School Children and Families: Challenges and Solutions

Examining Children’s Behavioral Health Services
What’s the need?
An estimated 20% of American children and adolescents between the ages of 5 to 18 have serious diagnosable emotional or behavioral health disorders resulting in substantial to extreme impairment.

(Committee on Health, 2004; Nemeroff et al., 2008)
Children who are poor are much more likely to develop behavior problems with prevalence rates that approach 30% (Qi & Kaiser, 2003).
Of those children with serious diagnosable emotional or behavioral disorders, less than 4% are identified as ED eligible for special education services.

(Dataquest, CDE, 2009)
It begins early...
Campbell (1995) estimated that approximately 10-15% of all typically developing preschool children have chronic mild to moderate levels of behavior problems.
Young Children with Challenging Behavior

• Are rejected by peers
• Receive less positive feedback
• Do worse in school
• Are less likely to be successful in kindergarten

Center for Evidence Based Practice: Young Children with Challenging Behavior
www.challengingbehavior.org
Faculty in higher education early childhood programs report that their graduates are least likely to be prepared to work with children with persistently challenging behavior (Hemmeter, Santos, & Ostrosky, 2008).
Preschool children are three times more likely to be “expelled” than children in grades K-12 (Gilliam, 2005)
Children who are identified as hard to manage at ages 3 and 4 have a high probability (50:50) of continuing to have difficulties into adolescence (Campbell & Ewing, 1990; Campbell, 1997; Egeland et al., 1990).
The correlation between preschool-age aggression and aggression at age 10 is higher than that for IQ.

(Kazdin, 1995)
Early appearing aggressive behaviors are the best predictor of juvenile gang membership and violence.

(Reid, 1993)
• When aggressive and antisocial behavior has persisted to age 9, further intervention has a poor chance of success.

(Dodge, 1993)
• Children with ED reported higher use of:
  – alcohol (54%)
  – illegal drug use (36%)
  – marijuana use (33%)
  – smoking (53%)

than all other disability categories.

(NLTS2, 2008)
• More than 50% of students with ED drop out of grades 9-12—the highest rate among all disability categories.

(U.S. Department of Education, 2002; 2006)
• At 2 years post high school,
  – 58% of youth with ED have been arrested at least once, and
  – 42% are on probation or parole.

(NLTS2, 2005).
• Of the young children who need mental health services, it has been estimated that fewer than 10% receive services for these difficulties.

(Kataoka, Zhang, & Wells, 2002)
Suicide is the 4th leading cause of death among young adults—yet few educators know the signs, or how to keep a child safe.
School is “de facto” MH Provider
WE CAN'T AFFORD TO SAVE THIS ONE, BUT DON'T WORRY, SOMEONE WILL CATCH HIM.
There are evidence-based practices that are effective in changing this developmental trajectory...the problem is not what to do, but rests in ensuring access to intervention and support (Kazdin & Whitley, 2006).
Factors Beyond School

Interconnected

Parent Involvement

Factors in School
BIG Idea...

• How Multi-tiered Systems of Support (MTSS) can enhance mental health in schools

• Installing SMH through MTSS in Schools

• The Interconnected Multi-Tiered Systems Framework (IMTSF)

SMH + MTSS = IMTSF
School-Wide Positive Behavior Support

Primary Prevention: School-/Classroom-Wide Systems for All Students, Staff, & Settings

Secondary Prevention: Specialized Group Systems for Students with At-Risk Behavior

Tertiary Prevention: Specialized Individualized Systems for Students with High-Risk Behavior

~80% of Students

~15%

~5%
Core Features of an Interconnected Multi-tiered Systems Framework
Investment in Prevention

- Universal Academic, Behavioral and MH Screening
- Early Intervention for those not at “benchmark”

Multi-Tiered Approach

- Frequent Progress-Monitoring
- Data-driven decisions

Evidence-based Interventions

- Implementation with Fidelity
Supporting Social Competence, Academic Achievement and Safety

Supporting Student Behavior

Supporting Decision Making

Supporting Staff Behavior

School-Wide PBIS
Presenting Ken Berrick, President/CEO at Seneca Family of Agencies
WHEN FUNDING OPPORTUNITIES MEET REAL COMMUNITY NEEDS
No clear integrated system that crosses regular education, special education, and high end mental health.
Context: An Evolving System

Transformation of AB 3632 into AB 114

AB 97 creates greater school district responsibility

So where does this leave us?

???
In best case scenario, still no smooth access to EPSDT funding
Opportunity

Seneca saw an opportunity to create an integrated system within schools

- Earliest possible intervention point to enable maximum intervention opportunity
- Create whole school systems that include students in need of intervention
- Create seamless systems to access interventions
Understanding Student’s Mental Health Needs as Part of a Continuum

- Low Intensity of Student Needs
- High Intensity of Student Needs

- District Funds
- MHSA (PEI & FSP)
- EPSDT

- LCFF

- Special Education (disproportionality funds)
- Educationally Related Mental Health Services (ERMHS)
- Special Education (disproportionality funds)
Why Do We Care about LCFF?

- Schools with poor children are going to get more money.
- Schools with *foster children* are going to be held accountable for their outcomes.
- LCFF create opportunity for schools with higher percentage of low income students to be able to do what wealthier students have always done: pay attention to school culture and climate.

With a very small amount of regular education dollars, we can achieve enormous impact in schools.
Integrating Funding Streams to Support a Multi-tiered Framework
All-In! Multi-Tiered Model for Intervention

TIER 3 • INTENSIVE:
The most intensive of the three tiers often requires one-to-one support or addresses a considerable skill gap for students at the lowest levels of academic or social emotional achievement. Included in this group are many students with IEPs for a range of disabilities.

TIER 2 • TARGETED:
Students receiving targeted interventions have demonstrated the need for support to supplement what is offered in the classroom. These are most often small group interventions delivered to special or general education students within the classroom or as a pull-out.

TIER 1 • UNIVERSAL:
As part of high quality instruction, in a climate of positive classroom culture, students receive interventions at many points throughout the day. Skillful teachers plan for and execute interventions that adjust and accommodate to the unique behavioral and academic needs of their students.

DATA-BASED COORDINATION OF SERVICES
Seneca’s team structures and facilitates a high functioning process to support integrated service planning and develops school-wide procedures to ensure the identification of students requiring additional intervention.
COORDINATION OF SERVICES TEAM

TEACHER
Primary Case Manager

COST
Extra supports and resources to help ALL teachers find success with ALL students!
COST process is only successful when:

✓ Embedded in overall school climate and culture
✓ School culture and climate that supports students to access it
✓ Culture and climate celebrate and uphold inclusion

*COST only works when you have enough resources to keep your promises.*
Urban District X:
81% of students are of low socioeconomic status
27% of students are English Language Learners

81% of funds are used for separate classes & non-public schools

19% of funds are used for interventions in inclusive settings

<table>
<thead>
<tr>
<th>Cost Distribution</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separate Classes</td>
<td>60%</td>
</tr>
<tr>
<td>Resource Specialist Instruction</td>
<td>12%</td>
</tr>
<tr>
<td>Supplemental Aids/Services in Regular Classrooms</td>
<td>0%</td>
</tr>
<tr>
<td>Nonpublic Agencies/Schools</td>
<td>21%</td>
</tr>
<tr>
<td>Other Specialized Instructional Services</td>
<td>7%</td>
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An All-In! Partnership School:
94% of students are of low socioeconomic status
62% of students are English Language Learners

100% of funds are used for interventions in inclusive settings

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**Strengths:** Joseph is a bright, articulate, and persuasive 11 year old boy. School staff report that he is a fast learner with an infectious smile who has built strong bonds with adults who he trusts.

**History:** Joseph’s behavioral problems started when Joseph was in kindergarten. His mother attributes his emotional dysregulation to an early traumatic experience in which Joseph shot a gun and accidentally hit his grandmother in the foot. The behaviors escalated significantly in second grade, when his grandmother passed away.

**Presenting Behaviors:** Joseph often speaks disrespectfully to school staff and peers, has difficulty following directions, engages in classroom disruptions, and refuses to complete assigned tasks. Joseph engaged in assaultive behaviors in the community which resulted in police involvement. Joseph’s behaviors are significantly affecting his academic and social progress and have placed him at risk of losing his current school placement.

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**Joseph Star Case Study:**
Providing Intensive, Individualized Supports that Allow for Student Inclusion at $0 Net Cost to the School

**Highlight of Outcomes based on Treatment Goals**

1. Joseph has **decreased his engagement in physical and/or verbal altercations** from 2 times per week to 1 time per month.

2. Joseph has **increased his time in the classroom** from 30% of the day to 90% of the day.
Presenting Leslie Preston, Behavioral Health Director at La Clinica de La Raza
Understanding Student’s Mental Health Needs as Part of a Continuum

Intensity of Student Needs

- Low
  - LCFF
  - Special Education (disproportionality funds)

- High
  - MHSA (PEI & FSP)
  - EPSDT
  - Educationally Related Mental Health Services (ERMHS)
  - Special Education (disproportionality funds)
Understanding EPSDT & FQHCs

- What is an FQHC?
- What are the difference in services?
- What is the difference in staffing?
- What is the difference in population served?
- What are the limitations of FQHCs? EPSDT?
- Does a school need both EPSDT and an FQHC?
- How do they work together with a COST team?
Options for Treatment

- What is an FQHC?
  - Federally Qualified Health Center
  - Required Services
  - Population Served
  - Specific Eligible Providers
  - Rate Setting
  - Establishing FQHC sites/clinics
## Funded Service Comparison

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<thead>
<tr>
<th>EPSDT</th>
<th>FQHC</th>
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<tbody>
<tr>
<td>- Assessment</td>
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</tr>
<tr>
<td>- Therapy</td>
<td>- Therapy</td>
</tr>
<tr>
<td>- Crisis</td>
<td>- Crisis</td>
</tr>
<tr>
<td>- Psych. Testing</td>
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<tr>
<td>- Medication Visits</td>
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<tr>
<td>- <em>Rehab</em></td>
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<td>- <em>Collateral</em></td>
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<td>- <em>Brokerage/CM</em></td>
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<tr>
<td>- <em>Treatment Planning</em></td>
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<td>- Face-to-Face, Phone, Observation</td>
<td>- Face-to-Face only</td>
</tr>
<tr>
<td>- Location flexible</td>
<td>- Within “4 walls”</td>
</tr>
<tr>
<td>- ASW, LCSW, MFTI, MFT, Psych Tech, Lic PhD/PsyD, PNP/MD</td>
<td>- LCSW, Lic PhD/PsyD, PNP/MD</td>
</tr>
<tr>
<td>- Included MH Dx only</td>
<td>- Med. necessity for a MH, SUD or Physical Health condition</td>
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<td>• Enrollment Specialists</td>
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<td>• Many (not all) health insurances</td>
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## Student Eligibility Comparison

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<th>EPSDT Only</th>
<th>FQHC</th>
</tr>
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<tbody>
<tr>
<td>• Full-Scope (FFS) Medi-Cal</td>
<td>• Full-Scope (FFS) Medi-Cal</td>
</tr>
<tr>
<td>• Full-Scope Managed Care Medi-Cal</td>
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</tr>
<tr>
<td>• Temporary <strong>Gateway</strong> Medi-Cal</td>
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Additionally...
FQHC Additional Insurances

• Medi-Cal Minor Consent/Sensitive Services - outpatient mental health (7P)

• Medi-Cal Minor Consent/Sensitive Services (7M) - sensitive services

• Medicare

• Covered California Programs (If credentialed/contracted)

• Private Insurances (If credentialed/contracted)

• FamilyPACT

• Victims Of Crime (If credentialed)

• CMSP/County
What about uninsured students?
## Capacity & Sustainability Considerations

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<th>EPSDT</th>
<th>FQHC</th>
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<tr>
<td>• Caseload Maximum</td>
<td>• Open capacity</td>
</tr>
<tr>
<td><em>(Paperwork limitations)</em></td>
<td><em>(Paperwork ≠ limiting factor)</em></td>
</tr>
<tr>
<td>• Quick Start Up Time</td>
<td>• Longer Start Up Time</td>
</tr>
<tr>
<td><em>(facility/license req)</em></td>
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</tr>
<tr>
<td>• Low Start-Up Cost</td>
<td>• Higher Start-Up Cost</td>
</tr>
<tr>
<td>• Sustainability based on EPSDT eligible students in school</td>
<td>• Sustainability based on Size &amp; M/C population in school(s)</td>
</tr>
</tbody>
</table>
Which better serves a school?

• Both have advantages/disadvantages

• Each are only part of serving the academic, social, emotional needs of the student population

• Crucial that either EPSDT or FQHCs are part of the COST Team and closely collaborate

• Most schools do not have FQHC-SBHCs

• Establishing EPSDT services at schools
  + Can occur more quickly
  + Wider range of available clinicians
  + Wider range of eligible services
  + More flexible location options
    – Limited to EPSDT eligible students if only EPSDT funded!!!
Questions?
Comments?
Thoughts?
Discussion?
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