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“Creating Self-Sustaining, Replicable School Mental Health Programs: A User’s Guide”

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“If you want to build a ship, don't herd people together to collect wood and don't assign them tasks and work, but rather teach them to long for the endless immensity of the sea.”

Antoine de Saint-Exupery

There is a wide variety of school mental health programs across the country. They are based on multiple models.

Some have all services provided by school staff, some have co-located diagnostic and treatment services and some have a combination.

There are numerous funding mechanisms for school mental health programs

Unfortunately, many of the potential funding streams are not necessarily sustainable

For example, some states that had school-linked mental health grants discontinued funding, and programs were no longer sustainable.

First things first:

Before getting into funding issues,

what is meant by “school mental health”?

The concept is broad, and encompasses many service models.

For the purpose of this presentation, it refers to the identification, diagnosis and treatment of students who have mental health disorders.

Definitions:

Counseling is a supportive service, assisting a student in succeeding in the school environment

Therapy is the actual treatment of a mental health disorder, e.g. providing psychotherapy to treat Major Depression

Skills Training teaches specific skills that can be mastered and practiced (e.g., social skills, organizational skills, daily living skills, etc.)

It cannot be done in a vacuum- ideally the school system is simultaneously providing supports for all students, based on their needs.

Tier 1: Universal Interventions and supports

Tier 2: Targeted Interventions

Tier 3: Intensive/individualized intervention/treatment

Tier 1 is the bottom of the pyramid- universal services for all students

Tier 2 is for at-risk services, generally providing group interventions

Tier 3 is the top of the pyramid, and is individualized for students who have significant risks.

Should school professionals (school social workers, school counselors, school psychologists) limit their services to tiers 1 and 2?

Should mental health professionals limit their services to tier 3?

Models of service vary from "bare bones" to a full array of services, many of which are not reimbursable through third party (e.g. insurance) billing

Also, service models vary in regard to who is providing the diagnostic and treatment services.

This impacts payment mechanisms.

Model #1:

School employees provide diagnostic and treatment services

School staff (e.g. , school social workers who are licensed to diagnose and treat patients) may do so within the school setting.

Advantages of this model:

-District has control over what is done

-Services are targeted to students identified by the district

-May be able to obtain reimbursement through Medicaid as well as special education funding for some students

Disadvantages of this model:

-Data privacy (all documentation is part of the educational record)

-Malpractice (district's "errors and omissions" policy may not cover their liability

-Evening, weekend and vacation coverage

-Boundary issues

-Not likely to bill private insurance (due to FAPE, etc.)

Model #2:

Co-located, on-site mental health services provided by community mental health provider

Advantages:

-The provider is responsible for billing, crisis backup, malpractice, data privacy, psychiatric consultation, etc.

-Bridges to mental health while maintaining legal and financial firewalls for the school district

Disadvantages:

-District does not have direct control over services provided

Services in this model can also be provided by a community health clinic that employs mental health professionals. Then, both health and mental health services are provided. Some students are more comfortable with this model vs. a mental health clinic provider model

Model #3:

Division of labor between school and clinic.

For example the school staff might provide counseling and skills training while the clinic provides diagnostic and treatment services.

Skills training may be Medicaid reimbursable to the district. It does not have the problems of data privacy, crisis intervention, malpractice, payer of last resort or other concerns that diagnostic and treatment services have.

It is not considered "double dipping" if a district is reimbursed for skills training by Special Education funds (for educational necessity) and by Medicaid (medically necessary).

The next question: What is the array of services that will be provided?

The "Bare-Bones" model:

The provider of mental health services provides the same services that would be done in a typical clinic. This model is basically as if there were a clinic next door to the school.

More expanded models of services cover ancillary (some are unbillable) activities such as:

-Consultation to teachers and other school staff

-Inservice presentations

-Attendance at school meetings (e.g., IEP teams) if requested by parent

-Provision of services to uninsured or underinsured students

Most advocates of school-based services promote the expanded model. However this requires additional funding. Many schools would be thrilled to have "bare bones" services for students who otherwise would receive no mental health treatment.

Typical Start-Up Costs of the expanded model:

Orientation meetings
Relationship building
Presentations to staff
Building up a case load
Classroom presentations
Marketing
Space arrangements
Technology set-up

Typical Ancillary Services

Treatment Related Ancillary Services:

School Conferences (IEP meetings, etc.)
Consultation to teachers
Consultation to support staff
Consultation to administration
Child-specific observation
Parent consultation
Case coordination

Translation services
Student observation
School conferences/meetings
Screening
Student meeting prior to diagnostic assessment
Case management
Travel

School Wide Ancillary Services:

Training for staff
Consultation (not student-specific)
Observations (classroom-wide)
Classroom presentation
Building support teams

Treatment Services:

Psychological testing
Individual, Family and Group skills training
Individual therapy
Family therapy without client
Family therapy with client

Diagnostic assessments
Group psychotherapy
Medication management
Crisis management
Psychiatric services
Medicine consultation

E.g.: Hennepin County, MN

Approximately 70 schools
55 FTEs of Mental Health Professionals
$3.1 Million/year
64% Billable, 36% Ancillary

Ancillary Funding

State Grant= 65%

School District= 26%

LCTS Grants= 7%

Other= 2%

$30,000.00 Gap in stable funding per each FTE

Partners:

Providers
Local and State Government
School District
Health Plans
Foundations

In Hennepin County,
3rd party= 51%
State Dept. of Human Services Grant= 30%
School District= 9%
County= 3%
LCTS Grants= 3%
Other= 4%

It is helpful to start with an understanding of basic services, and then expand from there.

Question: In any given town where there is a school district and a community mental health clinic...

And neither has funds to pay for unbillable services....

and neither wants to seek grant funding due to concerns about sustainability...

Can the two systems get together to provide mental health services within the schools?

Good news #1

The Affordable Care Act will result in a significantly lower percentage of uninsured children and adolescents.

Although a state may have a relatively low percentage of uninsured individuals, these children, adolescents and adults tend to have a disproportionate amount of mental health disorders

Good news #2:

Some states have expanded Medicaid benefit sets that cover some or most ancillary clinically related services.

Examples:

Family consultation/guidance
Clinical care consultation from one professional to another (including teachers)
Expansion of coverage for assessment and treatment planning
Obtaining assessment information from multiple sources

Nothing is 100% guaranteed sustainable.

But some funding is more sustainable than others.

Most sustainable: third party reimbursement

Least sustainable (by definition): time limited grants

Third party reimbursement for direct service

Is the reimbursement rate for mental health treatment adequate to break even?

Medicaid good news- may have a benefit set that is significantly more comprehensive than private insurance.

Bad news- reimbursement rate is low

If counties or the state is responsible for mental health services for the uninsured or underinsured, they may provide funds to the clinic for this population

One potential consideration:

Federally Qualified Health Centers (FQHCs)

These are community-based organizations that provide comprehensive care and preventive care including health, oral and mental health/substance abuse services to patients of all ages regardless of their ability to pay or their health insurance status.

Generally, FQHCs can be reimbursed by Medicaid at a substantially higher rate than are non-FQHC clinics.

Depending on the percentage of Medicaid and uninsured students, clinics may have significant difficulty in providing even "bare bones" diagnostic and treatment services

Although they may not be paying rent to the school, and although the fail and cancel rate is lower, the drop-off of billable hours during the summer tends to offset these advantages

Although families have the option to go to the clinic over the summer months, many do not do so.

Ideally, the provider would be a large enough, and diversified enough organization that it could re-deploy staff in the summer

Or, alternatively, the school district could identify a population of extended school year students who require ongoing mental health services over the summer

"Bare bones" services are not the ideal. However, they can be provided under some circumstances, and they benefit families, schools and mental health providers.

Providers under this model of service should not be expected to provide unbillable ancillary services to the school.

Before considering expanded services it is important to understand the ways schools do (or do not) adequately address students' mental health disorders in the educational context.

Does the school district have a mental health plan that outlines policies, procedures and guidelines for addressing the needs of students who have mental health disorders?

Are the roles and responsibilities of school social workers, psychologists, counselors and nurses clearly defined in their work with students who have mental health disorders?

Are there protocols for communicating with health and mental health professionals who are treating students who are being considered for special education?

(About half of students being evaluated for special education EBD services are taking medication for symptoms that are the behaviors that caused the evaluation to be initiated)

Does the district have protocols for educational evaluations of students who have mental health disorders?
Do FBAs identify intrinsic causes of behaviors?
(rather than, for a student who has ADHD:
Problem: Inattention
Function of problem: Avoiding Schoolwork

Does the district have clarity regarding mental health related services on IEPs?

Does the district analyze its data: e.g., the nature and types of high-risk students' mental health disorders, and the services that are being provided to them?

Do district staff know how to make the connection between students' behavior, students' academics and students' mental health? Is this considered relevant?

Can resource mapping identify gaps in services? Can school staff have redesigned priorities that would allow them to do some of the ancillary services that are provided by school mental health providers?

For example:

Gathering information from mental health providers, consulting with teachers, providing inservice presentations, translating mental health concepts into educational interventions, etc.

Many thanks to Elizabeth Freeman:

School Mental Health Sustainability

Funding Strategies to Build Sustainable School Mental Health Programs

Technical Assistance Partnership for Child and Family Mental Health

Washington, DC.

More comprehensive programming, and the reimbursement needed to fund it, ideally arises from a Systems of Care model.

Systems of care facilitate the identification and early referral of youth who require services, increase school performance, reduce suspensions, improve school attendance, and decrease school mobility (Center for School Mental Health, 2007).

The system of care governance body is composed of community agencies and organizations that address various issues related to mental health/substance abuse, and usually includes the following groups and agencies:

Youth and family representatives, school, mental health, substance abuse, health, juvenile justice, law enforcement, community non-profits, and cultural leaders

The involvement
of those with expertise in family
and youth engagement and in
culturally and linguistically
competent
services and supports is critical to
the development of effective
school mental health programs.

Steps:

1. Create a shared vision, mission, goals, and objectives for school mental health program

2. Build mutual respect and trust between school staff and mental health agency partners

3. Clearly define the roles and responsibilities of school staff and mental health counselor

4. Provide cross-training/professional development opportunities for school staff and mental health counselor

5. Develop a memorandum of agreement and/or contract to define the scope of work for school/ mental health agency

6. Work with mental health state oversight agency to develop systems to establish funding streams for school mental health programs

Collaborating with other systems for sustainable funding streams

Collaboration:

“An unnatural act committed between non-consenting adults”

Shared Funding

For example, a mix of third party billing and additional sources from the county.

E.g., California's "Billionaire Tax"
Washington's "one tenth of one percent"
county referendum
Used to fund mental health initiatives

Community coalitions: businesses raise funds through donations and fundraisers

Funding from members of the system of care governance body (e.g., health, juvenile justice, social services)

Non-profit organizations can open up a new stream of funding opportunity

State/County Temporary Assistance for Needy Families (TANF) funds can help pay for school's Tier 1 and Tier 2 interventions through social service agencies

State-supported legislative line item for school mental health
e.g. South Carolina legislature budgeted a line item for reoccurring funds to the state mental health department to be used for school mental health services in rural/underserved communities

Grants

-Safe Schools/Healthy Students

-Elementary and secondary school counseling grant

-OJJDP grants (mentoring, truancy, juvenile justice, mental health, substance abuse)

-Healthy School, Healthy Communities program (Bureau of Primary Health Care)
-Title XX Social Services block grant
-Preventive Health and Health Services block grant
-Maternal and Child Health block grant
Department of Education grants

State Funds

States can have their own funds for this purpose- E.g., Minnesota Department of Education has Alternative Delivery of Specialized Funds available to school districts.

The district would need to match these dollars with other funding streams

The state may have school based health and mental health services in their budget as a line item

The state may have grants for a specific program (e.g., Safe and Drug Free Schools

State health initiatives and state taxes (e.g., tobacco tax, property tax) may offer support for school mental health services

The state may have grants for pilot school mental health demonstration projects

Private foundation grants

E.g., Annenberg Foundation (Los Angeles)
Duke Endowment (North Carolina)
Robert Wood Johnson Foundation
Kellogg Foundation

Other foundation grants

E.g., Blue Cross/Blue Shield Foundation of South Carolina funded $200,000.00 for mental health services in Orangeburg County Schools

Private grants tend to be for seed funding, not sustainability

School Districts

Special Education Funds

15% of Federal Special Education dollars (CEIS, or Consolidated Early Intervening Services funds) can be used to identify and address the needs of students at risk of requiring Special Education services

Many special education directors do not want to commit themselves to using federal funds in this way, as they cut into the budget for serving special education students

Some have been forced through Office of Civil Rights, for example, to use them for services related to mental health (e.g., overrepresentation of students of color in restrictive settings for Emotionally Disturbed students)

The ideal use of these funds would be to increase mental health interventions for students at the pre-referral stage, being considered for Special Education assessments for the Emotionally Disturbed category.

Psychiatric Characteristics of Students at Time of First EBD Assessment

(n=33)

Diagnosis	Has been made	Evidence	Total
ADHD	48%	52%	100%
Depression	21%	55%	76%
Dysthymia	3%	0%	3%
Bipolar	6%	12%	18%
Chemical Abuse or Dependency	0%	0%	0%
Psychotic Disorders	0%	6%	6%
Schizo-Affective Disorder	0%	0%	0%
Obsessive-Compulsive Disorder	3%	0%	3%

PTSD	3%	0%	3%
Other Anxiety Disorders	3%	58%	61%
PDD	3%	9%	12%
Tic Disorder	3%	0%	3%
Bulemia	0%	0%	0%
Adjustment Disorder	0%	48%	48%
Speech and Language Disorders	6%	0%	6%
Learning Disabilities	21%	0%	21%
Developmental Delays	0%	0%	0%
FAE/FAS/ FDE/FDS	0%	0%	0%

Early intervention can prevent students from requiring special education, and from requiring expensive, high intensity restrictive placements.

Some school districts use General Education funds to support school-based clinic services

Volunteer and University internships

E.g. AmeriCorps, Vista

Masters/Bachelor level interns from University

University Departments E.g., use of Resident Physicians supervised by Academic staff

Negotiation with insurance companies for an expanded benefit set that includes ancillary services

Negotiation with State Medicaid for an expanded benefit set

Local Collaborative Time Study (LCTS) funds= Indirect Medicaid Reimbursement

Random phone calls are made to staff in the Social Services, Corrections, Public Health and Education systems to calculate the percentage of time that represents indirect billable activities

This can generate a substantial amount of funds for a school district

The funds can be routed through local collaboratives (e.g., Mental Health Collaborative, Family Services Collaborative, etc. and disbursed for school-based mental health activities.

EPSDT

(Early, Periodic Screening, Diagnosis and Treatment)

EPSDT provides Medicaid payment for services identified as being needed, even if the services are not covered in the State's Medicaid benefit set.

EPSDT is the best kept secret in Medicaid reimbursement.

Some states, (e.g., Pennsylvania) have providers who are reimbursed at high rates (significantly higher than typical fee for service Medicaid rates) and who provide a wide variety of preventive and treatment services.

The State Medicaid agency may allow schools to bill Medicaid directly for mental health services,

and the district, by putting the service on the student's IEP, will effectively be paid back at a higher rate than the clinic would be if it billed Medicaid

Clinics may encourage the district to bill Medicaid and subcontract at the higher rate to the clinic, but this incurs potential financial liability for the district

They would encourage to do so, because the school could bill Medicaid for the entire cost of doing the service, which includes some services which would not be reimbursable if the clinic billed Medicaid.

Putting mental health related services on an IEP puts the district at financial risk should the student lose Medicaid coverage or require more intensive services (e.g., Residential Treatment).

States have varying policies. The best is Montana, which allows for school districts to bill Medicaid for General Education as well as Special Education students, and allows Seriously Emotionally Disturbed children and adolescents to qualify for Medicaid with no need for a family copay based on income.

Problem: most systems, especially school systems, do not have accurate databases that clarify the nature and extent of mental health disorders in their population.....

Nor the overlap of individuals in each system.

For example, what percentage of adolescents in Juvenile Corrections are in the Emotionally Disturbed category of Special Education?

What percentage of Emotionally Disturbed Special Education students have mental health disorder?

How much money do students in the restrictive, Setting 4 educational placements cost the Education system? The Corrections system? The Child Protection system? The Health system?

Maryland identified hundreds of thousands of saved dollars when school-based mental health services were demonstrated to substantially reduce out of district, self-contained school placements.

The students in restrictive Emotional/ Behavioral programs tend to have more severe mental health disorders than those in the Day Treatment programs. The ED students tend to be kicked out of Day Treatment, and generally receive little or no mental health services.

This consultant provided consultation services to a small (5000 student) Minnesota suburban district. 85% of the students from that district who were in self-contained programs had been diagnosed with mental health disorders. Only 5% were receiving any mental health treatment.

By bringing students back to the district, and providing school-based mental health services, students' academics and behaviors improved. The district saved $800,000.00/year as a result.

It is important to have services targeted appropriately

(This consultant worked with a school mental health program in which 50% of the students served had no DSM diagnosis- not a good use of resources!)

Can a collaborative effort quantify the savings to multiple systems if mental health services are targeted to:

-Students at risk for ED Special Education placement?

-Students in Special Education who are at risk for needing more restrictive services?

-Students in restrictive (e.g., Setting 4) ED programs?

Can each system guarantee long-range funding if it is cost-effective?

If funds are saved, and savings go to the district's general budget, can they be earmarked to return to Special Education so that these mental health services can continue to be funded?

What kind of multi-system database is necessary to demonstrate that school mental health services improve educational performance, reduce behavioral problems and are cost-effective?

What additional funding can be provided by each system, from savings resulting from school mental health interventions?

Punchline:

Understand the basics and work up from there

Maximize efficiency

Consider reducing unbillable ancillary percentage of time as much as possible

Assure that the school system is mental health oriented

Use a data-driven model to justify funding

Assure appropriate role boundaries within and out side of the school

Use funds for startup costs, aiming at sustainability as soon as possible

Share the funding with several partners in a systems of care model

Good luck!

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The concept of integrating mental health services within the school environment:

William Wurt, Superintendent of schools in Gary, Indiana:

"The schools should serve as a clearinghouse for children's activities so that all child welfare agencies may be working simultaneously and efficiently, thus, creating a child world within the city wherein all children may have a wholesome environment"

Thomas Elliot, Sociologist:

"All agencies dealing with neglected or behavior problem children should be closely coordinated under the aegis of the school, including medical inspection, school nursing, attendance control, vocational guidance, placement, psychological testing, visiting teachers, and special schools and classes."

William Wurt quote- 1923

Thomas Elliot quote- 1928