

DRAFT

**School-based Mental Health Services:
What California's School District Leaders Should Know
about Mental Health Funding and 2011 Realignment**

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NOTE: We would like your feedback. Is this paper helpful? Does it give you enough and the right information to reach out to your peers in county governance to initiate or enhance a partnership around planning and delivering comprehensive school-based mental health services?

Please contact us with questions or suggests:

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Introduction

Children and youth across California struggle with unmet mental health needs. While over 20 percent of all school-age children have a mental health diagnosis, only one third of all those diagnosed receive treatment.¹ Access is even more elusive for youth living in poverty, and among older youth. For teens living in poverty, only one in ten with a mental health diagnosis is able to access treatment.² Not surprisingly, mental health disorders are particularly concentrated in system-involved youth – over 90 percent of youth in the juvenile justice system have mental health problems, and as many as 70 percent of foster children.³

In California, as around the country, families, educators, children’s advocates, and lawmakers have recognized that schools are a natural place to deliver mental health services to children. This awareness has led to the development of a number of innovative and more comprehensive school-based programs that conduct mental health screenings and assessments, provide treatment, coordinate case management, and coordinate with other resources in the community – for all students, not just those identified as needing Special Education services. Indeed, nationwide, 70 percent of children receiving mental health services access them through their school.⁴

To make significant strides in improving access to mental health care – by making the most of the school setting and maximizing the public funding streams available – school districts and counties must work together. There are a number of administrative barriers to the effective integration and expansion of services delivered in the school setting. In addition to a lack of sufficient resources to bring access in line with need (and legal entitlement to services), the various agencies that have to collaborate in order to build effective programs operate under different laws, regulation, financing structures, and governance. Each is charged with addressing a particular domain – academics, behavior, mental health, and disability – and none alone is responsible for the big picture.

Counties are responsible for the administration of the major mental health programs available to low-income children – chief among them Early and Periodic, Diagnosis, Screening and Treatment (EPSDT), Medi-Cal’s benefit category that provides for comprehensive health, mental health, and dental services for enrollees under 21 years of age. Through EPSDT, Medi-Cal children are entitled to mental health services. When counties and schools work together to plan and finance effective mental health systems for children, these child-serving agencies can address their mutual goal of increasing children’s access to mental health services. It takes strong leadership to prioritize the comprehensive planning that results in a vision for services, sustainable financing, and administrative strategies for mental health programs. Despite the challenges, evidence suggests that it is well worth the work – effectively identifying and addressing students’ mental health needs supports both individual academic achievement as well as teachers’ ability to

¹ Barrett, S., Eber, L., & Weist, M. (2013). Advancing Education Effectiveness: Interconnecting School Mental Health and School-wide Positive Behavior Support. *Center for School Mental Health*.

² California Health Interview Survey. CHIS 2005 Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research.

³ Fight Crime: Invest in Kids *California. Proposition 63 Toolkit – From Promise to Practice: Mental Health Models that Work for Children and Youth*. 2004. Available at: <http://www.fightcrime.org/state/2004/reports/prop-63-toolkit-promise-practice-mental-health-models-work-children-and-youth-200>.

⁴ Hurwitz, Laura and Weston, Karen, *Using Coordinated School Health to Promote Mental Health for All Students*, National Assembly on School-Based Care, July 2010.

manage and optimize the school environment to the benefit of all students.⁵ And given the reach that schools have, school-based access to mental health care allows for an emphasis on prevention, early intervention, and better health outcomes for young people.

In 2011, California permanently shifted responsibility for administration and financing of most services for vulnerable children and youth to counties – including mental health services provided by EPSDT. This shift – referred to as ‘Realignment’ – provides increased funding, as well as significantly greater decision-making power and flexibility for county governments in their use of these funds. As such, 2011 Realignment presents a very promising opportunity for improving mental health programs for children by enhancing full collaborations between school districts and counties to build effective school-based programs.

The purpose of this paper is to increase understanding of how counties administer children’s mental health services and to explore how the 2011 Realignment of mental health services has created new opportunities for collaboration between schools and counties. It is our hope that school districts and their partners will use this information to initiate and guide collaborative planning efforts at this pivotal juncture.

Schools are critical access points for meeting young people’s mental health needs

Schools can be critical access points for mental health care for low-income and otherwise vulnerable children. Schools see the vast majority of children five days a week, making the school setting the likely place where a mental health issue is first identified. The opportunity to identify issues early also makes schools critical leveraging points for prevention and more timely and effective intervention. Finally, children and their families may feel more comfortable accessing services at or through schools. Indeed, offering services through schools to any students who need them can have a normalizing and destigmatizing effect.

Using schools as access points for care does not mean that school districts are responsible for building school-based programs on their own. Instead, building an effective system requires that counties and school districts work together to build out the school-based piece of such a system. When school and county infrastructure, financial resources, and expertise are fully leveraged, the school setting can play a critical role in a more comprehensive system of care.

Schools districts and counties each have important contributions to make in creating school-based programs that:

- **Conduct school-wide assessments in order to build out services that respond to unique student needs and leverage existing community assets.** School districts and their partners should map community assets together. But districts themselves are in a unique position to build a deep understanding of their students’ needs – by conducting needs assessments which provide a full picture of: poverty levels and Medi-Cal eligibility; social, emotional and mental health needs; as well as student and family perceptions and preferences regarding these needs. Funding a representative team to design and conduct a

⁵ See for example: Barrett, Susan; Eber, Lucille; and Weist, Mark. *Advancing Education Effectiveness: Interconnecting School Mental Health and School-wide Positive Behavior Support*. Center for School Mental Health. 2013.; Kataoka, S.H., Rowan, B., and Hoagwood, K.E. *Bridging the Divide: In Search of Common Ground in Mental Health and Education Research and Policy*. Psychiatric Services. 60(11): 1510-1515. 2009.

comprehensive needs assessment is a sound investment of Local Control Funding Formula (LCFF) resources.

- **Provide tiered services designed to meet a wide array of needs – with an eye to prevention, early intervention and universal access.** Some districts already partner with their counties to provide mental health care to all students, not just those in Special Education. Absent such partnerships, the most direct way that school districts have of connecting low-income students to Medicaid covered mental health care is through the LEA Billing Option, which is currently limited to special education services. This can create a perverse incentive in some cases to either delay care or to inappropriately assign students to Special Education. It is only possible to provide more universal care when access to mental health services through EPSDT is opened through a closer partnership between school districts and the county. It is important to note that the authors are suggesting that services be provided at schools. Not necessarily that school districts become EPSDT mental health care providers.
- **Address emotional and social wellness school-wide by creating an overall school climate that is nurturing and supportive.** To provide a strong foundation for mental health services, schools must first build positive and nurturing school environments. This includes providing opportunities for students to develop socially and emotionally. It also includes professional development and coaching that supports school staff in utilizing child and youth development principles in setting instructional design, managing classrooms, and implementing restorative school discipline practices. Investing in continuous and data-informed improvement of school climates will have significant payoffs in the emotional wellbeing and social adjustment of students. School climate improvement also helps schools attain educational goals and should be a considered a crucial area for investing LCFF funds.
- **Provide mental health interventions in a location that is considered safe and convenient to the youth and their family members.** Providing appropriate spaces for delivering services that help protect privacy, maintain dignity and encourage students and families to feel comfortable utilizing services is a very concrete way for school districts to contribute to a comprehensive system of services.
- **Enhance the effectiveness of services by coordinating case management through a multi-disciplinary team.** When services are coordinated through a multi-disciplinary team, they can be appropriately combined with other supports to ensure comprehensive care. For example, in addition to mental health services, a student's family may benefit from family-strengthening supports provided by the case manager from a family resource center. It is appropriate for school districts to cover the cost of full-time school-based staff to coordinate the partnerships and the day-to-day functioning of multi-disciplinary teams. Typical funding models include an investment of LCFF funds and participation in the School-based Medical Administrative Activities (MAA) program. Full participation of mental health workers in these teams requires county commitment to this practice and financial support of worker time – i.e. for 'administrative' functions not just direct services.
- **Ensure that human resources are maximized by providing professional development and promoting professional consultation between mental health workers and school staff.** To get the most out of the professional expertise represented in the multi-disciplinary team, time for consultation should be built into the school day so that teachers can develop skills to support students and implement positive classroom management strategies, such

as trauma-informed classrooms and staff wellness. In turn, through the team structure, mental health providers should contribute to planning and assessment regarding student needs, universal interventions, and school climate improving activities.

To effectively meet the mental health needs of all students, school districts and county mental health departments should collaborate around a mutual goal of increasing children's access to mental health services and developing programs that support their functioning in all settings, including the academic environment.

It's true that the responsibilities of schools and county agencies are distinct. Each child-serving system is responsible for addressing a different domain – academics, behavior, mental health, disability – and that none alone is responsible for the big picture or the whole child. However, the work of all these systems is undermined when low-income children and youth do not receive needed mental health services because of this fragmentation of responsibility. Absent effective collaboration between districts and counties, school districts often are in a position where they see the need among their students but can do little or nothing to address it. Meanwhile, the expertise and resources schools need are under the jurisdiction of county mental or behavioral health departments that are not in day-to-day contact with the young people themselves.

Working together, school districts and counties can better serve children and more effectively meet their shared obligations to ensure children get the mental health services they are entitled to receive.

2011 Realignment Transformed the Administration of California's Children's Mental Health Programs

In 2011, California permanently reorganized the administration and financing of most services for vulnerable children and youth. Referred to as "Realignment," the shift consolidated decision-making regarding children's programs at the county level. While California's health and human service programs have always been operated by county governments, Realignment further empowers those systems by establishing a permanent fiscal structure that pairs additional flexibility with significant revenue growth. Taken together, flexibility and growth dramatically increase the ability of county agencies to collaborate with other child-serving systems, including schools, to meet the mental health needs of children and youth. To understand how Realignment creates these opportunities, it is important to understand how counties provide mental health services.

Mental Health Services for Children: Overview of EPSDT

Medicaid is the federal government's health insurance program for low-income individuals. California refers to its Medicaid program as Med-Cal. *EPSDT* is Medi-Cal's benefit category that provides for comprehensive health, mental health, and dental services for enrollees under 21 years of age. *Medically necessary services* is a component of EPSDT that provides a broad scope of services, including mental health services, based on a clear federal intention to identify and treat conditions in children that would become more costly to treat later in life. Due to the breadth of services covered and the inclusion of mental health services for children, Medi-Cal EPSDT provides for a critical continuum of mental health services for children and youth from low-income families.

EPSDT stands for Early and Periodic Screening, Diagnosis and Treatment.

Due to a number of court cases confirming that mental health services were a critical component of Medicaid's EPSDT coverage for children, California's children's programs often use 'EPSDT' as shorthand for children's specialty mental health services. In fact, EPSDT is a benefit category for children enrolled in Medicaid (Medi-Cal in California) that covers a range of physical and mental health services. EPSDT extends coverage beyond what might be available for adults in a state's Medicaid program to include any medical assistance to "correct and ameliorate physical and mental conditions and illnesses" for children and youth. Included in these services are medically necessary specialty mental health services. In California, the delivery of services and funding for EPSDT children's specialty mental health services is administered through county mental health departments.

There is currently very wide variation among counties regarding the enrollment of children and youth in Medi-Cal relative to estimates of eligibility (i.e. poverty), as well as variation in the proportion of all covered individuals who actually access and receive services. Even in counties where the majority of eligible children are enrolled, access and services do not generally correspond to epidemiological estimates of the prevalence of qualifying mental health conditions. The data suggests that California still has a way to go in ensuring that all children who are entitled to EPSDT services under federal law actually receive them. In this context, by providing flexibility and growth, Realignment creates an opportunity to make progress towards a goal of providing all necessary treatment to all children in need.

In California, county agencies administer many of the mental health services covered under the EPSDT benefit. Specifically, county mental or behavioral health departments administer EPSDT *specialty mental health services*. EPSDT specialty mental health services are those which are necessary to treat an identified mental health condition, and are not provided in a primary care setting (i.e. a doctor's office or hospital). Each of California's 58 counties creates a Mental Health Plan that contracts with the state to provide Medi-Cal mental health services, including those covered under EPSDT. The contract specifies procedures by which county mental health departments will conduct all mandated EPSDT activities, including screenings and the delivery of medically necessary services including Specialty Mental Health Services.

Generally, for an eligible child to receive services through the county mental health plan, a child must be referred to the county mental health department and then undergo an assessment for mental health needs. County staff may conduct the assessment directly or through a contracted provider, either an individual mental health professional or non-profit organization. With a qualifying mental health diagnosis, the county mental health department is responsible for providing, or arranging for the provision of, EPSDT specialty mental health services. These services can be provided directly by county employed staff through counseling, therapy, or other covered services. Additionally, counties may contract with community-based organizations that have the administrative and organizational capacity to deliver services and maintain the records necessary to file claims for federal reimbursement.

Once counties develop programs and deliver services, they then submit verified expenditure information to the state. The state uses this information as the basis for claims for federal reimbursement. The federal government reimburses 50% of the total cost of providing Medi-Cal services, including EPSDT mental health services, which the state then returns to the counties. The financing of the other half of the cost for EPSDT mental health services, the non-federal share, changed significantly with 2011 Realignment.

Overview of 2011 Realignment

As described above, county agencies have always been primarily responsible for the delivery of EPSDT specialty mental health services. 2011 Realignment transferred additional responsibilities for planning and financial management to the counties. The federal government still sets the rules that allow access to federal funds, and the state is responsible for ensuring that all eligible children receive the services to which they are entitled and for funding the program as necessary to meet this obligation. However, counties now receive state dollars to finance the non-federal share of cost in a different way, giving them significant new choices for how to administer the programs that provide services to children on the ground.

Prior to 2011 Realignment	After 2011 Realignment
<p><u>Federal Share of Costs</u></p> <ul style="list-style-type: none"> The federal government reimbursed the state for 50% of the cost of services. <p><u>Non-federal / State Share of Costs</u></p> <ul style="list-style-type: none"> Counties were required to contribute 5% of the total cost of services, which they financed through various local sources, including the county general fund. The state financed 45% of the total through the state General Fund, which required an annual budget allocation and was made only upon verification of eligible claims for expenses by the county Mental Health Plan, through a “cost settlement” process. 	<p><u>Federal Share of Costs</u></p> <ul style="list-style-type: none"> The federal government still reimburses the state for 50% of the cost of services, and the funds are transferred to the counties. <p><u>Non-federal / State Share of Costs</u></p> <ul style="list-style-type: none"> Counties are responsible for assembling the entire 50% non-federal share of cost, but receives state funding in advance. This “Realignment revenue” is not dependent on local match and not dependent on the state’s annual budget process. <p><u>New Flexibility</u></p> <ul style="list-style-type: none"> Counties have increased flexibility to prioritize funds within Realignment subaccounts according to local need.

2011 Realignment reassigned fiscal and programmatic responsibility for most foster care programs, community based mental health programs for children and adults (including EPSDT), alcohol and other drug programs, and a number of smaller, related programs. The funding for these programs now bypasses the State General Fund and budget process entirely. Instead, 2011 Realignment diverts a proportion of total state Sales and Use Tax and a portion of Vehicle Licensing Fee collections to a set of new state special funds, from which dollars are then distributed among the counties according to a set of formulas based primarily on historical spending.

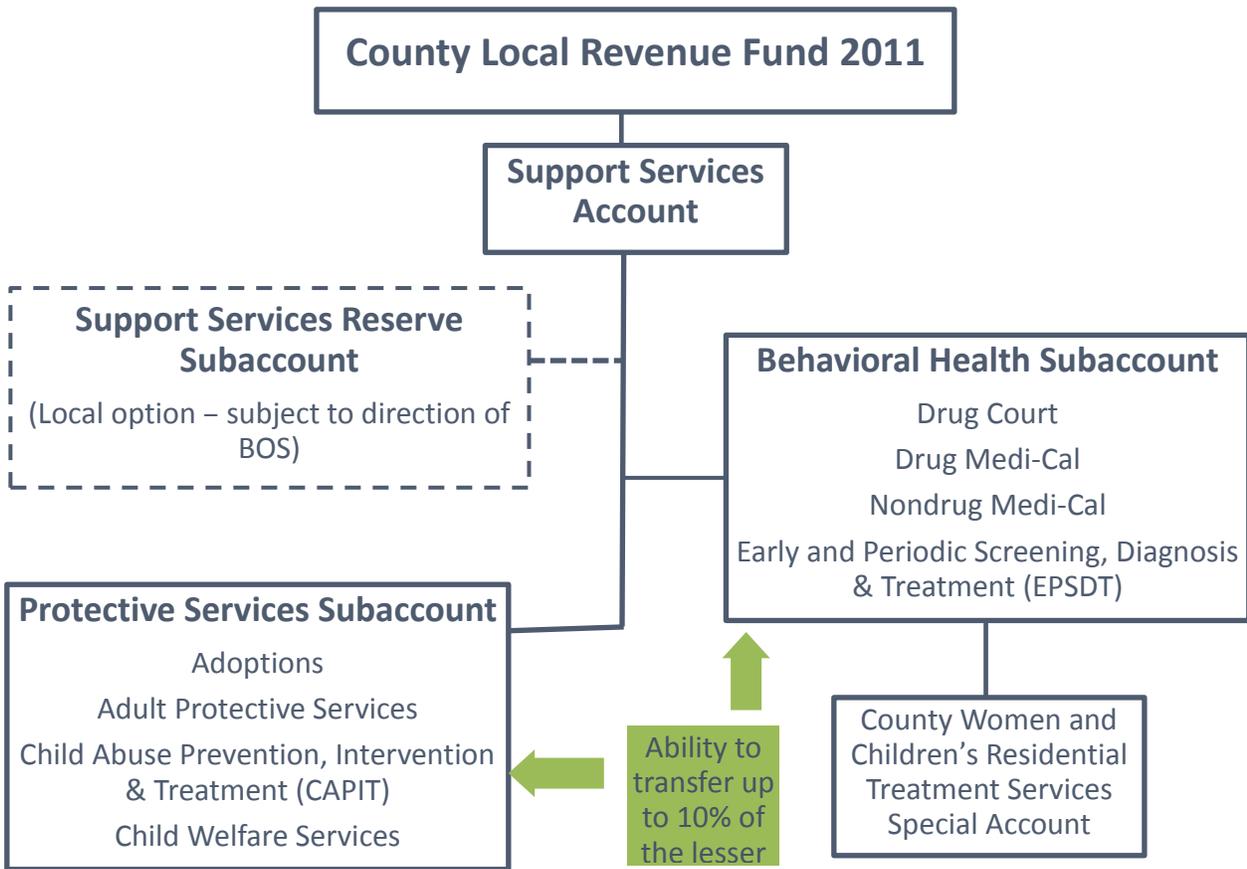
Each month, counties receive disbursements of 2011 Realignment revenues to each of several local subaccounts. Foster care and related programs are grouped in the Protective Services subaccount, while EPSDT, Medi-Cal Managed Care, and several Alcohol and Drug programs are included in the Behavioral Health Subaccount.⁶ The monthly disbursements to each subaccount are determined by allocation formulas that divide total available Realignment revenues among the 58 counties. “Base” allocations for each subaccount are composites of calculations based on

⁶ Several Law Enforcement funding streams were also realigned, and are managed at the county level through an additional set of subaccounts. This paper concerns only the health and human services programs impacted by 2011 Realignment.

historical spending for each of the programs included in the subaccount. A second set of state “growth” accounts receives revenues over and above the base and distributes these among county growth subaccounts according to a separately calculated growth allocation formula. Both base and growth allocation formulas are determined by the Department of Finance.

The permanent structure of Realignment subaccounts and growth has two primary implications for the administration of all realigned programs, including EPSDT: it creates new flexibility and, so long as the economy is strong, provides for significant growth in total funding.

Figure 1



Flexibility under Realignment

Realignment was intentionally designed to provide counties with flexibility and choice about how to manage realigned programs. Once the Realignment base allocation is deposited to the local Protective Services or Behavioral Health subaccounts, counties are allowed to allocate funding among the programs according to local need (See Figure 1 above). The same is true for allocations of growth – upon receipt, counties may invest Realignment growth according to local need.

Legislation implementing 2011 realignment mandates that all Realignment revenues are to be used to fund the programs included in the subaccounts. Guidance from the state has clarified that priority for funding must be given to the federal entitlement programs included in each subaccount – in the case of the Behavioral Health Subaccount, this means EPSDT Specialty Mental Health Services and Drug Medi-Cal – even if mandated expenditures exceed total funding to the subaccount under the allocation methodology established by the Department of Finance. Keeping in mind these obligations, the subaccount structure of Realignment provides significant flexibility to respond to local need:

- **Counties have the discretion to reallocate dollars among programs within a subaccount, for instance by redirecting funds from optional or ineffective programs towards those better targeted to community needs.** Thus counties could increase their total investment in children’s mental health services by increasing the proportion of total subaccount allocation dedicated to EPSDT.
- **Counties also have the flexibility to transfer funds between the Protective Services and Behavioral Health subaccounts – up to 10% of the lesser subaccount can be transferred between the subaccounts.**
- **Counties also have the option to establish a reserve account as a backstop against future scarcity, funding it with up to 5% of the total allocation of each subaccount.** There is evidence that the flexibility allowed by Realignment is already being utilized at the local level. EPSDT mental health claims data⁷ indicate wide variation among counties in their investment in EPSDT mental health since the implementation of 2011 Realignment. This raises questions of whether flexibility facilitated increased investment in EPSDT mental health (in counties that increased their claiming), or whether funds initially allocated to fund EPSDT mental health were redirected to other purposes (in counties that decreased their claiming). There are also examples of counties transferring funds between subaccounts in order to finance expansion of programs with more favorable federal match.

Realignment Growth

Because the revenue sources for Realignment are responsive to the economy, and because Realignment was first implemented towards the end of the recession when revenues were expected to grow as the economy recovered, a second set of subaccounts was necessary to receive and distribute revenue growth. These “growth Special Accounts” receive Realignment revenues in excess of the statewide base allocations, which are then allocated among counties according to a distinct set of allocation formulas. The state Department of Finance (DOF) is responsible for developing the Realignment allocation methodology for both base and growth allocations. As of this writing, the base and growth allocations to Protective Services subaccounts have been made “permanent,” while base and growth allocation formulas for the Behavioral Health subaccounts are the subject of continued deliberation.

The initial phase of Realignment, which occurred during the recession, left counties to grapple with these new responsibilities against a backdrop of persistent concerns about funding adequacy and questions about what ‘growth’ would look like. With the economic recovery, revenue growth has

⁷ See: <http://www.calegro.com/> Significant variation in EPSDT expenditures among counties precedes the implementation of 2011 Realignment, but the implications of variation since must be considered in the context of Realignment flexibility and the ability to retain or redirect unexpended funds.

been robust, and total revenue available to fund realigned programs well exceeds even pre-recession levels. Still, concerns about the long-term financial picture linger in counties, just as they do in school districts. Nonetheless, current and anticipated revenue growth undeniably provides significant new opportunities to expand the delivery of EPSDT specialty mental health services.

2011 Realignment provides opportunities for expansion and greater collaboration around school-based services

By providing flexibility and growth, Realignment expands the scope of possibility for EPSDT (and all realigned programs) and should be regarded as a powerful tool to advance local goals and strategies, including increased investment in providing services to children in the school setting.

Strategies to Expand EPSDT Mental Health Services under Realignment

Taken together, the flexibility and growth provided by the structure of Realignment create significant opportunities for counties to expand the availability of EPSDT funded mental health services. Counties can maximize funds available for EPSDT specialty mental health services as follows:

- Utilize 100% of the EPSDT proportion of the Behavioral Health Subaccount allocation for EPSDT services.⁸
- Allocate Behavioral Health Subaccount growth to EPSDT.
- Reallocate revenues among programs included in the Behavioral Health Subaccount to increase total investment in EPSDT.
- Transfer funds from the Protective Services Subaccount to the Behavioral Health subaccount to increase available funds for investment in EPSDT.
- Use other county discretionary funds to increase their investment in EPSDT beyond what is provided for by the Realignment allocations.⁹

It is important to acknowledge that several of these choices represent a trade-off, insofar as increasing investment in EPSDT may reduce the funds available for other priorities. The planning and political considerations underlying such a decision will be unique to each of the 58 counties. By design, Realignment increases local control and choice, in turn requiring that local government, administration, and communities engage in sophisticated planning.

Strategies to Expand ESPDT Mental Health Services in the School Setting

Schools are an ideal setting in which to identify children in need of mental health services. A mental health condition that affects a child's functioning across domains is likely to be first identified in the school setting – regardless of whether the mental health condition is understood to directly impact the student's academic achievement. Given that the school setting lends itself to

⁸ The Department of Finance differentiates EPSDT in its development of Behavioral Health Subaccount allocations, underscoring the expectation that these funds be used to finance the non-federal share of cost for EPSDT services. Nonetheless, funds are distributed as part of an allocation to the Behavioral Health Subaccount, meaning that counties must subsequently make an affirmative choice to invest them in EPSDT expenditures.

⁹ State law requires that counties exhaust the funds provided by 2011 Realignment, as well as any available funds from a previous Realignment in 1991, before spending county general funds on Realigned programs. See California Government Code § 30026.5(g)

both early identification as well as intervention, many schools were an access point for EPSDT funded mental health services even before the 2011 Realignment.

There are two primary ways that county mental health departments and school districts (referred to in relevant federal law as a Local Education Agency or “LEA”)¹⁰ may structure the provision of EPSDT-funded services delivered in the school setting. These options require close collaboration between LEAs and county agencies:

1. The LEA may collaborate with the county mental health department to develop a contract or MOU that provides for the provision of mental health services in the school setting either by county staff or through contract with a community-based organization (CBO).
2. The LEA may be enrolled as a Medi-Cal provider of the county mental health plan. LEA staff that meet criteria as an eligible Medi-Cal specialty mental health service provider can provide services to students in the school setting according to the terms of their contract with the county, and the county submits claims for federal reimbursement through DHCS.

The first partnership is familiar to many school districts. Many schools may know their CBO mental health provider but it is important to understand that CBOs operate as contractors with the county. For school districts, there are opportunities to engage the county and CBOs to ensure that mental health services outlined in county contracts include services in a school setting. It is important to establish with the county and CBOs that schools can be critical access points for identifying and providing care to students with mental health needs. The authors strongly recommend collaboration to design and implement this first option as part of a larger, comprehensive system of care, in which the school setting is fully leveraged. The second partnership acknowledges that schools may already be providing similar services as those included in a county’s plan for EPSDT mental health services. Schools may be using their general fund dollars or special education dollars when a more sustainable option through EPSDT could be available. Whichever strategy is employed, the funding opportunity presented by 2011 Realignment should be fully leveraged to expand services delivered in school settings and to reach all young people in need of services early and effectively.

Answers to Local Concerns about Expanding EPSDT Mental Health Services

A history of inadequate funding as well as outstanding questions about the adequacy of growth and how it would be allocated, have caused some county mental health departments to be conservative in their planning. Many may have been reluctant to commit to expanding EPSDT mental health services and, in turn, to expanding their partnerships with school districts. However, in addition to the significant growth in revenues to date, the state has now affirmed its responsibility to support counties in providing all EPSDT mental health services to all eligible children in need. When planning their administration of EPSDT under Realignment, local decision-makers should consider the following:

- **EPSDT Specialty Mental Health Services are a federal entitlement.** While 2011 Realignment transformed its administration, it did not change the underlying requirements. All federal law and regulation still applies, including every eligible child’s individual

¹⁰ When discussing eligibility for federal funding and accompanying responsibility for federal mandates, the term “Local Education Agency” (LEA) refers to the unit of administration responsible for compliance with federal education law and compliance with the Individuals with Disabilities Education Act (IDEA). In California, county offices of education, school districts, and charter schools may be LEAs. <http://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx>

entitlement to both screening and medically necessary services - including specialty mental health services. This is true regardless of the complexities of Realignment financing, or the total dollar amount allocated to the Behavioral Health Subaccount. The state has recognized an ongoing responsibility to reimburse counties whose mandated expenditures on EPSDT exceed the allocation of Realignment revenues.¹¹

- **Realignment is permanent.** The administrative and fiscal structure of Realignment was established in law through legislation, and the financing of Realignment was written into the state Constitution through Proposition 30, passed by California voters in 2012. While there is continued debate about EPSDT allocation formulas, the basic structure of Realignment, including its structural provision of flexibility, is permanent.
- **Realignment provides for significant growth in EPSDT funding over the next 3 years.** In 2012, the Legislative Analysts Office estimated that total Realignment revenues would grow by approximately 6.5% year over year.¹² In fact, current growth in the underlying revenue sources has been 8.5% in each of the past two years.¹³ As much of this growth has yet to be distributed by the state, over the next two to three years, counties should expect very significant growth in the EPSDT allocation to their Behavioral Health Subaccounts.¹⁴
- **Realignment flexibility creates new ways to finance the non-federal share of cost for EPSDT expansion.** Even beyond the significant growth expected by counties, the structure of Realignment allows counties a range of strategies to increase or maintain investment in EPSDT mental health. In addition, this flexibility should mitigate concerns about long-term fiscal management of the program.

Recognizing the multiple priorities facing county mental health departments and the need to make a strong case for providing EPSDT mental health services in a school setting, school districts must be prepared with comprehensive information about the need for services among their student population.

To partner well, school districts must first prepare

School districts have long recognized the need for comprehensive and collaborative planning to address the social, emotional, and behavioral needs of their students, including mental health needs. Developing an overarching vision of student supports and conducting a needs assessment regarding services to children with unmet mental health needs provides an essential foundation for developing collaborations with other systems, including county mental health departments.

¹¹ See http://www.dhcs.ca.gov/formsandpubs/Documents/14-017_Info_Notice.pdf. To date, the state has elected to reimburse counties whose mandated expenditures exceed the subaccount allocation by providing them with “first call” on the subsequent year’s growth. The state will continue to hold this responsibility regardless of how the reimbursement is financed in any given year.

¹² See p. 30 at: <http://www.lao.ca.gov/analysis/2012/update/economic-revenue-update-022712.pdf>

¹³ See California State Board of Equalization Annual Reports at: <http://www.boe.ca.gov/annual/annualrptsarchives.htm>

¹⁴ See: <http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/SUB3/05182015Sub3HealthMayRevise.pdf>

Come to the table with data and a solid needs assessment

The California School-based Health Alliance recommends that districts interested in expanding or enhancing mental health services structure their initial planning as a needs assessment that addresses questions including the following:¹⁵

- What are the needs of our students, based upon data from sources such as California Healthy Kids Survey, Youth Risk Behavior Survey, suspension/expulsion data, and special education data?
- What do students think about mental health needs? What kind of services and programs would they participate in? What do families say they need/want?
- What mental health services do our students/families currently have access to in the community? Are these services well-utilized?
- What mental health resources do we now have on campus? Do we have school-site mental health staff who meet the criteria to be an eligible provider of Medi-Cal specialty mental health services?
- How are current services coordinated? Are they effective?
- What do our teachers and school staff need to know to support student mental health?
- Who are our existing mental health partners? Who are potential partners?
- To what degree is the county health department invested in schools?
- Who are the principal players and leaders?

Many schools and districts have progressed to developing and implementing a comprehensive model for school-wide supports including school climate interventions and student engagement strategies. Such models allow districts to contextualize any outstanding need for mental health supports when engaging with partner agencies.

In addition to comprehensive plans to meet the social, emotional, and behavioral needs of students, school districts should further equip themselves to establish productive partnerships with county mental health departments by collecting and analyzing data on unmet mental health needs among students, both at the district and school levels. Questions guiding this analysis should include:

- What are the poverty rates and the rates of Med-Cal eligibility among our students?
- How can we estimate the incidence of mental health needs among our students?
- Do our students currently have access to EPSDT programs to address their mental health needs?
- How do we currently refer students to the county mental health department for an assessment for EPSDT-funded services? What are the outcomes of those referrals?
- What needs are met by our Special Education programs, and what needs are outstanding?
- What resources does the district currently contribute to realizing its vision of a comprehensive system of supports for student's social, emotional, behavioral, and mental health needs? What additional resources could be brought to bear?¹⁶

¹⁵ See also the California School-Based Health Alliance website at: <http://www.schoolhealthcenters.org/healthlearning/mentalhealth/> and:

¹⁶ The California School-based Health Alliance website provides additional information about the range of funding streams available to address the individualized needs of students. <http://www.schoolhealthcenters.org/>

School districts that are able to articulate a well-defined need among their student populations and support their assessment with data are best positioned to engage in collaborative planning with county mental health departments and other child serving systems.

Conclusion

It takes strong leadership as well as sustainable financing and administrative strategies to prioritize the collaborative and comprehensive planning that can result in a bold vision for students. This is especially true for mental health programs that, by definition, must operate across legal, administrative, and fiscal silos. Despite the challenges, evidence suggests that it is well worth the work – effectively identifying and addressing students’ mental health needs supports both individual healthy levels of functioning which includes academic achievement as well as teachers’ ability to manage and optimize the school environment to the benefit of all students.

Perhaps the most significant opportunity presented by 2011 Realignment is to envision, plan, and build a comprehensive system of children’s mental health services. School districts can be invaluable partners both in identifying children who may be in need of mental health services, and in facilitating or delivering services. Counties that undertake collaborative planning processes can explore with districts which aspects of a children’s mental health service continuum can be best delivered in the school setting.

Whether planning is initiated by a district seeking to better meet the identified needs of its students, or by a county mental health department seeking to establish the pillars of a comprehensive system of care through partnering with schools, collaboration is essential. 2011 Realignment empowers local leadership at the very moment when awareness about the potential role of schools in meeting the health and mental health needs of children is at its height. Developing productive partnerships is thus not only timely, but given the significant new choices and opportunities presented by Realignment, should be considered essential.