Strong Interest in School Mental Health as Part of Prevention and Early Intervention- Approaches Vary Widely Across the State. Survey of Counties, Schools, and Providers

by Rusty Selix

With this blog, I am transmitting a survey done over the past year about school mental health. Counties' interest in school-based mental health programs has been going on for decades, and schools' interest in offering mental health services and supports on campuses has been going on as long.

For 20 years starting in the early 1990s, the state funded a program known as the Early Mental Health Initiative (EMHI) which supported children in kindergarten to third grade who were in the 10th to 25th percentile in function. The program had the best data support of any program I am aware of. It seems the children consistently improved performance to over the 35th percentile and maintained it for at least two years. The state Department of Mental Health reported that it never saw those kids again, meaning they never became special education placements due to serious emotional disturbance under what was then known as the AB 3632 program, and they also did not wind up in child welfare.

Nonetheless, as part of the realignment of schools funding under the Local Control Funding Formula, this program was eliminated six years ago as a categorical program that would only exist at the option of local districts.

In 1995, California created the supplemental children's Medi-Cal funding for mental health known as EPSDT, and in its first several years many counties worked to place county funded providers on school campuses. I remember a conversation in the late 90s with then LA County Children's Mental Health Director, John Hatakayama, who said that if we can reach children at school, almost all will receive the services that we offer. But if we tell the family they must go through their health plan, less than 20 percent will receive the care because of six procedural steps they must go through and most were not willing to complete those steps.

From the school side, the focus has been on the failure of traditional approaches to behavioral problems with discipline and suspensions only exacerbating problems instead of solving them. Concepts such as positive behavioral intervention and supports (PBIS), response to interventions (RTI), and multi-tiered systems and supports (MTSS) have emerged as model practices with growing numbers of school districts participating. Last year, it was estimated that over 25 percent of schools have implemented a reasonable level of PBIS focused on the first tier of school climate and school culture, which is a perfect parallel to the mental health approach of universal prevention for all individuals.

Not surprisingly, these historical approaches and recent innovations are getting some level of support in the Prevention and Early Intervention Programs (PEI) under the Mental Health Services Act (Proposition 63 or MHSA).

This led me to direct an intern, Daniela Guarnizo, to do a study and find out as much as we could about what is out there across the state. The **study** showed hundreds of programs under the MHSA, all of which were easy to find because they are in reported county expenditure plans. We knew there were also many other county programs funded through EPSDT and school programs which schools had received funding from other sources. We also asked counties, school districts, and providers to give us additional information. What we came up with is very comprehensive for the MHSA-PEI programs, but probably only a small percentage of the other programs because it relied upon voluntary responses to a survey. I wanted to highlight schools where it appears they had a system where there was a clinician on campus that teachers would regularly meet with, and who could provide on campus support services for children with mental health problems which were not yet severe and make that early

intervention happen as soon as a teacher could observe something wasn't right. I'm sure we did not capture all those programs, but at least it was gratifying to know that there are many across the state.

Despite its limitations, the report should be quite valuable and useful to school officials, counties, state officials, and providers.

The good news is that there is a great deal of interest in the subject that appears to be growing. The bad news is there is not yet a settled upon consistent comprehensive strategy. The primary problem in putting it all together is that it requires partnerships among schools and counties, as well as Medi-Cal funded providers in low income areas and private providers who are part of commercial insurance networks in more affluent areas. Additionally, as we move forward with county Alcohol and Drug Organized Delivery Systems and the Youth Alcohol and Drug Prevention, Early Intervention and Treatment Programs which is funded by Proposition 64, there are likely additional partnerships that will need to be created and additional philosophies that need to be incorporated into a consistent set of principles.

Creating these partnerships seems to be the biggest challenge in moving forward to create a consistent high standard approach. A small nonprofit called Breaking Barriers has convened teams of people representing schools and county behavioral health from a dozen or so counties in each of the past three years.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) will soon be releasing funds for county mental health to compete to develop school mental health programs that will require partnerships with schools.

What I have observed over the past few years of the discussions about this within Breaking Barriers, the MHSOAC, and the Department of Education School Mental Health Policy Workgroup, is that there is a consensus about the goals we hope to achieve. Everyone wants a positive school culture that reduces the school cause of stress and trauma and minimizes the number of students who will have significant behavioral health problems. Everyone also agrees that when children have signs of a diagnosable problem they should get help as soon as possible and ideally on campus at school.

School officials and mental health leaders use different terminology to describe their goals, even when the terminology is understood the context is often confusing. For example, MTSS is a multi-tier system of supports for academic support as well as social and emotional support. But sometimes, school officials speak only about the academic support as though that were the whole program. They also don't recognize that social and emotional support should mean mental health care once a child exhibits some level of functional impairment. Mental health leaders don't recognize that it's three tiers match up perfectly with the three tiers of universal prevention, limited services for those at risk, and intensive services for those with a serious emotional disturbance.

However, the biggest problem as is often the case is how will it be paid for? It is not a problem of lack of money but a problem of lack of control by either counties or schools. Part of that problem is the different understandings of how Medi-Cal works. Counties and their providers understand the EPSDT Managed-Care Program quite well. But when you mention Medi-Cal to school officials, they think of the fee-for-service LEA (Local Education Agency) billing option.

Equally important is the difference between FERPA (Family Educational Rights and Privacy Act) which provides parental access to school education records and HIPAA (Health Insurance Portability and Accountability Act), which provides confidentiality of health records that school officials would not have access to.

Putting it all together should mean that schools create positive school climate generally with their own funds, but also eligible to seek support from counties under PEI. Counties offer to place EPSDT funded providers on school

campuses to work with teachers to identify students who may present with a diagnosable condition and offer supports before the problem becomes a serious emotional disturbance. At schools where a significant percentage of the students are not in Medi-Cal, (slightly under 50 percent statewide but varying much more widely from school to school) there should be private therapists on campus who are part of the networks of commercial health plans with support from the school or county to address co-pays.

This is all for the students who are not placed in special education. About 80 percent of children who receive mental health services in special education do not have a serious emotional disturbance and are in special education due to a separate condition. For these individuals, the mental health service is a modest one that can be provided by a wide variety of providers, and only specialized providers can offer a comprehensive array of services for the 20 percent who have severe emotional disturbance will be appropriate. In general, these are the providers that counties contract with under EPSDT and that many schools also contract with under the AB 114 program. When that partnership is set up correctly, the federal share of EPSDT should be available through the county for Medi-Cal enrolled students.

For students with substance use disorders, the same approach should apply for Medi-Cal and private insurance. To the extent that there are gaps in available services, the Proposition 64 funds should help starting in 2019–20.

There is considerable evidence to support the premise that investment in a comprehensive school program to provide positive supports for all students and an early identification and treatment program for non-special-education students will pay for itself in reduced special education costs. The greatest savings will come from preventing significant numbers of students from having their emotional disturbance progress to the level where they can't be in a regular classroom and must be in a nonpublic school, with costs estimated at $60,000 annually. There also should be savings in EPSDT by serving larger numbers of students when the problems are less severe. The Early Mental Health Initiative (EMHI) reported that the average case was under $1000 with only a handful of service visits required.

Hopefully, the three-year pilot programs that will be funded by the MHSOAC will include evaluations that document changing trendlines in special education costs and placements, although it may take more years to fully realize the potential savings.

Hopefully, reviewing this survey will provide helpful information across the state to develop better programs.