Bringing Wellness to Schools: Opportunities for and Challenges to Mental Health Integration in School-Based Health Centers

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Objective: School-based health centers (SBHCs) reduce access barriers to mental health care and improve educational outcomes for youths. This qualitative study evaluated the innovations and challenges of a unique network of SBHCs in a large, urban school district as the centers attempted to integrate health, mental health, and educational services.

Methods: The 43 participants sampled included mental health providers, primary care providers, and care coordinators at 14 SBHCs. Semistructured interviews with each participant were audio recorded and transcribed. Themes were identified and coded by using Atlas.ti 5.1 and collapsed into three domains: operations, partnership, and engagement.

Results: Interviews revealed provider models ranging from single agencies offering both primary care and mental health services to colocated services. Sites where the health agency provided at least some mental health services reported more mental health screenings. Many sites used SBHC wellness coordinators and coordination team meetings to facilitate relationships between schools and health agency and community mental health clinic providers. Partnership challenges included confidentiality policies and staff turnover. Participants also highlighted student and parent engagement through culturally sensitive services, peer health advocates, and "drop-in" lunches.

Conclusions: Staffing and operational models are critical in the success of integrating primary care, mental health care, and education. Among the provider models observed, the combined primary care and mental health provider model offered the most integrated services. Despite barriers, providers and schools have begun to implement novel solutions to operational problems and family engagement in mental health services.

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Policy makers, clinicians, and advocates identify schools as key institutions for health and mental health intervention (1). Schools are the most common entry point into mental health services in the United States (2) and are recognized in recent reforms as an ideal setting for integrating primary care and mental health services (3). The 2003 President's New Freedom Commission on Mental Health declared, "Schools are in a key position to identify mental health problems early and provide appropriate services or links to services" (4,5). The 2010 Patient Protection and Affordable Care Act authorized $200 million to expand integrated health care systems by increasing the capacity of school-based health centers (SBHCs) nationally (6).

SBHCs reduce access barriers (for example, transportation, cost, and stigma) and improve health and educational outcomes for vulnerable youths (4). Use of SBHC services is linked to improved grades, school attendance (7,8), and health and mental health outcomes (9–11). SBHCs vary by available resources but typically consist of clinics providing a spectrum of primary care and mental health services on or near school campuses. According to the School-Based Health Alliance (12), of the more than 2,000 SBHCs nationally, 71% have mental health clinicians.

We describe one network of 14 SBHCs at the beginning stages of operation that provide health, mental health, and other services to predominantly underserved students and community members from racial-ethnic minority groups. The school district named these SBHCs Wellness Centers because of their unique focus on population health, providing preventive services, health promotion, education, and health care to students, families, and the community. The purpose of this qualitative study was to describe the first year of this school-based Wellness Center network, with sites that varied by operational stage and model of integrated care. To help inform SBHCs nationally, we evaluated the challenges and innovations of these Wellness Centers.

METHODS

Wellness Centers

The 14 Wellness Centers belong to a large urban school district serving primarily students from racial-ethnic minority groups (74% Latino, 11% African American, and 9% Caucasian) living in poverty (73% were eligible for free or reduced-cost lunch). Each Wellness Center was designed through a community stakeholder process and built on the strengths and resources of its local community. Each Wellness Center has a Student Advisory Board, student-led health promotion, parent and community engagement activities, and primary care and mental health services—some centers offer dental and vision care—all provided by local community agencies and school district staff.

Participants

Forty-three participants were recruited via referral from key school district staff working with the Wellness Centers. Participants included district-employed mental health providers (N=11), community mental health agency providers (N=8), district-employed wellness coordinators who help connect agencies with schools to provide needed care (N=13), a district-employed health provider (N=1), and primary care and mental health providers employed by federally qualified health centers (FQHCs) (N=10).

Procedures

Researchers and school district staff identified topics meaningful to the district's Wellness Center quality improvement efforts. The following topics were incorporated into a semi-structured questionnaire: types of services available; process for identifying mental health needs; patient engagement strategies; and coordination of health, mental health, and educational services (an interview guide is available on request). Trained public health and psychology students on the research team (KL and SG) read a consent script to participants, obtained their verbal consent to participate, and conducted the in-person or telephone 45-minute interview. Participation in this study was voluntary and without financial incentive. Interviews were audio recorded and transcribed. The university's Institutional Review Board and school district's Research Review Committee approved all study procedures.

Data Analysis

All interview transcripts were reviewed for main themes. Ten themes were identified by frequency and significance and coded by using qualitative data analysis software, Atlas.ti 5.1 (13). Content analysis was conducted by using inductive and deductive techniques (14). The research team discussed the contents of each domain and agreed on a refined list of codes after expanding, collapsing, or eliminating codes. Grounded theory was used to look for similarities and differences within and between interviews (15). Approximately 20% of the transcripts, coded by two team members (KL and SG), were further discussed by the entire team to ensure coding reliability.

Three major codes (operations, partnerships, and engagement) were selected for further review and analysis for this study. Operations included organizational structures of sites and coordination of services. Partnerships included collaborative strategies between different agencies within sites. Engagement included efforts to engage parents and students in services.

RESULTS

Operations

We found that types and level of integration between primary care and mental health services varied (Table 1). For primary care services, the school district contracted with local FQHCs, which are federally designated comprehensive health clinics serving underserved populations. One exception was site L (Table 1), where the school district directly operated the primary care services. (All primary care organizations are referred to here as "health agencies.") Participants reported that various agencies delivered mental health care at the sites: six sites had community mental health agencies (CMHAs), seven had the district's mental health unit, and at seven sites the health agency offered partial or full mental health services. In addition, the district employed wellness coordinators to facilitate care coordination between school employees (administrators, teachers, nurses, and counselors) and Wellness Center providers.

Interviews from the five Wellness Centers where the health agency did not provide mental health services (sites C, D, G, J, and L) revealed a desire for "warmer hand-offs" or greater coordination between health agency and mental health providers, particularly for students with multiple needs. As one Wellness Coordinator explained, "[I]f one of our students had a [health] problem, and . . . while treated for that problem [was] identified to . . . have another need, they can be cross-referred. . . . They can just be served in-house."

Participants at two Wellness Centers (sites M and N) reported that their health agencies provided all primary care and mental health services for the site. These health agency mental health providers described novel strategies linking health and mental health services. One participant described "shared group appointments. . . . We bring a group of ten to 15 patients with the same problem and give them an hour and a half. . . . The physician will see them, will do . . . a brief physical exam, get the vitals . . . and then [patients will] meet as a group, [with] the physician and a behaviorist together." Another theme was the ease of coordinating primary care and mental health services: "[T]he way her depression was expressed was through risky sexual behavior. . . . She was coming in repeatedly for STD testing or Plan B [emergency contraception]. . . . One of the counselors just took her under her wing, and . . . she's moving forward."

At the remaining seven sites, where health agencies provided partial services, the health agency employed part-time mental health providers who referred clients with more

TABLE 1. Agencies providing mental health services at 14 Wellness Centers and whether routine mental health screening was provided

Wellness Center	Health agency[a]				
	Full services	Partial services	CMHA[b]	District[c]	Screening
A		✓		✓	Yes
B		✓		✓	Yes
C			✓		No
D				✓	No
E		✓	✓	✓	No
F		✓	✓		No
G			✓		Yes
H		✓		✓	Yes
I		✓		✓	Yes
J			✓		No
K		✓		✓	Yes
L			✓		No
M	✓				Yes
N	✓				Yes

[a] Full services, health agency is the only source of mental health services; partial services, health agency provides some mental health services.
[b] Community mental health agency
[c] School district mental health unit

intensive mental health needs to the Wellness Center's community mental health providers or to school district providers (sites A, B, E, F, H, I, and K). Sites where a health agency provided partial or full mental health services were more likely to report using a standardized mental health screening (seven of nine sites), compared with sites where a health agency did not provide mental health services (one of five sites).

Generally, primary care and mental health providers employed by different agencies operating within one Wellness Center continued independent operations. These agencies reported separate electronic medical record systems, resulting in challenges sharing patient information. Participants recommended more streamlined referral processes between different agency providers through universal consent forms (one consent form for all providers within a Wellness Center) and regular meetings with all Wellness Center providers to facilitate care coordination.

Partnerships

Participants highlighted the importance of community partnerships within Wellness Centers. As one provider said, "Multiple partners from different areas, whether it's health, behavioral health, people that are in mentoring programs, or sports programs, or tutors, or other kind of activities, are all part of the Wellness Center."

Wellness coordinators were reported to be integral figures in developing and maintaining relationships between school staff (for example, teachers and administrators) and Wellness Center providers. Participants universally acknowledged the utility of "having that key person who understands both [school and community agency] systems." Budget cuts and staff turnover, however, prevented some sites from maintaining coordinators.

Participants also reported coordination meetings as crucial in developing partnerships between school staff and Wellness Center providers, such as the Coordination of Services Team (COST) meetings, collaborative efforts between various disciplines (for example, child welfare, juvenile justice, primary care, mental health, and special education) to coordinate services for high-need students. COST attendees included school employees (for example, administrators, teachers, and counselors) who were critical in referring students and coordinating educational efforts with the wellness coordinator, who facilitated Wellness Center services. Ten of 14 sites had ongoing COST meetings, although with variable meeting schedules and participation. This inconsistency in COST meetings was related to recent staff cutbacks, resource limitations, and lack of coordinated leadership.

Both school staff and agency providers highlighted confidentiality laws as a potential challenge to partnerships. Participants noted that laws, such as HIPAA and the Family Educational Rights and Privacy Act (FERPA), affect when and how student health information can be shared. Generally, HIPAA limits release of health information by health care providers, and FERPA limits release of information in educational records by schools (16). Consequently, communication, case management, referrals, and follow-up between district and nondistrict employees occasionally became fragmented. One community-based provider noted, "Because of . . . HIPAA/FERPA, it's very difficult. . . . If [the school] refers to [a community agency], then that's it. 'Thank you for the referral.' But then they as a school may not know where [the students] are." Participants described encountering a further layer of complexity when these laws interacted with state mandates allowing minors to access confidential services without parental consent. One health provider explained, "A lot of the services students seek . . . are confidential services: family planning, mental health. . . . When it becomes part of the school record, parents have access to that. So it's very tricky." To strengthen communication between school staff and community agency providers, participants discussed investigating novel information-sharing strategies, such as with universal consent forms. One community-based provider remarked, "We would like to start collecting data on achievement and attendance so we can track it and link it to the therapy progress. . . . But . . . electronically there is a firewall between . . . the medical provider's information . . . and the school information."

Engagement

Parent engagement. Participants emphasized the importance of partnering with and providing education to parents about potentially serious mental health issues. They reported including parent representatives in Wellness Center planning meetings, holding workshops on parent-chosen topics, and providing information about Wellness Centers at back-to-school nights. They described goals of having

parents view Wellness Centers as multipurpose facilities supporting community needs and minimizing mental health stigma. Participants also discussed structural barriers, including the need for extended hours, transportation, and child care.

Participants acknowledged sociocultural issues: "[Parents] say, 'Well no, we're fine,' because, as you know, mental health has a bad connotation . . . a taboo." Participants also reported concerns about immigration status as a hurdle for accessing care. One mental health provider explained, "Even if the child was born here, the parents [may be] undocumented. They see us maybe as a government agency. . . . They're worried about whether we're going to report to immigration." Participants further described some parents' negative educational histories as affecting service engagement: "A lot of things stem from parents' own experiences with schools. . . . If they didn't have a good experience while going to school, as an adult that's going to carry over. . . . They have a feeling of intimidation."

To overcome these barriers, several sites had Parent Centers that encouraged parent involvement, provided health education and programs on topics such as parenting and substance use, and offered culturally sensitive services (for example, bilingual case managers and community health navigators). As one wellness coordinator summarized, "That's the whole point of the Wellness Center, to get families involved in their kids' education and . . . take down the barriers that prevent children from succeeding."

Student engagement. Participants described student engagement as a major component of the Wellness Centers' initiative to improve health: "Ultimately, the Wellness Centers are about breaking down the barriers to health care that teenagers face." Challenges to engagement included concerns about trust, confidentiality, and stigma related to mental illness. Participants explained how lack of trust might inhibit use of services: "A lot of our students . . . don't think that people care, or [that] they're here to criticize."

Participants reported addressing these concerns in several ways, including partnering with students to raise awareness about mental health. Wellness Center providers have hired students as greeters, developed student advisory committees, and enlisted students as peer advocates. One participant explained this vision of student involvement as follows: "It's not just a clinic that dispenses pills but a place where students access services and get vocation by . . . providing classes or by getting involved." Participants also offered "drop-in" lunches to enhance trust.

In addition, participants felt that offering mental health services in a school-based primary care setting would reduce stigma: "Mental health services will be . . . part of the milieu, it won't just be the place where people with mental health problems go." Several providers integrated mental health services into the primary care visit, including mental health screening during every physical and screening patients with diabetes for depression. Participants believed that these mechanisms would increase the detection and engagement of students needing mental health services: "By providing a variety of avenues for people to get into mental health services, it helps them access these services."

DISCUSSION

This qualitative study described an SBHC network designed to provide integrated prevention and treatment services for ethnically diverse, low-income urban communities. Interviews revealed differences in provider models, ranging from single agencies offering both primary care and mental health services on site to separate agencies operating within one Wellness Center. This range of integration reflects the heterogeneous landscape of SBHCs (17). Ours is one of the first studies, to our knowledge, to compare provider models in SBHCs within one SBHC network, and our results suggest that staffing and operations, partnerships, and engagement may determine the depth of primary care–mental health care integration in caring for highly underserved populations. From these interviews, we highlighted several lessons learned for quality improvement and future research for primary care–mental health care integration in SBHCs.

In this study, operational integration of services within an SBHC appeared to be related to greater screening and detection of mental health problems. General models of primary care–behavioral health care integration can be applied to SBHCs to describe types of integration (18,19). One framework of integrated care suggests a progression of three models: coordinated care, in which primary care and mental health providers are in separate facilities and collaborate at a distance; colocated care, in which primary care and mental health services are both provided on site but have separate systems; and integrated care, which involves a shared treatment plan between primary care and mental health care providers (20). In our study, five sites most resembled colocated care, and seven demonstrated varying levels of integrated care. Some sites had part-time mental health providers who shared records and treatment plans within the health agency's system, with complex cases colocated to a CMHA or a school district mental health provider at the Wellness Center. Finally, two sites incorporated greater integration, with all primary care and mental health services provided within the health agency system and with shared team approaches. Weist and colleagues (21) provided practical strategies for improving operational integration, such as training in mental health screening for health providers and school personnel and information exchange through key individuals. Further research is needed to measure patient outcomes of these integration models in the context of SBHCs.

Partnership integration through wellness coordinators and coordination meetings highlights a key component of integrated care: the health care team. Unique to SBHCs, this health care team includes school staff, who are crucial members and support students' socioemotional and

cognitive development. Wellness coordinators provide a reciprocal link between school staff and Wellness Center providers. Creative solutions, such as shared agency and school district support, are needed for sustainability of this critical role.

Linking deidentified education data to health records could optimize the value of integrated SBHCs, such as by providing data to school administrators to assess who benefits from Wellness Center services. Sharing of records, however, was a major issue raised throughout the interviews. It is critical that school staff and agency providers understand laws that protect privacy and regulate the sharing of personal information. In SBHCs where school and community health and mental health staff interface, negotiating exchanges of information about students may be a particular challenge and can affect service operations in diverse ways (22,23).

Finally, engagement of parents and students in a school-based integrated care setting can help ensure that services are patient centered and relevant to the community. Studies demonstrate that in the delivery of integrated care, community engagement improves wellness and reduces social risk factors (24). We found sociocultural factors and stigma related to mental illness to be especially relevant to the communities served by these Wellness Centers. Because most youths served by SBHCs in the United States are from low-income households and from racial-ethnic minority groups (19), engagement strategies, such as those employed by the Wellness Centers (for example, student and parent participation on advisory boards and committees), may prove especially useful in reducing access barriers. This school district should continue to empower community members to be involved in Wellness Center quality improvement efforts to help identify solutions that matter most to students and community members.

This qualitative study had several limitations. First, interviews took place within the first one to two years of Wellness Center establishment. Second, although a broad set of service providers were interviewed, it was beyond the scope of this study to include parents and students. Further research should examine the diverse SBHC models and integration of care from the consumer perspective. Third, this study was conducted in a school district with a long-standing history of SBHCs. Lessons gleaned may vary for other school districts.

CONCLUSIONS

As SBHCs expand and move toward interconnected systems of care, further research is needed to study these systems' effects on children's health, mental health, and academic achievement. Furthermore, for novel SBHCs providing services to community members as well as students, future research should study downstream effects on community and population health, including how these SBHCs address health and mental health disparities. We hope this research informs future plans to build effective and integrated SBHCs that align with the Affordable Care Act's intent to truly integrate comprehensive health services that improve care, reduce costs, and satisfy community needs.

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