ARTICLE

Characteristic Differences Between School-Based Health Centers With and Without Mental Health Providers: A Review of National Trends

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ABSTRACT

Background: Minority racial/ethnic pediatric populations and those living in poverty are at greater risk of exposure to trauma, development of mental health disorders, and school failure yet are less likely to have access to mental health services (MHS). School-based health centers (SBHCs) staffed with mental health providers may be one strategy for decreasing health care disparities.

Methods: Secondary analysis of the cross-sectional *School-Based Health Alliance Census School Year 2010–2011 Report* was conducted. Descriptive statistics and chi-square analysis were used to describe differences between SBHCs with and without onsite MHS.

Results: A total of 70% of SBHCs offered MHS. SBHCs with more resources, more students, a longer history, and state funding were more likely to offer MHS, and geographic location had no impact on service availability.

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Conclusion: Reviewing SBHC characteristics that enable inclusion of MHS may help stakeholders expand this model of care to address exposure to chronic childhood trauma. J Pediatr Health Care. (2017) ■, ■-■.

KEY WORDS

Academic achievement, child and adolescent health, chronic childhood trauma, health care disparities, mental health services, school-based health centers

INTRODUCTION

Approximately 80% of children and adolescents in the United States have experienced childhood trauma in the form of victimization (Turner, Finkelhor, & Ormrod, 2010). Types of victimization include peer–sibling, physical abuse or assault, sexual victimization or assault, exposure to community violence, bullying, maltreatment, and witnessing family violence (Turner et al., 2010). The most common locations for victimization occurrences are in schools (54%) and in the home (44%; Turner, Shattuck, Finkelhor, & Hamby, 2016). Exposure to victimization and chronic childhood trauma is associated with increased risk for behavioral and mental health disorders (Ford, Elhai, Conner, & Frueh, 2010; Turner, Vanderminden, Finkelhor, Hamby, & Shattuck, 2011). Approximately one in five children and adolescents has a diagnosable mental health disorder that can cause severe lifetime impairment, yet estimates indicate that 70% do not receive mental health services, with youth of lower socioeconomic status and/or minority race and ethnicity even less likely to receive care (Alegria, Vallas, & Pumariega, 2010; Guo, Wade, Pan, & Keller, 2010; Merikangas et al., 2010; 2011). Increasing access, utilization, quality, and funding of mental health care is of national concern. Mental health disorders negatively affect academic and social functioning (McLeod, Uemura, & Rohrman, 2012). Poor academic achievement can lead to decreased employment opportunities, with less social mobility advancement, as well as severe disability and early death (Walsemann, Gee, & Ro, 2013).

Schools are an important point of contact for prevention, identification, and treatment of behavioral health problems because of the accessibility of students (Bruns, Walrath, Glass-Siegel, & Weist, 2004). The school-based health center (SBHC) is a model of pediatric primary care delivery that offers comprehensive services provided by a multidisciplinary team on school grounds (Keeton, Soleimanpour, & Brindis, 2012). SBHCs have been shown to increase access to and utilization of high-quality cost-effective health care services for children and adolescents, especially in underserved populations (Anyon et al., 2013; Bains, Franzen, & White-Frese, 2014; Guo et al., 2005; Soleimanpour, Geierstanger, Kaller, McCarter, & Brindis, 2010; Wade et al., 2008). Although school success is influenced by multiple factors, when comparing students who use an SBHC to those who do not, several studies have found an association between SBHC use and improved school connection, increased academic scores, increased school attendance, and decreased school dropout (Kerns et al., 2011; Strolin-Goltzman, 2010; Strolin-Goltzman, Sisselman, Melekis, & Auerbach, 2014; Van Cura, 2010; Walker, Kerns, Lyon, Bruns, & Cosgrove, 2010).

The SBHC is a successful model of care, yet fewer than 2% of U.S. schools have one, and among those schools with an SBHC, one third of SBHCs do not have a mental health provider as part of their staff (School-Based Health Alliance [SHA], 2016). Of the 70% of SBHCs with mental health providers on staff, there is a wide range of behavioral health services available; however, these do not necessarily equate to comprehensive mental health care (SHA, 2016). The expansion of the SBHC model of care may be a valuable health equity strategy in addressing gaps in the provision of pediatric health and mental health care. SBHCs staffed with mental health providers may be uniquely positioned to mitigate negative health effects from exposure to victimization and childhood trauma, both in the home and in schools. The purpose of this article is to describe factors associated with SBHCs in the United States that are staffed with mental health providers compared with those that are not to aid policy creation that promotes access, utilization, quality, and funding of pediatric mental health services both among SBHCs and other models of adolescent-specific care.

METHODS

Data Source

We conducted a secondary analysis of cross-sectional data from the *National School-Based Health Care School Year 2010–2011 Census Report* (SHA, 2013). The SHA, previously known as the National Assembly on School-Based Health Care, is a national advocacy group that has collected data every 2 to 3 years from SBHCs nationwide beginning in 1986. The census report survey of nominal scale items includes demographics of students and schools served, health professional staffing, services available, operations, prevention activities, and clinical services.

The SBHC Census surveys a variety of school-based and school-linked health organizations, including those that partner with schools and deliver health care to students within a fixed site on school campus (school based), programs that are formally or informally linked with schools but provide clinical services not directly on school campus (school linked), programs that provide health care without a fixed site (mobile), and programs offering clinical services via telehealth (SHA, 2016). Most survey items have remained consistent since 2005, although there have been some deletions and additions. Collection of data used in this study occurred