Materials for the Joint Informational Hearing
Special Committee on Pandemic Emergency Response
And
Education Committee

Back in School: Addressing Student Well-Being in the Wake of COVID-19

The County Behavioral Health Directors Association of California (CBHDA) represents the public mental health and substance use disorder program authorities in counties throughout California. County behavioral health departments provide and arrange for specialty behavioral health services to children and youth under the age of 21, in accordance with the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, substance use disorder, developmental, and specialty services. The county behavioral health delivery system continues to partner with other child-serving systems to provide support and specialty services to children and youth who are in need of behavioral health interventions. CBHDA and our members believe that coordination across education and behavioral health systems helps to identify vulnerable children and youth through school-based partnerships enabling the provision of necessary behavioral health services.

Given the fact that over half of all children in California public schools qualify for Medi-Cal, counties realized that schools are a perfect place for county behavioral health to identify and outreach to children and youth with behavioral health needs. County behavioral health agencies have partnered over decades with their local education systems to ensure the provision of prevention and treatment services on school campuses. *Currently, 85% of county behavioral health departments provide Medi-Cal specialty mental health services (SMHS) on school campuses today and 55% are providing substance use disorder (SUD) treatment on school campuses.*

This document outlines: (1) the existing obligation of counties and schools as well as the respective licensure and credentialed professionals that can render services, (2) the existing county behavioral health school-based footprint and core collaborative models, and (3) additional services counties are providing to support students with exacerbated needs due to the pandemic.

Medi-Cal Specialty Mental Health Services (SMHS), Local Educational Agencies (LEA) Services and School-Based Behavioral Health Workforce

There are various supports and mental health services that may be provided to children and youth in the K-12 education system through local collaboration across the county behavioral health and education systems. Our respective systems must collaborate and leverage the expertise provided by both licensed and credentialed professionals to provide a continuum of supports and services to students in the K-12 education system. At times, the differing regulatory provisions that govern these respective systems can make collaboration complex and difficult to navigate at the local level.

Below is a summary of the service types and professionals that may appropriately render school-based support.

County Behavioral Health Department/County Mental Health Plan	
Medi-Cal Specialty Mental Health Services (SMHS)	The Dept. of Health Care Services (DHCS) administers CA's Medi-Cal program. Medi-Cal SMHS are carved out of the Medi-Cal Managed Care and operates under the authority of a waiver approved by the Centers for Medicare/Medicaid Services (CMS) under Section 1915(b) of the Social Security Act. MHPs are required to provide or arrange for the provision of SMHS to beneficiaries that meet medical necessity criteria consistent with their mental health treatment needs and goals.[1]
Medi-Cal Drug Medi-Cal Organized Delivery System / Drug Medi-Cal	The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. Similarly, the Drug Medi-Cal (DMC) program provides medically necessary substance use disorder (SUD) treatment services to Medi-Cal beneficiaries.
Local Educational Agency (LEA)	
Educationally Related Mental Health Services (ERMHS)	In 2011, the California Legislature passed Assembly Bill 114, requiring school districts to be **solely responsible** for ensuring that students with disabilities receive special education and related services according to the Individuals with Disabilities Education Act (IDEA). This includes Educationally Related Mental Health Services (ERMHS) as specified in a pupil's Individualized Education Plan (IEP). [2]
The LEA Billing Option Program (BOP)	Reimburses LEAs (school districts, county offices of education, charter schools, community college districts and college campuses) the federal share of their maximum allowable costs for approved health-related services provided by qualified health service practitioners to Medi-Cal enrolled students. [3]

[1] https://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx#:~:text=The%20Medi%2DCal%20Specialty%20Mental,of%20the%20Social%20Security%20Act.
[2] https://www.cde.ca.gov/sp/se/ac/mhsfaq.asp
[3] https://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx

The School Based Medi-Cal Administrative Activities (SMAA) Program	Reimburses school districts for the federal share (50% and in some cases 75% for translation services) of certain costs for administering the Medi-Cal Program that may not be covered by the LEA BOP.[4]

County Behavioral Health Licensed Professionals

California's behavioral health licensed workforce has specific education and training to support children/youth through a continuum of services, such as prevention and early intervention treatment to that of specialty behavioral health interventions, including the utilization of psychotherapy for mental health treatment. Prevention/early intervention treatment provided by licensed behavioral health professionals typically consist of reducing risk factors or stressors and building protective factors and skills. This promotes positive cognitive, social and emotional development and encourages a state of well-being for individuals and families. Early Intervention is directed toward individuals and families for whom low-intensity intervention is appropriate to improve mental health problems avoiding the need for extensive mental health treatment. Therefore, the prevention and early intervention treatment provided by licensed behavioral health clinicians may differ from the types of prevention services credentialed school employees may provide. *To provide this level of specialty care for children/youth, County Behavioral Health Professionals are typically required to receive a doctoral or master's degree in addition to completing hours worked under the supervision of a licensed professional.*

LEA Credentialed Professionals

California's school credential workforce provide support geared towards a child or youth's development as it relates to their education. The Pupil Personnel Services (PPS) credential, authorized under the California Commission of Teacher Credentialing, may be obtained for school-based professionals in four authorizations: school counseling, school psychology, school social work and child welfare and attendance services. PPS credential programs ensure that candidates develop the knowledge, skills, personal and professional dispositions to help maximize the developmental potential of all students by preparing candidates to: 1) address the needs of all students by providing comprehensive and coordinated programs and services to help build safe, healthy, nurturing and effective learning environments; 2) recognize that, in addition to cognitive and academic challenges, students encounter personal, social, economic and institutional challenges that can significantly impact their lives, both in and outside of school; and 3) promote understanding that students need individualized opportunities, services, and supports to address life's challenges, and gain personal success and achieve academically. *The authorization and requirements for each typically include a baccalaureate degree or higher in a Commission-approved professional preparation program* and obtain a formal recommendation of a California college or university with a Commission-approved Pupil Personnel Services program.

[4] https://www.dhcs.ca.gov/provgovpart/Pages/SMAA.aspx

How Counties have Operationalized Regulatory Frameworks and Developed Collaborative Models with Schools to Support Students

Because there is limited statewide information on the various partnerships that have been developed across counties and schools, in January 2021, CBHDA developed a membership survey to help our association identify the quantity and models for school-based partnerships throughout the state. CBHDA received responses from 97% of our membership for this survey and found that 85% of county behavioral health departments are providing Medi-Cal SMHS on school campuses today. Among the survey respondents, just over a third (33%) indicated that they cover 80-100% of school campuses within their counties. Given that there are close to a thousand school districts across California, across 58 Offices of Education, this degree of collaboration demonstrates the commitment to students by county behavioral health departments.

Additionally, 55% of county behavioral health departments provide SUD treatment on school campuses with a majority of these services delivered by county employees. SUD services are so important in addressing youth mental health needs because youth have higher rates of co-occurring mental health and SUD needs than adults.

A key distinction is that, while education services are a broad public entitlement for all income levels, publicly funded behavioral health services are not. One significant barrier counties face in developing school-based partnerships is that schools rightfully want to offer school-based behavioral health services on campus to all students in need regardless of health insurance status while county behavioral health agencies are mandated to serve Medi-Cal eligible students. To establish school partnerships, 65% of counties provide services to non-Medi-Cal beneficiaries and county Mental Health Services Act (MHSA) funds are the main source of funding for these services. Only about 15% of county behavioral health agencies indicated that they are successful in recouping reimbursement from private commercial insurance for these purposes.

Overall, the three main funding streams that counties utilize to provide behavioral health services on school campuses are Medi-Cal, MHSA and County Realignment funds. Around 16% of respondents indicated that their education partners also contribute education Local Control and Accountability Plan (LCAP) funds to support county behavioral health services on school sites.

County Behavioral Health Department and Education Partnerships

There are four (4) core service delivery models and partnerships that have been developed in these county/school partnerships (although it should be noted that 33% of respondents indicated other ways to blend funding streams). The most common model is for school staff to provide ERMHS as prescribed by AB 114, and county behavioral health departments operate in parallel on the school site to provide specialty behavioral health services. In this model, school staff refer students to the county provider for on-site specialty services, as needed. For example, you may have a student who performs very well in school, and therefore would not qualify for ERMHS, but who nonetheless has significant behavioral health needs. That student would be referred to the county behavioral health team. Conversely, the student who is receiving ERMHS services to support their learning may require additional behavioral health services and supports beyond the services that can be delivered through ERMHS.

The second most common model reported enables schools to contract directly with county behavioral health departments to provide ***both*** ERMHS and specialty behavioral health services. Under this model, schools retain financial responsibility for ERMHS services delivered through the county providers.

Although not as common, we do have service delivery models where the county behavioral health agency will contract directly with licensed, and in some cases unlicensed school staff. With appropriate county behavioral health training and oversight, the counties are able to authorize these school-based providers to provide Medi-Cal SMHS at schools, in addition to fulfilling their ERMHS responsibilities.

County/School Partnership Model 1	**County/School Partnership Model 2**
Schools contract with county behavioral health agencies to provide ERMHS on school sites with schools paying for ERMHS services. In this model, county behavioral health agencies also provide and pay for SMHS for students both on school sites and when necessary, in the community.	County behavioral health agencies contract with appropriately trained school-based ERMHS staff to provide limited SMHS appropriate for delivery on the school site. In this model, schools pay and provide ERMHS and county behavioral health agencies pay for SMHS provided by ERMHS staff.
County/School Partnership Model 3	**County/School Partnership Model 4**
School staff provide ERMHS and county behavioral health agencies operate on school sites and provide SMHS. School staff refer students receiving ERMHS as well as other students that are meeting academic standards and may not qualify for ERMHS, for onsite SMHS.	County behavioral health agencies contract directly with licensed school staff to provide SMHS. In this model, schools continue to provide and pay for ERMHS outside of their county behavioral health contract.

Some of the key barriers identified in our membership survey that inhibit the expansion of school based behavioral health services include: 1) limited available space on campuses to provide confidential and appropriate services to students; 2) inadequate funding for commercially insured students; 3) hesitation on the part of schools to pull students away from instructional time; and 4) varied perspectives from one school district to another on the value of more comprehensively addressing students' behavioral health needs on school campuses. During the past year, it was at times challenging to rely solely on our school-based partnerships in serving children and youth. As children went home for virtual learning, referrals to services from schools plummeted – and in some cases, campuses were reticent to allow providers on campus because of evolving COVID protocols.

COVID-19 Impacts and County Plans to Support Students Returning to the Classroom

Children and youth throughout the nation are suffering because of the pandemic and have been uniquely hard hit. During the pandemic, several of our counties reported the numbers of children and youth in acute mental health crisis shot up – two and sometimes three-fold. We have children as young as eight years old who have been hospitalized due to suicidal ideation. Behavioral health directors

report that, consistent with historic trends with youth crisis and the school calendar, the transition back to in-person learning has resulted in a new surge of children and youth in crisis. CBHDA surveyed our county children's system of care leadership to better understand local efforts to address the growing behavioral health needs of children and youth and efforts to prepare for the return to school in the Fall of 2021.

- *Crisis Services and Mobile Response*
  Current county behavioral health agency crisis services and mobile response predominantly focus on addressing the needs of the entire community. Many counties are planning to offer mobile response specialized to target children and youth within the community including on school campuses. With new state resources dedicated to this purpose, still more counties are planning to provide mobile crisis response to children and youth. These efforts are underway in order to respond and support students through a potential surge in behavioral health crises as schools reopen. State funding will be necessary to support these mobile crisis services, which are often payer agnostic, and for which many of the costs are not insurance reimbursable (e.g. downtime when clinicians are not immediately responding to calls).

  Additionally, new state infrastructure funds should support the development of additional crisis residential services for youth which currently are non-existent in California. Regulatory relief to expedite and facilitate school-based services should include dedicated state funding for stays in crisis stabilization units which exceed the 23-hour Medi-Cal insurance reimbursement limit as counties use new infrastructure funds to build up additional youth-serving crisis capacity to address throughput.

- *County and School-Led Hybrid Approaches (In person and Virtual Platforms)*
  Counties are currently partnering with their local education systems and are developing service delivery approaches that build on effective virtual platforms used during the pandemic, such as virtual wellness spaces. In the developing hybrid approaches, telehealth modalities are coupled with in person, school-based treatment and/or community-based care to ensure student needs are addressed in the virtual, hybrid, or in-person modality that best suits the needs of the youth. Examples include:
  - Many counties are supplementing these hybrid approaches through virtual and recorded resources that can be shared widely with caregivers and school districts.
  - Some counties have or plan to extend the use of virtual telehealth modalities for evening and weekends in addition to services delivered during the school day to accommodate varying schedules.
  - Other counties are planning virtual workshops in the summer dedicated to responding to student and school staff depression and anxiety, vicarious trauma, self-care, and virtual and in-person strengths-based assessments.

- *School Readiness - Consultation, Triage/Referral and Planning Support*
  County behavioral health often serve as a consulting and triaging entity to support schools when they identify youth with behavioral health needs. County behavioral health agencies have increased these efforts in the summer before students returned to campus including convening large-group virtual outreach events to refresh school staff on referral opportunities and linkages to behavioral health services. Consulting with schools, developing processes for triaging and referring youth to appropriate programs and services, planning and coordinating care are services often difficult to

fund within existing insurance models. Counties also plan to support training needs to educate school personnel on identifying behavioral health indicators and appropriate responses including referral pathways within campus and into the community. Some workshops developed by counties during the pandemic include virtually assessing students for mental health crisis; staff wellbeing in a virtual world; and cultural competency.

- *Prevention, Early Intervention and Flexible Funding*
  Counties are also planning to expand, to the extent resources allow, support through school-wide prevention programs including behavioral health education, engagement activities, and workshops. Increased group and individual services including therapeutic services and social skills services are planned to support students as they re-engage in school. Counties are offering workshops for parents to provide behavioral health education and information to access resources locally.

- *Securing Federal Support for School-Based Services*
  Counties are seeking to allocate resources to conduct mass Medi-Cal certification of school sites to ensure federal funds can be drawn down to support school-based services. To provide services on campus, Medi-Cal requires each school site be independently certified. For districts with hundreds of school campuses, Medi-Cal certification becomes a barrier to school-based services. With resources for additional certification staff and a streamlined process, if possible, county behavioral health agencies could use what is left of the summer to expand the number of campuses where Medi-Cal services can be provided.

- *"Whatever it Takes" for Kids - Psycho-Social Care Delivery Model*
  Additionally, counties and contracted providers report the need for additional discretionary funding to support their clients with basic needs such as food, clothing and other needs such as mobile hot spots, etc. These interventions support the delivery of behavioral health services by preventing or mitigating social determinants of behavioral health.

- *2021 Workforce Retention and Recruitment Funding*
  Workforce recruitment and retention, particularly for existing experienced workforce is a top priority of county behavioral health agencies and their contracted providers. Pandemic fatigue and competition from commercial providers with more lucrative pay or flexible hours, including market demand for more child focused private pay services has put the existing provider capacity at risk. Also, with growing behavioral health needs associated with the pandemic, county behavioral health agencies are also focusing on increasing staff capacity through efficiencies (see: evidenced based practices description below), innovative staffing models (i.e. telehealth and hybrid models), and recruitment of new staff.

- *Efficiency Staffing Models*
  Many counties are developing models to address shortages of licensed clinicians, such as hiring clinicians that have not completed all requirements for licensure as counselors and supporting efforts for them to complete licensure. Other models focus on teaming clinicians with adjunct staff to support administrative work or paring licensed clinicians with peers to maximize the time clinicians provide therapy and ensuring clients have access to an effective behavioral health professional. Ensuring staff have access to training and preparation specific to the community behavioral health setting and the level of acuity of the client population is another important workforce development activity counties are pursuing.

- *Evidence Based Practices (EBPs) and Community Defined Practices.*
  EBPs offer supports that can provide better outcomes related to overall mental wellness. With better staff training, clinicians can improve their efficiency and effectiveness thus, creating more capacity to serve more children. EBPs are often high cost for the training and fidelity standards. Training and compliance with fidelity standards are also ongoing activities to ensure the success of the EBP. To lift-up the worthiest EBPs, counties will need additional resources for training on an ongoing basis to ensure the programs are sustainable overtime and as staff churn. EBPs may not include sufficient practices that developed their evidence base through services to diverse communities and individuals. Funding community defined practices as well as EBPs will ensure that practices shown effective in addressing the needs of individuals from historically underserved populations will also be funded.