



Special Considerations for Mental Health Services in Rural Schools

By Susan Wilger, MPAff, Southwest Center for Health Innovation

Families often turn to schools for assistance with recognizing, assessing, managing, and treating mental health disorders experienced by their children. In fact, for the majority of children and youth receiving services, the educational system was their sole source of care and the most frequent entry point for first receiving mental health services (Burns BJ, 1995, August; Farmer E, 2003). In rural areas where mental health services are scarce and families face unique barriers to accessing care, schools play a significant role in providing or linking students and their families to mental health services. This Issue Brief explores challenges faced by rural schools and innovations used to develop, implement, maintain, and expand mental health services for the students and the families they serve.

Background

Twenty percent--one in five--of children ages 13-18 currently has or previously had a serious debilitating mental disorder (National Institute of Mental Health, 2015). By comparison, 8.3 percent of children under age 18 have asthma, and only 0.2 percent have diabetes. Untreated mental health disorders can lead to school failure, family conflicts, drug abuse, violence, and suicide (C.J Kapphahn, 2006). Rural schools are looked to as a primary source of care because mental health services simply are not as available, accessible, or affordable in rural communities as in urban areas. If services are available, schools are more challenged to ensure that services address the developmental, situational, and cultural needs of students and their families.

Over the past decade rural communities have experienced demographic and economic shifts to which rural schools have had to adjust. A useful tool has been developed by the Carsey Institute at the University of New Hampshire to describe four broad kinds of places that we think of as "rural": (Hamilton, Hamilton, Duncan, & Colocousis, 2008).



- **Amenity-rich rural America:** Amenities may include resources, economic opportunities, jobs, and scenic areas within reach of a larger urban community. Some communities are experiencing in-migration and rising economic development as well as increasingly high costs of living.
- **Chronically poor rural America:** In these communities, the economic, social, and educational needs are particularly challenging and mental health and substance abuse resources are severely needed.
- **Declining resources-dependent rural America:** Many of these communities experience job losses and have a long history of boom and bust. There is often an out-migration of young adults.
- **Amenity/Decline rural America:** These communities attract older residents looking towards retirement while addressing the out-migration of younger adults who are leaving to find jobs and better opportunities.



Many rural schools have experienced growing ethnic and cultural diversity as immigrants disperse more widely into rural areas (Johnson, 2006; Hamilton, Hamilton, Duncan, & Colocousis, 2008). Other schools have experienced the impact of fast-paced economic growth due to the oil, gas, and mineral extraction industries in some parts of the country. These generate more tax revenues, and, at the same time, these communities are experiencing significant increases in the cost of housing, food, and other necessities. Other rural schools suffer from deteriorating infrastructure, pervasive poverty, limited employment opportunities, and declining population bases (Sawyer D, 2006; Hamilton, Hamilton, Duncan, & Colocousis, 2008).

Unique Challenges for Rural Schools

Although the prevalence and incidence of behavioral health disorders are not significantly different in urban and rural areas, there are factors that can drastically prevent children and youth from realizing mental wellness. Vivian Jackson proposes five domains that can influence health equity and health disparity, particularly among groups that have systematically experienced greater social or economic obstacles to health based on certain characteristics such as race, ethnicity, socioeconomic status, mental health status, and geographic location. The five domains include: availability, accessibility, affordability, appropriateness, and acceptability of care (Jackson, 2010). According to Jackson's research, improving one domain can have a positive impact on the other domains.

Availability

Availability is described as the existence of mental health services. The availability of mental health professionals significantly influences service availability. The scarce supply of mental health providers in rural areas is directly related to lower utilization of mental health services. Mental health service providers may include: primary care professionals, emergency responders, and members of the school staff (including school counselors, school psychologists, school social workers, school nurses, and other school staff). Equally important is the infrastructure that supports the availability of mental health services (appropriate facilities, technology, funding mechanisms, communications, etc.).

Schools typically depend on community-based organizations to provide mental health services either by having community-based providers on school campuses or by linking families to organizations located within the community. In fact, rural schools are twice as likely as urban or suburban schools to rely entirely on community-based organizations for mental health professionals; the most common entities being Juvenile Justice, Child Welfare, Community Health Centers, County Mental Health, and individual providers.

Children and adolescents with mental health disorders are a heterogeneous group with different service needs required for different mental health disorders and conditions. For example, a student with a serious emotional disturbance that interferes with his or her education requires different interventions than a student who is highly functional and gets good grades but suffers from depression or an eating disorder. Because rural communities do not have the volume of patients to financially support certain interventions or treatments, schools and communities are confronted with having to link the student and family to the appropriate level and type of care. This may require travel outside of the community to receive services, which is often the case when inpatient treatment services or a child psychiatrist is needed.

As a result, rural schools have come to build strong community partnerships; be knowledgeable of community resources and how to access them; and to use technology and school-based services to ensure that students have necessary services available. Best practices and resources for each of these areas are discussed further in the next section.

Accessibility

Accessibility refers to the ease and convenience to obtain and use mental health services. When it is recognized that someone needs care it is important to know what options are available to address the need and how to access those services. When connecting rural families to care, the following issues should be considered: referral process; wait time for appointments; arranging childcare; hours and days that services are provided; the ability to travel to services; the mode of travel (personal vehicle, public transportation, relying on another individual, etc.); the cost, time and distance of travel; and the system within which services are made available (private health practices, the school, mental health providers, criminal justice, etc.).

Mental health financing is a major factor in determining who can access care and the quality of care received. Over the years, states have become more reliant on federal Medicaid payments resulting in services limited to those that are deemed “medically necessary” (Buck, 2003). The increase in Medicaid spending has constrained state and local policymakers’ flexibility to fund a full range of mental health needs, especially among rural, poor, and disadvantaged populations (Frank & Glied, 2006). What this means for rural schools and communities is that they have limited flexibility to provide non-medical services—such as prevention, case management, care coordination, transition planning, transportation, traditional healing and alternative treatments—that can improve access to and the quality of mental health care in rural communities.

the number of uninsured individuals. Community outreach and enrollment services are critical to ensuring that those who are eligible for Medicaid or other insurance programs are identified and enrolled. Schools play an important role in linking families to Medicaid and other safety net programs, such as TANF, SNAP, or medicine assistance programs to help reduce out-of-pocket expenses carried by rural families.

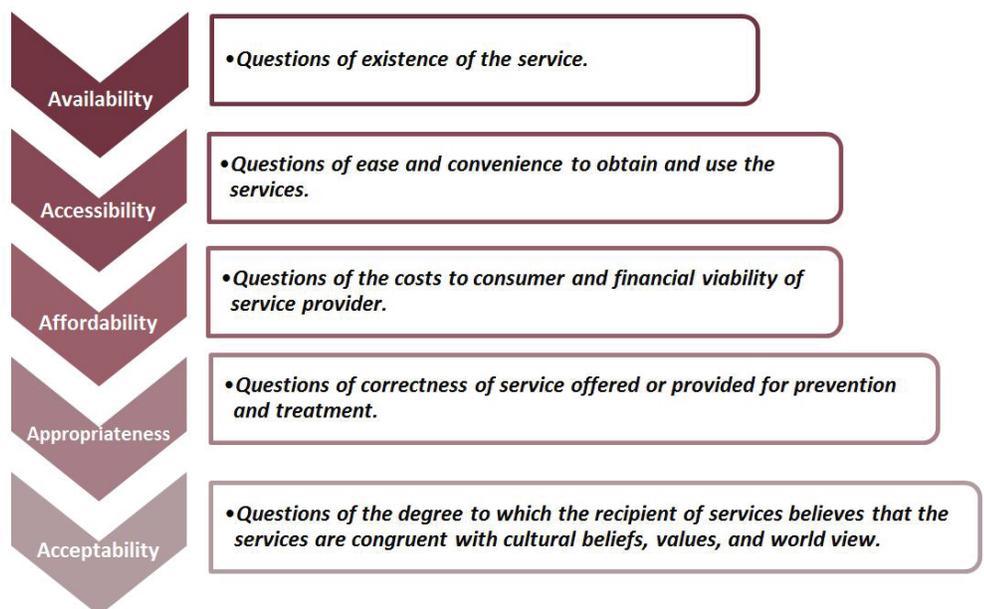
Appropriateness

Appropriateness looks at the correctness of services offered or provided and providers’ cultural competence is a factor that influences the appropriateness of mental health services. Appropriateness of care includes accurate diagnoses for the context of the population served. This is especially important when working with children and adolescents where the child’s social, emotional, and physical development, not just age, must be factored into the diagnosis.

Rural communities are often challenged to find mental health service providers who are trained specifically to work with children and youth. Culturally competent care, tools, and processes should reflect an understanding of the race, ethnicity, language, and culture of the population served, as well as an understanding of rural culture. Many rural providers are not rural natives. They are often trained in urban-centered models and programs, and often travel from urban areas to provide services in rural areas on an intermittent basis, creating a rural knowledge gap (Larson, Beeson, & Mohatt, 1993). Too often, the urban experience which is applied to rural and

Affordability

The cost to access or receive mental health services is one of the most significant barriers for rural families. Rural employment is typically dominated by low wages, fewer employment opportunities, higher rates of poverty and generational (persistent) poverty. Rural socio-economic factors may limit the financial resources that are available to support a continuum of mental health services within a community. Further, following the implementation of the Affordable Care Act, rural areas have now exceeded urban areas in



Source: Jackson, V. “A Look at Disparities by Availability, Accessibility, Affordability, Appropriateness, Acceptability. Georgetown Technical Assistance Call Series. 2010.

frontier settings simply does not fit. Turning to practices with a rural evidence-base and using innovation and partnerships to address the rural population and service needs are crucial for rural schools. Some of these rural practices are discussed below.

Acceptability

Acceptability includes the degree to which the recipient of services believes that the services are congruent with cultural beliefs, values, and world view. Stigma is a major barrier to receiving proper mental health services and rural residents tend to view help-seeking for mental health care more negatively than do their urban peers. The stigma attached to having a behavioral health issue (e.g. perceptions that people with mental health problems are 'crazy,' or people who seek mental health treatment are weak) is often more pronounced in rural areas, making individuals less likely to intervene and families more hesitant to seek help.

As a result, rural residents are significantly less likely to receive treatment and their conditions are often more severe when they do enter treatment than their urban counterparts (American Psychological Association). Education and communication strategies that target students, parents, and school staff to enhance their knowledge of mental wellness and mental illness, treatment options, best practices, and local resources will help to enhance the rural mental health care system.

Solutions and Best Practices for Rural Schools/Districts

The implementation of the Affordable Care Act combined with the emergence of telehealth, community and migrant health centers, community health centers, community behavioral health centers, and school-based health centers offer rural schools more opportunities to link students and families with needed mental health services. This section discusses some best- and promising-practices in the field of rural mental health and suggests resources appropriate for schools.

Raising Awareness

Particularly in rural areas, parent education is important to raise awareness of the long-term implications of children's mental health problems and to reduce perceived stigma associated with treatment for children. Rural schools are implementing a variety of activities to raise awareness, ranging from media campaigns to policy changes to on-site treatment.



[What to Expect and When to Seek Help](#) by Bright Futures offers a framework and tools for school staff and families to begin a discussion about how best to support healthy social and emotional development in children and teens. The tools are designed to encourage families who have questions or concerns about their child's development to contact school staff or mental health professionals for more information. Forms can be customized to provide local contact information.

The beginning of the school year, school open houses, parent-teacher conferences, Mental Health Awareness Month (an annual, national event that takes place each May) are all great opportunities to highlight the importance of mental wellness and school-based services that support children's and teen's positive learning and development. Schools often partner with community, regional or state entities to develop public awareness campaigns to inform parents of the importance of early intervention for children with potential mental health problems. Some resources that provide step-by-step instructions, materials, toolkits and activities to assist local schools in developing awareness campaigns include:

- The Substance Abuse and Mental Health Services Administration
<http://www.samhsa.gov/children/national-childrens-awareness-day-events/awareness-day-2015>
- Mental Health America
<http://www.mentalhealthamerica.net/may-mental-health-month-0>
- National Alliance on Mental Illness
http://www2.nami.org/template.cfm?section=may_is_mental_health_month
- National Association of School Psychologists
<http://www.nasponline.org/resources/mental-health/mha-ideas-resources.aspx>



Early Identification through Universal Screenings

Students in rural communities often experience inequities in accessing health care due to a lack of insurance, low parental education, lack of transportation, or cultural barriers. Universal screening for mental health disorders administered at schools, either by trained school staff or in partnership with a mental health or primary care practice, can minimize these inequities. Screening tools are designed to identify risk factors and may be administered with other universal health screenings (such as obesity, vision, hearing, and/or oral health screenings). Various primary care providers that serve rural areas may have a vested interest in partnering with school districts to conduct screenings because of new services expected as part of the Affordable Care Act.

If universal screenings are used it is imperative that they are administered by trained professionals and that protocols are in place to protect the confidentiality of the student and his or her family. The School Mental Health Screening Record (FR Wilson, 2009) is designed to be used as both a universal screening tool and/or as a risk assessment/triage tool for students who are identified as having risk factors. [Bright Futures](#) at Georgetown University is a national health promotion initiative that offers provider, student and family materials, including child and adolescent screening tools. If school staff administers the screening/triage tool they should be aware that the recorded results may be subject to the Family Educational Rights and Privacy Act or FERPA (FR Wilson, 2009). In general, when screening/triage tools are administered by a mental health professional from outside the school the results are the property of that entity and not subject to FERPA.

School Policies That Support Intervention

Far too many schools continue to use punitive discipline measures, such as zero-tolerance policies, that result in negative outcomes for students. Instead, school policies and procedures should promote prevention of and early intervention. [Positive School Discipline](#) provides a systemic approach to create environments for students to thrive and succeed. This approach utilizes five strategies that can enhance student mental wellness: policies; classroom management and engagement; using evidence-based programs to meet students' mental health needs; employing existing school and community support services; and engaging parents and other family members (Promote Prevent, 2015). If policy violations do occur, students and their families should be offered the option to seek assessment and participate in treatment, rather than punishment. Some school districts offer students incentives to participate in intervention services. For example, several school districts are now offering students who violate certain policies the option to obtain a clinical assessment and participate in treatment in lieu of or with a reduction of days suspended from school, athletic games and/or practice sessions, or extracurricular activities.

Multi-Tiered Systems of Support

A best practice for promoting student mental health is to implement multi-tiered systems of support that encompass prevention, wellness promotion, and interventions that increase with intensity based on student need, and that promote close school–community collaboration. [A Framework for Safe and Successful Schools](#) (Cowan, Vaillancourt, Rossen, & Pollitt, 2013) encompasses four key elements for school crisis and emergency preparedness: (1) prevention/mitigation, (2) early intervention, (3) immediate response/intervention, and (4) long-term recovery.

Prevention programs and early intervention services are important to linking mental health, school climate, school safety, and academic instruction. Staff training in effective, research-based teaching methods and behavioral interventions will help build a positive school climate. Peer-to-peer programs (e.g. [Peer Assistance and Leadership](#)) and service learning programs (e.g. [Project Venture](#)) are useful approaches to develop students' social and emotional competence, build resiliency, and facilitate youths' mental wellness.

Schools can encourage select staff to pursue professional development in prevention and wellness initiatives via webinars or self-paced internet (remote learning) courses. Schools can also use a “train-the-trainer” approach and have selected staff complete the training and then teach other staff members through in-service workshops or other professional development opportunities. Nationally recognized programs designed to create a healthy school environment that offer remote courses include:

[Promoting Healthy Mental Development](#) is an online curriculum that focuses on social, emotional, and cognitive development as well as mental health concerns.

The [Eliminating Barriers for Learning](#) program is a five-module, evidence-based course designed for either group training or a trainer-of-trainers format. The entire training package is available for free from SAMHSA and takes about six hours in total to deliver.

[Rural Mental Health FirstAid](#) is an eight-hour training that builds school capacity to identify mental health and substance use issues early and for school staff to gain confidence in intervening and referring a person to the resources that exist.

[The Whole School, Whole Community, Whole Child](#) model emphasizes alignment, integration, and collaboration among the school, health, and community sectors to improve each child’s learning and health. The school is a part of and reflection of the local community.

Because rural school districts typically lack behavioral health professionals who are available on site on a consistent, daily basis, it is recommended that teachers and other school staff are trained to recognize the early warning signs of mental illness and how to effectively communicate concerns with families. Trained school staff can provide triage and stabilization when mental health incidents occur. For example, if a student presents suicide ideation, it is important to be able to assess the level of intervention required to ensure the safety of the student and others. The School Mental Health Screening Record, developed by Robert Wilson at the University of Cincinnati (FR Wilson, 2009) is an interview guide and data collection tool that takes about 15 minutes to administer by trained school mental health staff.



Access to Behavioral Health Care Services

The following practices and models are gaining national recognition as innovative ways to provide quality and cost-effective mental health care, especially in medically underserved areas.

Planning and Communication: It is good practice to allocate time and resources to allow for interdisciplinary planning and regular communications among school staff and crisis team members in order to ensure a quick and appropriate response within the rural context. The school safety and crisis team should, at a minimum, include principals, school mental health professionals, school security personnel and other school staff, in addition to community stakeholders (such as representatives from local law enforcement, emergency personnel, and treatment providers).

Behavioral Health Aides: According to the 2012 report *Behavioral Health Aides: A Promising Practice for Frontier Communities* (VanHecke, 2012), many states are developing behavioral health aide models in an effort to provide additional support to students, families, and residents. Behavioral health aides--also referred to as support workers, case managers, peer specialists, community health workers or promotores, and community health representatives--are recognized for their understanding of the local culture and language. One key function of the behavioral health aid is to help families address barriers to care by assisting them with insurance enrollment, transportation issues, financial concerns, etc., and by linking them to community resources. School districts could partner with community resources to request that a behavioral health aide be school-based to serve students and families within the district.

Technology: Numerous studies have demonstrated the value of school-based telehealth, including one study where 99 percent of parents reported that the telehealth-provided services offered through the Kansas TeleKidcare program were better or just as good as in-person care (RJ Spaulding, 2006). As of 2013, 44 states had some form of Medicaid coverage for healthcare services delivered via telehealth using video-conferencing (Center for Connected Health Policy, 2013). Behavioral health services conducted via telehealth may include clinical assessments, client education, therapy sessions, consultations between school staff and providers, and staff professional development training.

For districts interested in pursuing telehealth programs a free, [on-line course](#) is available through Rural Behavioral Health. The course provides information about how to develop and implement telebehavioral health programs and services. *School-Based Telehealth: An Innovative Approach to meet the Health Care Needs of California's Children* (Kattlove, 2009) is another resource that provides valuable lessons, guidance, and resources based on the experience of school-based telehealth programs from across the country.

Integrated Care

A best practice that may be particularly critical for rural schools is the integration of mental health and primary health care. The intent of integrated care is to better address all physical, mental, and social support needs of the student in a manner that is continuous and family-centered. In rural areas where there are severe shortages of mental health providers, both schools and primary care clinics have become a gateway for the behavioral health care system. When a mental health issue is identified by school staff it is important that the school have internal protocols to govern referrals for clinical assessment and treatment. These may include standards for timeliness of communications with the family and identified school staff. It may also include others who are responsible for facilitating the flow of communication between the school, the primary and behavioral health providers, other care team members, and the family. Depending on the needs of the child or youth, schools may request parental consent to allow communication among all parties (specifying the type of information the school is allowed to receive, by whom and for how long).

School-based health centers (SBHCs) have gained popularity over the past decade as an effective way to improve access to mental and primary healthcare for children and adolescents. Generally located on a school campus, the clinic provides primary, mental health, and in some cases, oral health services. SBHCs provide students access to health care that is safe, convenient, and accessible. They are staffed by licensed professionals with the experience and expertise to deliver quality care that addresses the broad range of concerns that affect students' healthy development. SBHCs strive to provide quality, integrated care. To learn more about SBHCs see the [School Based Health Alliance](#).

Actions

As the current health care delivery system begins to respond to increasing demands for quality improvement and cost control, access to mental health care services is critical, especially for rural communities. The availability, cost, and quality of care is impacted by the five domains of accessibility, affordability, availability, appropriateness, and acceptability. Building a strong mental health service system in rural America will require schools to:

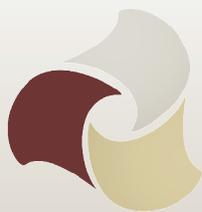
- Leverage resources by collaborating with community partners and health care providers
- Focus on prevention, mental health wellness and early identification of mental health issues
- Use technology (e.g. telebehavioral health) to expand access to appropriate care
- Know how and where to access services to meet diverse needs of students and families
- Have a system of care coordination in place to ease transitions and communications between the school, family and providers
- Provide or identify services to improve access to affordable, quality, and appropriate care
- Advocate with policy makers to ensure equitable access to a full continuum of services and financing for services necessary to improve access to and the quality of care.

Bibliography

- American Psychological Association. (n.d.). *The Mental and Behavioral Health Needs of Rural Communities*. APA.
- Buck, J. (2003). Medicaid, Health Care Financing Trends, and the Future of State-Based Public Mental Health Services. *Psychiatric Services*, 969-975.
- Burns BJ, C. E. (1995, August). Children's Mental Health Service Use Across Service Sectors. *Health Affairs*, 14:147-159.
- C.J Kapphahn, M. M. (2006). Financing mental health services for adolescents: A position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health*, 456-458.
- Center for Connected Health Policy. (2013). *State Telehealth Laws and Regulations*.
- Center for Mental Health. (2011). *Immigrant Children and Youth: Enabling Their Success at School*. Los Angeles: Center for Mental Health at University of California Los Angeles.
- Cowan, K., Vaillancourt, K., Rossen, R., & Pollitt, K. (2013). *A framework for safe and successful schools*. Bethesda, MD: National Association of School Psychologists.
- Farmer E, B. B. (2003). Pathways into and Through Mental Health Services and Children and Adolescents. *Psychiatric Services*, 54:60-66.
- Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., & Teich, J. (2005). *School Mental Health Services in the United States, 2002-2003*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- FR Wilson, M. T. (2009). No Child Overlooked: Mental Health Triage in the Schools. *Michigan Journal of Counseling*, 24-35.
- Frank, R., & Glied, S. (2006). Changes in Mental Health Financing Since 1971: Implications for Policymakers and Patients. *Health Affairs*, 601-613.
- Hamilton, L., Hamilton, L., Duncan, C., & Colocousis, C. (2008). *Place Matters: Challenges and Opportunities in Four Rural Americas*. Durham, NH: University of New Hampshire, Carsey Institute.
- Holzer, C. (1999). WICHE.
- Jackson, V. (2010). *SlidePlayer*. Retrieved September 25, 2015, from <http://slideplayer.com/slide/2800671/>
- Johnson, K. (2006). *Demographic Trends in Rural and Small Town America*. Durham, NM: Carsey Institute, University of New Hampshire.
- Kattlove, J. (2009). *School-based Telehealth: An Innovative Approach to Meet the Health Care Needs of California's Children*. The Children's Partnership.
- Larson, M., Beeson, P., & Mohatt, D. (1993). *Taking rural into account: A report of the National Public Hearing on rural Mental Health*. St. Cloud, MN: National Association for Rural Mental Health and the Federal Center for Mental Health Services.
- Lenardson J., Z. E. (2010). *Access to Mental Health Services and Family Impact of Rural Children with Mental Health Problems*. Portland, ME: University of Southern Maine, Muskie School of Public Services.
- LG Gamm, S. T. (2010). *Mental Health and Mental Disorders – A Rural Challenge: A Literature Review in Rural Healthy People 2010*. College Station, TX: Texas A&M University.
- Moore et al. (2005). *Mental Health Risk Factors, Unmet Needs, and Provider Availability for Rural Children*. Columbia, SC: South Carolina Rural Health Research Center.
- National Center for Safe Supportive Learning. (n.d.). Retrieved August 05, 2015, from Safe and Supportive Learning: <http://safesupportivelearning.ed.gov/events/webinar/enhancing-peer-peer-relationships-strengthen-school-climate>
- National Institute of Mental Health. (2015, July 20). *About Us!*. Retrieved July 20, 2015, from National Institute of Mental Health: <http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml>

Bibliography (continued)

- Office for the Advancement of Telehealth. (2013). *State Medicaid Best Practice: School-based Telehealth*. Health Resources and Services Administration.
- PH Deleon, M. K. (2012). Advancing Federal Policies in Rural Mental Health. In J. W. KB Smalley, *Rural Mental Health: Issues, Policies, and Best Practices* (p. 392). Springer Publishing Company.
- Promote Prevent. (2015). *What is Positive School Discipline?* Retrieved September 29, 2015, from Promote Prevent: <http://positiveschooldiscipline.promoteprevent.org/what-positive-school-discipline>
- RJ Spaulding, D. C. (2006). *School-based telemedicine in Kansas: Parent perceptions*. Athens institute for Education and Research.
- Rost, K., Fortney, J., Fischer, E., & Smith, J. (2002). Use, quality, and outcomes of care for mental health: The rural perspective. *Medical Care Research and Review*, 59(3), 231-265.
- SAMHSA-HRSA Center for Integrated Health Solutions. (2013). *Integrating Behavioral Health and Primary Care for Children and Youth: Concepts and Strategies*. Washington DC: U.S. Department of Health and Human Services.
- Sawyer D, G. J. (2006). *Rural and Frontier Mental and Behavioral Health Care: Barriers, Effective Policy Strategies, Best Practices*. National Association of Rural Mental Health.
- VanHecke, S. (2012). *Behavioral Health Aides: A Promising Practice for Frontier Communities*. Silver City, NM: National Center for Frontier Communities.



The Now Is The Time Technical Assistance (NITT-TA) Center

Toll-Free Phone: (844) 856-1749

Email: NITT-TA@cars-rp.org

Website: www.samhsa.gov/NITT-TA



This Issue Brief was developed under contract number HHSS283201200030I for the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA).

The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.