

# SCHOOL MENTAL HEALTH 101

A Primer for Medi-Cal Managed Care Plans



National Center  
for Youth Law

# Acknowledgements

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H O P E L A B



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The National Center for Youth Law (NCYL) advances justice through research, community collaboration, impact litigation, and policy advocacy that fundamentally transforms our nation's approach to education, health, immigration, foster care, and youth justice. Our mission is to amplify youth power, dismantle racism and other structural inequities, and build just policies, practices, and culture in support of young people. Learn more at [www.youthlaw.org](http://www.youthlaw.org).

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*This document includes general legal information, not legal advice. Readers are encouraged to consult their legal counsel for advice on these topics.*

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# Executive Summary

**This Primer was created to help facilitate conversations between MCPs, schools, and other partners in implementing the MCP incentive program component of the Children & Youth Behavioral Health Initiative and reaching school-age youth at scale to address the growing mental health crisis.**

**D**uring 2020 and 2021, California’s children and youth have faced endless new challenges, stressors, and trauma, exacerbating an already troubling uptick in mental health needs. Many students have returned to in-person learning with new or heightened fears, anxieties, and emotional needs. Families, teachers, and school staff are helping students navigate this reality while also recovering from two academic years of severe learning loss. In under-resourced schools and communities—which have borne the brunt of the crisis—the challenge is especially staggering. Most of the children and youth served by these schools are Black and brown, underscoring the systemic inequities of our child-serving systems.

Helping California’s students heal is an urgent, all-hands-on-deck situation. Child-serving systems must break through historical silos and provide a robust, coordinated response to identifying and meeting children’s needs, early and effectively. Failing to do so will lead to negative long-term outcomes for students, and deepen existing inequities in access to healthcare and education.

Fortunately, policymakers have begun to take note, and take action. Earlier this year, California announced it would invest more than \$4 billion in the Children and Youth Behavioral Health Initiative (CYBHI), a multi-pronged initiative to improve mental health care for the state’s children and youth. One component of this investment is an incentive program for Medi-Cal Managed Care Plans (MCPs), intended to foster partnerships with schools and increase access to school-based and school-linked care for students on Medi-Cal. This is an important opportunity for MCPs to expand their reach and impact and contribute to



children’s mental health and wellness.

To implement effective school partnerships that will truly add value, MCPs must start by developing a deep understanding of—and commitment to addressing—the expressed needs of the students and families they are serving. MCPs will also need to equip themselves with a solid understanding of how schools work, what mental health supports and services schools are already providing for students, and where there are gaps and unmet needs.

This primer is intended to help jumpstart that learning process by providing MCPs with an introduction to California’s vast and complex K-12 education system. It provides:

- An overview of the state’s K-12 student population and the key state, county, and local leadership and oversight structures and principles;
- A summary of the ways in which schools are currently supporting the social, emotional, and mental health of students, including through: Multi-Tiered System of Support (MTSS) frameworks; school-employed mental health professionals; Individualized Education Programs (IEPs) and 504 Accommodations Plans; school-based health centers (SBHCs); partnerships with county mental health plans (MHPs); partnerships with community-based organizations (CBOs); leveraging Medicaid funding streams; and other strategies;
- A description of the state’s newly-created MCP incentive program;
- Guiding principles and templates for MCPs beginning the process of developing or expanding school partnerships; and
- Additional resources for further learning.

# Introduction and Background

Children and youth are experiencing growing mental health needs, requiring a collaborative, coordinated cross-system response. Even prior to the COVID-19 pandemic, needs were rising sharply and far too many youth were going without adequate support and services.<sup>1</sup> In 2020, as the world abruptly shifted to respond to a global pandemic, young people were faced with an avalanche of both new and increased stressors impacting them, their families, and their communities. At the same time, they faced new barriers to accessing in-person care. We do not yet know the cumulative, long-term impact of these events on children and youth, but early data points to increased anxiety, depression, and suicidal ideation among youth, coupled with a decline in utilization of mental health services.<sup>2</sup> As the world re-opens, it is crucial that California take proactive, bold steps to ensure that child-serving systems are effectively serving the social, emotional, and mental health needs of young people.

Schools are critical sources of mental health support for young people. Schools are where children and youth learn, grow, and interact with peers, and are a central point of community and connection for many families. Teachers and school staff interact with students daily and may be among the first adults to notice the signs and symptoms of students' stress and mental health needs. When needs are identified, school campuses are important access points for services: According to one estimate, approximately 70% of students who receive mental health services access them through their schools.<sup>3</sup> Providing services where students are—in schools—can also be a tool to help fight structural inequities. Students whose families are experiencing poverty or other risk factors, or students in rural

Approximately 70% of students who receive mental health services access them through their schools.

*—Using Coordinated School Health to Promote Mental Health for All Students, National Assembly on School-Based Care (July 2010)*

areas, may face added challenges to accessing care in their communities, due to provider shortages, lack of transportation, or other barriers. Creating access points to care at school sites can help mitigate these inequities.

Moreover, mental health and education are intrinsically linked. Childhood development and learning are impacted by a variety of factors, including psychological, social, and emotional processes; “emotions can trigger or block learning.”<sup>4</sup> When students receive the social, emotional, and mental health support they need, they can focus on engagement in school and learning.<sup>5</sup> Conversely, untreated mental health needs can interfere with school attendance; research shows a connection between a child's unwillingness to attend school and conditions such as depression, separation anxiety disorder, and generalized anxiety disorder.<sup>6</sup> Increasingly, schools are being reconceptualized as centers for wellness, healing, and whole-child support, consistent with this understanding of the inherent relationship between mental health and learning.<sup>7</sup> Schools can play an important role in increasing mental health promotion, early identification of needs, and early intervention.

Many California school districts are implementing innovative approaches to supporting the social, emotional, and mental health of students. And there is a new opportunity to help ensure that every child has access to the supports and services they need and deserve. California's 2021-22 state budget invests more than [\\$4 billion](#) over multiple years in improving mental health care for children and youth, including dedicating funds to expand school-based services and partnerships between schools, counties, and managed care plans (MCPs). Effective partnerships with external providers can expand schools' capacity to leverage Medi-Cal funding and deliver a broader range of services, and can help MCPs, counties, and community-based providers reach more children and youth, and ultimately, increase student mental health and well-being.

This primer is intended to provide an introduction to California's K-12 education system and school mental health care and related programs for Medi-Cal MCPs preparing to embark on effective partnerships with schools to expand access to mental health care for students. It begins by describing a new funding opportunity for MCP-school partnerships in the state budget, and offering high-level suggestions for steps MCPs can take to prepare for those partnerships. It then provides a general overview of California's K-12 education system, including the state's student population, leadership and governance structure, and school funding framework, followed by a summary of key mental health structures, supports, and practices in schools. Finally, it offers a list of resources for further learning, a list of school health terms, and an appendix containing sample questions for planning school partnerships. While we hope this resource provides helpful general background, we urge MCPs to invest time and energy in learning about the specific schools and districts they intend to partner with; the existing services, structures, and partnerships in place in those schools and districts; and, most importantly, the students and families they serve.



# Funding for MCP-School Partnerships in California's 2021-22 Budget

In recognition of escalating needs and the power of early identification and intervention, California's [2021-22 budget](#) invests approximately \$4 billion in children's mental health over the next five years, including through the launch of the state's Children and Youth Behavioral Health Initiative (CYBHI). The CYBHI is "intended to transform California's behavioral health system into an innovative ecosystem in which all children and youth 25 years of age and younger, regardless of payer, are screened, supported, and served for emerging and existing behavioral health needs."<sup>8</sup> It is intended to include several components, including a virtual platform for behavioral health services and grants for school-linked partnership, capacity, and infrastructure building.<sup>9</sup>

Another component of the initiative consists of "incentive payments to qualifying Medi-Cal managed care plans to implement interventions that increase access to preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers for children in publicly funded childcare and preschool and TK-12 children in public schools, as described by [Welfare & Institutions Code] Section 5961.3"<sup>10</sup> Qualifying plans must meet "predefined goals and metrics... associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for K-12 children in schools."<sup>11</sup> Interventions, goals, and metrics for determining eligibility are to be set by the Department of Health Care Services (DHCS) in consultation with the California Department of Education (CDE), plans, county behavioral health departments, and Local Education Agencies (LEAs); activities that increase Medi-Cal-reimbursement services, reduce inequities, and serve children who are in transition, homeless, or child welfare-involved may result in higher incentive payments.<sup>12</sup>

Possible examples of goals, metrics, and interventions identified in legislation are as follows:

"(1) Local planning efforts to review existing plans and documents that articulate children and youth needs in the area; compile data; map existing behavioral health providers and resources;

identify gaps, disparities, and inequities; and convene stakeholders and develop a framework for a robust and coordinated system of social, emotional, and behavioral health supports for children and youth.

(2) Providing technical assistance to increase coordination and partnerships between schools and health care plans to build an integrated continuum of behavioral health services using contracts, a memorandum of understanding, or other agreements.

(3) Developing or piloting behavioral health wellness programs to expand greater prevention and early intervention practices in school settings, such as Mental Health First Aid and Social and Emotional Learning.

(4) Expanding the workforce by using community health workers or peers to expand the surveillance and early intervention of behavioral health issues in school-age children 0 to 25 years of age, inclusive.

(5) Increasing telehealth in schools and ensur[ing] students have access to technological equipment.

(6) Implementing school-based suicide prevention strategies.

(7) Improving performance and outcomes-based accountability for behavioral health access and quality measures through local student behavioral health dashboards or public reporting.

(8) Increasing access to substance use disorder prevention, early intervention, and treatment."<sup>13</sup>

The Department of Health Care Services (DHCS) has launched a workgroup to support implementation of the MCP incentive program, also known as the [Student Behavioral Health Incentive Program](#) (SBHIP).<sup>14</sup> The program is expected to launch in January 2022, and continue for three years, with the objective that the partnerships developed will continue beyond that timeframe.<sup>15</sup> This represents an important opportunity for MCPs to develop and deepen relationships with schools and counties to expand the reach and impact of mental health services for students.



# How MCPs Can Prepare for Effective School Partnerships

## IN THIS SECTION:

- ✓ Learn about the student population being served.
- ✓ Identify and build relationships with key education and community stakeholders.
- ✓ Meaningfully engage youth and families.
- ✓ Learn about the existing systems and structures for supporting students in each partnering district and/or county, including any perceived gaps or needs.
- ✓ Embrace a student-centered and family-centered approach.
- ✓ Understand how education has changed during the pandemic, and how the changes are impacting students and families.
- ✓ Be prepared to introduce the MCP and explain its goals, operations, and strategic direction to potential school district partners.
- ✓ Jointly develop and document a shared vision, and strategies to complement, expand, and strengthen existing school-based services.

**T**here are many steps that MCPs can take to prepare for effective, impactful partnerships with schools. Below are some high-level principles and strategies to keep in mind.

### ***Learn about the student population being served.***

MCPs should identify where their school-age members attend school (the [CDE school directory](#) can be searched by zip code and/or other criteria), and learn about the student populations in those districts and schools. This should include reviewing data on child and adolescent health indicators and using data sources like the [California Schools Dashboard](#) to understand how students are doing in the districts with which MCPs are partnering. MCPs should also review their own member encounter data to evaluate the screening and other services they are providing to these students, which services they are receiving from county mental health plans or other carved-out services (e.g. California Children's Services (CCS)), demographic data, and educational data such as eligibility for special education services, school attendance data, and school suspension/expulsion data.

### ***Identify and build relationships with key education and community stakeholders.***

MCPs should take time to identify and meet with leaders and stakeholders in their local districts and communities, and hear their perspectives about what programs and partnerships may currently be in place, and where there are gaps, needs, and opportunities to expand services. This includes education leadership (e.g., county and district-level superintendents, assistant superintendents, district-level behavioral health directors, school board members, teacher and parent groups), county mental health plans, leaders of existing school-based health centers (SBHCs), community-based organizations, and other community representatives.

### ***Meaningfully engage youth and families.***

It will be essential for MCPs to actively engage families/ caregivers and age-appropriate youth in efforts to implement the school-based components of the youth behavioral health initiative. For example, MCPs can support youth involvement by funding peer health programs and tapping into existing student/parent school forums.

### ***Learn about the existing systems and structures for supporting students in each partnering district and/or county, including any perceived gaps or needs.***

MCPs should invest time and energy in learning about the districts they are partnering with, how each district is currently addressing students' social, emotional, and mental health needs, and where gaps in services are. Once in contact with key school leaders, as discussed above, MCPs should work with the school district(s), county office of education, and county to review relevant data and Local Control and Accountability Plan (LCAP) activities and investments to understand the student population and needs, and reach out to contracted mental health providers to understand if and how they are already coordinating with schools, school-based programs, and SBHCs in the relevant districts. The better an MCP understands the current reality, the more successful it will be in developing partnerships that build upon existing services and add real value for students and families.

### ***Embrace a student-centered and family-centered approach.***

It is crucial for MCPs to understand and ensure their plans reflect the needs and perspectives of the students and families in their local communities. How are students and families thinking and talking about mental health? Where are students and families currently accessing mental health care? What challenges and barriers are they facing? What are the major deterrents or barriers to getting support? How will the MCP-district partnership maximize access to care and be responsive to these needs? MCPs should consider hosting a series of community-engagement or listening session opportunities, such as parent forums, in partnerships with school districts, to engage and hear directly from the school community. The school community's input should directly inform the MCP's planning and implementation.

“The biggest thing for managed care organizations, that would be the most beneficial, is to have meaningful youth engagement opportunities in providing mental health services on school grounds. With workforce shortages, MCPs will need to engage students and youth.”

–Nghia Do, High School Student,  
CCY and CMHACY Board Member,  
Founder Youth Minds Alliance

### ***Understand how education has changed during the pandemic, and how the changes are impacting students and families.***

California's education system has experienced unprecedented changes over the last year and a half; most notably, much of the 2020-21 academic year consisted of distance learning, with students receiving instruction over platforms such as Zoom and rarely having in-person interactions with their teachers and peers. It will be important for MCPs to understand how a district responded to the pandemic, how the return to in-person learning is going, and how social, emotional, and mental health services and supports were delivered during the pandemic and are currently being delivered. MCPs should ask the district to share what they learned about students' needs during the pandemic and during the return to in-person learning. How have student needs increased or shifted? How has the school responded? How has the pandemic experience impacted school leaders' approaches to the current academic year? How can a partnership with an MCP help further address these needs and changes? How might student needs evolve over the coming school year as students, families, and communities continue to navigate uncertainty and change?

***Be prepared to introduce the MCP and explain its goals, operations, and strategic direction to potential school district partners.***

Do not assume that the school leaders or staff you work with will have had prior experience with or background knowledge regarding the Medi-Cal managed care system. Consider preparing a brief overview document and/or presentation for potential school partners offering relevant introductory information and sharing initial insights on your strategic vision for the partnerships you are hoping to develop. Take the time to answer questions that your school partners have about Medi-Cal, MCPs, and mental health care.

***Jointly develop and document a shared vision, and strategies to complement, expand, and strengthen existing school-based services.***

This plan should clearly document expectations and commitments from each partner, shared goals and objectives, an implementation plan (e.g. staffing facilities, referrals and communications, service delivery plan, records access, confidentiality and information sharing expectations), funding and billing, a plan for data-driven evaluation, reassessment, and course correction along the way, as needed, and plans for population-level school and community-based prevention initiatives.



# California's K-12 Education System

## IN THIS SECTION:

- ✓ California's K-12 Students
- ✓ State-Level Leadership and Oversight
- ✓ County-Level Leadership and Oversight
- ✓ Special Education Local Plan Areas (SELPA)
- ✓ School Districts
- ✓ School Sites
- ✓ Other Key Players in K-12 Education
- ✓ Local Control, School Funding, and Accountability Plans
- ✓ Education Data Systems
- ✓ California School Climate, Health, and Learning Surveys

## CALIFORNIA'S K-12 STUDENTS

California's public school system serves more than six million students in kindergarten through Grade 12 across 1,037 school districts and 10,588 individual schools.<sup>16</sup> It has the highest student enrollment of any state in the country.<sup>17</sup>

California's students are socioeconomically, racially, and ethnically diverse. About 60% percent of students are considered low-income, as measured by eligibility for free or reduced price school meals under federal nutrition programs, and are eligible for Medi-Cal.<sup>18</sup> According to the California Department of Education (CDE), approximately 55% of students are Hispanic or Latino, 22% are White (not Hispanic), about 9% are Asian, about 5% are Black, 3.9% are two or more races (not Hispanic), 2.4% are Filipino, 0.5% are American Indian or Alaska Native, and 0.4% are Pacific Islander.<sup>19</sup> Roughly 20% of students are English Language Learners, and students' families speak more than 65 different languages in their homes, with Spanish being the most common.<sup>20</sup>

Approximately one-tenth of California's public school students have been identified as having a disability that impacts their education, such as dyslexia, speech and language impairments, or autism, and are eligible for special education services (SPED, discussed in more detail below).<sup>21</sup> Statewide, in a given year, approximately 25,000 children and youth ages 0-22 receive special education services based on a disability classification of "Emotional Disturbance" (see Special Education section below).<sup>22</sup>





## STATE-LEVEL LEADERSHIP AND OVERSIGHT

The [California Department of Education](#) (CDE) is the state agency responsible for overseeing compliance with state education laws and regulations, collecting educational data, allocating education funds, and supporting school districts and county offices of education.<sup>23</sup> CDE is led by the State Superintendent of Public Instruction (SSPI, or state superintendent), who is an elected official. California’s current SSPI is [Tony Thurmond](#), who took office in January 2019.

The [State Board of Education](#) (SBE) is the governing and policy-making arm of CDE, whose role is to adopt regulations regarding academic standards, curricula, instructional materials, assessments, and accountability. SBE members are appointed by the Governor.<sup>24</sup> The current State Board of Education President is [Dr. Linda Darling-Hammond](#), whose term began in February 2019.

The [Commission on Teacher Credentialing](#) (CTC) is California’s state agency overseeing state standards, licensing, credentialing, and discipline of educators—including credentialed school mental health professionals—and approving and accrediting credential training programs.<sup>25</sup>

The [California Collaborative for Educational Excellence](#) (CCEE) is a state agency established through statute in 2013 that is responsible for helping create and strengthen the “system of support” for school districts across the state, to help improve student outcomes and address disparities, in collaboration with CDE, SBE,

County Offices of Education (COE), school districts, and Special Education Local Plan Areas (SELPA) (see below for more information about SELPA). CCEE can help facilitate local collaboration, including around links between student health and wellness and improvements in school climate, student engagement, and academic outcomes.<sup>26</sup>

The [Fiscal Crisis and Management Assistance Team](#) (FCMAT) is a state agency established through statute in 1991, tasked with helping Local Education Agencies (LEAs) (see below for more information about LEAs) “identify, prevent and resolve financial, operational and data management challenges by providing management assistance and professional learning opportunities.” FCMAT assists COEs, school districts, charter schools, and community colleges.<sup>27</sup>

## COUNTY-LEVEL LEADERSHIP AND OVERSIGHT

County-level education entities include [County Offices of Education](#) (COEs), county superintendents, and county boards of education. COEs provide certain support services to school districts, and serve a monitoring and oversight function, which was strengthened through the 2018 passage of AB 1840.<sup>28</sup> County superintendents (who lead COEs) are responsible for reviewing and approving school district budgets and planning documents called Local Control and Accountability Plans (LCAPs) (see below for more information about LCAPs).<sup>29</sup> COEs also provide educational instruction directly to certain students, such as students with juvenile justice involvement or

students who have been expelled from school, through “alternative education” programs.<sup>30</sup> Sometimes alternative education options are referred to as “county community schools” or “community day schools.” (Note, however, that “community schools” is also a term used in California to refer to schools that partner with families, community agencies, and local governments to support “whole child” education, including integrated supports and services, to improve teaching and learning.<sup>31</sup>) In some instances, the state also contracts with COEs to perform statewide functions.<sup>32</sup>

COEs are led by county superintendents. Most county superintendents are publicly elected, while a handful are board-appointed. County superintendents work with school districts in their counties to support and guide their operations, and have responsibilities such as fiscal oversight.<sup>33</sup> A directory of county superintendents is available [here](#). County-level boards of education hold responsibilities such as approval of annual county superintendent budgets.<sup>34</sup>

## SPECIAL EDUCATION LOCAL PLAN AREAS (SELPAS)

California has approximately 132 geographic consortiums, called Special Education Local Plan Areas (SELPAs). SELPAs are responsible for the planning and delivery of special education services, either for a single school district (for large districts) or for regional groupings of school districts.<sup>35</sup> A list of SELPAs by



county is available from CDE [here](#). The majority of state and federal funding for special education flows through SELPAs. Some of this funding is used for regional services and the remainder is passed to school districts.<sup>36</sup>

## SCHOOL DISTRICTS

The vast majority of California counties are home to multiple school districts, though there are seven single district counties in California: Alpine, Amador, Del Norte, Mariposa, Plumas, San Francisco and Sierra.<sup>37</sup> School districts vary considerably in size. Los Angeles Unified School District (LAUSD) is the largest district in the state—and the second-largest school system in the country, after New York City Public Schools—serving nearly 10% of all California public school students.<sup>38</sup> At the opposite end of the spectrum, a handful of very small districts serve fewer than 10 students each.<sup>39</sup> The average school district enrollment is about 5,600 students.<sup>40</sup> Many school districts are “unified,” meaning that they include both elementary and secondary schools, while some districts are elementary-level or secondary-level only.<sup>41</sup> A searchable directory of California schools and school districts is available from CDE [here](#). School districts (along with COEs and charter schools, discussed below) are often referred to as “Local Education Agencies,” or LEAs.

School districts are led by district-level superintendents.<sup>42</sup> Local school boards, whose members are publicly elected, provide oversight and make education policy and budget decisions for their districts.<sup>43</sup>

## SCHOOL SITES

Most school districts include multiple school sites, although there are some single-site districts. Principals oversee the day-to-day operations of a school site and lead their school communities.

As discussed above, COEs provide education directly to certain students, such as students with juvenile justice involvement or students who have been expelled from school, through “alternative education” programs, which are sometimes referred to as “county community schools” or “community day schools.”<sup>44</sup>

California also has approximately 1,300 charter schools.<sup>45</sup> Charter schools are publicly funded schools that operate much like traditional public schools, but their operation is based on approved charters that provide flexibility and exemption from certain laws.<sup>46</sup> Charter schools are generally considered their own

“LEAs” for the purposes of local policy making and budget autonomy.

California also has a small number of schools run directly by the state. These include schools that serve students who are blind or deaf, or in juvenile justice facilities, or schools whose performance of standardized student outcome measures has not improved with prior interventions or technical assistance.<sup>47</sup>

Collectively, California schools are staffed by approximately 300,000 full-time-equivalent teachers, and more than 300,000 other full-time-equivalent staff members.<sup>48</sup> This includes “certificated” staff holding [state credentials](#), such as administrators (e.g., principals, assistant principals) and pupil personnel services (PPS) staff (e.g., counselors, psychologists, speech pathologists) in addition to teachers, as well as “classified” staff who do not hold state credentials, such as support staff, janitors, and aides.<sup>49</sup>

## OTHER KEY PLAYERS IN K-12 EDUCATION

Professional unions and associations also play a powerful role in California’s public education system. These include the following:

- The [California Teachers Association](#) (CTA), a union of public school and community college teachers;
- The [California Federation of Teachers](#) (CFT), a teachers union affiliated with the national [American Federation of Teachers](#);
- The [California School Boards Association](#) (CSBA), an association representing elected officials leading school districts and COEs;
- The [California County Superintendents Educational Services Association](#) (CCSESA), an association of the 58 county superintendents of schools;
- The [Association of California School Administrators](#) (ACSA), an organization of school district superintendents and principals;
- The [California Association of School Counselors](#) (CASC);
- The [California Association of School Psychologists](#) (CASP); and
- The [California Association of School Social Workers](#) (CASSW).

At the school site level, another set of leadership bodies are school site councils (or “site councils”), which are comprised of teachers, parents, students,

and school staff, that support school planning, including developing and updating the School Plan for Student Achievement (SPSA).<sup>50</sup> Schools with 21 or more students who are English learners are also required to have an English Learner Advisory Committee (ELAC). The ELAC must include parents or guardians of English learners, and is responsible for advising on the development of English learner site plans and the schoolwide needs assessment, among other tasks.<sup>51</sup> School-level parent-educator groups, such as Parent-Teacher Associations (PTAs) and Parent-Teacher Organizations (PTOs), also play a central role in supporting schools and students, including through a school district’s Local Control and Accountability Plan process, discussed below.

## LOCAL CONTROL, SCHOOL FUNDING, AND ACCOUNTABILITY PLANS

California’s public education system represents a “local control” approach,<sup>52</sup> in which school districts and county education officials hold a high degree of local responsibility and autonomy. California’s [Education Code](#), the body of state laws governing California’s education system, is considered a “permissive” code. This generally means that school districts can undertake any program or activity that is consistent with their overall purposes and that is not prohibited, without needing to have specific statutory authority permitting it.<sup>53</sup>

California schools are funded through a combination of federal, state, and local sources, with state funds comprising the largest share.<sup>54</sup> State funding allocations are determined primarily through the [Local Control Funding Formula](#) (LCFF). Passage of the LCFF in 2013 represented a significant shift in California’s approach to school funding, from a categorical approach driven by state-directed grants to promote discrete goals, such as improving outcomes for pregnant and parenting youth, to a formula that allocates additional funds to LEAs that have higher percentages of high-needs youth.<sup>55</sup> Under the LCFF, LEAs are funded through “base” grants reflecting average daily attendance (ADA), plus “supplemental” and “concentration grants,” which are impacted by the unduplicated percentages of English learners, students eligible for free or reduced-price meals, homeless students, and students in foster care in the LEA.<sup>56</sup>

Historically, California’s per pupil education funding has been significantly below the national average.<sup>57</sup> For the 2021-22 academic year, schools will be receiving increased levels of funding, in comparison to what they

received in prior years, due in large part to an influx of federal COVID-response dollars.<sup>58</sup>

LEAs are required to develop [Local Control and Accountability Plans](#) (LCAPs), three-year roadmaps with annual updates, describing how they will use their funding and provide services to support students. The plans must be developed with public input from the broader school community, including students, parents, staff, and other community stakeholders, and must describe services that will be provided to support specific student subgroups, including students in foster care, students who are English Learners, and low-income students.<sup>59</sup> School district LCAPs are subject to approval by COEs, but the approval process is high-level and compliance-oriented. It focuses on three determining factors: whether the LCAP complies with the State Board of Education (SBE) LCAP template; whether the district's budget includes the expenditures needed to implement the LCAP; and whether the LCAP complies with the expenditure requirements specified in the California Education Code.<sup>60</sup> Even if a district's LCAP is approved, poor progress on performance outcomes as indicated through the [California Schools Dashboard](#) (discussed below) can trigger technical assistance from the COE or CCEE.<sup>61</sup>

## EDUCATION DATA SYSTEMS

School districts use web-based Student Information Systems (SIS) to track and manage data. Many SIS have "parent portals" that allow parents to access information regarding their child(ren), such as attendance and course grades, online.

The California Longitudinal Pupil Achievement Data System, or [CALPADS](#), is a statewide system that holds student data, such as demographic information, course information, discipline information, and assessment results. School districts submit student data to CALPADS, and the information is used for state and federal reporting purposes.<sup>62</sup>

The [California School Dashboard](#) is a publicly accessible online tool that provides performance data for districts, schools, and specific student subgroups based on a series of state and local performance indicators. These performance indicators are based on the priority areas under the LCFF.<sup>63</sup> Education data is also publicly available through CDE's [DataQuest](#) system, and through [EdData](#), a website provided through a partnership between CDE, FCMAT, and EdSource.<sup>64</sup>



## CALIFORNIA SCHOOL CLIMATE, HEALTH, AND LEARNING SURVEYS

[California School Climate, Health, and Learning Surveys](#) (CaSCHLS) is a collection of CDE-supported surveys for district use to assess and improve academics, school climate, student engagement, and parental involvement.

One component of CaSCHLS is the [California Healthy Kids Survey](#) (CHKS), a self-report survey tool based in resilience and youth development research that is used with students ages 10 and older. The CHKS assesses student connectedness, learning engagement/motivation and attendance; school climate, culture and conditions; school safety; physical and mental well-being and social-emotional learning; and student supports, including developmental factors for promoting resilience. During the 2019-20 and 2020-21 academic years, 662 school districts administered the CHKS to students.<sup>65</sup>

The [California School Staff Survey](#) (CSSS) and the [California School Parent Survey](#) (CSPS) seek information from staff and parents, respectively, about perceptions of learning and teaching.

The surveys are available [here](#), and reports and data are available [here](#).



# Mental Health in Schools

## IN THIS SECTION:

- ✓ School Mental Health Frameworks
- ✓ School Staff Providing Mental Health and Wellness Services
- ✓ IEPs and Mental Health
- ✓ 504 Plans and Mental Health
- ✓ School-Based Health Centers
- ✓ How SBHCs Work: Examples
- ✓ County-School Mental Health Partnerships
- ✓ CBO-School Partnerships
- ✓ MCPs and Schools
- ✓ Interdisciplinary Teams Supporting Mental Health Needs
- ✓ Community Schools Approach
- ✓ Other School-Based Mental Health and Wellness Programs
- ✓ Schools and Medi-Cal Financing
- ✓ Additional Considerations in School-Based Mental Health Service Delivery

**S**chools play a critical role in supporting the social, emotional, and mental health of California students. Below is an overview of school-based mental health services, supports, and structures, as well as related processes and important considerations impacting service delivery. It is important to note that each district that an MCP partners with may be working from a different starting point, may fund mental health at different levels, and may have unique ways of structuring, financing, and delivering services, including through existing relationships with county mental health plans and/or community-based providers. As a result, it is critical for each MCP to understand the specific landscape of each district with which they are partnering.



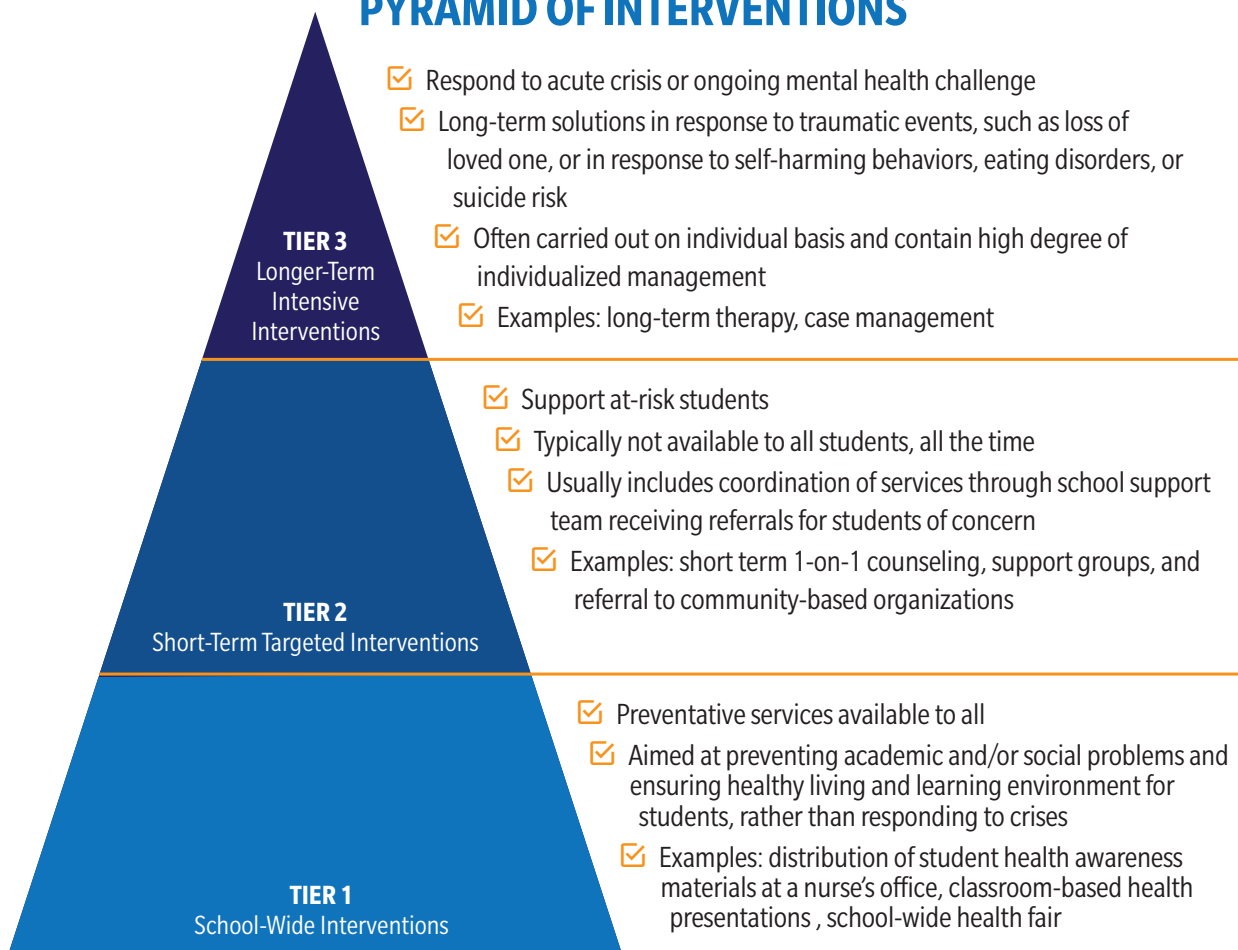
# SCHOOL MENTAL HEALTH FRAMEWORKS

## Multi-Tiered System of Support (MTSS)

In many schools, social, emotional, and mental health services and support for students are organized into a Multi-Tiered System of Support (MTSS) framework. CDE describes MTSS as “an integrated, comprehensive framework that focuses on [Common Core State Standards], core instruction, differentiated learning, student-centered learning, individualized student needs, and the alignment of systems necessary for all students’ academic, behavioral, and social success.”<sup>66</sup>

In a fully implemented MTSS framework, Tier 1 consists of universal, school-wide services, supports, and interventions made available for all students. Examples of school-wide supports include social-emotional learning, universal screenings, restorative justice, and the integration of trauma-informed practices into school and classroom environments. Tier 2 consists of short-term, targeted early interventions provided to a subset of students. Examples include student support groups and mentoring programs. Tier 3 consists of longer-term, intensive interventions provided to students with higher needs. Examples include Educationally Related Mental Health Services (ERMHS) provided to students with Individualized Education Programs (IEPs) or Section 504 accommodations plans (discussed below), individual therapy, and crisis intervention.<sup>67</sup> Note that in practice, given time and resource constraints and other barriers, the degree to which schools are implementing MTSS may vary, and some tiers may be more built-out than others.

## PYRAMID OF INTERVENTIONS



*MTSS is often conceptualized as a pyramid structure, with Tier 1 representing the base of the pyramid with universal services provided to students generally, Tier 2 representing the middle level of the pyramid with services provided to a subset of students, and Tier 3 representing the top of the pyramid, with services provided to a narrower subgroup of high-needs students.*

Graphic adapted with permission from the California School-Based Health Alliance (CSHA)

## Positive Behavioral Interventions and Supports (PBIS) and Interconnected Systems Framework (ISF)

Positive Behavioral Interventions and Supports (PBIS) is an evidence-based approach that “focuses on the emotional and behavioral learning of students, which leads to an increase in engagement and a decrease in problematic behavior over time.”<sup>68</sup> PBIS includes a continuum of supports and services intended to promote positive behavior, positive school climate, and academic success. It is used in approximately 3,000 California schools.<sup>69</sup> PBIS can be integrated into an MTSS framework, such as through the Interconnected Systems Framework (ISF) approach.<sup>70</sup>

MTSS is also generally understood to encompass Response to Intervention (RTI) / Response to Intervention and Instruction (RTI<sup>2</sup>), a tiered framework that promotes research-based screenings and interventions to support students who are struggling academically.<sup>71</sup> As CDE explains: “MTSS is a framework that brings together both RTI<sup>2</sup> and PBIS and aligns their supports to help serve the whole child.”<sup>72</sup> California is working to expand MTSS implementation through a statewide effort called Scaling Up MTSS Statewide (SUMS) Initiative, led by the Orange County Department of Education (OCDE).<sup>73</sup>

## SCHOOL STAFF PROVIDING MENTAL HEALTH AND WELLNESS SERVICES

Many schools directly employ staff with Pupil Personnel Services (PPS) credentials, awarded by the [California Commission on Teacher Credentialing](#) (CTC), to support students’ mental health and wellness. PPS-credentialed staff may specialize in four areas: school counseling, school psychology, school social work, or child welfare and attendance.<sup>74</sup> Their roles can be broadly described as addressing the academic, special education, environmental, and attendance barriers students may experience.

School counselors’ credentials allow them to develop and implement school counseling and guidance programs addressing academic, career, personal and social development needs; advocate on academic and social issues; offer schoolwide prevention, intervention, and counseling services; and train and support teachers and parents around how best to meet students’ needs.<sup>75</sup>

School psychologists’ credentials allow them to provide services to enhance academic performance; address

adjustment issues that students are experiencing; provide consultations on social development and behavioral and academic issues; provide psycho-educational assessments for identification of students’ special education needs; provide individual, group, and family counseling, and coordinate interventions in the event of student or school-wide crisis situations.<sup>76</sup>

School social workers’ credentials allow them to assess a variety of factors impacting student learning (school, home, personal, and community); offer interventions such as counseling, case management, and crisis intervention; provide consultations regarding students’ social-emotional needs; and coordinate additional resources for students as needed.<sup>77</sup>

School child welfare and attendance specialists hold responsibilities relating to promoting school attendance and academic success.<sup>78</sup>

A list of specific requirements for receiving each type of PPS credential is available [here](#).

In some instances, LEAs directly hire community providers who do not hold PPS credentials— such as Licensed Clinical Social Workers (LCSW) or Licensed Marriage and Family Therapists (LMFT), whose licenses are instead regulated by the California Board of Behavioral Sciences—though there are challenges to doing so, including ensuring appropriate supervision for their school-based work.<sup>79</sup>

In addition, some schools employ CTC-credentialed school nurses, who hold an R.N. license and can assess students’ health and developmental status, make referrals to community resources, implement health education, and provide related services, and licensed vocational nurses (LVNs) working under the direction of a school nurse.<sup>80</sup>

The presence of school counselors on campuses is connected to improved academic outcomes, reduction of suicide risk factors, and improved discipline and attendance.<sup>81</sup> Yet the number of counselors and other school mental health professionals currently employed by schools is inadequate. Based on recommendations created decades ago by national professional associations, CDE advises a ratio of one school counselor for every 250 students, as well as ratios of one school psychologist for every 1,000 students, one social worker for every 800 students, and one nurse for every 750 students, respectively.<sup>82</sup> As of 2019, the reported ratios statewide were one counselor for every 626 students, one psychologist for every 1,041 students,



one social worker for every 7,308 students, and one school nurse for every 2,410 students.<sup>83</sup> California’s student-to-counselor ratio is the fifth-highest in the United States,<sup>84</sup> and the state auditor has reported that approximately 25% of LEAs do not employ any mental health professional.<sup>85</sup>

Given these numbers, school-employed mental health staff often operate in administrative and crisis-response capacities on school campuses. Even if California’s schools met all of the minimum recommended staffing ratios referenced above, such staffing would not put schools in a position to meet all of the ongoing clinical needs of students. Consequently, as discussed in detail below, many schools form partnerships with outside mental health providers (who are not school employees) to offer students mental health services. This may involve co-locating those providers at school sites or linking students to community-based providers off-site.<sup>86</sup>

*For more information about school-based mental health staffing, see this [resource](#) from the California School-Based Health Alliance (CSHA) and this [resource](#) from the California Association of School Psychologists (CASP).*

## IEPS AND MENTAL HEALTH

Some students receive school-based mental health services in connection with their special education needs. The [Individuals with Disabilities Education Act](#) (IDEA) is a federal law that ensures children with disabilities receive a free appropriate public education (FAPE) in the least restrictive environment (LRE), and receive special education and related services “designed to meet their unique needs and prepare them for further education, employment, and independent living.”<sup>87</sup> Students must be provided with an educational plan and services that allow them to make appropriate educational progress.<sup>88</sup> The IDEA was originally signed into law as the Education for All Handicapped Children Act in 1975.<sup>89</sup> IDEA Part B provides for special education and related services for children ages 3 through 21, while IDEA Part C provides for early intervention services for infants and toddlers.<sup>90</sup> During a given school year, approximately 795,000 California children and youth receive special education services.<sup>91</sup>

Under the IDEA, LEAs have a proactive obligation (called the “child find” obligation) to identify and evaluate students with disabilities in need of special education and related services.<sup>92</sup> Students may also be referred for evaluation by parents, teachers, or others. When a school receives a written request for assessment, it has 15 days to respond by providing an assessment plan or a denial of the request.<sup>93</sup> Once the student’s parent or education rights holder agrees to the assessment plan, the school has an additional 60 days to conduct the assessment and convene an

individualized education program (IEP) team meeting.<sup>94</sup> One type of assessment used is a psychoeducational evaluation, which examines the students' mental process in connection with their educational performance, and may lead to the identification of any learning disabilities the student is experiencing.

Qualifying disabilities for special education include intellectual disability, hearing impairment (including deafness), speech or language impairment, visual impairment (including blindness), orthopedic impairment, autism, traumatic brain injury, other health impairment, specific learning disability, deaf-blindness, multiple disabilities, developmental delay (for certain ages), or emotional disturbance (ED).<sup>95</sup> A student can qualify based on ED if they have an inability to learn that is not explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships; exhibit inappropriate behaviors or feelings in normal circumstances; exhibit a general pervasive mood of unhappiness or depression; or show a tendency to develop physical symptoms or fears, and this is present "over a long period of time" and has an adverse effect on their educational performance.<sup>96</sup>

Note that the standard for qualifying for special education services based on ED is different from the medical necessity standard for receiving mental health services under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.<sup>97</sup> This is consistent with the specific focus of the IDEA: to ensure that students with disabilities can fully participate in school and progress educationally. It is possible for a student to be entitled to Medi-Cal mental health services but not be found eligible for special education on the basis of ED, if there is no impact on their education, as described above.

When a student is found to be eligible for special education, their needs, goals, school placement, plans for specialized instruction, and plans for the related services that they will receive to allow them to make educational progress are documented in an individualized education program (IEP).<sup>98</sup> IEPs are developed collaboratively by a team that includes the student's parents, teachers, and district/school staff. As noted above, the IDEA requires that children be placed in the least restrictive environment, or LRE; the more time a child spends outside of a general education classroom with nondisabled students, the more restrictive their environment is considered to be. Most school-age California students receiving special

education services are placed in mainstream (general education) classrooms, and either receive special education services in those classrooms or receive "pull-out" services outside of their classrooms.<sup>99</sup> Others with more severe disabilities are placed in special day classes to receive specialized instruction with other students with disabilities, or spend a portion of their time in mainstream classrooms and a portion in special day classes.<sup>100</sup> A very small percentage attend separate schools that only serve students with disabilities, such as non-public schools (NPS) or residential treatment programs.<sup>101</sup> IEPs may also include a variety of services, ranging from specialized academic instruction to physical therapy to Educationally Related Mental Health Services (ERMHS). Examples of ERMHS include psychological services, social work services, and counseling services.<sup>102</sup>

Historically, school districts and county mental health agencies in California were jointly responsible for providing ERMHS (previously "AB 3632 services") to students to meet their special education needs under the IDEA; however, in 2011, California policy changed through [AB 114](#), and school districts now hold that responsibility.<sup>103</sup> Districts provide ERMHS in a variety of ways, including by hiring their own mental health staff to deliver the services, contracting with county mental health agencies, contracting with community-based organizations (CBOs), and/or contracting with other qualified professionals in the community.<sup>104</sup> As discussed earlier, SELPAs play an important role in the funding and coordination of special education service delivery.<sup>105</sup> When preparing for district partnerships, it is important for MCPs to understand how each of the individual districts they will be working with currently provide mental health services to students with IEPs.

As discussed below in the section on Medi-Cal Financing, LEAs can seek Medicaid reimbursement (federal share) for medically necessary services provided to students on Medi-Cal, including those that are provided pursuant to IEPs. However, the obligation to provide students with IEP services is governed by the IDEA and is not contingent on receipt of Medicaid funding.<sup>106</sup>

## 504 PLANS AND MENTAL HEALTH

Section 504 of the federal Rehabilitation Act of 1973 protects people with disabilities—defined here as a physical or mental impairment, such as a mental illness, which substantially limits one or more major life activities—from discrimination on the basis of their disability.<sup>107</sup> Disability includes, but is not limited to, “any mental or psychological disorder, such as... emotional or mental illness.”<sup>108</sup> Under Section 504, schools must provide students with disabilities with a Free and Appropriate Public Education (FAPE), including educational services, aids, and accommodations that meet their individual needs, to the same extent that the needs of students without disabilities are met, so that they can access education.<sup>109</sup> This may include providing the student with specific accommodations to enable their learning; examples include extended time to complete assignments or exams, modified textbooks, use of visual aids, behavior management support, preferential seating in the classroom, or time to regroup or “cool down” when feeling anxious. Students eligible for 504 plans can also receive ERMHS, such as counseling and psychological services. Like IEPs, 504 plans are documented in writing and must be periodically reviewed and re-evaluated to ensure they are meeting the student’s current needs.<sup>110</sup> This document and set of accommodations is sometimes referred to as a “504 plan,” a “504 accommodations plan,” or simply a “504.”

IEPs and 504 Plans are similar in some ways, and are often confused. But they stem from different federal laws (the IDEA and Section 504 of the Rehabilitation Act, respectively), and differ in other important ways.<sup>111</sup> Because the Section 504 definition of disability is broader than the IDEA definition of disability, some students qualify for a 504 Plan but not for an IEP.<sup>112</sup> Procedurally, the IDEA/IEP process also involves more rules and safeguards than the more flexible 504 process.<sup>113</sup> IDEA also provides federal funding to states to assist in serving students, whereas Section 504 does not provide such funding.<sup>114</sup>

ERMHS provided through IEPs and/or 504 plans are a critical component of school-based mental health. However, these services reach only a subset of students in need of mental health support. California schools are implementing a number of other strategies to support their students, described below.

## SCHOOL-BASED HEALTH CENTERS

California has nearly 300 school-based health centers (SBHCs), health clinics that are located on or close to school campuses.<sup>115</sup> There are SBHCs in 35 of the state’s 58 counties, with high concentrations in the Los Angeles and San Francisco Bay areas.<sup>116</sup> SBHCs provide students with access to a wide range of health care services and can function as a student’s “home base” for health care. Most SBHCs provide integrated behavioral health with physical health services, a model of care that brings together clinicians to address the whole-health needs of students and identify treatable conditions early.<sup>117</sup> Research shows that the presence of SBHCs increases students’ access to mental health care.<sup>118</sup>

About half of California SBHCs are operated by Federally Qualified Health Centers (FQHCs) (community-based health centers that provide primary care to underserved populations), about a quarter are operated by school districts, and the remainder are operated by other entities such as hospitals or health departments.<sup>119</sup> SBHCs can be funded through a combination of sources. Those that are led by licensed health care providers may bill both public and private health insurance, including Medi-Cal, for reimbursement.<sup>120</sup> Most organizations that operate SBHCs, particularly FQHCs and hospitals, have contracts with Medi-Cal managed care plans so they can provide physical and mental health services to school age children on Medi-Cal, most of whom are enrolled in a Medi-Cal managed care plan, and can seek Medi-Cal reimbursement from those plans.<sup>121</sup>

A list of SBHCs by county, including information about types of services provided at each, is available [here](#), and in-depth profiles of specific SBHCs prepared by the California School-Based Health Alliance (CSHA) are available [here](#). Note that the specific terminology used for SBHCs may vary from district to district. For example, San Francisco Unified School District has several school-based “[wellness centers](#)” that offer, among other services, therapeutic groups, individual case management, and school-based counseling and therapy services.<sup>122</sup> Other SBHCs may be referred to as “health centers” or “clinics,” for example.

*To learn more about SBHCs, see the [Resources](#) page of the CSHA website, which provides detailed information about SBHC funding, operations, and outcomes.*



## HOW SBHCS WORK: EXAMPLES

### MADERA SOUTH SCHOOL-BASED HEALTH CENTER

**LOCATION:** Madera County

**LEAD AGENCY:** Camarena Health, a federally qualified health center (FQHC) serving families and communities in Madera, Chowchilla, and Oakhurst.

Examples of behavioral health services provided:

- **Schoolwide**—Trainings with school staff on how to identify student behavioral health needs and refer to the SBHC; behavioral health campaigns around reducing mental health stigma, suicide prevention, and how to access services on campus.
- **Targeted**—Trainings for small groups of students participating in health pathway classrooms and peer counseling groups.
- **Intensive**—One-on-one counseling services with licensed clinical social workers; referrals to county agencies that provide specialty mental health services and access to telepsychiatry for more intense behavioral health needs.

#### COORDINATION WITH SCHOOLS AND COUNTY

**BEHAVIORAL HEALTH:** SBHC staff work closely with school counselors and facilitate “warm hand-offs” to connect identified students with services through the SBHC. Through these warm hand-offs, almost 100% of students follow-up for care. Camarena also has a track record of coordinating care for patients with county health and social services departments. Through these trusted relationships with county departments and schools, Camarena has helped bridge coordination between the entities to support school-based mental health services. Through the county’s Mental Health Student Services Act grant, Camarena provides care coordinators at schools throughout the county to connect students to behavioral health services through SBHCs or other providers.

**MEDI-CAL MANAGED CARE:** Camarena is a contracted provider with the two Medi-Cal Managed Care Plans in the county and a majority of the reimbursements for services provided at the SBHC are through Medi-Cal billing. Most of the

adolescent patients served by Camarena come through the SBHC sites and 90% of child and adolescent patients served at the SBHC in 2020 were on Medi-Cal. Camarena also works closely with Medi-Cal MCPs through incentive programs to improve patient outcomes.

### MONROE HIGH SCHOOL WELLNESS CENTER

**LOCATION:** San Fernando Valley in Los Angeles County

**PARTNERS:** Child & Family Guidance Center (CFG) provides school and community-based specialty mental health services through a contract with LA County’s Department of Mental Health. Valley Community Healthcare is a federally qualified health center and provides medical care and some behavioral health care. Warm handoffs for primary care and mental health services occur between the two organizations (and with the school).

Examples of behavioral health services provided:

- **Schoolwide**—Parent trainings on youth substance use; tabling events on various mental health concerns such as suicidality and self-harm; building awareness on grief and loss issues during campus-wide “Day of the Dead activities.”
- **Targeted**—Consultation with student advisory boards (i.e. health squad) on mental health awareness activities and trainings; group therapy if warranted (e.g. creative arts, LGBTQ youth, newcomers).
- **Intensive**—Individual and family therapy (e.g. functional family therapy, dialectical behavior therapy) for Medi-Cal covered students meeting medical necessity, with adjunctive services such as case management, psychiatry, psychological testing, and therapeutic behavioral services to support students and families.

*\*Content provided by the California School-Based Health Alliance.*

## COUNTY-SCHOOL MENTAL HEALTH PARTNERSHIPS

A growing number of school districts have partnerships with county mental health plans (MHPs, which are typically managed by the county behavioral health agency) to provide services to students. There are several possible ways to structure these relationships. For example, a county mental health plan may co-locate its staff at school sites to provide services to students; a school might function as an approved, contracted provider of specialty mental health services (SMHS) through an agreement with the county mental health plan; or a county mental health plan may contract services out to a community provider operating a school-based health center (SBHC) or co-located at a school site.<sup>123</sup>

A matrix summarizing examples of county-school mental health partnerships in seven California counties, developed by the California School-Based Health Alliance, CDE, and other partners, is available [here](#).

One important and growing source of support for school-county partners are grants administered by California's [Mental Health Services Oversight and Accountability Commission](#) (MHSOAC). In 2004, California voters passed the [Mental Health Services Act](#) (MHSA) (Proposition 63) to fund improved mental health care for people of all ages. Many MHSA Prevention and Early Intervention (PEI) grants given to county mental health agencies support school-based mental health staff and interventions.<sup>124</sup> Counties are required to have three-year spending plans for all components of their MHSA funding (including PEI), in addition to annual updates, that are open to public input.<sup>125</sup> County PEI funds are typically used as part of a braided funding strategy with Medi-Cal, intended to expand services to a broader student population,<sup>126</sup> though they can also be used to fund innovative programs that meet the needs of a school or student community, such as universal school climate or prevention efforts.<sup>127</sup>

The state's MHSOAC also administers the Mental Health Wellness Act (SB 82, enacted in 2013), which was amended in 2016 to provide "Triage" grants for crisis intervention for children and youth; this resulted in grants to four school-county partnerships and four agencies operating school-based programs.<sup>128</sup>

During the 2019-20 state budget cycle, the state established the [Mental Health Student Services Act](#) (MHSSA), a MHSOAC-administered statewide grant

program that supports LEA-county behavioral health agency partnerships in schools, including provision of school-based services, suicide prevention, drop-out prevention, placement assistance, and development of service plans, and outreach to students at high risk.<sup>129</sup> In 2020, MHSOAC awarded MHSSA grants to 10 [counties](#) with existing school mental health partnerships (totaling \$45 million) and eight counties with new or emerging partnerships (totaling \$30 million). The 2020-21 state budget provides \$205 million in funding for additional MHSSA-supported partnerships, signaling a continued and growing investment in county-school mental health partnerships.<sup>130</sup>

School districts can also partner with Public Health Departments to claim [Targeted Case Management services](#) (TCM) and [County-Based Medi-Cal Administrative Activities](#) (CMAA), though most are not doing so at this time.<sup>131</sup>

## CBO-SCHOOL PARTNERSHIPS

Many schools provide mental health services through partnerships with community-based organizations (CBOs). CBOs might be co-located at school sites as approved, contracted providers with county MHPs or MCPs, or through direct contracts with schools or LEAs.<sup>132</sup> Under such models, the CBOs typically provide direct services through their staff and manage all related administrative and billing work.<sup>133</sup>

*For additional information and examples of CBO-school partnerships, see CCT's [Practical Guide for Financing Social, Emotional and Mental Health in Schools](#).*

## MCPS AND SCHOOLS

Historically, schools and MCPs have not engaged in robust partnerships to provide school-based mental health.<sup>134</sup> However, a number of Federally Qualified Health Centers (FQHCs) that run School-Based Health Centers (SBHCs) have contracts with MCPs to provide mental health services. While there are some instances of schools partnering with plans and being directly reimbursed for limited services provided to members, this remains exceedingly rare.<sup>135</sup>

As discussed earlier in this document, California's 2021-22 budget creates a new Children and Youth Behavioral Health Initiative (CYBHI) with several components, including a nearly \$400 million program to incentivize MCP-school-county partnerships.<sup>136</sup> This provides an unprecedented opportunity for MCPs to develop and deepen partnerships with schools to expand the reach and impact of mental health services for students.



## INTERDISCIPLINARY TEAMS SUPPORTING MENTAL HEALTH NEEDS

In addition to IEP teams (discussed above), school staff may participate in other types of interdisciplinary teams that play a role in supporting the social, emotional, and mental health needs of students.

[Multidisciplinary Teams](#) (MDTs) are cross-agency teams that allow for the sharing of information to prevent child abuse or neglect, and can include medical providers, law enforcement, child welfare agency staff, and school staff. MDTs may also be formed to support specific subgroups of youth.<sup>137</sup>

[Child and Family Teams](#) (CFTs) are family-centered teams to support children and youth in the dependency system.<sup>138</sup> Team members may include the youth, family members, medical and mental health providers, educators, staff from social services and probation agencies, and other supportive adults in the youth's life.<sup>139</sup> CFTs drive the youth's case plan and service plan and address their needs, including those related to mental health. CFT meetings take place within 60 days of the date a child or youth enters foster care, and at least every six months thereafter (or, for youth receiving *Katie A.* services, every 90 days), and at certain transition points such as changes in placements, or when barriers to care arise.<sup>140</sup>

[Coordination of Services Teams](#) (COST) are multidisciplinary teams that support students' learning and development through a system of regular meetings, referrals, and linkages to individualized interventions and resources, including universal preventive supports.<sup>141</sup> The COST process includes a schoolwide referral system, a process for intake and assessment of needs, regular team meetings, service delivery through collaboration, and a process for tracking and evaluation. Individual schools may adapt the model to fit their individual needs.<sup>142</sup> Services include, but are not limited to, services to address social, emotional, and mental health needs, such as counseling, and include services provided within the school site as well as outside referrals.<sup>143</sup> Team members may include administrators and educators, school nurses, school psychologists, social workers, clinical case managers, parent representatives, staff from SBHCs, and others.<sup>144</sup> Teams based on the COST model may also be referred to as CARE Teams, Star Teams, Coordinated Services Teams, or Student Assistance Programs.<sup>145</sup>



## COMMUNITY SCHOOLS APPROACH

As noted above, California has an increasing number of school districts implementing a “community schools” approach.<sup>146</sup> Community schools aim to function as local support hubs, connecting students and families to resources and services in a trusting and collaborative setting that is relationship-centered. The key evidence-based components of community schools are: (1) integrated student support services (for which Medi-Cal is one potential funder), which may include school-based mental and physical health care and supports, social-emotional learning, trauma-informed care, and restorative justice practices; (2) family and community engagement; (3) collaborative approaches to leadership and practice; and (4) extended learning time beyond the typical school day.<sup>147</sup> Each community school has a unique set of programs and services based on local assets and needs, often facilitated by a full-time coordinator. (See [here](#) for examples of this work happening in Los Angeles County and Alameda County).<sup>148</sup> The MTSS and COST strategies described above can help partners to coordinate, target, and deploy their resources effectively at school sites. California's 2021-22 budget allocates approximately \$2.8 billion to a statewide initiative to support and expand community schools.<sup>149</sup> Further, federal recovery funds going directly to LEAs can also be used to support community schools.<sup>150</sup>

## OTHER SCHOOL-BASED MENTAL HEALTH AND WELLNESS PROGRAMS

### *Suicide Prevention Programs*

State law requires LEAs to adopt suicide prevention, intervention, and postvention policies, developed in consultation with suicide prevention experts, school mental health professionals, and other stakeholders.<sup>151</sup> The plans must specifically address high-risk students, including youth bereaved by suicide, youth with disabilities, mental illness, or substance abuse disorders, youth experiencing homelessness, youth in foster care, and LGBTQ youth.<sup>152</sup> CDE collaborated with the state-level Student Mental Health Policy Workgroup to develop a model youth suicide prevention policy for school boards to consider and adopt; the model policy is available through this [page](#), along with related resources and a link to an online suicide prevention training that CDE provides to LEAs who wish to use it as part of their prevention policy. However, a state audit reviewed a small subset of LEAs and found that they had not adopted adequate suicide prevention responses.<sup>153</sup>

Schools serving students in Grades 7-12 (as well as higher education institutions) that issue student identification cards are also required to include on those cards contact information for national and local suicide prevention hotlines and the Crisis Text Line.<sup>154</sup>

### *Restorative Justice Programs*

Some schools have begun to implement restorative justice programs—an alternative to punitive school discipline practices such as expulsions and suspensions—that aim to resolve conflicts within schools and promote healthy relationships through positive, trauma-informed practices. This typically involves implementing practices such as restorative justice circles or mediation. Examples of school-based restorative justice include programs at [Oakland Unified School District](#) (OUSD), [San Diego Unified School District](#) (SDUSD), and [Los Angeles Unified School District](#) (LAUSD). Between the 2011-12 and 2017-18 academic years, these districts experienced a 48% (OUSD), 41% (SDUSD), and 76% (LAUSD) decline in suspensions attributed to implementation of restorative approaches in combination with other reforms.<sup>155</sup>

### *Social-Emotional Learning*

Social-Emotional Learning (SEL) refers to education that helps students develop social and emotional skills and strategies for school and life, such as relationship-building, goal-setting, responsible decision-making, and understanding emotions and empathy.<sup>156</sup> Many California school districts have integrated SEL into classroom learning, and the state recently launched an initiative to expand collaboration on SEL across the state.<sup>157</sup> For an example of SEL integrated into an elementary classroom setting, see this [brief](#).

### *Trauma-Informed Practices*

Schools are increasingly recognizing the impact that experiencing trauma can have on a child’s educational engagement and learning, and incorporating trauma-informed practices into school and classroom environments. Under a trauma-informed or trauma-sensitive schools model, “all aspects of the educational environment—from workforce training to engagement with students and families to procedures and policies—are grounded in an understanding of trauma and its impact and are designed to promote resilience for all.”<sup>158</sup> Specific examples of trauma-informed practices in classrooms include creating a sense of safety by providing predictable, consistent schedules and routines and notifying students in advance about any scheduling changes and staying aware of environmental triggers, such as loud noises, that may cause a child stress.<sup>159</sup>

### *Student-Led Mental Health Groups*

Youth themselves have a powerful role to play in promoting mental health and wellness on school campuses. Some California schools have student-led clubs or groups that focus on mental health and wellness. One example is [NAMI On Campus](#), a collection of high school clubs that “tackle mental health issues... by raising mental health awareness, educating the community, supporting students, promoting services, and advocating for more support.”<sup>160</sup> Another example is [Bring Change to Mind](#) (BC2M), a collection of student clubs that aim “to erase the stigma around mental illness by increasing awareness and education, fostering student empowerment, building mentoring opportunities, and encouraging youth to challenge the misconceptions that so commonly surround mental health conditions.”<sup>161</sup> These groups mirror evidence-based peer-support models and intervention strategies in the adult mental health system.



## SCHOOLS AND MEDI-CAL FINANCING

As discussed above, LEAs may have partnerships with Medi-Cal-billing entities, or may be contracted providers of Medi-Cal services (e.g. through contracts with a county mental health plan). LEAs may also be direct billers of Medi-Cal dollars.<sup>162</sup>

### **Local Education Agency Billing Option Program (LEA-BOP)**

School districts, COEs, and SELPAs can bill the California Department of Health Care Services (DHCS) for the federal share of the cost of mental health services they provide through the [Local Education Agency Billing Option Program](#) (LEA-BOP), a cost reimbursement program. To qualify, services must be provided to an eligible student (i.e. a student enrolled in Medi-Cal), must be medically necessary, and must be delivered by an eligible Medi-Cal enrolled provider.<sup>163</sup> Examples of billable services include psychosocial assessments and individual and group psychology and counseling treatments.<sup>164</sup> LEAs can provide the services directly (by employing eligible providers) or through providers who are contracted with the LEA.<sup>165</sup>

Currently, fewer than half of California school districts participate in the LEA-BOP, in part due to administrative and billing challenges, but there are opportunities for growth.<sup>166</sup> Previously, reimbursement through the LEA-BOP was limited to services provided to

eligible students receiving special education services. However, through a 2020 federally-approved State Plan Amendment (SPA), California expanded its LEA-BOP to include reimbursement for services provided to general education students enrolled in Medi-Cal (not only students receiving special education services) and to include additional providers and services, creating potential for expanded use of the LEA-BOP.<sup>167</sup> An example of a school district that participates in the LEA-BOP is LAUSD.<sup>168</sup>

### **School-Based Medi-Cal Administrative Activities Program (SMAA)**

LEAs can also bill for the federal share of reimbursement for administrative costs through the [School-Based Medi-Cal Administrative Activities](#) (SMAA) program. This program provides 50% reimbursement for activities such as outreach to students, referral and care coordination, facilitation of Medi-Cal applications, arrangement of non-emergency/non-medical transportation, program planning, policy development, and claims coordination.<sup>169</sup>

### **SELPAs and COEs as Intermediaries and Collaborators**

SELPAs can also serve as intermediaries for school districts' Medi-Cal contracts and billing, and may be able to achieve scaled efficiencies by pooling resources across districts, such as by contracting out to CBOs, or by providing services themselves.<sup>170</sup> Some COEs also provide professional development, coordination, and other support related to mental health.<sup>171</sup>

*For more detailed information about Medi-Cal financing of school-based mental health services, see CCT's [Practical Guide for Financing Social, Emotional, and Mental Health in Schools](#).*

## ADDITIONAL CONSIDERATIONS IN SCHOOL-BASED MENTAL HEALTH SERVICE DELIVERY

### **Telehealth Services**

Some schools were implementing telehealth services—use of technology to provide remote health care service delivery—long before the COVID-19 pandemic began.<sup>172</sup> Often, pre-pandemic, this meant a student was physically in a school setting with a nurse or aid and connected virtually to a health care provider who was not physically present.<sup>173</sup> During the school

closures in 2020 and 2021, when new barriers arose to in-person care, many more schools embraced the use of telehealth as a primary means of service delivery to support students' mental health needs.<sup>174</sup>

While telehealth significantly expands access to care for many students, it is important to keep in mind that it does not eliminate inequities in access to care. For example, some students may not have adequate internet connectivity or devices needed to access services. Others may not have a safe space in their homes to have a confidential conversation with a mental health provider. And others simply may not feel they can connect with a provider who is not in the same physical space with them. Lack of interpretation and language support may also be a barrier for students who are English learners. Ideally students should have access to both in-person and virtual options for school-based mental health support.

*For more information about use of telehealth delivery mental health services during the pandemic and moving forward, including best practices and factors to consider in implementation, see resources from the California Children's Trust available [at this link](#).*

### **Information-Sharing: HIPAA and FERPA**

School-based mental health involves many questions regarding confidentiality and information-sharing. Confidentiality and information-sharing laws have implications for early referral and identification, continuing service delivery, and outcomes and evaluation. Each of the interdisciplinary teams described above, for example, need to consider who is involved, what information they wish to share, and the applicable laws, and then determine what release of information forms and policies may be needed.

One key question is determining whether information is governed by the [Family Educational Rights and Privacy Act \(FERPA\)](#) or the [Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#), and which state confidentiality laws may apply. A federal law that applies to any elementary, secondary, or post-secondary school that receives federal education funding, FERPA governs the sharing of information from a student's education record. HIPAA is a federal law that protects the privacy of patient health information held by "covered entities." Records can be subject to FERPA or HIPAA, but never to both simultaneously.

Generally, school health records created by a provider who is a school employee or agent are covered by FERPA, while records created by an outside provider that is a "covered entity" are covered by HIPAA; however, it is important to carefully consider with legal counsel the particular situation and what its implications are for specific scenarios and questions. For in-depth information about FERPA, HIPAA, California confidentiality laws, and school-based mental health services, see this [primer](#), this [flow-chart](#), and this [web-based tool](#).

### **Consents**

School-based mental health care also involves questions regarding consent. There are a few different types of consent, including: (1) consent to treatment/services; (2) consent (or authorization) to release of information; and (3) consent to insurance billing. It is important to distinguish between them because there are different legal requirements for each—including whether the consent must be written, who may provide consent, and what elements or language the consent must include.

For consent to treatment, in general a parent or guardian must provide consent for medical services for children and youth under age eighteen. However, in California, minors ages 12 and older may consent to their own outpatient mental health services under certain circumstances defined by law.<sup>175</sup> For detailed information regarding California's minor consent laws, see this [resource page](#).

Processes and forms for obtaining consent to release of information must comply with HIPAA or FERPA (depending on which federal information-sharing law applies) and applicable state law. It is quite possible for someone to have authority to consent to services for a minor but not have authority to sign a release of health information related to that care. For a summary of who may sign an authorization to release information under FERPA and HIPAA, see this [resource](#). For a list of mandatory requirements for release of information forms under FERPA, HIPAA, and state law, see Appendix B of this [resource](#).

## Appendix A: Where to Learn More

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California Children's Trust, Practical Guide for Financing Social, Emotional, and Mental Health in Schools:

<https://cachildrenstrust.org/wp-content/uploads/2020/08/practicalguide.pdf>

California Department of Education, California School Dashboard: <https://www.caschooldashboard.org/>

California Department of Education, California Healthy Kids Survey: <https://calschls.org/about/the-surveys/#chks>

California Department of Education, Mental Health Resources: <https://www.cde.ca.gov/ls/cg/mh/mhresources.asp>

California School-Based Health Alliance, Resources for Health Providers: <https://www.schoolhealthcenters.org/resources/start-an-sbhc/resources-for-provider/>

California School-Based Health Alliance, Student Mental Health Implementation Guide: [http://www.schoolhealthcenters.org/wp-content/uploads/2021/01/CA-SMH-Implementation-Guide.pdf?mc\\_cid=492f479b04&mc\\_eid=897c21380d](http://www.schoolhealthcenters.org/wp-content/uploads/2021/01/CA-SMH-Implementation-Guide.pdf?mc_cid=492f479b04&mc_eid=897c21380d)

California School-Based Health Alliance, School-Based Health Centers: Central to Addressing Child and Youth Behavioral Health in Schools: <http://cshca-wpengine.netdna-ssl.com/wp-content/uploads/2021/06/SBHCs-Behavioral-Health-Recommendations-for-DHCS.pdf>

California School-Based Health Alliance, Sustaining and Growing Behavioral Health Services at School-Based Health Centers (2021): <http://www.schoolhealthcenters.org/wp-content/uploads/2021/08/CSHA-IBH-Sustainability-Guide-2021.pdf>

California State Auditor, Report 2019-125, Youth Suicide Prevention: Local Educational Agencies Lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self-Harm, Sept. 2020: <https://auditor.ca.gov/pdfs/reports/2019-125.pdf>

California School-Based Health Alliance HIPAA/FERPA Guide for School-Based Health: <https://www.schoolhealthcenters.org/resources/sbhc-operations/student-records-consent-and-confidentiality/california-guide/faq/hipaa-and-ferpa/>

Center for Healthy Schools and Communities, Alameda County Health Care Services Agenda, Coordination of Services Team Guide, 2020: [https://achealthyschools.org/wp-content/uploads/2020/05/149\\_01\\_COST\\_Guide\\_email.pdf](https://achealthyschools.org/wp-content/uploads/2020/05/149_01_COST_Guide_email.pdf)

Glossary of Education Reform: <https://www.edglossary.org/>

Healthy Schools Campaign, A Guide to Expanding Medicaid-Funded School Health Services: <https://healthyschoolscampaign.org/wp-content/uploads/2019/12/A-Guide-to-Expanding-Medicaid-Funded-School-Health-Services-12-19-19.pdf>

Legislative Analyst's Office, California's Education System: A 2019 Guide: <https://lao.ca.gov/Publications/Detail/3924>

Legislative Analyst's Office, K-12 Education in Context: <https://lao.ca.gov/Publications/Report/3736>

Mental Health Services Oversight & Accountability Commission, Every Young Heart and Mind: Schools as Centers of Wellness, 2020: [https://mhsoc.ca.gov/sites/default/files/schools\\_as\\_centers\\_of\\_wellness\\_final.pdf](https://mhsoc.ca.gov/sites/default/files/schools_as_centers_of_wellness_final.pdf)

National Health Law Program, National Center for Youth Law and California Children's Trust, Meeting the Moment: Understanding EPSDT and Improving Implementation in California to Address Growing Mental Health Needs: [https://cachildrenstrust.org/wp-content/uploads/2021/01/Meeting-the-Moment\\_FINAL.pdf](https://cachildrenstrust.org/wp-content/uploads/2021/01/Meeting-the-Moment_FINAL.pdf)

The Children's Partnership, Advancing the Adoption of Telehealth in Child Care Centers and Schools to Promote Children's Health and Well Being, 2018: <https://childrenspartnership.org/research/telehealth-report/>

The Children's Partnership, First 5 Center for Children's Policy, Addressing Infant and Early Childhood Mental Health Needs: Opportunities for Community Solutions, 2021: <https://childrenspartnership.org/wp-content/uploads/2021/10/IECMH-Report-FINAL.pdf>

## Appendix B: Education and School Health Acronyms

<b>ACSA</b>	Association of California School Administrators	<b>CTA</b>	California Teachers Association
<b>ADA</b>	Average Daily Attendance	<b>CTC</b>	Commission on Teacher Credentialing
<b>CALPADS</b>	California Longitudinal Pupil Achievement Data System	<b>CCSESA</b>	California County Superintendents Educational Services Association
<b>CalSCHLS</b>	California School Climate, Health, and Learning Surveys	<b>CSBA</b>	California School Board Association
<b>CASC</b>	California Association of School Counselors	<b>CSPS</b>	California School Parent Survey
<b>CASP</b>	California Association of School Psychologists	<b>CSSS</b>	California School Staff Survey
<b>CBO</b>	Community-Based Organization	<b>ED</b>	Emotional Disturbance
<b>CCEE</b>	California Collaborative for Educational Excellence	<b>ELAC</b>	English Learner Advisory Committee
<b>CCS</b>	California Children's Services	<b>EPSDT</b>	Early and Periodic Screening, Diagnostic and Treatment
<b>CDE</b>	California Department of Education	<b>ERMHS</b>	Educationally Related Mental Health Services
<b>CFT</b>	California Federation of Teachers; also, Child and Family Team	<b>FAPE</b>	Free and Appropriate Public Education
<b>CHKS</b>	California Healthy Kids Survey	<b>FCMAT</b>	Fiscal Crisis and Management Assistance Team
<b>CSHA</b>	California School-Based Health Alliance	<b>FERPA</b>	Family Educational Rights and Privacy Act
<b>CMAA</b>	County-Based Medi-Cal Administrative Activities	<b>FQHC</b>	Federally Qualified Health Center
<b>COE</b>	County Office of Education	<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>COST</b>	Coordination of Services Team	<b>IDEA</b>	Individuals with Disabilities Education Act
		<b>IEP</b>	Individualized Education Program

<b>ISF</b>	Interconnected Systems Framework	<b>SBE</b>	State Board of Education
<b>LCAP</b>	Local Control and Accountability Plan	<b>SBHC</b>	School-Based Health Centers
<b>LCP</b>	Learning Continuity and Attendance Plan	<b>SBHIP</b>	Student Behavioral Health Incentive Program
<b>LCFF</b>	Local Control Funding Formula	<b>SEL</b>	Social-Emotional Learning
<b>LEA</b>	Local Education Agency	<b>SELPA</b>	Special Education Local Plan Area
<b>LEA-BOP</b>	Local Education Agency Medi-Cal Billing Option Program	<b>SIS</b>	Student Information Systems
<b>LRE</b>	Least Restrictive Environment	<b>SMAA</b>	School-Based Medi-Cal Administrative Activities Program
<b>MAA</b>	Medi-Cal Administrative Activities	<b>SPED</b>	Special Education
<b>MCO</b>	Managed Care Organization	<b>SPA</b>	State Plan Amendment
<b>MCP</b>	Managed Care Plan	<b>SPSA</b>	School Plan for Student Achievement
<b>MDT</b>	Multidisciplinary Team	<b>SSPI</b>	State Superintendent of Public Instruction
<b>MHP</b>	County Mental Health Plan	<b>SSW</b>	School Social Worker
<b>MHSA</b>	Mental Health Services Act	<b>TCM</b>	Targeted Case Management
<b>MHSOAC</b>	Mental Health Services Oversight and Accountability Commission	<b>504</b>	Rehabilitation Act Section 504 Accommodations Plan
<b>MHSSA</b>	Mental Health Student Services Act		
<b>MTSS</b>	Multi-Tiered Systems of Support		
<b>NPS</b>	Nonpublic school		
<b>PBIS</b>	Positive Behavioral Interventions and Supports		
<b>PEI</b>	Prevention and Early Intervention		
<b>PPS</b>	Pupil Personnel Services		
<b>PTA</b>	Parent-Teacher Association		
<b>PTO</b>	Parent-Teacher Organization		
<b>RTI</b>	Response to intervention		
<b>RTI<sup>2</sup></b>	Response to Intervention and Instruction		

# Appendix C:

## Sample Questions for Developing School Partnerships

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### 1. STUDENT POPULATION

- Review data from sources such as: the [California School Dashboard](#), the [California Healthy Kids Survey](#), [Kids Data](#), and [Race Counts](#)
- What proportion of students are enrolled in Medi-Cal?
- What proportion of students are enrolled in a Medi-Cal MCP?
- What proportion of students are low-income, as measured by eligibility for free/reduced school lunches?
- What proportion of students have IEPs or 504 plans?
  - How many of those students have ERMHS in their plans?
- What is the racial and ethnic composition of the student population?
- What is the percentage of each high-risk student subgroups (e.g. students in foster care, students experiencing homelessness, English Language Learners) in the district?

### 2. LEADERSHIP AND KEY STAKEHOLDERS

- Who are the key district-level stakeholders and decision-makers?
- Who are the key school site-level stakeholders and decision-makers?
- Who are the key county-level education stakeholders and decision-makers?
- What are the key parent and student groups to engage?

### 3. EXISTING SCHOOL-BASED MENTAL HEALTH SERVICES AND PARTNERSHIPS

- Is there a school-based health center (SBHC) in the district?
  - Does the SBHC provide mental health services?
  - How many students does it serve annually?
  - How is it funded and structured?
  - Where is it located?
- Does the district have an existing partnership with the county mental health plan (MHP)?
  - What does this partnership entail?
  - Who provides services, and where?
- Does the district have existing partnerships with any

community-based organizations (CBOs)?

- What mental health screening services can students currently access at school sites?
- What mental health treatment services can students currently access at school sites?
- How are ERMHS provided for students with IEPs and 504 plans? Who delivers the services?
- What is the district's suicide prevention plan?
- Does the district have a restorative justice program? What does it entail?
- Does the district use an MTSS framework?
  - What are the Tier 1 services?
  - What are the Tier 2 services?
  - What are the Tier 3 services?
- Does the district have Coordination of Services Teams (COST)?
- Where does the district and school-site leadership perceive there to be gaps in mental health services and supports?
- Where do students and families perceive there to be gaps in mental health services and supports?
- What does the district's LCAP say about supporting social, emotional, and mental health?
- Does the district (or do the schools within the district) have a community schools initiative in place and/or a California Community Schools Partnership Program grant?
- Does the SBHC engage students in a formal way, such as peer educators? Is there a platform for lifting the youth voice in implementing new partnerships?

### 4. MEDI-CAL FINANCING

- How does the district fund its mental health services and supports?
- Does the district directly bill Medi-Cal for mental health services under the LEA-BOP?
- Does the district bill for administrative activities under the SMAA?
- If not covered above (see services and partnerships section), does the district have contracts, MOUs, or other working relationships with Medi-Cal billing entities? Does the district have any current or past contracts with MCPs?



# Endnotes

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- 1 See, e.g., Report 2019-125, *Youth Suicide Prevention: Local Educational Agencies Lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self-Harm*, Cal. State Auditor (September 2020), 1, <https://auditor.ca.gov/pdfs/reports/2019-125.pdf> (stating that from 2009 through 2018, the annual number of suicides of youth between the ages of 12 and 19 increased by 15 percent, and incidence of self-harm increased by 50 percent).
- 2 See Press Release, Centers for Medicare & Medicaid Services, *CMS Data Shows Vulnerable Americans Forgoing Mental Health Care During COVID-19 Pandemic* (May 14, 2021), <https://www.cms.gov/newsroom/press-releases/cms-data-shows-vulnerable-americans-forgoing-mental-health-care-during-covid-19-pandemic>.
- 3 See Cal. School-Based Health Alliance, *Public Funding for School-Based Mental Health Programs*, 1, <https://www.courts.ca.gov/documents/BTB25-MHReform-08.pdf> (citing Hurwitz, Laura and Weston, Karen, *Using Coordinated School Health to Promote Mental Health for All Students*, National Assembly on School-Based Care (July 2010)).
- 4 L. Darling-Hammond, L. Flook, C. Cook-Harvey, B. Barron & D. Osher, *Implications for educational practice of the science of learning and development*, *Applied Developmental Science*, 24:2, 97-140, 98 (2020), <https://www.tandfonline.com/doi/full/10.1080/10888691.2018.1537791>.
- 5 See National Association of School Psychologists, *Comprehensive School-Based Mental and Behavioral Health Services and School Psychologists* (2021), <https://www.nasponline.org/resources-and-publications/resources-and-podcasts/mental-health/school-psychology-and-mental-health/comprehensive-school-based-mental-and-behavioral-health-services-and-school-psychologists>.
- 6 See T. Henderson, C. Hill & K. Norton, *The Connection Between Missing School and Health: A Review of Chronic Absenteeism and Student Health in Oregon*, Upstream Public Health (October 2014), <https://www.attendanceworks.org/wp-content/uploads/2017/08/Chronic-Absence-and-Health-Review-10.8.14-FINAL-REVISED.pdf>.
- 7 See, e.g., Mental Health Services Oversight & Accountability Commission, *Every Young Heart and Mind: Schools as Centers of Wellness* (2020), [https://mhsoac.ca.gov/sites/default/files/schools\\_as\\_centers\\_of\\_wellness\\_final.pdf](https://mhsoac.ca.gov/sites/default/files/schools_as_centers_of_wellness_final.pdf). See also J. DePaoli, L. Hernandez, R. Furger, & L. Darling-Hammond, *A Restorative Approach for Equitable Education* (March 16, 2021), <https://learningpolicyinstitute.org/product/wce-restorative-approach-equitable-education-brief>.
- 8 See Assembly Bill (AB) 133 (Health), chaptered July 27, 2021, adding Cal. Welf. & Inst. Code § 5961, [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=202120220AB133](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB133).
- 9 *Id.*
- 10 See AB 133 (Health), chaptered July 27, 2021, adding Cal. Welf. & Inst. Code §§ 5961(d)(3), 5961.3, [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=202120220AB133](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB133). For the associated budget appropriations, see Senate Bill (SB) 129 (Budget Act of 2021), chaptered July 12, 2021, Item 4260-101-0001, Provision 16(a) and Item 4260-101-0890, Provision 3, [https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=202120220SB129](https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB129).
- 11 See AB 133 (Health), chaptered July 27, 2021, adding Cal. Welf. & Inst. Code § 5961.3(a), [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=202120220AB133](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB133). Section 5961.3 appears to omit the specific reference to childcare, preschool, and TK that is included in Section 5961, instead referring only to K-12 students: “(a) As a component of the initiative, the State Department of Health Care Services shall make incentive payments to qualifying Medi-Cal managed care plans that meet predefined goals and metrics developed pursuant to subdivision (b) associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for K-12 children in schools.” The budget appropriations in SB 129 also appear to refer specifically to the K-12 population. See Senate Bill (SB) 129 (Budget Act of 2021), chaptered July 12, 2021, Item 4260-101-0001, Provision 16(a) and Item 4260-101-0890, Provision 3, [https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=202120220SB129](https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB129). DHCS has provided informal guidance that the target student population is K-12.
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