

Mental Health Models

Selected Documents and Information
from the CDE Website

www.cde.ca.gov/sp/se/ac/

Compiled by:
Valerie J. Samuel, Ph.D.
PENT Leader

Transitioning from AB3232 to AB114

Mental Health Models

Compiled by Valerie J. Samuel, Ph.D., PENT Leader

This section contains several mental health models that exist given the transition of services from County Mental Health (CMH) to the schools. Desert/Mountain SELPA and San Diego are well-established programs that have been in existence for years. Santa Barbara County SELPA and North Regional SELPA (Alameda County) programs are in the initial stages of development. In addition, there are two other documents. One provides information on Wraparound Services and one on Promising/Replicable Practices. These resources can provide PENT Cadre members with information to support your school district or SELPA in the development of a new mental health model.

Further information is also located on the CDE website: www.cde.ca.gov/sp/se/ac/.

Mental Health Models

Desert/Mountain SELPA

Compiled by Valerie J. Samuel, Ph.D., PENT Leader

Contacts

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The model has been in existence since 2003 and is a collaborative one with San Bernardino County Behavioral Health and SELPA's. It grew from 2 therapists to a comprehensive mental health center that focuses on children. The Children's Center focuses on both Special Ed eligible students and all Medical eligible students who need services.

Overview

- Superintendents agreed state funds will stay at the SELPA Level
- All SELPA's participate except West End SELPA.
- Desert/Mountain SELPA Children's Center provides the mental health services for over 200 students in 15 districts as well as in 11 charter school campuses in San Diego

Services

- Individual, group, family
- Community Outreach Program
- SART - Screening, Assessment, Referral and Treatment - (Clients 0-5 years of age)
- Residential Assessment & Monitoring of SELPA students
- School based services for neighboring SELPA's

Unique Components

Desert/Mountain SELPA Children's Center applied to be a provider through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

- This allows them to bill Medi-Cal for the services they provide to students.
- It also allows them to hire mental health workers without requirements of both a professional license and PPL.
- Districts pay a fee for service for their Special Ed students. However, there is no fee for their Medi-Cal eligible students.
- Memo of Understanding(MOU)with Behavioral Health to handle severe mental health cases
- Children's Center has contracted with SELPA's to provide assessments and monitoring of residential placements.
- SELPA's are responsible for Residential placement costs

Any district, SELPA or agency that would like further information please contact Desert/Mountain SELPA Children's Center.

Mental Health Interventions

**Psychotherapy and residential
placement as related services**

Desert/Mountain SELPA

- **Consortium of 15 school districts and 11 independent LEA charter schools**
- **99,400 enrollment**
- **10,649 students with disabilities (10.7%)**

Mental Health Services

- **SELPA Staff**
 - MSW/MFT with PPS credentials
 - Fee for Service funded
- **NPA Staff**
 - LCSW/MFT and MSW/MFT interns
 - No requirement for PPS credential
 - SELPA provided clinical supervision

Mental Health Services

- **DBH Partnership**
 - Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) RFP
 - Access to full-scope MediCal funding

EPSDT Medi-Cal Funding

Percent



\$2.61 @ minute: \$156.6 @ hour

Mental Health Services

- **Desert/Mountain SELPA Children's Center**
 - School-based EPSDT services
 - All MediCal eligible children
- **Contracted DBH Clinic**
 - LCSW/MFT and MSW/MFT Interns without the necessity to concurrently hold a PPS credential
 - Local, County, and State MediCal audits

Mental Health Services

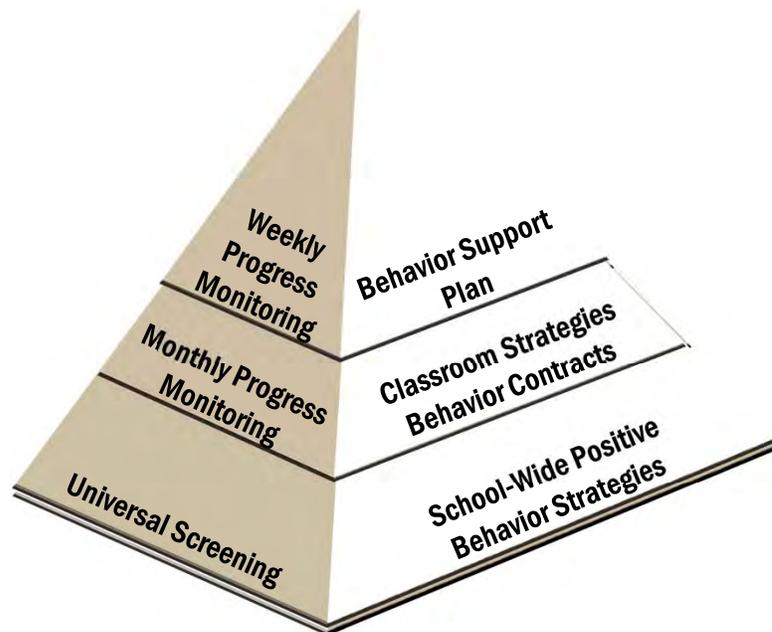
- **\$10 million budget**
- **>80 therapists**
- **>3000 children 0-21 served annually**
- **About 680 children with disabilities**
- **In >200 schools in all 15 districts as well as our 11 charter school campuses in San Diego County.**

What has Changed?

- **Non-MediCal eligible receive services at no cost to school districts.**
- **Residential placement is now paid for by the SELPA**
- **Residential assessment**
- **Residential monitoring**
- **Provide school-based mental health services for neighboring SELPAs**

Where do we go from here?

- **Keys to successful mental health treatment:**
 - Early identification and treatment,
 - Comprehensive system of supports,
 - Family training and supports,



Mental Health Models

San Diego Unified School District

Compiled by Valerie J. Samuel, Ph.D., PENT Leader

Contacts

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Mental Health Resource Center (MHRC)
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The model has been in existence since 2001 and is a collaborative one with San County Mental Health. A grant allowed for the development of the Mental Health Resource Center (MHRC). It is a school district coordinated mental health service model.

Overview

- District enrollment is 120,000 students
- MHRC is part of the Student Services Department of SDUSD.
- MHRC uses the Least Restrictive Environment model for both education and mental health needs of student.
- MHRC collaborates with County Mental Health, and has become a contract provider for CMH submitting requests for proposals. As such, MHRC is a Medi-Cal facility through the County of San Diego and is partially funded through the Safe Schools/Healthy Students grant with the Departments of Education, Juvenile Justice, and Children's Mental Health Services.
- Selected outside agencies provide contracted services to deliver mental health services to those students and their families who need specialized care.

Services

Mental Health Intervention Teams – These mental health staff work with schools, teachers and staff. The focus is on classroom wide strategies, teaching Positive Behavioral Supports, and improving staff skills.

Outpatient Services – These services are for students who are likely to improve if given individual therapy. Students can be sent to a clinic for individual therapy or to an *Enhanced Classroom (K-8)*.

Enhanced Classroom (K-8) is a special site program that provides an integrated approach to treatment. Embedded within the school's educational program are therapeutic services. These include mental health clinicians, rehabilitation specialist, and access to psychiatrist.

Day Treatment Services – At elementary, middle school and high school levels there are designated facilities designed to provide a more intensive therapeutic experience. Mental health clinicians, rehabilitation specialist, and access to psychiatrist are key components to program. Students are provided individual, group, family therapy. Mental health is integrated to provide better services that help student benefit from their education. Goal is to support student in being able to return to a more least restrictive learning environment.

Unique Components

MHRC is a Medi-Cal provider and contract provider through mental health.

- This allows them to bill Medi-Cal for the services they provide to students.
- It allows them to hire mental health workers from CMH who provide assessment, treatment, and case management for targeted schools.
- MHRC use day treatment verses residential. This significantly reduces number of students having to go to residential placement and saves about \$100,000 per student.
- Day Treatment costs are virtually offset by reimbursement from Medi-Cal.
- Day treatment can offset costs of paraprofessionals in program.
- Focus is on integrated services within school setting as opposed to wrap around which focuses on home and community setting.

SAN DIEGO UNIFIED SCHOOL DISTRICT

SAN DIEGO UNIFIED SCHOOL DISTRICT
SPECIAL EDUCATION PROGRAM
Susan Martinez, Executive Director

MENTAL HEALTH RESOURCE CENTER
Shirley Culver, LCSW, Program Manager

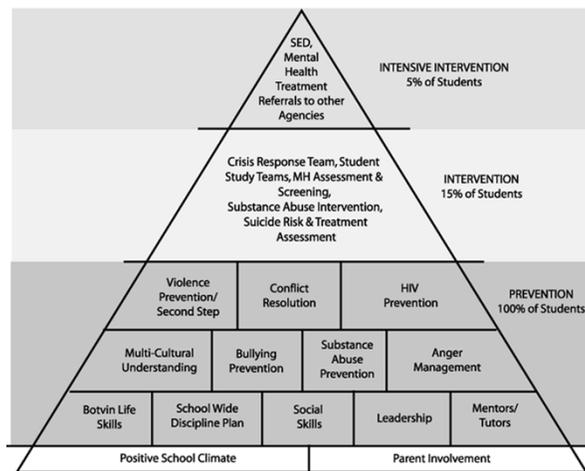
BACKGROUND

- ▶ Started with SS/HS grant in 2001
- ▶ Focus:
 - General education students at high risk – who were expelled
 - Early intervention with high risk students in middle school
 - Prevention with preschoolers
- ▶ Developed partnerships:
 - CountyMental Health in 2002
 - Special Ed in 2002,
 - County Probation in 2005
 - County Child Welfare in 2006

Goals of MHRC

- ▶ Establish and sustain mental health center
- ▶ Develop partnerships with various collaborators to insure sustainability and to maximize impact of services
- ▶ Strategically infuse school system with trained, expert mental health staff to:
 - Change outcomes for sub-populations of students
 - Provide supports to education staff

Model for Structuring Service Delivery



INTENSIVE PROGRAMS for SPECIAL ED

- ▶ Early intervention for Special Education students
 - District Mental Health Intervention Team – \$1.3 million (pre2726 dollars)
 - District funded Day Treatment – \$900,000

- ▶ Intensive Treatment for high need students
 - CMH Contract for Day Treatment – \$2.9 million (expanding to \$3.4 million)
 - CMH Contract for Outpatient – \$950,000

DAY TREATMENT

- ▶ High School Day Treatment – Capacity – 105
75 slots paid from contract – put all Medi-Cal (MC) eligible students in these slots
 - ▶ Middle School Day Treatment – Capacity – 42
30 slots paid from contract – put all Medi-Cal eligible students in these slots
 - ▶ Child Day (K-5) Treatment – Capacity – 24
In process of negotiating for 12 slots with CMH for MC eligible students.
- TOTAL – 171 District Enrollment – 120,000**

Day Treatment Mental Health Staffing

- ▶ Lead Licensed Mental Health Professional – supervisor
- ▶ Mental Health Clinicians (licensed and unlicensed) – one for every 10–12 students
- ▶ Rehabilitation Specialists (experienced paraprofessionals) – two for every classroom – one funded through day treatment, one through school budget.
- ▶ Psychiatry time – 6–8 hours per week
- ▶ Clerical support – 1.0 FTE

DAY TREATMENT PLUSES

- ▶ 100% Revenue Offset through MC for eligible students
- ▶ Annual non-educational cost of a day treatment slot approximately \$27,000 vs. \$140,000 for non-educational cost of residential
152 day treatment students last year vs. 54 residential students
- ▶ Day treatment offsets 40–50% of the costs of paraprofessionals
- ▶ Provides most frequent mental health interventions with the least documentation in integrated classroom. Providing: mental health groups, individual treatment and family treatment.

Outpatient Array of Services

- ▶ Enhanced Classrooms K-8 -Capacity 40
 - 1 Mental Health Clinician for 10 students
 - 2 Rehabilitation Specialists for each classroom
 - Psychiatry time
 - Lead Licensed Mental Health Clinician
Integrated education and treatment.
Intensive outpatient treatment
Two of four clinicians funded through
outpatient Medi-Cal contract.

Outpatient Array con't

- ▶ Individual Therapy - Capacity - 90-100
 - ▶ 6 Mental Health Clinicians
 - ▶ See students at school, home visits periodically
 - ▶ Consult with teachers, other school staff
 - ▶ Contract with CMH - MC pays for all eligible MC students
 - ▶ Prioritize students who would not get to a clinic or would not be successful without educational integration.

Outpatient Array – con't

▶ Mental Health Intervention Teams

Teams of LMHC and Rehabilitation Specialists , who support a cluster of schools – previously only elementary and middle school

- ▶ Work in classrooms with teachers and aides to increase structure, positive reinforcement and behavioral management skills.
- ▶ Work with students in the classroom and in group therapy
- ▶ Work with parents of children with special needs to provide specialized skills
- ▶ Work with school psychologists and IEP teams to meet the individualized needs of children in the least restrictive level of care.

OUTPATIENT PLUSES

- ▶ Develop an array services with fullscope Medi-Cal and LEA Medi-Cal
 - MHIT uses LEA MC
 - Individual Therapy uses fullscope MC
 - Enhanced Classrooms use fullscope MC
- ▶ Minimize documentation requirements depending on funding.
- ▶ Clinician who knows the student does the assessment to minimize time and cost
- ▶ Move treatment as close to the primary educational setting as possible. Focus treatment focus on IEP goals to improve ability to benefit from education

TRANSFORMATION ONE

- ▶ Expanding MHIT from 50 schools to 200
- ▶ Having MHIT Clinicians become the assessors
- ▶ Having MHIT teams provide most outpatient type treatment needed on site
- ▶ Individual Therapy team providing supports for students who primarily need individual.
- ▶ Re-emphasizing assessment to focus on need for services “to benefit from their education.”
- ▶ Referring all other treatment needs of students to community mental health clinics or parent health insurer

TRANSFORMATION TWO

- ▶ Create Interdisciplinary Team (ID) to review all recommendations for more restrictive level of care. Includes representatives from: Psychologists, Behavioral Specialist Unit, Day Treatment staff and MH Administration
- ▶ ID Team will explore available resources to support student at their school site.
- ▶ Day Treatment assessor will work with site assessor
- ▶ Attempt to support students in day treatment prior to residential
- ▶ Educate site staff to know which students really need day treatment

Transformation Three

- ▶ Develop support programs at secondary schools to:

Transition students returning or at-risk of more restrictive placements.

- Physical space where students come 1-3 periods a day for supported class instruction. Staffing includes teacher and rehabilitation specialist
- LMHC and Rehab staff available at all times for students who need interventions due to crises, planned interventions or having a difficult day.

General Education Mental Health Services

- ▶ Prevention & Treatment for general education students with medically necessary conditions and sub populations. Contracts with CMH
 - Preschool – \$600,000
 - Probation students – \$660,000
 - Suicide Prevention – \$750,000

Provides mental health staff to support general educators and to develop proactive interventions.

MENTAL HEALTH IEP SERVICES TRANSITION

Santa Barbara County SELPA
November 16, 2011



By Jarice Butterfield, Ph.D.
SBCSELPA Director

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About SBCSELPA

- Approximate SPED Pupil Count of 8,000 students
- 22 LEAs spread over a large geographical area ranging from Carpinteria to Cuyuma
- Vast diversity between LEAs (100 ADA to 16,000 ADA; basic aid and non basic aid; urban and rural)
- No NPS' (residential or non residential) in SB County
- LEA frustration over CMH declining to provide IEP MH services and lack of decision making regarding NPS IEP placements
- 1.4 million loss of IDEA MH funding in 2011-2012 due to Casemis errors & low rate of students identified for MH svc.

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Mental Health Funding Background Information



- AB3632 legislation related to IEP MH services was repealed and became inoperative July 1, 2011
- The mandate to provide IEP mental health services became the responsibility of SELPAs/LEAs versus county department of mental health
- State and IDEA federal mental health funding began flowing to SELPAs
- SBCSELPA formed an Ad Hoc Mental Health Committee to advise and consult with SELPA Director on how to provide IEP mental health related services to students;
- SELPA Director made recommendations to JPA Board

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Education Taking Back Coordination of IEP Related Mental Health Services- It Can be Done!



Born to migrants, his motto was, "Si, se puede"
Yes, it can be done...

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Recommendations Made to SBCSELPA JPA Board



- Equivalent funding to the prior year's "Pre Referral" mental health funding to flow directly to LEAs to continue pre referral MH services
- SELPA engage in a 6 month MOU with Department of County Mental Health (CMH) for only provision of IEP mental health related services and funding of mental services for students placed in residential non public schools (funded out of Prop 63 one time funding)
- SELPA hire a **Clinical Mental Health Specialist** by 9-1-11

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Hiring a SELPA Clinical Mental Health Specialist



- Qualifications: Licensed MFT, LCSW or Clinical Psychologist (combined with PPS preferred)
- Oversee mental health services referral process
- Solicit mental health service providers/vendors
- Network with mental health vendors
- Track and monitor students receiving IEP mental health services – ensure Casemis accuracy
- Provide consultation and support to LEA staff and parents
- Assist LEAs in assessment of need for NPS placements
- Oversee students placed in NPS (seek placements, monitor progress, make site visits, and engage in transition planning)

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Process for Providing IEP Related Mental Health Services



➤ Role of LEAs:

- Psychologist Assessment of need for mental health related services
- Make referrals to SELPA Clinical Mental Health Specialist

➤ Role of SELPA:

- Process referrals for mental health services
- Send referrals for IEP related services County Mental Health (CMH) or other MH NPA vendors when declined by CMH
- Selpa Clinician participation in assessment with LEA psychologist to determine need for residential NPS placements
- Coordinate and oversee student NPS residential placements
- Provide mental health service training to LEA staff
- Fund all mental health services not covered by Prop 63 funding through ADMHS (out of IDEA and State mental health funding)

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Process for Providing IEP Related Mental Health Services Cont'd.



➤ Role of County Mental Health (ADMHS)

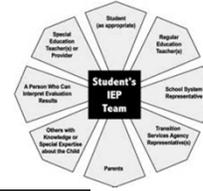
- Determine if referrals for MH related services are within “scope of practice” – deny or accept
- Provide collateral, case management, individual therapy (emotional or behavioral) and medication management services
- Provide support to Centers for Therapeutic Education (CTE) ED programs (individual, group, and family)
(Note: CMH engages in sub-contracts with outside vendors)

➤ Role of Other Vendors:

- Determine if referrals for MH related services are within “scope of practice” – deny or accept

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Barriers to Implementing Change



- **Paradigm shift for CMH and LEA Staff**
 - Educational model versus medical model for providing MH IEP related services and NPS placements
 - CMH accepting and understanding new role
 - Fear of change; negative community perception
 - Lack of time to develop process & training
- **Financial:**
 - Uncertainty regarding cost of services versus funding due to lack of accurate student data
 - LEA needs vary
 - Ensure all LEAs receive their proportionate share of funding and services in an “off-the-top” funding model

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Transition Plan 2-16-11 when County Mental Health MOU Ends



- SELPA to solicit contracts with various mental health providers and/or CMH to provide IEP related mental health services on behalf of 22 LEAs in SELPA beginning 12-1-11
- All providers except CMH are requested to have NPA certification through the CDE
- SELPA will contract with any agency that does not provide “direct agency services (no sub-contracting)
- SELPA to begin funding 100% of all costs of IEP related MH services for 22 LEAs to include NPS costs (education, MH, and residential) 2-16-11

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Transition Plan Cont'd

- SELPA will no longer be funding indirect services services with CMH such as “collateral”, “case management”, etc.
- Mental health NPA vendors must submit proposals to SELPA that indicate the following:
 - scope of services they can provide (individual therapy, group therapy, social working, family counseling, behavioral support, etc.
 - hourly rate for IEP related services (hourly rate must include any indirect services such as phone calls, contact with LEA staff, etc.)
 - Hourly rate for attendance at IEPs

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Projected Cost Savings



Estimated savings of over \$1,000,000 per year by going to a SELPA coordinated mental health service model versus a County Mental Health (CMH) coordinated mental health service model !



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Future Plan for Providing IEP Mental Health Services Through Implementation of SELPA Coordinated Model

- Be able to provide a broader array of mental health services to students who need mental health related services to include behavioral support, social work with families, and research based therapies specific to student's area of need (CBT, DBT, etc.)
- Be able to provide a continuum of intensive services to students who are ED to prevent need for out-of-home restrictive NPS placements and to students returning from NPS placement to ensure successful transition
- Provide research-based training to school-based mental health personnel – potentially hire additional school-based personnel



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For More Information....

- Go to SBCSELPA.org – look under “Publications”
- Email Jarice Butterfield at jariceb@sbceo.org or Claudia Echavarria at cechavarria@sbceo.org
- Call SBCSELPA 805-683-1424

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Transition from AB3632 to ERMHS

Dr. Elizabeth A. Uno, Chief of
Children's Specialized Services
Suzanne A. Nelson, Director North
Region SELPA

Alameda County

SELPA	2010-11 CALPADS ENROLLMENT	12/1/10 AGES 5-22 SPECIAL ED. PUPIL COUNT	% OF SPECIAL EDUCATION STUDENTS	STUDENTS RECEIVING MENTAL HEALTH SERVICES
NORTH REGION	27,181	2,935	11%	194
MID-ALAMEDA	57,725	4,941	9%	269
MISSION VALLEY	52,720	4,866	9%	188
TRI-VALLEY	35,243	4,103	12%	126
OAKLAND	46,584	4,973	11%	436
ALAMEDA COUNTY	216,199	24,705	12%	1228 (includes 15 out of county)
CALIFORNIA	6,217,113	678,929	11%	

2

Transition from AB3632 to ERMHS

- ◆ In December 2010, Alameda County held a stakeholders meeting that included school districts, mental health providers, Regional Center, and family members to confirm the commitment that students would continue to be served
- ◆ Alameda County Mental Health and SELPA Directors developed the ERMHS workgroup that began meeting in January 2011
- ◆ Alameda County Mental Health continued accepting referrals and providing mental health services through March 30, 2011.
- ◆ ACMH continued to provide services through June 30, 2011 to students already in their system.
- ◆ SELPAs paid Social Services for Board and Care expenses for April, May and June 2011.
- ◆ SELPAs paid ACMH for mental health services for new students during April, May and June 2011.

Transition from AB3632 to ERMHS

Challenges:

- ◆ Language/Terminology
- ◆ Understanding Costs
- ◆ Medical vs. Educational
- ◆ Compliance
- ◆ Staff Training on Procedural Changes
- ◆ Student Lists
- ◆ Defining Mental Health Services
- ◆ Medi-Cal

Transition from AB3632 to ERMHS

The ERMHS Workgroup:

- ◆ Began our work with the premise that student needs come first
- ◆ Developed a MOU
- ◆ Created written descriptions of mental health services: residential, day treatment, outpatient, counseling enriched classes, case management
- ◆ Revised referral form and procedures
- ◆ Revised assessment procedures
- ◆ Developed ERMHS authorization form

ACMH also provided a "Medi-Cal" workshop for SELPA and LEA staff

Transition from AB3632 to ERMHS

Mental Health Service delivery system:

- ◆ The majority of students continue to receive services provided through ACMH
- ◆ Some districts have begun to develop school based models for the provision of mental health services
- ◆ Minor changes made to the referral process:
 - ◆ Pre-referral counseling no longer required
 - ◆ School districts determine need for referral

Transition from AB3632 to ERMHS

Additional changes:

- ◆ Changes to assessment process and recommendations
 - ◆ School district can choose to assess utilizing qualified staff
 - ◆ Closer collaboration between ACMH assessors and school district staff regarding mental health services and assessment recommendations
 - ◆ IEP team decides on appropriate services based on assessment results

Transition from AB3632 to ERMHS

Additional changes:

- ◆ Authorization for ERMHS (new form)
 - ◆ Districts fill out and send to ACMH after each IEP meeting
 - ◆ Form authorizes ACMH to provide specified Mental Health services
 - ◆ This form enhances the ability of ACMH and LEA to track students

Funding

- ◆ACMH funded mental health services for all AB3632 students through June 30, 2011
- ◆2010-11 & 2011-12 Mental Health Grants and Apportionment funds will be used by the districts to provide mental health related services, whether contracting with ACMH, developing their own programs, or contracting directly with an agency
- ◆Prop 63 funds will be used by ACMH to pay for mental health services for non-Medi-Cal students.
- ◆ACMH will continue to access full scope Medi-Cal for all eligible students

Medi-Cal

Within Alameda County, there is a range of Medi-Cal eligible students:

- ◆Piedmont USD has 0%
- ◆Oakland USD has over 80%

Transition from AB3632 to ERMHS

Districts with low % of Medi-Cal students plan to provide mental health services directly by:

- ◆ creating their own school based therapy programs
- ◆ expanding their already existing school based therapy programs (developed with MHA funds)
- ◆ contracting with agencies to provide services
- ◆ hiring their own staff

Transition from AB3632 to ERMHS

Districts with higher percentages of Medi-Cal eligible students will continue to contract with ACMH.

Districts closer to 50-50 % will continue to contract with ACMH for the Medi-Cal students and will begin to develop school based and other programs for their non-Medi-Cal students.

This has the potential of creating a splintered system of services.

Changes to LEA Programs

Albany USD has hired a full time School Psychologist who is also licensed as a Marriage and Family Therapist

Assignment includes: assessment, school based therapy, family support, classroom support

LEA Cost: \$76,337 (salary and benefits) + \$2,985 (laptop , narrow band assessment tools, curriculum) = \$79,322

Funding for this program will come from Prop. 98 funds

Future plans include: provide outpatient services for all eligible students, incorporate preventative strategies, hire and supervise interns

Changes to LEA Programs

New Haven USD is contracting directly with an agency to create a Rehabilitation Day Treatment Program:

- ◆ Serves up to 10 high school students
- ◆ Housed within the district
- ◆ 1 teacher and 2 instructional aides (LEA)
- ◆ 1 full time clinician and .5 program director (agency)
- ◆ 1 mental health rehabilitation specialist (agency)

LEA Costs: \$240,000 (mental health) + \$150,00 (staffing) = **\$390,000**

NPS costs are saved by educating students on public school site.
Prop. 98 and IDEA funds used to support this program.

Transition from AB3632 to ERMHS

Outcomes:

- ◆ Students have continued to receive M.H. services
- ◆ Greater understanding of both systems
- ◆ Improved relationships
- ◆ Increased communication = Tighter controls

Transition from AB3632 to ERMHS

Future Goals of ERMHS Workgroup:

- ◆ Provide training in assessment for school and ACMH staff
- ◆ Establish consistent ERMHS related protocols and procedures to be utilized by all school districts
- ◆ Individualize mental health services for each SELPA region
- ◆ Expand already existing school based counseling services to include students with disabilities
- ◆ Create wrap around services for students before placement in more intensive treatment (RTC, Day Treatment) and for students moving into less intensive treatment/back to public school
- ◆ Maintain collaborative efforts to sustain and develop ERMHS that meet the needs of students with disabilities

Wraparound

...from a provider's perspective

November 17, 2011

Lyn Farr

EMQ FamiliesFirst

With acknowledgement of content developed by
Vroon-Vandenberg

Why Wraparound?

- Wraparound is what you do when you don't know what to do, and everything you have tried in the past hasn't worked, and probably won't work if tried again. -John Franz
- Wraparound can provide an effective "virtual" residential/in-home and school treatment option with similar levels of **intensive services and supports**; developing and implementing an **individualized** integrated plan using a mix of professional, community and natural supports; and obtaining **similar or better outcomes** than traditional residential group home treatment for **less cost**.

How is Wraparound provided locally?

- Counties submit a Wraparound implementation plan to CDSS for approval.
- The county Wraparound plan **“braids” funding** from different sources with different requirements **to maximize flexibility and benefit** to children and families.
- Counties directly provide or contract with community-based agencies for services.
 - Lead Agency varies county to county: typically Child Welfare or Mental Health
 - Funding has traditionally been provided from two sources: foster care (RCL 10 to 14) and mental health (EPSDT, AB3632, MHSA or other) funding

Who benefits from Wraparound?

- Wraparound serves children and families with serious, persistent, and complex needs who would otherwise need residential treatment.
 - Typically, children have failed other placements and many interventions prior to referral to wraparound.
 - They often lag several grade levels behind same age peers in school performance.

What is Wraparound?

Wraparound is a **process** for supporting youth and families that:

- Is defined by 10 principles of how the process is implemented;
- Is done in four phases and includes related activities that describe what is to be done; and
- Fits the four components of the theory of change that explains why it works.

What has been implemented and called wraparound varies widely across our state and nation. Research results also vary, and are related to fidelity to the outlined process.

Wraparound Principles

- Family and Youth Voice and Choice
- Team Based
- Natural Supports
- Collaboration (and Integration)
- Community Based
- Culturally Competent
- Individualized
- Strengths Based
- Persistence
- Outcome Based and Cost Responsible

Phases and Activities of the Wraparound Process

Engagement & Team Prep

- Orient family to Wrap
- Stabilize crises
- Develop strengths, needs, and culture discovery
- Engage team members
- Make meeting arrangements

Initial Plan Development

- Develop a plan of services and interventions
- Develop a detailed crisis and safety plan

Implementation

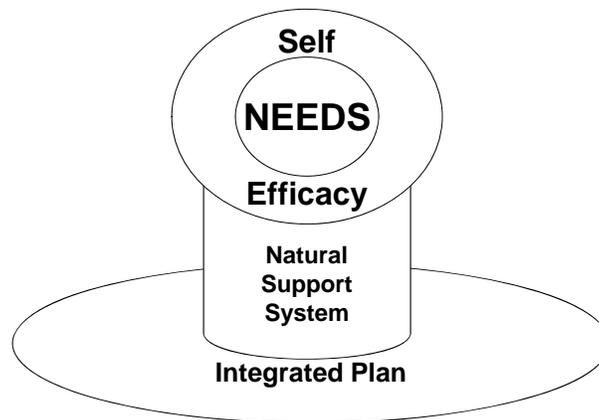
- Implement the plan
- Revisit and update the plan
- Maintain team cohesiveness and trust
- Complete documentation and handle logistics

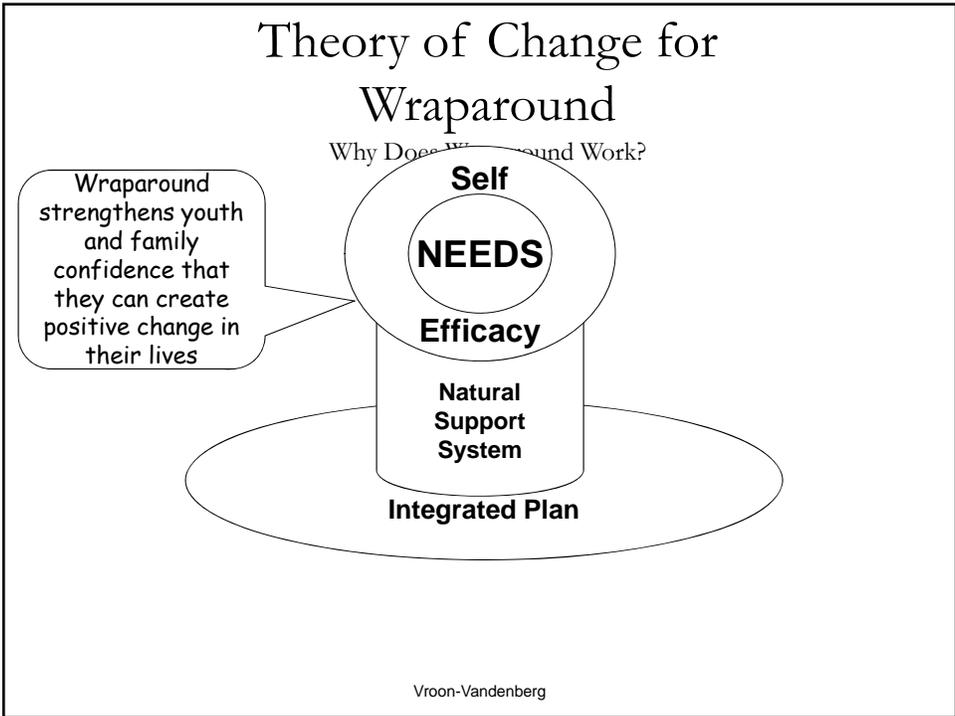
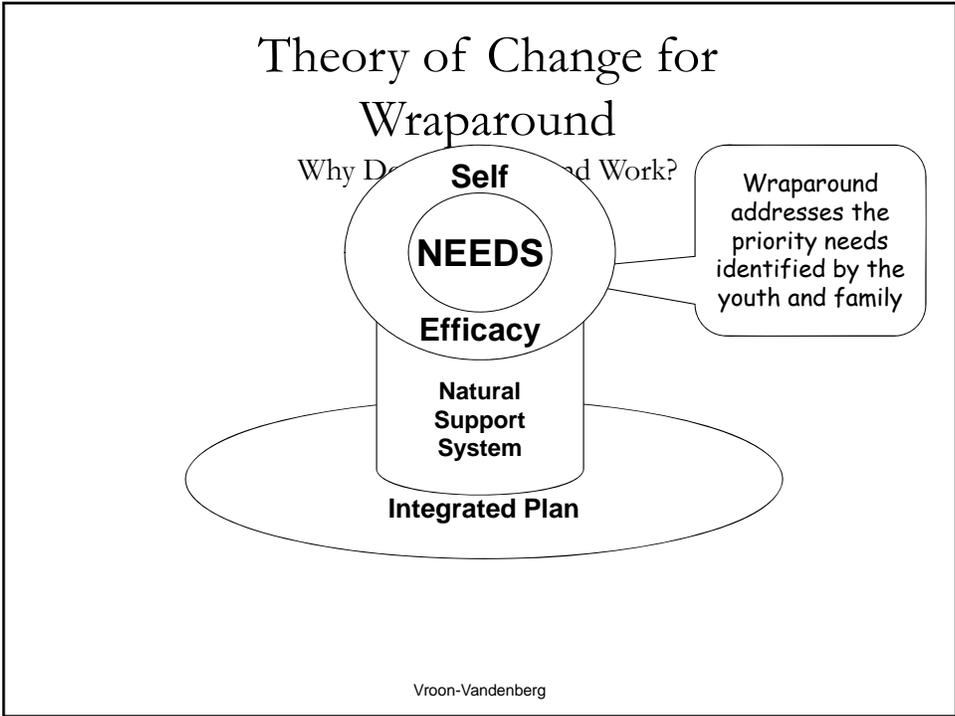
Transition

- Plan for cessation of wrap
- Achievement recognition ceremony
- Follow-up with the family to assure sustainability of change

Theory of Change for Wraparound

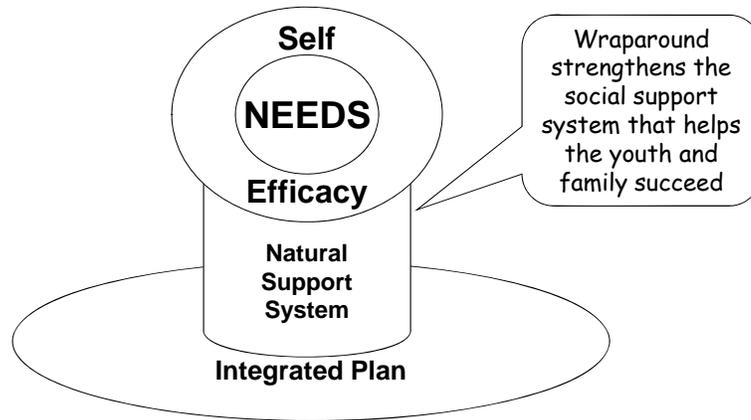
Why Does Wraparound Work?





Theory of Change for Wraparound

Why Does Wraparound Work?



Vroon-Vandenberg

Strengths, Needs, and Culture Discovery

- Life Domains
- Family Story
- Long Range vision and goals
- Prioritized Needs
- Detailed Strengths
- Detailed Culture
- Natural Supports
- Team Members

Culture

- Language
- Arts
- Habits
- Learned preferences
- Dress
- Rules
- Pets
- Spiritual
- Beliefs
- Assumptions
- Standards
- Societal expectations
- Roles
- Play
- Economics

EMQ FamiliesFirst Wraparound FY2011

- **1187 young people served; brief length of service** (median of 8.5 months).
 - Programs in Los Angeles, Fresno, Nevada, Sacramento, San Bernardino, Santa Clara, and Yolo Counties
- **Positive Outcomes at Discharge:**
 - 79% of the young people served are living in a community setting at discharge.
 - 76% percent of the young people served are in school at discharge.
 - 76% of the young people served are out of trouble at discharge.
- **Outcomes maintained six months after discharge.**
- **High Levels of Satisfaction six months after discharge.**
 - 80% Satisfied
 - 79% Needs addressed

Sources of child and family support →		Parent/caregiver	Extended family/friends	Community resources	Referral agency	Specialized services (not wrap)	Wraparound
Types of Support							
*Wraparound planning/facilitation		☒					●
*Natural support mobilization		☒	☒				●
*Tangible resources		●		☒	☒		○
*Service coordination/brokerage					☒		☒
*Direct 1:1 emotional support		☒	☒	☒		☒	☒
*Direct 1:1 coaching		☒	☒	☒		☒	☒
*Intensive behavioral support							●
*Financial support		●		☒	☒		○
*Counseling/therapy/treatment				☒	☒	☒	☒
*Medical-general				●			
*Medical-psychiatry						●	○
*Respite			☒	☒		☒	○
*24-hour on-call intervention				☒		○	●

○ Lead responsibility
☒ Shared responsibility
○ Backup responsibility*

*Backup responsibility means providing resources to meet an emergent need until sustainable resources can be developed and put in place.

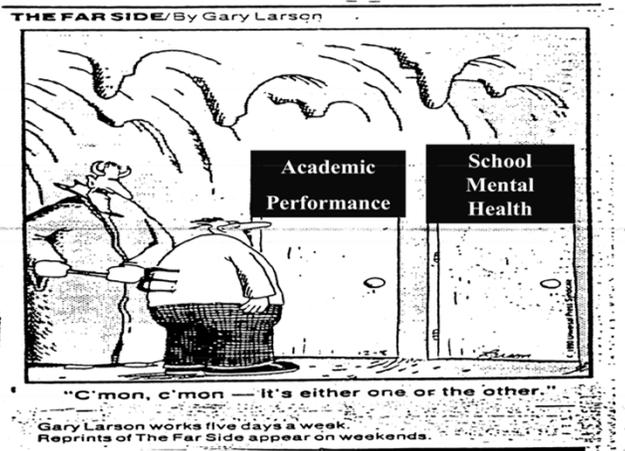
Promising/Replicable Practices

Megan Vinh, Ph.D.
Western Regional Resource Center

Adapted from several presentations from National Assembly on School-based Health Care (NASBHC)

Hurwitz et al., 2009

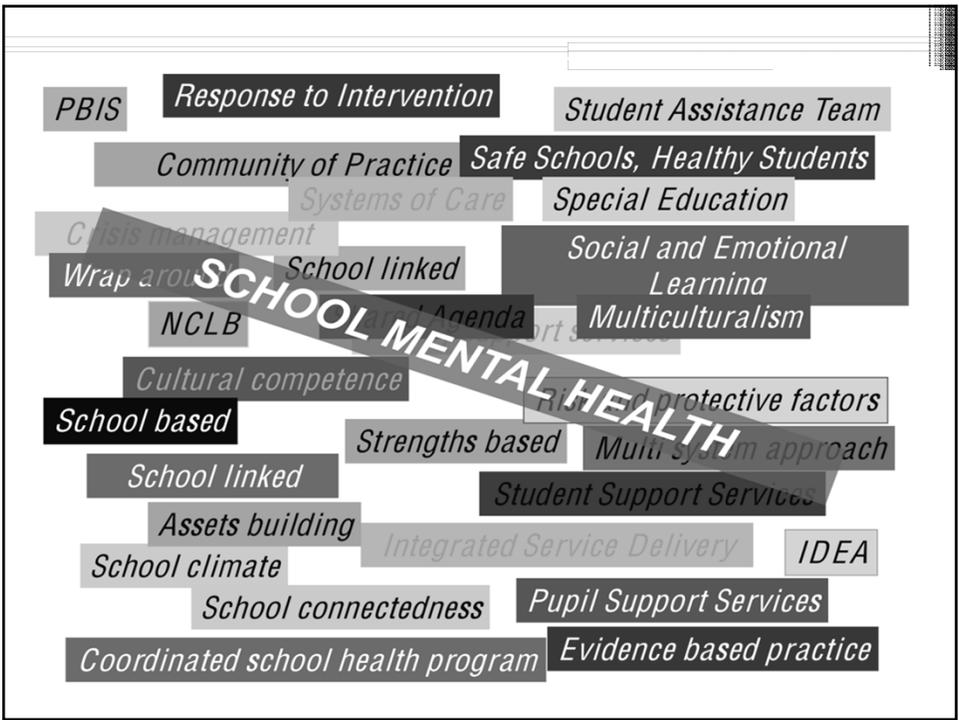
The Conundrum



Mental health and academic outcomes



ADAPTED FROM: Geierstanger, S. P., & Amaral, G. (2004). School-Based Health Centers and Academic Performance: What is the Intersection? April 2004 Meeting Proceedings. White Paper. Washington, D.C.: National Assembly on School-Based Health Care.



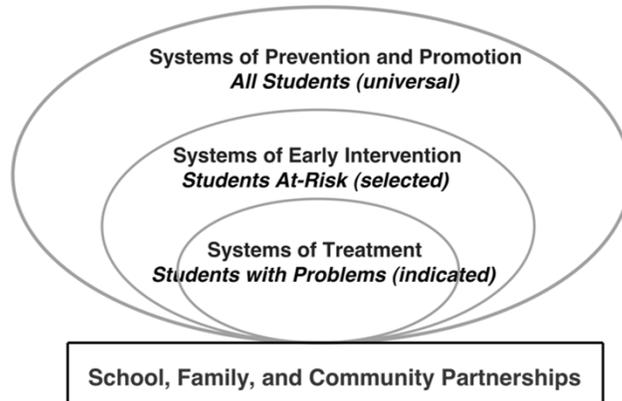
What is School Based Mental Health?

- **A full continuum of mental health programs and services in schools, including:**
 - **Enhancing environments**
 - **Broadly training and promoting social and emotional learning and life skills**
 - **Preventing emotional and behavioral problems**
 - **Identifying and intervening in these problems early**
 - **Providing intervention for established problems**

School Based Mental Health:

- **Involves partnership between schools and community health/mental health organizations, as guided by families**
- **Builds on existing school programs, services, and strategies**
- **Focuses on all students, general and special education**
- **Includes a full array of programs, services, and strategies**
- **Emphasizes schools as locus of engagement for school-based, school-linked, and community-based work**

What does school mental health look like?



From work of Joe Zins

Schools: The most universal natural setting

- Over 52 million US youth, 114,000 schools
- Over 6 million adults work in these schools
- Combining students/staff, 1/5th of the U.S. population (From New Freedom Commission, 2003)
- Approximately 75% of children receiving mental health services receive them in schools (Rones & Hoagwood, 2000)

Advantages of the school setting

- Students don't miss school, parents don't miss work
- Increases "seat time" for schools
- Less threatening environment
- Students are in their own social context
- Services are more timely
- Potential to impact the learning environment and educational outcomes

School based mental health has been shown to improve outcomes in:

- Academic achievement
- Discipline referrals
- Graduation rates
- Attendance
- Teacher retention
- School environment/connectedness



School Based Mental Health Program Models/Frameworks

- Expanded School Mental Health (ESMH)
- School-Based Health Centers (SBHCs)
- Positive Behavioral Interventions & Supports (PBIS)
- Response To Intervention (RTI)
- Community Schools
- American School Counselor Association Model (ASCA)
- Coordinated School Health (CSH)
- ***Others...?***

Weist, et al., Weist, 1997

Expanded mental health services framework

- Framework for programs and services upon which other elements may be added
- Provide a full range of mental health services including assessment, prevention, case management and treatment services
- Refers to programs that build on the core services typically provided by a school
- Augments services in schools by emphasizing shared responsibility
- Involves community mental health agencies
- Addresses full continuum of MH services
- Serves all students

Expanded Mental Health Services	More common scenarios
<ul style="list-style-type: none">•Provides focused evaluation•Individual, group and family therapies•Referral for more intensive services (e.g., medication, hospitalization)•Preventative services (e.g., support groups, mental health education, "school wide" intervention)	<ul style="list-style-type: none">•School offer assessment, minimal treatment, and consultative services for youth in special education combined with academic advisement and limited counseling for youth in regular education

School-Based Health Centers

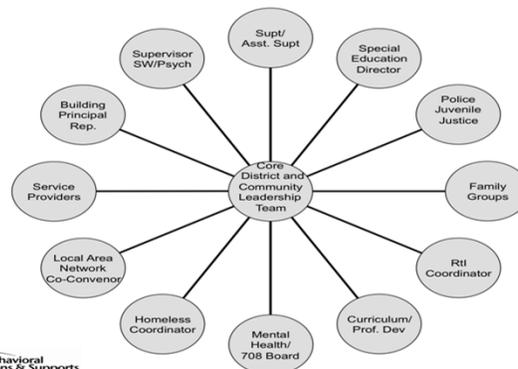
- School and community health partnerships
- On-site comprehensive primary care and mental health services
- Strategically targeted to underserved populations
- Multidisciplinary team of providers
- Promoting student success

Positive Behavioral Interventions and Supports

- Nationally recognized system-wide approach to preventing and improving problem behaviors
- Aims to prevent inappropriate behavior by teaching and reinforcing appropriate behaviors
- Offers a broad range of interventions that are applied to students based on their level of need
- Addresses the role of the environment as it applies to development and improvement of behaviors

Eber, Barrett, Weist,
2010

Need for a core leadership team!



Positive Behavioral Interventions & Supports

ILLINOIS PBIS NETWORK

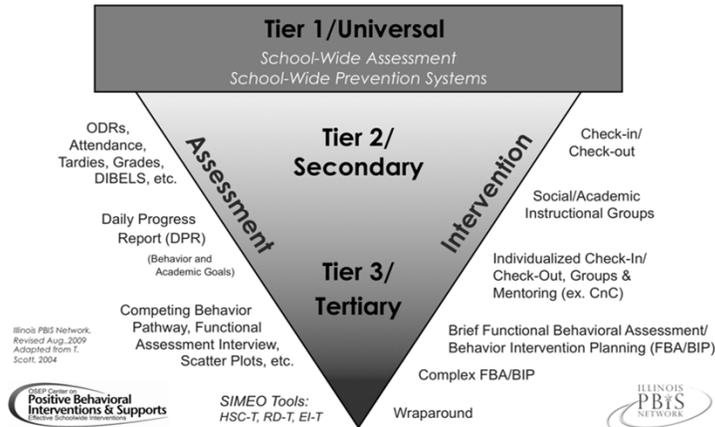
Core Leadership Team

- Develops a three tiered support network that integrates schools and communities
- Review data for community and school planning
- Develop a consistent mission for mental wellness for all youth
- Address re-positioning staff for more integrated support systems
- Assess how resources can be used differently
- Creating integrated system, procedures and protocols

Response to Intervention

- Based on a problem-solving model
- Considers environmental factors as influencing student's difficulty
- Provides services/intervention as soon as student demonstrates a need
- Primarily addresses academic problems
- Thought of as disability identification AND early intervention assistance

Positive Behavior Interventions & Supports: A Response to Intervention (RtI) Model



Community Schools

- A partnership between school and community resources
- Offer a range of services to children, youth, families and communities
- Focused on academics, health and social services, youth and community engagement
- Open to everyone, all day, every day/evening and weekends

American School Counseling Model

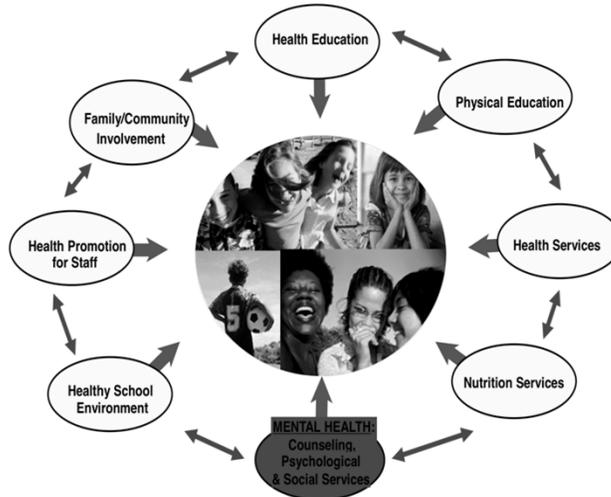
- National model
- Framework for schools to create a comprehensive, data-driven school counseling program
- Includes four components:
 - Guidance curriculum infused in K-12 classroom curriculum
 - Individual student planning to assist students in establishing personal goals
 - Responsive services to address immediate student needs
 - Systems support

Barbour & Hurwitz, 2010

Coordinated School Health

- A framework developed in the late 1980's by the Centers For Disease Control and Prevention.
- Designed to promote health and mental health in schools by addressing the physical, social, emotional, and general needs for student well-being
- Consists of eight interrelated components
- Administered at state, district, school building levels

Coordinated School Health Mental Health Strand



Key Elements in Coordinated School Health

- Link between health and learning
- Coordination
- Data-driven decision making
- Professional development and training
- Evidence-based action planning
- Partnerships
- Policies
- Integration

Commonalities of these service delivery models

- **Full continuum of services**
 - School-wide mental health promotion
 - School based prevention
 - Early intervention
 - Treatment
- **Modality**
 - Individual, group, family
- **Crisis intervention, case management**

Common barriers

- **Limited knowledge**
- **Bureaucracy**
- **Waiting**
- **Cost**
- **Stress**
- **Stigma**

How do other states fund these practices?

- **Federal Grants**
 - Bureau of Primary Health Care grants
 - Safe Schools/Healthy Students Initiative (Departments of Education, Justice and Health and Human Services)
 - Title XX Social Services block grant
 - Preventative Health and Health Services block grant
 - Maternal and Child Health block grant

Funding continued...

- **State funding**
 - Services financed partially by state allocations (e.g., line budget items) or
 - Implementing specific programs (e.g., Safe and Drug Free Schools) that come with budgets to supplement general money for school mental health programs or
 - State health initiatives and state taxes (e.g., tobacco tax, property tax).

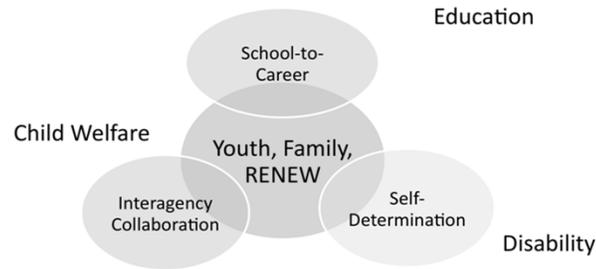
Funding continued..

- **Fee-for-service reimbursement**
 - States Children's Health Insurance Programs
 - Commercial insurance
 - Medicaid
- **Outpatient Mental Health Center Funding**
 - Partnering with an already existing outpatient mental health center helps facilitate the ability to bill public and private insurance for programs for services.
- **Solicited funds**
 - Funding from private donors, foundations, and federal agencies
- **Pooled, blended or braided funding**

RENEW Model in New Hampshire

- **Implementing since 1996**
 - Through research and demonstration projects (since 1996)
 - Provided by a community-based organization (1998-2006)
 - Provided by high school staff as part of PBIS 3-tiered approach (2002-present)
 - Provided by Community Mental Health Center staff for an intervention for adolescents (2008-present)
- **Built upon principles adapted from Systems of Care**

RENEW: Conceptual Framework



3

RENEW Strategies

- **Personal future planning**
- **Individualized team development and wraparound**
- **Braided (individualized) resource development**
- **Flexible, or alternative education programming**
- **Individualized school-to-career planning**
- **Naturally supported employment**
- **Mentoring**
- **Sustainable community connections**

New York

- **Models of Service**
 - **On-site mental health programs**
 - Offer treatment, groups, family counseling and crisis intervention on school campus
 - **School-linked mental health programs**
 - Offer screenings, consultations, assessments, and referrals for treatment
 - **STARS (Screening the At-Risk student)**
 - Implemented by nurses in middle schools. Offer depression screenings and refers for further assessments
 - **KOGNITO**
 - Web based training for high school teachers referring the psychological stressed student for counseling
 - **Presentations**
 - Presentations and trainings on a wide variety of emotional topics relevant to youth
 - **NYC TEEN website**
 - Teen friendly website for teens dealing with depression, drugs and violence

New York Continued..

- **Definition of school-based mental health**
 - “Mental health office in a school”
 - Offers a wide range of full, comprehensive mental health services in the schools for past 20 years
- **300 school based mental health programs serving NYC schools in all five boroughs**

NYC School Based Mental Health Program Offers:

- **Identification**
- **Assessment**
- **Intervention**
- **Consultation**
- **Facilitation**
- **Training**

Payment/funding

- **Programs do not bill parents or students for care**
- **Parents provide insurance information and program bills them directly**
- **If not insured, school based mental health may be able to help family obtain public health insurance**
- **Referrals to other community mental health programs can made, if needed**

School Community Mental Health Project in Ohio

- 110 Schools in Cleveland Metropolitan District
- School/community mental health partnership provides:
 - In-school mental health assessments
 - Individual and group counseling
 - Consultation (e.g., school trainings on de-escalation techniques or behavior management)
 - Preventative services
- Services provided by seven community mental health agencies
- Agency mental health intervention specialist remains part of the school team and attends school team meetings throughout the year

School Community Mental Health Project in Ohio

- Piloted in 20 Cleveland Schools and have become district wide.
- School/Community Mental Health Services Program is part of the Cleveland Metropolitan School District Premier Health Plan, approved by the CMSD Board of Education in 2002.

Funding for School Community Mental Health Project in Ohio

- Originally developed in 1999 through a federal Safe Schools/Healthy Students grant
- 80% of students served are Medicaid eligible
- Mental Health Board maintains a commitment to provide services to students without mental health insurance and to provide services not billable to Medicaid or insurance

Participants of School Based Mental Health Community of Practice

- Seed Grant States: NH, VT, NM, OH, MO, HI, SC, MD, NC, TX, PA, OR
- 22 National Organizations
- 5 TA Centers (OSEP, SAMHSA)
- Federal Partners

The education pipeline loses young people at many points along the path.

For every 10 who start H.S.



Fewer than 7 will get a diploma in 4 years



4 will enroll in college the fall semester after graduation



Fewer than 2 will complete a 2 or 4 year degree within 150% of the required time.



Resources

- Center for School-Based Mental Health Programs
 - <http://www.units.muohio.edu/csbmhp/>
- Substance Abuse and Mental Health Services Administration (SAMHSA)
 - <http://www.samhsa.gov/>
- National Community of Practice on School Behavioral Health
 - http://www.ideapartnership.org/index.php?option=com_content&view=article&id=251&Itemid=49
- Ohio Mental Health Network for School Success Effective Practice Registry
 - <http://www.units.muohio.edu/csbmhp/network/registry.html>