBH) report that could provide empirically-supported recommendations for advancing school behavioral health services. Creation of this report represented a tremendous collaboration amongst stakeholders—including members from education, healthcare, and state organizations—and the report presents relevant key differences in prevalence of services, variability of quality, and different approaches to financial sustainability for CP-SBH. Overarching recommendations include creating guidance documents for Memorandums of Understanding, standardized reporting and collecting procedures for outcomes, and expanding access to funding school behavioral health. This report identifies key opportunities to guide future policy work and demonstrates the essential need for increased state policymaker support focusing on youth behavioral health.

The higher tiers of the MTSS, Tiers 2 and 3, illustrate the most natural partnerships between the education and health sectors. Here, students with identified behavioral health problems seek indiviudal or group counseling or treatment. In an ideally integrated system, these students receive clinical services during the school day which are provided by school or community clinicans, including: school counselors, school therapists, or school psychologists, clinicans working at school-based health centers, or community behavioral health partners working in or near schools. When true integration occurs, these services are provided at school. The internal school location convienently limits missed classroom time, and research demonstrates that students are more likely to attend behavioral health services when they are located on campus.[33,34]

To assist in coordinating integrated behavioral health care, research demonstrates that a school-health care liaison can effectively communicate and translate health information between the medical community, the family, and school.[35] Designating a liaison in the schools, such as school nurse, school psychologist, counselor, or administrator, provides a point-person to begin and sustain collaboration across sectors. This role is similar to a nurse case manager or a family navigator in the healthcare system. Working collaboratively, the liaisons assist youth and families in ensuring treatment plans are coordinated in schools. This work requires that appropriate release of information is already in place for straightforward transitions of care between systems.

Finally, data sharing to evaluate outcomes of programs or clinical services is critical to sustain a synergistic partnership. Often times, these data-driven evaluations are not a top priority as they can be time intensive or require an additional administrative burden. To address these concerns, schools may enter into research partnerships with universities or a local department of public health to assist in program evaluation, data collection, and management.[9,27] Harnessing the expertise of academic or public health partners can place less administrative burden on schools and community behavioral health partners while also ensuring data are properly collected and maintained so that high-quality programs are being delivered and the impact is appreciated.

Privacy Policies: Bridging HIPAA-FERPA

Communication and data management between the schools and healthcare must follow specific guidelines as each sector has separate laws to protect a student's, or patient's, confidential health information. These laws afford differing levels of protection of information and can present barriers to continuous care for youth transitioning between the school and healthcare settings. School health information is protected under the Family Educational Rights and Privacy Act (FERPA) and health information, from a hospital or clinic, is protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Questions from school administrators and health professionals about information sharing for youth health led to development of the 2008 Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to Student Health Records. In brief, under HIPAA, healthcare providers can disclose student health information to the school nurse or school healthcare provider when that information is used for treatment purposes.[36] This can include discussing student's medication and other health needs to ensure the student is obtaining the care needed when at school. Similarly, with FERPA, a student's treatment records may be shared with a healthcare provider if the information is disclosed only for treatment purposes. However, many aspects of sharing behavioral health information between schools and healthcare settings remain unclear despite development of the Joint Guidance. Teachers, for example, are rarely included in the shared communication between healthcare providers, potentially weakening the effectiveness of a collaborative healthcare team.

Among Tiers 2 and 3 of the MTSS, schools and healthcare can set a tone for collaboration when developing partnerships by first determining the optimal method to promote clear and legal communication. This includes engaging the school or district's legal team to ensure student and family privacy is maintained while limiting interference of information sharing between the school and community or hospital behavioral health team.[32] Other options include creating tiered consent forms for families and youth that address the barriers related to HIPAA and FERPA. While these forms traditionally include information sharing only related to treatment, consents inclusive of data sharing elements such as school attendance, grades, or symptom screeners allow for additional measurement of outcomes related to the intervention.[28] For example, the State of Colorado created an Authorization-Consent to Release of Information Form that, if adopted widely, could represent a tool to streamline information sharing between schools, community organizations, and healthcare systems.[23]

Sustainable and Diversified Funding Streams

Providing high-quality integrated behavioral health for youth requires sustained funding for services to continue without interruption. At present, school behavioral health programs stay afloat by blending and braiding diverse public and private funding streams, these include federal, state, and private health insurance plans, as well as philanthropic support from non-profit organizations.[38,39] Medicaid is the primary insurer and funding source for school mental health services, but is still limited.[39] The National Alliance for Medicaid in Schools estimates that roughly 1 percent of Medicaid funds (about $4-5 billion) goes to local school districts.[40] A 2017 survey conducted by the School Superintendent Association found that 68% of respondents (nearly 1000 individuals from 42 states) used Medicaid funding for direct salaries of health professionals who provide services at school. However, many smaller districts find that administrative barriers prevent leveraging any Medicaid dollars, claiming that the paperwork for reimbursement is too resource and time-intensive, may require hiring additional staff, and the funding is insufficient compared to the value added.[39,41,42] More sustainable funding options are essential but require recognition that a "one size fits all approach" cannot be applied; every state and community funds school mental health services differently.[43] Unique needs of the district, individual schools, and students require some personalized assessment to determine priorities for strategic blending and braiding of private and public funds.[43]

To begin addressing integrated behavioral health in schools, ensuring all students have health insurance is imperative. While it is known that healthy students are better able to learn,[44-46] having health insurance allows students to access behavioral health services that can be reimbursed. For students who are eligible, but not enrolled in Medicaid, schools can connect families with resources for enrollment in Medicaid. Some states, such as California under Assembly Bill 2706, require schools to provide health insurance coverage information in their enrollment packets.[47] Schools can claim federal reimbursement for administrative activities associated with enrolling students in Medicaid. This permits students to both obtain general health care and fee-for-service mental health care if needs arise.[39]

Tier 1 behavioral health services, such as development and delivery of social and emotional curricula, require innovative approaches for capturing diverse funding options. Increasingly, federal initiatives are focusing on integrated youth behavioral health. An example includes the *Substance Abuse and Mental Health Services Administration Safe School/Healthy Students* (SAMHSA SS/HS) federal grant program, which emphasizes better systems coordination to provide a continuum of coordinated and comprehensive services. With this funding, a 5-year evaluation of schools with SS/HS initiatives finds a "263% increase in the number of students who received school-based mental health services, and a 519% increase in those receiving community-based services."[25] In addition to federal funding, school behavioral health services can be supported by applying state funding such County Block Grant Programs or local tax levies. For example, the Preventive Health and Health Services block grant program is being applied in some communities for funding social and emotional curricula with a focus on substance use, effectively addressing a priority for teens.[38] Another approach in Washington state allowed a Families and Education Levy to invest hundreds of millions in education processes, many of which connect schools with community health services that offer curricula.[38,48]

The higher tiers of the MTSS that support more intensive services position sectors for alternative forms of reimbursement. Presently, community mental health organizations or healthcare systems provide individual therapy utilizing fee-for-service reimbursement. To optimize fee-for-service funding, schools and community organizations must be mindful of the *3 E's* to third party reimbursement: eligible services, eligible clients and eligible providers.[43] With healthcare shifts toward value-based payment, partnerships between school and community-based providers could benefit from global payment models that could overcome restrictive eligibility requirements and support delivery of care when and where it is needed most. Accountable care organizations are beginning to include schools in their systems of support and non-traditional community providers among the health care teams. Continued demonstration projects are needed to measure behavioral health outcomes that support the value of alternative delivery and payment models.

SPOTLIGHT

Aurora Public Schools AWARE Online Referral System

Aurora Public Schools (APS) and Aurora Advancing Wellness and Resilience Education (AWARE) is an integration collaborative that is successfully overcoming barriers to care with support of a federal SAMHSA grant. The aims of this grant are to promote youth mental health awareness and improve connections to services for school-aged youth.[37]

APS applied for funding in response to the high burden of mental health needs among students and difficulty having these youth connect with services. To address this problem, APS personnel and community mental health partners created a simple HIPAA-compliant online referral process that allows for a two-way communication loop between the school-based staff and community behavioral health partners. The school-based staff partner completes the referral with the family and after receiving the referral, the community behavioral health partner reaches out to the family to schedule an intake. If the community partner is unable to connect with the family about intake, they inform the school-based partner that the connection was not made. This allows the school to loop back with the family and inquire about needed resources to decrease barriers for accessing mental health services.

During the first two-school years of implementation (2015-2017), APS behavioral health staff referred over 1600 students to community behavioral health partners. In addition to serving these students and families, APS built stronger relationships with over half a dozen community mental health partners. One middle school counselor in APS described her experience: "I love the new referral process because it makes me better at what I do. Now parents come in to sign a release and I make connections with them, then and there, and they can begin getting supports outside of school. My biggest thing is that it's [the referral system] leading a meeting with parents that is face-to-face and that creates a stronger connection between us."

With the complexity of funding streams for school behavioral health, schools and healthcare must align to ensure youth have access to needed services. Often this means that schools must capitalize on using multiple funding streams to ensure program security if one funding opportunity ends. In effect, harnessing multiple funding streams can provide a more comprehensive array of services since many funding opportunities have specific criteria or requirements of the services, providers, or types of youth served.[27] Further, schools can assign a funding behavioral health champion to ensure schools are taking full advantage of blending and braiding available federal, state, and local funding resources. Ultimately, further work is needed to establish policies that secure additional sustainable funds for integrated school behavioral health.

Conclusion

In conclusion, integrating behavioral health by effective partnerships between the schools and healthcare systems leverages resources across sectors to promote adolescent behavioral health. The evidence clearly points to behavioral health concerns starting in adolescence or earlier,[2,3] with most students receiving services in the schools.[5,6] The burden of adolescent behavioral health concerns is too great for each sector to address in isolation, and the outcome of this work is more effective in partnership. To achieve integrated behavioral health priorities, a common framework is required to establish clear and flexible communication for developing and enhancing collaboration across sectors. Forging pathways for communication between stakeholders in education and healthcare encourages evidence-based practices for universal and tiered services to be performed in the school. Policies, programs, and funding opportunities at the federal, district, and state levels will enable and strengthen sustainable partnerships via innovative blending and braiding of funding streams, coordinating HIPPA-FERPA discussions, and using strategic data sharing for enhancing care across sectors. By prioritizing integrated behavioral health through partnerships between schools and healthcare, all youth can receive a tiered level of attention to behavioral health support for establishing a pathway towards academic excellence and optimal whole adolescent health.

The MTSS framework articulating policy actions to integrate behavioral health for schools and healthcare partners

MTSS Tier Level	Policy Action	Principal Sector Involved
Tier 1: Universal Supports for *all*	• Develop state-level guidance documents for implementing Memorandums of Understanding (MOU) between community mental health organizations and schools • Policy makers ensure MOUs include data collection relevant to both academic and health outcomes • Schools and community partnerships prioritize health insurance coverage for all students with outreach and information in all school enrollment packets. • School districts require school based behavioral health curriculum for youth and training for teachers • State policymakers and payers support funding for school health liaison to coordinate between sectors	State-level health care and education partners Education and non-profits Education State level policy
Tier 2: Targeted Intervention for *some*	• Stakeholders in mental health and education create Release of Information Forms that streamline communication and comply with HIPPA and FERPA. • Leverage diverse funding and relationship building by promoting opportunities for community mental health organizations to integrate into school programs	All sectors
Tier 3: Intensive Intervention for *few*	• Operationalize opportunities for intensive individual therapy in schools by both school and community mental health professionals with supportive reimbursement policies	Health care

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