

A PRESCRIPTION FOR EXPANDING

SCHOOL-BASED MENTAL HEALTH SERVICES

IN NEW YORK CITY PUBLIC ELEMENTARY SCHOOLS



AUGUST 2013



CITIZENS' COMMITTEE for CHILDREN
OF NEW YORK INC

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MENTAL HEALTH SERVICES

IN NEW YORK CITY PUBLIC ELEMENTARY SCHOOLS

INFORMED BY LOCAL ELEMENTARY SCHOOL PRINCIPALS AND

MENTAL HEALTH CLINICIANS

AUGUST 2013

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TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
INTRODUCTION.....	4
BACKGROUND.....	6
A) Prevalence of Children’s Mental Health Needs and Estimate of NYC Slot Treatment Capacity.....	6
B) School-Based Mental Health Services and School-Wide Behavioral Intervention Programs.....	7
FINANCING SCHOOL-BASED MENTAL HEALTH SERVICES	15
A) Existing Financing Mechanisms	15
B) Financial Challenges and Opportunities.....	16
C) Regulatory Challenges to Sufficient Provider Payments.....	19
D) Challenges and Opportunities Created by Federal Healthcare Reform and New York State Medicaid Redesign for Children’s Mental Health Care Financing and Delivery Systems.....	20
METHODOLOGY	23
A) Mapping.....	23
B) Demographic Indicators	24
C) Principal Survey	24
D) Clinician Interview.....	25
E) Data Collection Limitations	25
FINDINGS.....	26
A) Location of School-Based Clinical Mental Health Services.....	26
B) Elementary School Children’s Mental Health Needs and Diagnoses.....	32
C) DOE Elementary School Staff Roles and Responsibilities in Providing Clinical Mental Health Services.....	32
D) Staffing Structure and Clinical Mental Health Services Delivered by School-Based Clinicians.....	34
E) Crisis Intervention Services and Protocol.....	36
F) Benefits of School-Based Clinical Mental Health Services and School-Wide Behavioral Intervention Programs.....	36
G) Perceived Barriers to Providing Comprehensive School-Based Clinical Mental Health Services.....	37
H) Establishing and/or Expanding Clinical Mental Health Services, School-Wide Behavioral Intervention Programs and DOE School Personnel in Elementary Public Schools.....	39
RECOMMENDATIONS	41
A) Stabilize and Expand School-Based Mental Health Services.....	42
B) Combat Stigma and Improve the Mental Health Literacy of Parents, Students and School Staff.....	46
C) Reduce Unnecessary Emergency Room Admissions.....	50
D) Invest in Programs and Services that Improve School Climate and Increase Connections to Community-Based Supports	51
E) Improve Data Collection, Information Sharing and Dissemination of Performance and Utilization Data on DOE School-Based Mental Health Services.....	57
CONCLUSION	54
APPENDICES	57
ABOUT CCC.....	INSIDE BACK COVER

EXECUTIVE SUMMARY

Far too many children and youth have unmet mental health needs. Nationally, only one in five children diagnosed with mental health needs actually receives treatment. In New York City (“NYC,” or the “City”), children’s access to mental health treatment is considerably hindered by low slot capacity reported throughout the City. Unmet children’s mental health needs can impede their ability to reach their full potential and increase their risk for experiencing an array of negative life outcomes such as school failure, victimization, self-destructive behavior, family discord, violence, alcohol and drug abuse and suicide.

With the local supply of community-based children’s mental health services unable to meet local demand, school settings are a convenient alternative for meeting the mental health needs of young New Yorkers. By bringing mental health workers to school grounds, students with mental health needs are far more likely to get evaluated and treated. These school-based services bridge major access gaps for children, increasing the likelihood that children will connect to the right amount of mental health care at the right time.

Moreover, by successfully connecting students to care at a time when they are first engaging with the school system and most responsive to treatment, they are poised to better reach their full academic potential. In fact, the availability of clinical mental health services in schools has been linked to higher test scores, fewer discipline referrals and fewer absences. These benefits extend not just to students receiving services, but also spillover to the greater school community, including teachers, other students, school staff and families.

Aside from these services, some NYC elementary schools have also started administering complementary school-wide behavioral intervention programs that strive to improve student academic outcomes by improving individual student behavior and the overall school environment. Recent examples of these intervention programs include Positive Behavioral Interventions and Support (“PBIS”) and the Turnaround Model (“Turnaround”).

Despite efforts by the NYC Department of Education (“DOE”) Office of School Health (“OSH”) to bring more mental health clinicians to City schools over the past few years, the total number of DOE elementary schools offering these services has stagnated since the spring of 2010, when CCC first began its research to inform this report. Three years ago, the DOE reported the same share of DOE elementary schools offering on-site clinical mental health services that exists today (disappointingly, about one-sixth). Most gains in new clinic sites have been negated by clinic losses at other school sites.

The small presence and high attrition of clinical mental health services in NYC public elementary schools not only suggest insufficient citywide capacity to meet the mental health needs of the City’s school-aged children, but also underscore clinics’ ongoing operational instability and financial struggles.

Most NYC public schools lack the necessary resources to sustain these services. Regulatory and financial challenges drive most school-based health and mental health clinics to operate at a financial deficit. These clinics need to be subsidized to remain afloat – a grim reality confronting principals tasked with budgeting inadequate resources year after year. Public grant opportunities dedicated toward stabilizing these clinics are short-term solutions in short supply and continue to diminish as government budgets further tighten. Additionally, delivering on-site mental health care to students also requires physical space and student time, which – especially in the NYC public school system – are often scarce and confront competing demands.

Data Collection Methods

Ensuring children are holistically healthy (both in mind and body) is central to CCC's mission. CCC is dedicated to improving child health and mental health outcomes and continues to advance opportunities to better meet children's unmet needs. Understanding the tremendous value of school-based mental health services to young New Yorkers and their surrounding communities, CCC initiated a multi-year, intensive research project to study the need and feasibility of expanding this service delivery model throughout New York City's public elementary school system.

This effort included an extensive literature review, ongoing collaborations with community partners, data mapping, demographic analyses, surveys of NYC public elementary school principals and interviews with mental health clinicians serving local elementary school children. CCC suspected this research would reinforce the importance, need for and benefits of school-based clinical mental health services and inform a strategy toward improving elementary school students' access to mental health services.

Highlights from CCC's Findings

Irrespective of whether on-site clinical mental health services were available in their schools, all surveyed elementary school principals believed that some of their students had unmet mental health needs impeding their learning or disrupting the learning of other school children. Principals, along with clinicians, attributed moderate to significant improvements among various measures of student academic and classroom performance to the availability of on-site clinical mental health services.

All surveyed principals were proponents of school-based clinical mental health services and behavioral intervention programs, indicating widespread interest in bringing and/or keeping these services in their schools. However, these respondents also cited clinic operating deficits, difficulty in accessing external financing to offset these deficits, school space constraints and students' competing educational needs as the biggest barriers to sustaining these on-site services and expanding them to new sites.

Clinicians indicated that students' most significant barriers to accessing on-site mental health care in schools were external to the child, such as parental concerns about stigma and clinician's limited access to the children. Clinicians reported observing family instability (e.g., single-parent family, divorce/separation, economic stress) in nearly every child they treated. Clinicians also lamented the financial challenges of providing services on schools grounds, such as insufficient reimbursements from third party payers (insurers), a mandate to serve all children regardless of insurance status and a prohibition against collecting co-payments from students on school grounds.

Highlights from CCC's Recommendations

While CCC's survey findings pre-date New York State-led initiatives to reform Medicaid and the federal enactment of health care reform, they remain extremely relevant today. These findings affirm the benefits of school-based mental and behavioral health service delivery to the entire school community and reinforce the need to expand these services citywide. They also underscore the importance of correcting faulty financing systems that persist today and continue to jeopardize the solvency of school-based clinics.

In this report, CCC puts forth fiscally-responsible recommendations to increase children's access to elementary school-based mental health services. These recommendations strategically target public investments in school-based mental health to stabilize and expand these services while also strengthening students' connections to community-based supports. Highlights include:

Stabilize and Expand School-Based Mental Health Services:

- Bring more clinical mental health services to elementary schools;
- Address the challenges creating financial instability to providers of school-based mental health care including insufficient reimbursements and uncompensated care, and developing a transition plan for when the State discontinues its Medicaid managed care carve-out for school-based health centers; and
- Sustain dedicated funding supports until clinics' regulatory and financial challenges are resolved.

Improve the Mental Health Literacy of Parents, Students and School Staff:

- Train parents, students, teachers and school leaders on how to recognize students' mental health needs and how they can connect students to appropriate levels of care; and
- Combat the stigma attached to mental illness and treatment by launching a citywide messaging campaign.

Reduce Unnecessary Emergency Room Admissions:

- Mandate protocols and standard operating procedures for the use of emergency medical services by DOE school officials for students.

Invest in Programs and Services that Improve School Climate and Increase Connections to Community-Based Supports:

- Expand behavioral intervention programs to more NYC elementary schools;
- Expand NYC's pilot programs for rapid crisis response in schools; and
- Screen more children for mental health needs so that those in need can be linked to care.

Improve Data Collection and Dissemination of Information on DOE School-Based Mental Health Services:

- Create opportunities and vehicles to report, analyze and share information among DOE principals and across DOE schools on existing school-based mental and behavioral health programs and practices; and
- Document the impact of school-based clinical mental health services on City schools and students over time.

Cost-benefit analyses have shown that investments in early mental health detection and treatment can deliver substantial cost-savings to society over the course of a lifetime while existing research overwhelmingly suggests that these same investments improve children's quality of life. To that end, CCC's recommendations can help policymakers better stretch the public mental health care dollar while better meeting the mental health needs of young New Yorkers. Altogether, these actions will facilitate children's access to timely and appropriate levels of mental health care and, in turn, enable elementary school-aged children with mental health needs in NYC to develop into a healthy, happy and productive New Yorkers.

INTRODUCTION

Mental health is integral to a child's healthy development, influencing academic performance, school readiness, capacity to learn, social competence and life-long health.¹ Conversely, unmet mental health needs can impede children's ability to achieve their full potential and increase their risk for an array of negative life outcomes such as school failure, victimization, self-destructive behavior, family discord, violence, alcohol and drug abuse and suicide.² That disadvantage is further compounded without access to timely and appropriate treatment. As symptoms can worsen over time, failure to intervene can turn treatable conditions into potentially avoidable life-long disabilities and chronic conditions.³

Early detection and treatment can steer children on a path toward recovery and resiliency that promotes better outcomes for children, youth and families and reduces dependence on more intensive, higher-cost interventions down the road. The urgency ascribed to treating children presenting symptoms reflects a growing body of evidence showing that the onset of mental disorders⁴ usually emerges before young people enter high school, with the average lag to treatment taking nine years.⁵ Half of all lifetime cases of mental health and substance abuse disorders start by age 14.⁶ Prevalence studies have found that symptoms of anxiety disorders can emerge as early as age six, behavioral disorders by age 11 and mood disorders by age 13.⁷

Mental disorders can be described as "serious deviations from expected cognitive, social and emotional development,"⁸ and have emerged as an important public health concern because of their widespread incidence and detrimental cost to individuals and society (in the form of reduced quality of life and negative economic impact). While mental disorders develop indiscriminately among children of all racial and ethnic backgrounds and socioeconomic classes, certain genetic and environmental factors can increase a child's risk (e.g., having a biological relative with a mental disorder, exposure to alcohol and other harmful substances while in the womb, exposure to trauma, etc.).⁹

In the wake of the Newtown tragedy,¹⁰ there has been a renewed focus on the role and value of community- and school-based mental health treatment and supports in the national conversation on school safety and gun violence. While it is encouraging to see interest in better addressing mental illness emerge nationwide, the value of these efforts to society should not be evaluated within this limited context. Mental illness is not a reliable predictor of violence. Existing

1 National Scientific Council on the Developing Child. "Mental Health Problems in Early Childhood Can Impair Learning and Behavior for Life: Working Paper No. 6." *Center on the Developing Child*, Harvard University. December 2008. www.developingchild.harvard.edu (accessed October 16, 2012).

2 U.S. Department of Health and Human Services. *Mental Health*. September 6, 2012. <http://www.healthypeople.gov/2020/LHI/mentalHealth.aspx> (accessed October 16, 2012).

3 Scott, Kate M., et al. "Association of Childhood Adversities and Early-Onset Mental Disorders with Adult-Onset Chronic Physical Conditions." *Arch Gen Psychiatry* 68, no. 8 (August 2011): 838-844.

4 In the U.S., the most mental disorders prevalent in children ages three through 17 include, but are not limited to, attention deficit/hyperactivity disorder (6.8%), behavioral or conduct problems (3.5%), anxiety (3.0%), depression (2.1%), autism spectrum (1.1%) and Tourette syndrome (0.2%). Centers for Disease Control and Prevention. "Mental Health Surveillance Among Children – United States, 2005-2011." *Morbidity and Mortality Weekly Report*. U.S. Department of Health and Human Services. May 17, 2013. <http://www.cdc.gov/mmwr/pdf/other/su6202.pdf> (accessed on May 18, 2013). (Hereinafter, "CDC Children's Mental Health Surveillance Report, 2013".)

5 Hogan, Michael F. "Testimony: Hearing Assessing the State of America's Mental Health: What We Can Do Now." *United States Senate Committee on Health, Education, Labor and Pensions*. January 24, 2013. <http://www.help.senate.gov/imo/media/doc/Hogan.pdf> (accessed March 1, 2013).

6 Kessler, Ronald C., Wai T. Chiu, Olga Demler, Kathleen R. Merikangas, and Ellen E. Walters. "Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication." *Archives of Gen Psychiatry* 62, no. 6 (June 2005): 617-27.

7 CDC Children's Mental Health Surveillance Report, 2013, *supra* note 4.

8 U.S. Department of Health and Human Services. "Mental Health: A Report of the Surgeon General." *Reports of the Surgeon General*, U.S. Public Health Service. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services National Institutes of Health, National Institute of Mental Health. 1999. (Hereinafter, "Mental Health: A Report of the Surgeon General, 1999.") CDC Children's Mental Health Surveillance Report, 2013, *supra* note 4.

9 Mental Health: A Report of the Surgeon General, 1999, *supra* note 8. Mayo Clinic staff. "Mental illness." *Mayo Foundation for Medical Education and Research*. September 15, 2012. <http://www.mayoclinic.com/health/mental-illness/DS01104> (accessed on May 18, 2013).

10 On December 14, 2012, a young man believed to have had a diagnosable mental illness stormed Sandy Hook Elementary School in Newtown, Connecticut and massacred 20 children (ages six and seven) and six school employees with his mother's firearms. This tragedy has ignited a national conversation on the intersection of gun violence and mental illness and has engendered numerous legislative actions at every level of government to prevent a tragedy of this magnitude from recurring.

behavioral health research and practice show that most people who are violent do not have a mental disorder.¹¹ Rather, most people with a mental disorder are not violent and are actually more likely to be the victims of violence.¹²

Improving the availability, accessibility and quality of mental health supports may not be the panacea to curbing the nation's horrific epidemic of violence senselessly targeting youth. It will, however, help unlock the innumerable benefits to children, families, schools, communities and society as a whole that arise when children's mental health needs are better met. Consequently, there is enormous value to exploring and meaningfully improving upon New York City's existing children's mental health care infrastructure.

11 Hyde, Pamela S. "Hearing Assessing the State of America's Mental Health: What We Can Do Now." *United States Senate Committee on Health, Education, Labor and Pensions*. January 24, 2013. <http://www.help.senate.gov/imo/media/doc/Hyde1.pdf> (accessed March 1, 2013).

12 *Id.*

BACKGROUND

A) PREVALENCE OF CHILDREN'S MENTAL HEALTH NEEDS AND ESTIMATE OF NYC SLOT TREATMENT CAPACITY

Far too many children and youth have unmet mental health needs. In New York City, the incidence of children with mental health needs appears to be aligned with national averages.¹³ CCC's research¹⁴ shows that close to 270,000 children ages five through 17 in NYC are believed to have a diagnosable mental disorder. One in 10 (or approximately 134,000) NYC school-age children are likely suffering from a mental disorder severe enough to impair their daily functioning (a diagnosable condition known as a "serious emotional disturbance," or "SED").¹⁵ Additionally, nearly 50,000 children under five years of age in New York City are estimated to have a behavioral problem.¹⁶

Nationally, only one in five children diagnosed with mental health needs actually receives treatment.¹⁷ In New York City, children's access to mental health treatment is negatively impacted by low slot capacity reported throughout the City.¹⁸ While a citywide estimate of unmet need is currently unavailable, CCC's analysis of mental health treatment slot capacity for Brooklyn, Bronx and Staten Island suggests that, in the aggregate, there are available slots for only *one percent* of children ages zero through four and *12 percent* of children ages five through 17 who have treatment needs in NYC.¹⁹

The City's existing mental health care delivery system is inaccessible to the many children and families who need it and barely begins to scratch the surface of addressing children's outpatient mental health needs. Community supports cannot meet the demand and this shortfall has only been compounded by the stresses of a prolonged economic downturn.

With most community-based outpatient mental health care providers reportedly operating under-resourced and over-capacity,²⁰ waitlists are a common occurrence with average wait times for appointments typically ranging from four to six weeks and sometimes as long as 12 weeks.²¹ Given that most appointments for these services are made when acute symptoms emerge, long wait times can inadvertently encourage drop off, and consequently, deter children and families from seeking the care they need at a time when they need it the most.

13 CDC Children's Mental Health Surveillance Report, 2013, *supra* note 4.

14 In an attempt to quantify the unmet need for children's mental health services, CCC, in coordination with the New York City Citywide Children's Oversight Committee and NYC Early Childhood Strategic Mental Health Workgroup, launched a research project to estimate the gap between the need for and availability of mental health treatment slots for children throughout New York City. These estimates are generated from CCC's research findings, which were published in January, 2012. Citizens' Committee for Children of New York, Inc. "New York City's Children and Mental Health: Prevalence and Gap Analysis of Treatment Slot Capacity." *Citizens' Committee for Children of New York, Inc. NYC Citywide Children's Committee and NYC Early Childhood Strategic Mental Health Workgroup*. January 2012. <http://www.ccnnewyork.org/wp-content/publications/CCCReport.MentalHealthPrevalence.pdf> (accessed October 14, 2012). (Hereinafter, "Prevalence and Gap Analysis of Treatment Slot Capacity, 2012.")

15 U.S. Department of Education. "Sec. 300.8 Child with a disability." Subpart A: Part 300 – Assistance To States For the Education of Children With Disabilities. *Individuals with Disabilities Education Act*. 2004. <http://idea.ed.gov/explore/view/p/%2Croot%2Cregs%2C300%2CA%2C300%252E8%2C> (accessed October 21, 2012).

16 Prevalence and Gap Analysis of Treatment Slot Capacity, 2012, *supra* note 14.

17 U.S. Public Health Service. *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: Department of Health and Human Services. 2000.

18 *Id.*

19 *Id.*

20 *Id.*

21 Soule, Charles. YouthAction PSA panel on May 1, 2013. *Citizens' Committee for Children of New York, Inc.*

B) SCHOOL-BASED MENTAL HEALTH SERVICES AND SCHOOL-WIDE BEHAVIORAL INTERVENTION PROGRAMS

School-Based Mental Health Services

With community supports unable to sufficiently accommodate children's outpatient mental health needs, schools are a convenient alternative to identify and treat these needs.²² They enable clinical mental health services to be provided in a normative setting where children typically spend most of their day and are already being consistently observed.

"These [mental health services and school-wide behavioral intervention programs] services are desperately needed in our schools."

—Surveyed Principal

By bringing mental health workers to school grounds, students with mental health needs are far more likely to get evaluated and treated. Unlike local community-based services, school-based settings overcome several access barriers afflicting consumers of community-based care by offering students a shorter wait time for scheduling sessions, shorter clinician office wait times and greater scheduling flexibility.²³ They also greatly improve accessibility for the students of working parents who may not be able to accompany their young children to community-based care.²⁴

Additionally, the availability of clinical mental health services in schools has also been linked to higher test scores, fewer discipline referrals and fewer absences.²⁵ These benefits extend not just to students receiving services, but also spillover to the greater school community, including teachers, other students, school staff and families.

The NYC DOE provides primary and secondary education to over one million students in pre-kindergarten through grade 12 in more than 1,700 schools throughout the five boroughs.²⁶ The DOE, to its credit, has undertaken efforts spanning more than two decades to integrate primary, preventive and mental health services into the NYC public school system. The DOE has successfully established hundreds of school-based health centers ("SBHCs") and school-based mental health clinics ("SBMHCs") throughout the five boroughs that deliver clinical mental health services in school settings.

These efforts were amplified in the 10 years following the September 11, 2001 terrorist attacks on New York City ("9/11") in response to the surge of local students suffering from psychological trauma. Now, dedicated resources once supporting these students' mental health needs in schools have begun to recede as they begin graduating from the City's public school system. As a result, on-site clinical mental health services in DOE schools remain relatively scarce despite the initial gains made post-9/11.²⁷ During School Year ("SY") 2012-2013, less than a quarter (approximately 400 sites) of all

22 CDC Children's Mental Health Surveillance Report, 2013, *supra* note 4.

23 Catron, Thomas, and Bahr Weiss. "The Vanderbilt School-Based Counseling Program: An Interagency, Primary-Care Model Of Mental Health Services." *Journal of Emotional and Behavioral Disorders* 2, no. 4 (October 1994): 247-253. Kaplan, D. W., P. N. Calonge, B. P. Guernsey, and M. B. Hanrahan. "Managed care and school-based health centers: Use of health services." *Arch Pediatr Adolesc Med* 152, no. 1 (January 1998): 25-33.

24 *Id.*

25 Jennings, Jenni, Glen Pearson, and Mark Harris. "Implementing and maintaining school-based mental health services in a large, urban school district." *Journal of School Health* 70, no. 5 (May 2000): 201-205.

26 The total DOE student enrollment and count of DOE schools was most recently reported in the February 2013 *Fiscal 2013 Preliminary Mayor's Management Report (PMMR)* under "Department of Education" and can be accessed at <http://www.nyc.gov/html/ops/downloads/pdf/pmmr2013/doe.pdf>.

27 Soulé, Charles. "Testimony of the School-Based Mental Health Committee." *New York City Council Oversight Hearing on School-Based Mental Health Services*. Federation for Mental Health, Mental Retardation & Alcoholism Services. May 1, 2012. <http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=1108301&GUID=28898978-357B-42F3-AD8D-C88BE8C88482&Options=&Search=> (accessed October 12, 2012). (Hereinafter, "May 1, 2012 Testimony of the School-Based Mental Health Committee.")

1,700 DOE schools reported offering on-site clinical mental health services.²⁸ As of April 2013, these schools reported an aggregate student enrollment of approximately 224,200 students, or 22 percent of all DOE students.²⁹

Of the DOE's estimated 626³⁰ traditional elementary³¹ schools, approximately one-sixth (17 percent or 108 sites)³² delivered on-site clinical mental health services. Altogether, these elementary schools enrolled a combined total of close to 66,700 students³³ and comprised about 27 percent of all DOE schools delivering clinical mental health services on-site.³⁴ A little less than two-thirds of these schools (61 percent or 66 sites) delivered clinical mental health services through a stand-alone mental health clinic and 34 delivered these services through an on-site health center. Eight schools delivered clinical mental health services through co-located school-based health centers and mental health clinics.

28 See "Table 2" in *Appendix 1: Additional Maps and Tables* on page 59 herein for details. New York City Office of School Health. "List of Mental Health Program Locations." *School-Based Mental Health Program: Eliminating Barriers to Academic Achievement*. New York City Department of Education. February 15, 2013. <http://schools.nyc.gov/Offices/Health/SBHC/MentalHealth.htm> (accessed March 28, 2013). (Hereinafter, "SY 2012-13 SBMH Program Listing.") New York City Office of School Health. *School Search*. New York City Department of Education. 2013. <http://schools.nyc.gov/default.htm> (accessed April 11, 2013). (Hereinafter, "DOE School Search Tool.") *Progress Report (PR) Results 2011-12 Elementary / Middle / K-8*. New York City Department of Education. n.d. <http://schools.nyc.gov/Accountability/tools/report/default.htm> (accessed January 4, 2012). (Hereinafter, "DOE SY 2011-12 School Progress Report.")

29 *Id.*

30 Total elementary school count reflects all elementary schools submitting progress reports to the DOE for SY 2011-12, including District 75 elementary schools (exclusively serving students with special needs).

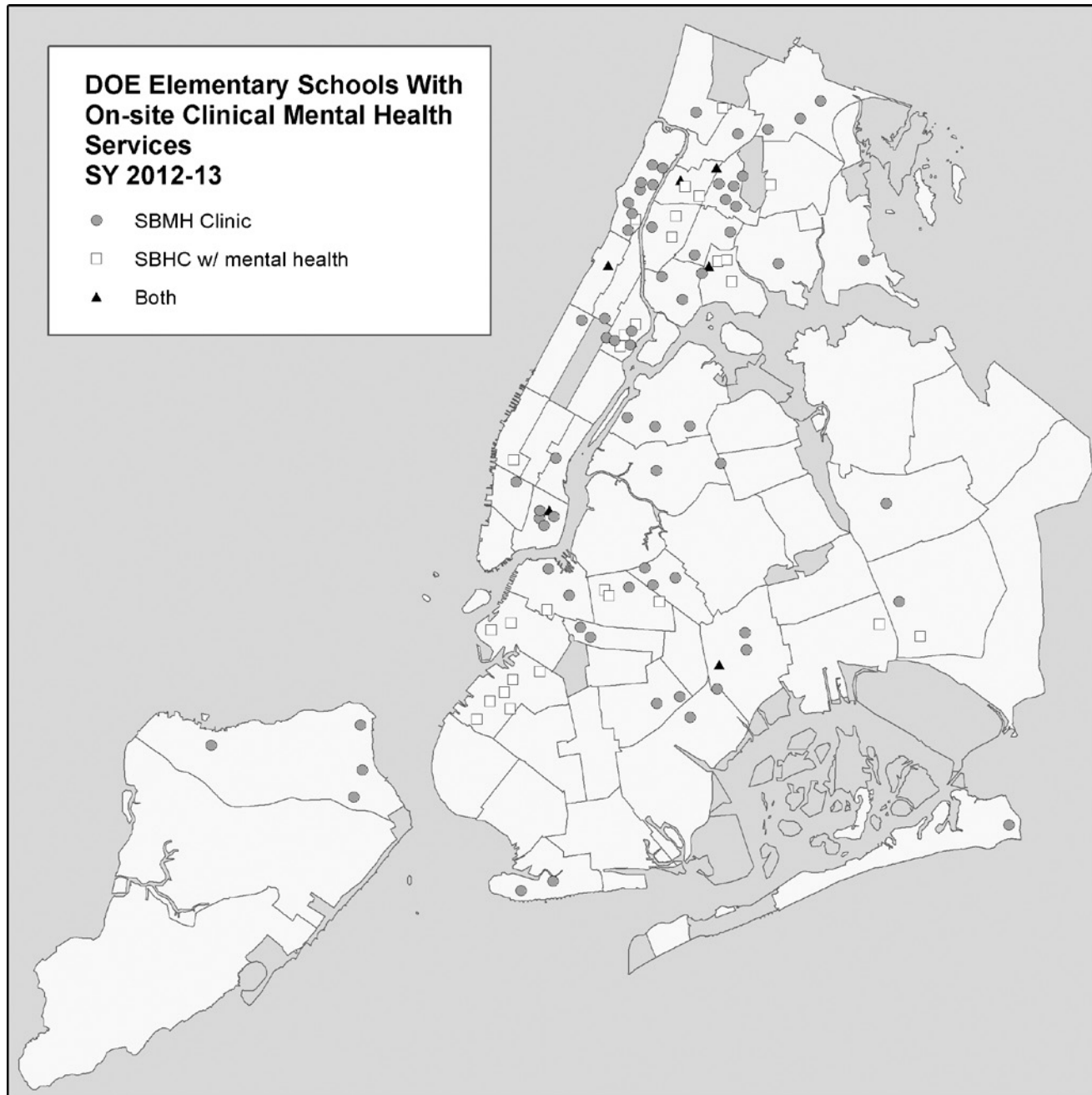
31 The scope of CCC's data analysis is limited to schools categorized by the DOE School Progress Reports as "Elementary," which most often enroll students in grades pre-kindergarten (or kindergarten) through the fifth grade. A handful of schools categorized by the DOE as "Elementary" also enroll students up through the sixth grade. Schools enrolling other ranges of elementary school-aged children, such as K-2, K-3, K-8 and K-12, are excluded from CCC's analysis.

32 SY 2012-13 SBMH Program Listing, *supra* note 28. DOE School Search Tool, *supra* note 28.

33 *Id.*

34 *Id.*

**Map 1:
All SY 2012-13 DOE Elementary Schools Offering On-Site Clinical Mental Health Services.**



One hundred and eight DOE elementary schools reported offering on-site mental health services in SY 2012-13, sixty-six of which delivered these services through SBMHs, thirty-four of which delivered these services through an on-site SBHC and five delivering these services through a combination of both on-site delivery models.

The scope of CCC's data analysis is limited to schools categorized by the DOE School Progress Reports as "Elementary," which most often enroll students in grades pre-kindergarten (or kindergarten) through the fifth grade. A handful of schools categorized by the DOE as "Elementary" also enroll students up through the sixth grade. Schools enrolling other ranges of elementary school-aged children, including K-2, K-3, K-8 and K-12, are excluded from this analysis.

Sources: SY 2012-13 SBMH Program Listing, *supra* note 28. DOE School Search Tool, *supra* note 28.

Little has changed since the spring of 2010, when CCC administered its survey to inform this report. Three years ago, the DOE reported that about a sixth (approximately 101 sites) of New York City's then 612 elementary schools offered on-site clinical mental health services.³⁵ In the years since, new clinics have been founded while others have closed,³⁶ failing to produce net gains in the presence of school-based clinical mental health services throughout the DOE elementary school system. According to CCC's data analysis, since SY 2009-10, twenty-five schools gained SBMHCs while 37 schools lost theirs. Meanwhile, twenty-four schools gained SBHCs offering mental health components while three schools lost theirs. A map of DOE elementary schools offering on-site clinical services as of the spring of 2010 can be found in the *Findings* section under the subheading "A) Location of School-Based Clinical Mental Health Services" on page 29 herein.

Moreover, the DOE mental health professional workforce has also contracted in recent years. According to the United Federation of Teachers,³⁷ from 2008 to 2012, the number of DOE guidance counselors, psychologists and social workers in schools had declined by eight percent, six percent and 11 percent, respectively.³⁸

In NYC, the decision to establish a comprehensive mental health component in a school is largely at the discretion of its principal. Principals decide whether to offer any on-site health or mental health services and can choose between an on-site health center providing clinical mental health services or a stand-alone mental health clinic. To determine the viability of establishing an on-site clinic, the principal must weigh the benefits and value to students and the greater school community against the availability of resources (e.g., funding, physical space etc.) to support these services.

In New York State ("NYS, or the "State"), SBHCs and SBMHCs operate under the auspices of independent, licensed not-for-profit health care institutions (e.g. voluntary community-based providers or local hospitals).³⁹ These sponsoring agencies contract with participating schools to provide services through satellite clinics located on school grounds. Sponsoring agencies are responsible for staffing these clinics with medical and/or mental health professionals, as required, and for developing the clinics' billing infrastructure. In return, school principals are responsible for providing a safe and secure space, in accordance with State regulations,⁴⁰ to administer services to students.⁴¹

35 For details, see "Table 1" under the Findings section on page 31 herein. Progress Report (PR) Results 2009-10 Elementary / Middle / K-8. New York City Department of Education. n.d. <http://schools.nyc.gov/Accountability/tools/report/default.htm> (accessed January 4, 2012). (Hereinafter, "DOE SY 2009-10 School Progress Report.") New York City Office of School Health. "List of Mental Health Program Locations." School-Based Mental Health Program: Eliminating Barriers to Academic Achievement. New York City Department of Education. 2010. <http://schools.nyc.gov/Offices/Health/SBHC/MentalHealth.htm>. (Hereinafter, "SY 2009-10 SBMH Program Listing.")

36 Information submitted to the Chairs of the New York City Council Committee on Education and Committee on Mental Health, Developmental Disability, Alcoholism, Drug Abuse and Disability Services as follow-up from the May 1, 2012 Council Oversight Hearing on School-Based Mental Health Services. Together, these clinics served a total student population of approximately 22,000. One quarter of those clinics served elementary schools with an aggregate enrollment of 6,500. Four clinics served students in grades kindergarten through the 8th grade, 2,400 students. New York City Office of School Health. DOE School Search Tool, *supra* note 28.

37 United Federation of Teachers is a trade union for over 200,000 teachers, nurses and other professionals working in public schools New York City's five boroughs. "Who We Are." *United Federation of Teachers*. 2013. <http://www.uft.org/who-we-are> (accessed April 25, 2013).

38 Ezra, Lila. "Testimony of the United Federation of Teachers." *New York City Council Oversight Hearing on School-Based Mental Health Services*. Federation for Mental Health, Mental Retardation & Alcoholism Services. May 1, 2012. <http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=1108301&GUID=28898978-357B-42F3-AD8D-C88BE8C88482&Options=&Search=> (accessed October 12, 2012).

39 New York State Department of Health. "Principles and Guidelines for School Based Health Centers in New York State." School Based Health Centers in New York State. March 1, 2006. http://www.health.ny.gov/facilities/school_based_health_centers/docs/principles_and_guidelines.pdf (accessed November 7, 2012). (Hereinafter, "Principles and Guidelines for SBHCs.")

40 "Section 599.9." *Part 599 Clinic Treatment Programs*. New York State Office of Mental Health. January 9, 2013 http://www.omh.ny.gov/omhweb/clinic_restructuring/part599/599.text.full.1.9.13.pdf (accessed on April 28, 2013). (Hereinafter, "Part 599 Clinic Treatment Programs.")

41 New York City Office of School Health, Mental Health Services. *School-Based Mental Health Programs: Eliminating Barriers to Academic Achievement*, New York City Department of Education. 2012. <http://schools.nyc.gov/offices/health/sbhc/mentalhealth.htm> (accessed October 14, 2012). (Hereinafter, "NYC OSH SBMH Programs.")

Although they use a similar service delivery model, SBHCs are quite distinct from SBMHCs. This distinction is reflected in New York State law and in the designated State agencies directed by State law to govern these providers. In New York, Article 28 of the State's Public Health Law ("Article 28") grants the State Department of Health ("DOH") authority to license and oversee SBHCs, a free-standing primary care service model that may include a mental health component. The NYS Office of Mental Health ("OMH") is granted authority by Article 31 of the New York State Mental Hygiene Law ("Article 31") to license and monitor freestanding school-based mental health clinics.

In New York City, the DOE Office of School Health ("OSH") is a joint program⁴² of the DOE and the NYC Department of Health and Mental Hygiene ("DOHMH"). OSH is charged with facilitating the delivery of direct school health and mental health services. OSH offers a School-Based Mental Health ("SBMH") program that brings a variety of mental health services to select schools through brokering partnerships with local mental health agencies, hospitals and youth serving non-profits.⁴³ Article 28 SBHCs and Article 31 SBMHCs comprise the largest share of OSH's SBMH program portfolio. OSH also disseminates information to students, parents and teachers to educate them on recognizing mental health needs and how to connect to appropriate supports. OSH does not directly finance the delivery of school-based mental health services.⁴⁴

Article 28 SBHCs are required to provide primary care and preventive health services, first aid care and emergency care.⁴⁵ SBHCs must also address the mental health needs of enrolled students, either by referring students out to the community for services (most often, to the clinic's sponsoring agency or its affiliates) or through delivering on-site care.⁴⁶ The DOH encourages – but does not require – SBHCs with on-site mental health programs to include assessment, crisis intervention, referral and treatment (in both individual and group settings).⁴⁷ There is no uniform or minimal level of on-site mental health care mandated for SBHCs. Consequently, the availability and scope of on-site mental health services directly delivered by SBHCs varies considerably across the State.

An Article 31 SBMHC is a comparably more comprehensive model of mental health care delivery in a school setting, with on-site mental health clinicians⁴⁸ providing a wider array of services. These clinics offer students and families assessments and evaluations; individual, group and family therapy sessions; service coordination; case management; and crisis intervention.⁴⁹ Aside from offering standard assessment and treatment services, school-based mental health clinics also focus on the following prevention services:

- Classroom observation;
- Participation in school-based committee or interdisciplinary team meetings;
- Consultation with school staff (e.g. principals and teachers) regarding the social/emotional/behavioral needs of children;

42 Office of School Health. *NYC Department of Education*. n.d. <http://schools.nyc.gov/Offices/Health/default.htm> (accessed March 24, 2013) (Hereinafter, "OSH Description.")

43 The DOE SBMH Program offers a variety of services targeting those students who have emotional and behavioral difficulties in general education. NYC OSH SBMH Programs, *supra* note 41.

44 New York City Office of Management and Budget. *The City of New York Adopted Budget Fiscal 2014 Supporting Schedules*. New York City Office of Management and Budget. New York City Office of the Mayor. July 2013. http://www.nyc.gov/html/omb/downloads/pdf/ss6_13.pdf (accessed June 28, 2013). (Hereinafter, "NYC Fiscal 2014 Supporting Schedules.")

45 Principles and Guidelines for SBHCs, *supra* note 39.

46 *Id.*

47 *Id.*

48 The most common mental health clinicians serving school settings include licensed social workers, psychologists and psychiatrists. Grimm, Kathleen. "Testimony of the New York City Department of Education on School-Based Mental Health Services." *New York City Council Oversight Hearing on School-Based Mental Health Services*. May 1, 2012. <http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=1108301&GUID=28898978-357B-42F3-AD8D-C88BE8C88482&Options=&Search=> (accessed 12 2012, October). (Hereinafter, "Grimm May 1, 2012 Testimony.") For a complete listing of staff qualified to serve Article 31 clinics, see Part 599 Clinic Treatment Programs, *supra* note 40.

49 *Id.*

- Trainings to school staff on various mental health topics, including classroom management, bullying prevention and conflict resolution; and
- Parent outreach and workshops on various mental health topics, including parenting skills, conflict resolution, bullying prevention and domestic violence.⁵⁰

Unfortunately, traditional SBMHC and SBHC models can be extremely cost-prohibitive to both schools and their sponsoring agencies. They usually generate only between 50-70 percent⁵¹ of the revenue necessary to sustain their operations and often require outside annual investments of at least \$100,000 to remain solvent.⁵² Many NYC public schools, especially those confronting space and budget constraints, may not be able to support these care delivery models. Similarly, many sponsoring agencies also lack the resources to cover their clinics' operating deficits. Consequently, several school-based clinics delivering mental health care have already shuttered in recent years in response to external funding losses.⁵³

Consequently, the acute psychiatric needs of students are likely met with more costly, and usually avoidable, interventions such as emergency medical services ("EMS") and emergency room ("ER") admissions.⁵⁴ In New York City, schools are required by the DOE Chancellor's regulations to administer a same-day risk assessment of students posing a risk to themselves or others.⁵⁵ NYC public schools either lacking access to on-site mental health services or underutilizing existing on-site services – including reportedly nearly 80 percent of DOE elementary schools⁵⁶ – refer students in psychiatric crisis to the ER.⁵⁷

School-wide Behavioral Intervention Programs

Over the past few years, many NYC schools have started to adopt preventive approaches aimed at improving school-wide behavioral health, such as PBIS⁵⁸ and Turnaround.⁵⁹ These alternative, less costly models of service delivery capitalize on economies of scale by intervening at the school level to improve student academic and behavioral outcomes and create a positive climate more conducive to learning.⁶⁰ PBIS and Turnaround prioritize mitigating environmental risk factors over treating the individual needs of each student. This is, in part, accomplished by reducing students' social and emotional stressors that can often lead to the disruptive behavior that precedes crisis situations.

50 Based on findings from CCC's policy briefings and clinician surveys, which are described in greater detail in the *Methodology* and *Findings* sections herein.

51 May 1, 2012 Testimony of the School-Based Mental Health Committee, *supra* note 27. "Hearing Transcript." *New York City Council Oversight Hearing on School-Based Mental Health Services*. Federation for Mental Health, Mental Retardation & Alcoholism Services. May 1, 2012. <http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=1108301&GUID=28898978-357B-42F3-AD8D-C88BE8C88482&Options=&Search=> (accessed October 12, 2012). (Hereinafter, "Transcript of the May 1, 2012 City Council Oversight Hearing on SBMH.")

52 May 1, 2012 Testimony of the School-Based Mental Health Committee, *supra* note 27. Transcript of the May 1, 2012 City Council Oversight Hearing on SBMH, *supra* note 51.

53 Over the past few years, City subsidies defraying SBHC operating costs have been targeted for elimination as part of the Mayor's budget gap closing strategy. The State's Child and Family Clinic-Plus funding and other historical funding supports supplementing comprehensive school-based care have also diminished in recent years. See the section on *Financing School-Based Mental Health Services* starting on page 15 herein for more details.

54 Winerip, Michael. "Keeping Students' Mental Health Care Out of the E.R." *The New York Times*, April 8, 2012: A19.

55 New York City Department of Education. "A-755: Suicide Prevention/Intervention." *Regulation of the Chancellor*. August 18, 2011. <http://schools.nyc.gov/NR/rdonlyres/381F4607-7841-4D28-B7D5-0F30DDB77DFA/109109/A75581811FINAL.pdf> (accessed October 8, 2012). See Sections (II) and (III)(A)(d). (Hereinafter, "Chancellor's Regulation A-755.") New York City Department of Education. "A-412: Security in the Schools." *Regulation of the Chancellor*. November 8, 2006. <http://schools.nyc.gov/NR/rdonlyres/44A34025-2D84-4494-B34C-2F567CC9FA4F/0/A412SecurityintheSchoolsCellPhoneAmendedVersion11806.pdf> (accessed October 8, 2012). See Sections (II)(A)(1)(a) and (b). (Hereinafter, "Chancellor's Regulation A-412.")

56 Preliminary data collected by the DOE and analyzed by Bronx Legal Services NYC. 2012. (Hereinafter, "Bronx Legal Services Preliminary Analysis of DOE Student EMS Referrals.")

57 "Reducing School Usage of EMS Referrals." *Campaign for Effective Behavioral Health Supports for Students*. The Campaign for Effective Behavioral Health Supports for Students seeks to significantly reduce the current practice of sending students with disruptive behaviors or unmet social emotional needs to the emergency room via emergency medical service. The campaign is comprised of advocacy, social service and community based organizations that support increasing student access to mental health services, and improving staff training and systemic policies to diminish the need for the use of EMS referrals.

58 OSEP Center on Positive Behavioral Interventions & Supports. "What is School-Wide Positive Behavioral Interventions & Supports?" *National PBIS Leadership*. May 4, 2009. <http://www.pbis.org/common/cms/documents/WhatIsPBIS/WhatIsSWPBS.pdf> (accessed October 24, 2012). (Hereinafter, "OSEP Center on PBIS, 2009.")

59 *Turnaround USA. How We Work*. n.d. <http://turnaroundusa.org/how-we-work> (accessed October 21, 2012). (Hereinafter, "How Turnaround Works.")

60 OSEP Center on PBIS, 2009, *supra* note 58.

Seven DOE elementary schools enrolling a total of close to 3,300 students participated in Turnaround during SY 2012-13.⁶¹ While data on DOE elementary schools currently participating in PBIS is unavailable, the DOE reported in 2011 that more than 200 schools, or 12.5 percent of all NYC public schools, had been trained in all three tiers of PBIS.⁶² In 2010, fourteen schools had launched school-wide behavioral intervention programs (11 in PBIS and three in Turnaround). Thirteen of these 14 schools administered behavioral intervention programs concurrently with the delivery of on-site mental health clinical services.⁶³

School-wide behavioral intervention program costs vary. The cost to administer PBIS is a function of the number of participating schools, existing district and State capacity for training and coaching and existing systems for data collection.⁶⁴ Depending on the size of the school, the cost of Turnaround is approximately \$250,000 per school per year, ranging from \$500 to \$900 per student.⁶⁵

Positive Behavioral Interventions and Support

PBIS provides schools a framework for improving academic and behavior outcomes for all students using evidence-based practices. The PBIS framework is designed to respond to students' behavioral needs and engage them through three tiers of positive behavioral support intensity in school settings: (1) universal (classroom-level), (2) secondary (group-level) and (3) individualized.⁶⁶ Avoiding the "one-size fits all" intervention pitfall, PBIS trains schools to build a continuum of supports that begins with the whole school and diffuses to intensive, wraparound support for individual students with greater needs and their families.⁶⁷

Interventions at the universal level target all students, staff and settings in the school building.⁶⁸ Secondary interventions are designed for students who require additional support (mainly, students with repeated office discipline referrals).⁶⁹ The tertiary (individualized) intervention level is recommended for students not responding to the lower-intensive interventions. This third tier of intervention provides students with individualized plans that are tailored to their unique behavioral needs.⁷⁰

Turnaround for Children

Turnaround for Children is a nonprofit that works with high-poverty, underperforming schools to create sustainable environments conducive to effective teaching and learning.⁷¹ Turnaround partners with schools for a period of three to five years, gradually developing a school's capacity to address its students' social, emotional and academic needs.⁷² Turnaround provides each partner school with the skills and resources necessary to sustain these interventions after the partnership concludes.

61 Turnaround USA. Who We Work With. n.d. <http://turnaroundusa.org/who-we-work-with> (accessed October 21, 2012). (Hereinafter, "Turnaround USA: Who We Work With.") DOE School Search Tool, *supra* note 28.

62 Moorthy, Satish. "New York City PBIS Technical Assistance Center Update: Adaptation, Alignment, and Integration." *National PBIS Leadership Forum*. Chicago, Illinois, 2011. (Hereinafter, "NYC PBIS Update, 2011.")

63 See "Table 3" *Appendix 1: Additional Maps and Tables* on page 59 herein for details.

64 Horner, Rob, et al. "What Does it Cost to Implement School-wide PBIS?" *OSEP Technical Assistance Center on PBIS Effective Schoolwide Interventions*. July 2012. http://www.pbis.org/common/pbisresources/publications/20120802_WhatDoesItCostToImplementSWPBIS.pdf (accessed October 23, 2012).

65 These programs are often supported by State demonstration dollars. How Turnaround Works, *supra* note 59.

66 OSEP Center on PBIS, 2009, *supra* note 58.

67 *Id.*

68 *Id.*

69 *Id.*

70 *Id.*

71 "About Turnaround for Children." *New Profit Inc.* n.d. <http://newprofit.com/cgi-bin/iowa/do/invest/33.html> (accessed October 24, 2012). (Hereinafter, "About Turnaround.")

72 *Id.*

Each partner school must have a committed principal and a school-based social worker. In return, Turnaround will deploy an education coach, instructional coach and social work consultant to each partner school.⁷³ Together, this multidisciplinary team works to (1) identify moderate- to high-risk students; (2) connect at-risk students to community services; and (3) train teachers in classroom management, effective behavioral intervention, family engagement and social-emotional learning strategies.

⁷³ *Id.*

FINANCING SCHOOL-BASED MENTAL HEALTH SERVICES

A) EXISTING FINANCING MECHANISMS

Providers of school-based clinical mental health services claim payment from a mix of third party payers⁷⁴ including Medicaid fee-for-service (“FFS”), Medicaid managed care (“MMC”) plans,⁷⁵ Child Health Plus (“CHP”) plans⁷⁶ and commercial (or, private) insurers.⁷⁷ Medicaid is the single largest third party payer for services in school-based settings.⁷⁸

SBHCs and SBMHCs are usually only able to recoup a fraction of the total cost of care from third party payers even after all efforts to maximize claims have been exhausted.⁷⁹ Commercial insurers typically reimburse clinical mental health services well below the cost of care,⁸⁰ and New York State recently cut Medicaid FFS reimbursement, including payment for clinical mental health services delivered by Article 28 providers, to help meet reduced State Medicaid spending targets.⁸¹ Chronic insufficient payments to school-based providers threaten their solvency, and consequently jeopardize their ability to continue delivering care in school settings.

To break even, clinics seek additional outside support by soliciting their sponsoring agencies and applying for public (federal,⁸² state⁸³ and local⁸⁴) and private grants. Eligibility and scope for these opportunities, however, are limited and vary significantly across jurisdictions. Furthermore, recent and ongoing budget crises at all levels of government and reduced philanthropic giving have forced many grant opportunities to constrict. This has renewed calls for Medicaid payment reform and triggered policymakers, practitioners and consumer representatives to explore other innovative funding mechanisms.

74 Defined herein as an organization other than the patient (first party) or direct health care provider (second party) that finances personal health services.

75 Fee-for-service and managed care are the two main mechanisms for Medicaid provider payments: Under a FFS system, beneficiaries are able to receive care from any provider accepting Medicaid and those providers are reimbursed for each service rendered, billing the State directly. Conversely, in the managed care model, the Medicaid managed care organization (“MCO”) is paid a capitated rate (flat monthly fee) to cover nearly all of the beneficiary’s basic health care needs through a managed care plan that contracts with a select network of health care providers. Providers bill the MCO directly.

76 CHP is a public health insurance option available to children in families with incomes too high to qualify for Medicaid, but too low to afford private insurance. CHP only pays for care through managed care plans contracted with the State. “Child Health Plus.” *New York State Department of Health*. November 2011. http://www.health.ny.gov/health_care/child_health_plus/ (accessed on April 25, 2013).

77 National Assembly on School-Based Health Care. Critical Issues in School-Based Health Care.” *National Assembly on School-Based Health Care*. September 1999. http://www.nasbhc.org/atf/cf/%7B4BD0466E-8D42-4AF0-9163-8755180C3662%7D/Funding_IB_CriticalIssues.pdf (accessed November 6, 2012).

78 Medicaid describes the nation’s means-tested federal program of medical assistance for low-income children, pregnant women, parents and caretakers of dependent children, seniors and individuals with disabilities. Medicaid.gov. “Eligibility.” *Centers for Medicare & Medicaid Services*. n.d. <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html> (accessed on April 24, 2013).

79 Most insurers of mainstream health care consumers generally do not reimburse providers for the following preventive and administrative services critical to promoting student mental health and a positive school environment: workshops/trainings for school staff; consultation with teachers on children who mental health clinics have not yet received parental consent to treat; crisis services for children who are not already admitted to the clinic; case management; referrals and parent outreach. “Barriers to Fiscal Sustainability: School Based Clinics.” School-Based Mental Health Subcommittee to the Children’s Mental Health Committee. *The New York City Federation for Mental Health, Mental Retardation & Alcoholism Services*. April 2013. (Hereinafter, “SBMH Committee Paper on Barriers to Fiscal Sustainability.”) Transcript to the May 1, 2012 City Council Oversight Hearing on SBMH, *supra* note 51.

80 *Id.*

81 In January 2011, New York State Governor Andrew Cuomo and a team of stakeholders began a multi-year effort to overhaul the state’s Medicaid payment and delivery systems to make them more efficient, patient-centered and outcome-driven (hereinafter, “Medicaid Redesign”). Phase I of Medicaid Redesign instituted a two percent across the board reduction to most Medicaid payments, including managed care providers, and all institutional providers, including hospitals, nursing homes and clinics. Shah, Nirav R., and Sue Kelly. “Provider Notification Letter Re: State to Implement 2% Across the Board Medicaid Payment Reductions.” *New York State Department of Health*. November 3, 2011. http://www.health.ny.gov/health_care/state/docs/provider_letter.pdf (accessed April 5, 2013).

82 The federal maternal and child health block grants are the most common source of federal funding for school-based health centers. National Assembly on School-Based Health Care. “Critical Issues in School-Based Health Care Financing.” National Assembly on School-Based Health Care. September, 1999. http://www.nasbhc.org/atf/cf/%7B4BD0466E-8D42-4AF0-9163-8755180C3662%7D/Funding_IB_CriticalIssues.pdf (accessed November 11, 2012).

83 The 2013-14 New York State Enacted Budget contains many dedicated local assistance line items to support school-based health clinic services. New York State Division of Budget. “Fiscal Year 2013-14 State Budget: Enacted Appropriations; Aid to Localities – Chapter 53.” *New York State Office of the Executive*. April 2013. <http://publications.budget.ny.gov/budgetFP/enacted1314.html#enactedBills> (accessed on April 7, 2013). (Hereinafter, the “NYS 2013-14 Enacted Budget.”)

84 New York City sponsors select SBHCs through a dedicated line item in the DOHMH expense budget. NYC Fiscal 2014 Supporting Schedules, *supra* note 44. The City’s Department of Education also supports the construction and operation of several SBHCs through resources made available in its budget. New York City Office of Management and Budget. “The City of New York Adopted Capital Commitment Plan Fiscal Year 2013.” New York City Office of Management and Budget. *New York City Office of the Mayor*. October 2012. http://www.nyc.gov/html/omb/downloads/pdf/ccp_10_12b.pdf (accessed March 24, 2013). (Hereinafter, the “NYC Fiscal 2013 Capital Commitment Plan.”)

B) FINANCIAL CHALLENGES AND OPPORTUNITIES

Medicaid managed care and the unique challenges to school-based clinics

In managed care, health insurance plans reimburse contracted (or, “in-network”) providers for the delivery of a pre-determined set of covered benefits (or services). Plans negotiate payment rates with each in-network provider, often creating a wide variation of provider reimbursement rates for the delivery of the same service. This process creates an advantage to school-based providers affiliated with larger health care institutions possessing more negotiating power. Conversely, this process handicaps smaller sponsoring agencies lacking the resources or ability to negotiate competitive rates with managed care plans.

The State’s ongoing transition from Medicaid fee-for-service to Medicaid managed care poses unique financing challenges for providers in school-based settings. In fee-for-service Medicaid, providers are able to bill the State directly for the delivery of care to Medicaid enrollees. In managed care, providers directly bill the health plan. This means that school-based clinical providers would need to join each student’s managed care plan network in order to be reimbursed for care delivered to all students enrolled within their school.

In theory, school-based clinical providers should be able to bypass the administrative burden of contracting with plans by using their sponsoring agencies as a conduit. In practice, however, most school-based mental health clinics in NYC are not (and will not be) contracted to serve a given school’s entire student population. The composition of any school’s student population is likely to be diverse and dynamic, with the presence of participating plans fluctuating with each student’s insurance and school enrollment status.

Nevertheless, a school-based clinic (licensed under either Article 28 or 31) is obligated to see a student presenting for service, even if that clinic is not recognized as a participating provider within that student’s health plan network or if the student is uninsured.⁸⁵ Since Medicaid managed care does not reimburse clinics for delivering care to uninsured Medicaid-eligible students – even if that clinic facilitates Medicaid enrollment for that student the same day services are rendered⁸⁶ – this obligation heightens clinics’ risk of providing uncompensated care.

Managed care also requires providers to develop a sophisticated billing infrastructure to successfully process billable claims.⁸⁷ Many school-based mental health clinics do not have this infrastructure, nor do they have the resources to build one.⁸⁸ Sponsoring agencies will need to assume this administrative responsibility on behalf of its satellite clinics that are unable to directly process claims; however, not all agencies have the administrative capacity to do so.

Lastly, managed care can obstruct student access to continued care to treat chronic mental health needs. Managed care often sets limits⁸⁹ on the number of visits it will reimburse and will likely either reduce or eliminate provider payments altogether once that threshold is surpassed.

85 New York City Office of School Health. School-Based Health Centers. *New York City Department of Education*. n.d. <http://schools.nyc.gov/Offices/Health/SBHC/SBHC.htm> (accessed March 28, 2013). (Hereinafter, “OSH SBHC Description.”) NYC OSH SBMH Programs, *supra* note 41.

86 SBMH Committee Paper on Barriers to Fiscal Sustainability, *supra* note 79.

87 *Id.*

88 *Id.*

89 *Id.*

Different treatment of Article 28 and Article 31 school-based providers by the State and City

The two distinct governing bodies and corresponding laws for school-based Article 28 and Article 31 clinics present two markedly different sets of financing challenges and opportunities for supporting clinical mental health service delivery in New York's public schools.

Since 2004, all New York-based Article 28 SBHCs have been able to bill the State directly fee-for-service for all Medicaid-eligible patients, regardless of whether some students are enrolled in a Medicaid managed care plan. This mechanism, which is commonly known as the "Medicaid managed care carve-out," has been an important source of financial stability for school-based Article 28 clinics.⁹⁰ It shields them from the financial risks of insufficient managed care plan reimbursement rates and delivering uncompensated – or undercompensated – out-of-network care. The State, however, plans to discontinue this mechanism beginning in the fall of 2014 as it nears completing its transition to Medicaid managed care.

Payment for care delivered by Article 31 SBMHCs is currently excluded from this managed care carve-out. Consequently, Article 31 SBMHCs must navigate managed care's inherently more restrictive payment system, which heightens their risk of nonpayment for serving students who are covered by Medicaid managed care (and today, most are⁹¹).

Supplemental financing opportunities for school-based providers also vary by their respective State governing laws. The New York State⁹² and New York City⁹³ expense budgets each possess a patchwork of smaller-scale dedicated line items granting awards to select at-risk Article 28 SBHCs; however, neither budget offers equivalent dedicated funding for stabilizing Article 31 school-based clinics. Conversely, Article 31 providers once received supplemental financing through OMH's 1989 Comprehensive Outpatient Program Services ("COPS"), which offered rate enhancements to outpatient mental health clinics to partially offset the financial challenges presented by managed care.⁹⁴ This option was not available to Article 28 SBHCs.

OMH began restructuring the State's mental health care delivery and payment system in 2009 to reduce provider (including Article 31 school-based clinics) dependence on funding subsidies and to adopt more recovery-oriented approaches to State-sponsored mental health care.⁹⁵ Accordingly, the restructuring also marked the beginning of the end for major supplemental funding programs once stabilizing cash-strapped voluntary mental health care providers (including COPS). COPS has been gradually eliminated over a four-year period ending September 2013 and its beneficiaries will likely experience greater financial hardship once COPS funds are completely phased out.

90 This "carve-out" is made possible through a waiver of New York State statute exempting these providers from first billing Medicaid managed care and it has existed since 2004. Horton, Joey Marie, and Jane Lima-Negron. "School-Based Health Centers: Expanding the Knowledge and Vision." New York State Coalition for School-Based Health Centers. *Community Health Foundation of Western & Central New York*. July 2009. http://www.chfwcny.org/Tools/BroadCaster/Upload/Project45/Docs/School_Based_Health_Centers_July_2009.pdf (accessed November 9, 2012).

91 As of March 1, 2013, over 666,000 children between the ages of five and 17 were enrolled in NYC mainstream Medicaid managed care. Victoria Wagner, e-mail message to Pamela Corbett (co-author), April 26, 2013. During that same year, nearly 110,000 New York City youth under age 19 were enrolled in CHP. "Child Health Plus Enrollment by Insurer: March 2013." *New York State Department of Health*. April 2013. http://www.health.ny.gov/statistics/child_health_plus/enrollment/ (accessed on April 24, 2013). Nearly all mainstream Medicaid enrollees have already transitioned into managed care. "New York State Medicaid Redesign Team (MRT) Waiver Amendment: Achieving the Triple Aim." *New York State Medicaid Redesign Team*. August 2012. http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf (accessed August 12, 2012). (Hereinafter, "Medicaid Redesign Team Waiver Amendment, 2012")

92 The State Fiscal Year 2013-14 budget includes over \$19 million in dedicated local assistance line items to support school-based health clinic services. NYS 2013-14 Enacted Budget, *supra* note 83.

93 The New York City Fiscal 2013 Adopted Budget for the DOHMH appropriates approximately \$2.6 million to support five SBHCs. The DOHMH budget also funds three positions for administering five other SBHCs supported by the City's Center for Economic Opportunity. NYC Fiscal 2014 Supporting Schedules, *supra* note 44.

94 New York State Office of Mental Health. "Clinic Restructuring Implementation Plan." *New York State Office of Mental Health*. March 11, 2009. http://www.omh.ny.gov/omhweb/clinic_restructuring/report.html#a (accessed November 6, 2012). (Hereinafter, "OMH Clinic Restructuring Implementation Plan, 2009.")

95 *Id.*

Additionally, other financing mechanisms that once supported outpatient mental health clinics have substantially changed over the past few years. For example, in 2007, OMH launched Child and Family Clinic-Plus (“Clinic-Plus”), a statewide initiative encouraging the early recognition and treatment of unmet mental health needs in children and youth. Clinic-Plus supported screening and follow-up services for children in normative settings, such as schools, early childhood programs and child abuse prevention programs. These funds also created a mechanism to pay for essential non-billable services that were already being performed by clinics, such as facilitating insurance enrollment, which helped to mitigate clinics’ chronic operating losses.⁹⁶ Medicaid rate enhancements were assigned to designated select outpatient clinics delivering these services, many of which were school-based mental health providers.⁹⁷

The success of Clinic-Plus was predicated upon providers’ ability to gain administrator buy-in and parental consent prior to administering screenings. Accordingly, Clinic-Plus was intended to launch in tandem with an accompanying media campaign to alert administrators (e.g., principals) and parents of the benefits of the Clinic-Plus program; however, the media campaign never reached fruition. In the absence of a media campaign or some other effort to target engagement with key stakeholders, many principals were indifferent to the program and few parents consented to having their children screened. With restricted access to children, participating providers were unable to meet performance targets. Unable to demonstrate program success, Clinic-Plus was phased-out at the end of calendar year 2011.⁹⁸ Several NYC school-based Article 31 clinics depended upon Clinic-Plus to remain solvent and eventually closed when the last of the Clinic-Plus funds were depleted.⁹⁹

OMH has since redirected a share of resources once supporting Clinic-Plus toward a portfolio of services supporting early detection and linkage to care for young New Yorkers with mental health needs. Some funds support the co-location of behavioral health into child-serving primary care settings while other former Clinic-Plus dollars now support the Clinic Technical Assistance Center, which is dedicated to helping all child- and adult-serving New York State mental health clinics navigate the recent changes in clinic regulations, financing and overall health care reforms.

The remaining portion of available former Clinic-Plus dollars now support OMH’s Performance Based Early Recognition Coordination and Screening (“ERS”) program,¹⁰⁰ which is designed to be a smaller-scale successor to Clinic-Plus. Like Clinic-Plus, ERS promotes the early identification of and linkage to care for children with mental disorders by supporting child mental health screenings and referrals across the State. Unlike Clinic-Plus, ERS awards directly support the salaries of qualified full-time early recognition specialists to administer at least 1,000 screenings each and perform other related activities, such as referrals to community-based care. To achieve this screening target, early recognition screeners expand their reach into settings where children are, including schools, early childhood centers, juvenile justice settings and primary care providers by partnering with several child-serving agency networks.

ERS applies some of the lessons learned from Clinic-Plus and has demonstrated success in the program’s first year; however ERS is not equivalent to Clinic-Plus. ERS does not have the resources or site-specific focus to support the same level of services in schools that were once made possible through Clinic-Plus. While Clinic-Plus providers were predominantly located in school settings, there is greater variation among the settings served by early recognition specialists, with other settings now prioritized over schools. Grantees still face an uphill battle in gaining parental consent. And notably, the budget for ERS is only about a fourth of the total State dollars that once supported Clinic-Plus.¹⁰¹

96 SBMH Committee Paper on Barriers to Fiscal Sustainability, *supra* note 79.

97 *Id.*

98 New York State Office of Mental Health. “Performance Based Early Recognition Coordination and Screening, Section 5.1.” *New York State Office of Mental Health*. September 2011. http://www.omh.ny.gov/omhweb/rfp/2011/early_recognition/rfp.pdf (accessed on April 7, 2013). (Hereinafter, “ERS RFP, 2011.”)

99 May 1, 2012 Testimony of the School-Based Mental Health Committee, *supra* note 27. Transcript of the May 1, 2012 City Council Oversight Hearing on SBMH, *supra* note 51. Bronx Legal Services Preliminary Analysis of DOE Student EMS Referrals, *supra* note 56.

100 OMH’s five New York State regions include Long Island, the Central Region, the Hudson River region, New York City, and the Western Region. *Id.*

101 Information submitted to the Chairs of the New York City Council Committee on Education and Committee on Mental Health, Developmental Disability, Alcoholism, Drug Abuse and Disability Services as follow-up from the May 1, 2012 Council Oversight Hearing on School-Based Mental Health Services.

Episodic care reimbursements and its impact on managed care

In recent years, the State has been making strides toward unifying Medicaid fee-for-service reimbursement rate methodologies and bringing them closer to, albeit still not completely,¹⁰² covering the full cost of care. These efforts include transitioning Article 28 and Article 31 outpatient care providers (including school-based clinics) toward a new payment methodology: Ambulatory Patient Groups (“APG”).¹⁰³ Unlike traditional Medicaid FFS, which reimburses for services claimed during a patient visit, APG reimbursement codes bundle payments to providers based on the expected level of resources required for an entire episode of care for a patient and are weighted for resource intensity.¹⁰⁴

School-based Article 28 clinics are able to access these rates through the State’s managed care carve-out. In September 2012, these codes also temporarily set the floor for reimbursements to Article 31 Medicaid managed care providers (known as “Government Rates”), establishing higher payment thresholds to correct historical Medicaid managed care underpayment to these providers.¹⁰⁵ Similar to the treatment of the now defunct Clinic-Plus program, resources that once supported COPS are now redirected toward financing the payment increase attributable to the more generous APG rate reimbursements to Article 31 clinics.¹⁰⁶

C) REGULATORY CHALLENGES TO SUFFICIENT PROVIDER PAYMENTS

In addition to financial barriers, several regulatory barriers also widen school-based clinic providers’ structural deficits. For example, most managed care plans will only process provider claims once co-payments have been collected. Pursuant to DOE Chancellor’s Regulation A-610, NYC’s school-based service providers are prohibited from collecting a co-payment for services provided on school grounds.¹⁰⁷ School-based providers are allowed to bill parents for delivering services to their children; however, parents do not always pay.¹⁰⁸ Consequently, this regulatory barrier complicates a clinic’s ability to be reimbursed by insurers and occasionally forces them to forego reimbursement altogether. In contrast, these clinics’ sponsoring agencies may collect co-payments from students receiving care at their main site.

Also, DOE policy currently imposes a fee for security and janitorial services on school-based clinics (both Article 28 and 31 providers) operating outside of regular school hours.¹⁰⁹ School-based clinics must be able bring in enough business to offset the fee to serve students during extended hours or risk exacerbating their financial struggles.¹¹⁰ Accordingly, this costly fee can discourage school-based clinics from operating after school hours, on the weekends or when the school is not in session, which

102 Initial forecasts of the APG conversion estimated that Article 31 agencies would lose, on average, a little over a third of their pre-implementation base revenue during the transition period. However, estimates pre-dated implementation and may no longer apply. Aronowitz, Gene, and Dan Still. *Stress Test Report on the New York State Office of Mental Health’s Proposed Clinic Restructuring Initiative*. 2nd. The Robert Sterling Clark Foundation. New York, NY: The Coalition of Behavioral Health Agencies, Inc., May 5, 2010.

103 Article 28 outpatient providers began the transition in 2008 and Article 31 providers followed suit beginning in 2010. “Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual: Revision 2.1.” *New York State Department of Health*. August 2012. http://www.health.ny.gov/health_care/medicaid/rates/apg/docs/apg_provider_manual.pdf (accessed November 9, 2012). Weiskopf, Gary, Gwen Diamond, and Glenn Gravino. “Mental Health Outpatient Clinic: APG Payment Basics & Updates.” *New York State Office of Mental Health*. June 2012. http://www.omh.ny.gov/omhweb/clinic_restructuring/training_materials/2012_07_11_clinic2_training.pdf (accessed November 13, 2012).

104 *Id.*

105 OMH “Government Rates” Statute Part H of Chapter 11 of the Laws of 2010. *Id.*

106 The rate increases are wholly supported by former Comprehensive Outpatient Program Services funding that is “passed through” the State directly to the Medicaid managed care plans via premium enhancements. *Id.*

107 New York City Department of Education. “A-610: Fund Raising Activities and Collection of Money from Students.” *Regulation of the Chancellor*. November 22, 2002. <http://docs.nycenet.edu/docushare/dsweb/Get/Document-26/A-610.pdf> (accessed October 8, 2012). See Section 4. (Hereinafter, “DOE Chancellor’s Regulation A-610.”) While these clinics are permitted to bill parents on a monthly basis, not all parents pay. SBMH Committee Paper on Barriers to Fiscal Sustainability, *supra* note 79.

108 SBMH Committee Paper on Barriers to Fiscal Sustainability, *supra* note 79.

109 New York City Department of Education. “D-180: Extended Use of School Buildings.” *Regulation of the Chancellor*. March 4, 2010. <http://schools.nyc.gov/NR/rdonlyres/023114D9-EA44-4FE0-BCEE-45778134EA14/0/D180.pdf> 3/4/10 (accessed on April 5, 2013). See section (IV)(B). (Hereinafter, “DOE Chancellor’s Regulation D-180.”)

110 Children’s mental health service utilization patterns are cyclical in nature. Consequently, the capacity of most SBMHCs peak by November and wane during the summer months. SBMH Committee Paper on Barriers to Fiscal Sustainability, *supra* note 79.

can in turn, limit student access. Students depending on school-based clinic services for meeting most of their health and mental health care needs would not have access to those clinics during school breaks and vacations, and due to a citywide capacity shortage, may have difficulty being served in the community.

Schools' failure to collect complete student health insurance information also inadvertently increases the financial risk to school-based clinics. Per Chancellor's Regulation A-701, schools are required to collect this information from all students as part of the Student Health Record and share it with their on-site health and mental health providers.¹¹¹ Unfortunately, often times this information is incomplete, which prevents on-site providers from successfully claiming payment from third party payers. As has been noted repeatedly throughout this report, failure to claim payment for reimbursable services further deepens on-site provider budget shortfalls.

D) CHALLENGES AND OPPORTUNITIES CREATED BY FEDERAL HEALTHCARE REFORM AND NEW YORK STATE MEDICAID REDESIGN FOR CHILDREN'S MENTAL HEALTH CARE FINANCING AND DELIVERY SYSTEMS

New York City's school-based clinical mental health services remain financially fragile, even as the State pursues Medicaid payment reform strategies intended to better cover the actual cost of care. Medicaid payments are still widely regarded by the mental health provider community as limited and insufficient, contributing to providers' chronic operating deficits. The New York State Medicaid Program's move toward a bundled payment methodology holds promise in correcting some institutional underpayment while possibly worsening others.¹¹² More importantly, these changes are now being implemented in tandem with other large-scale payment and delivery reforms at the federal and State levels. As these moving parts begin to converge, the overall outcome may either further stabilize or weaken providers' ability to serve, depending on the State's ability to position these services within this shifting context.

The 2010 Patient Protection and Affordable Care Act ("federal health care reform," or the "ACA") offers sweeping health insurance coverage expansions for tens of millions of Americans – including children and youth – as well as new protections for those who are covered. Over one million New Yorkers are expected to gain coverage through these expansions. The ACA also aims to improve overall population health through targeted investments in the nation's primary and preventive health care infrastructure. Throughout the U.S., not only will more school-aged children be able to gain health coverage, but children should also have improved access to covered services. For example, the ACA appropriates new funding to support both the construction and operation of new and existing SBHCs. As noted earlier herein, these investments improve a child's access not just to primary care, but also to mental health care delivered directly by SBHC.

Notably, the ACA also advances the concept of Health Homes, a highly integrated model of care management intended to improve the coordination of services for high cost/high needs Medicaid enrollees, and will eventually include children and youth in New York. In this model, Medicaid pays for a "care manager," who is assigned to each enrollee to oversee and facilitate access to all necessary primary, acute, behavioral health and long term services and supports.¹¹³ This multifaceted approach toward enhanced care coordination is supposed to enable those with complex needs to better navigate increasingly confusing and fragmented systems of physical and behavioral health care and social supports. By recognizing this care coordination activity as a Medicaid-billable service, Health Homes create a financing mechanism to support qualified providers for delivering essential services that have historically been either ineligible for mainstream Medicaid reimbursement or undercompensated.

111 New York City Department of Education. "A-701: School Health Services." *Regulation of the Chancellor*, August 15, 2012. <http://schools.nyc.gov/NR/rdonlyres/94BDEBD7-2A89-41EE-99F2-4959DA0B9EB5/0/A701.pdf> (accessed on April 5, 2013). See Section B(1)(a). August 15, 2012. (Hereinafter, "DOE Chancellor's Regulation A-701.")

112 When adequately priced, bundled payments discourages unnecessary care, encourages coordination across providers, and potentially improves quality, all without penalizing providers for treating sicker patients. However, bundling payments can increase the risk for underpayment if the value of the lump sum payment falls below the entire cost of care for the student. Miller, Harold D. "From Volume To Value: Better Ways To Pay For Health Care." *Health Affairs*. September/October 2009. <http://healthaffairs.org/content/28/5/1418.full> (accessed on April 5, 2013).

113 MRT Waiver Amendment, 2012, *supra* note 91.

On the State level, in January 2011, New York State Governor Andrew Cuomo and a team of stakeholders (known as the State’s “Medicaid Redesign Team”) began a multi-year effort (known as “Medicaid Redesign”) to align the State’s Medicaid payment and delivery systems with the principles of the “Triple Aim:” (1) improving the quality of care; (2) improving health by addressing root causes of poor health; and (3) reducing per capita costs (a concept commonly referred to as “bending the cost curve”).¹¹⁴ The Medicaid Redesign Team’s recommendations focused on increasing emphasis on early identification, preventive services and treatment, as well as the inclusion of behavioral and mental health benefits into a managed care structure. Medicaid Redesign also initiated the final phase of the State’s more than decade-long effort to move nearly all of its Medicaid beneficiaries out of fee-for-service and into managed care.

These transitions are concurrent with State efforts to eventually carve the behavioral health benefit into Medicaid managed care. This benefit carve-in for adult Medicaid enrollees will occur through one of three types of plans: (1) Special Needs Health and Recovery Plans (“HARPs”)¹¹⁵ for adults with significant behavioral health needs; (2) Mainstream Managed Care Plans meeting rigorous standards established by the State; and (3) partnerships with Behavioral Health Organizations (“BHOs”) for mainstream Managed Care Plans failing to meet those standards. A children’s behavioral health workgroup was formed by the Medicaid Redesign Team to recommend an appropriate risk-bearing design to manage the behavioral health benefit for children on Medicaid and to plan a transition toward that new model of behavioral health financing and service delivery.¹¹⁶ At this point in time, the children’s Medicaid behavioral health benefit carve-in is still under development.

While these federal and State reforms hold promise, it is critical that they be implemented in a manner that does not restrict (and rather, increases) a school-based mental health provider’s access to third party payments from Medicaid and commercial insurers. As the State concludes transitioning its Medicaid beneficiaries into managed care, there is growing anxiety among the provider community regarding the planned discontinuation of the Article 28 SBHC carve-out. Once the carve-out is discontinued, Article 28 SBHCs will no longer be able to bill State Medicaid directly and may, therefore, succumb to the same out-of-network penalties distressing Article 31 school-based clinics. Similarly, because BHOs and HARPs are also forms of managed care, they may also present a similar set of financial challenges to school-based providers. Meanwhile, school-based Article 31 providers continue struggling to survive after recent losses of major supplemental State dollars.¹¹⁷

Newly available federal and State funds to preserve, enhance and expand SBHCs will help school-based providers temporarily offset operating losses, but more must be done to correct the model’s inherent structural deficits. The establishment of Health Homes creates a more permanent solution to historic third party under- and non-payment to providers for undervalued, yet important care coordination services. That said, in the face of these reforms there is an opportunity to address the long-term structural deficits of school-based clinics and to revisit rate reform to ensure that services are reimbursed at a level reflective of the actual cost of care.

Opportunities and challenges in New York for financing school-based clinical mental health service delivery are constantly evolving. These dynamics are illustrated in this section’s synopsis of existing financing mechanisms, which accounts for notable changes since CCC first administered its surveys in 2010 and points to future actions that will once again reshape this landscape.

114 Berwick, Donald M., Thomas W. Nolan, and John Whittington. “The Triple Aim: Care, Health, and Cost.” *Health Affairs* 27, no. 3 (May 2008): 759-769.

115 HARPs will be modeled after Special Needs Plans, which is a health plan design for Medicaid enrollees with complex care needs requiring provider expertise and enhanced care managements. Helgerson, Jason A. “Medicaid Redesign Team Update and Next Steps: Significant Progress, Lots Still to Be Done.” Conference, *Medicaid in New York: Strengthening Care Management and Coverage*. United Hospital Fund Conference on Medicaid. July 10, 2013. Medicaid Redesign Team Amendment, 2012, *supra* note 91.

116 *Id.*

117 Funding supplements to Article 31 clinics, such as COPS and Clinic-Plus were recently discontinued. For details, see subsection on “Different treatment of Article 28 and Article 31 school-based providers by the State and City” under the *Financing School-Based Mental Health Services* section herein starting on page 17.

The *Findings* section of this report documents CCC's 2010 survey findings and will show that, despite emerging opportunities and challenges, many of the barriers to establishing and expanding school-based clinical mental health services documented in CCC's survey results persist. Given this reality, it is incumbent upon all stakeholders (e.g., legislators, agencies, school administrators, DOE staff, students, parents and advocates) to take full advantage of these emerging financing opportunities and to take steps to proactively mitigate challenges. Following a discussion of the survey findings, CCC puts forth a set of recommendations to improve children's access to direct and wraparound services, to optimize existing resources and to protect child-serving mental health providers from financial risk.

METHODOLOGY

Ensuring children are holistically healthy (both in mind and body) is central to CCC's mission. Growing concern over children's lack of timely access to appropriate mental health supports in New York City inspired CCC to research school-based mental health care and behavioral interventions to better appreciate their role in helping to meet children's mental health needs.

At the start of this project three years ago, CCC began an intensive literature review to gather background information and develop a sound knowledge-base on school-based mental health and school-wide behavioral intervention programs. From September through December 2009, CCC also held 11 meetings with the DOHMH, DOE, OMH and community-based mental health providers to augment research efforts and inform qualitative data collection techniques. CCC also held three policy briefings that presented on the academic benefits to students in schools with on-site health and mental health clinics. In February 2009, CCC hosted panels on "Adolescent Mental Health – Issues and Approaches,"¹¹⁸ and "Understanding the Implications of Infant Brain Development."¹¹⁹ In October 2010, CCC hosted a panel on "School-Based Health Services and Academic Outcomes."¹²⁰

CCC applied findings from this research to inform data collection efforts. In the next phase of the project, CCC sought to identify the existing landscape of these services; to better understand who is accessing these services; and to gain insight into the perspectives of elementary school principals and clinicians on the opportunities and challenges presented by these school-based services.

A) MAPPING

CCC received lists of public elementary schools¹²¹ and lists of public schools with on-site mental health services for the 2009-10 school year from the Department of Education.¹²² CCC mapped the locations of all public elementary schools (on page 28 herein) and separately mapped those elementary schools offering on-site mental health services during the 2009-10 school year (on page 29 herein).

CCC then overlaid the locations of these elementary school-based mental health services on CCC's Risk Ranking Map (on page 30 herein).¹²³ This risk ranking map is based on CCC's "Risks to Child Well-Being Index," which measures risks to child well-being in New York City by community district and is published bi-annually, along with a map, in

118 Panelists presenting at the "Adolescent Mental Health – Issues and Approaches" policy briefing include: Dr. Jennifer Petras, Attending Psychiatrist, Children's Village and Assistant Professor of Psychiatry, Westchester Medical College; Dr. Owen Lewis, Senior Vice President, Mental Health Supports and Interventions for School Environment Change, Turnaround; Dr. Myla Harrison, Assistant Commissioner, Bureau of Child and Adolescent Services, DOHMH.

119 Panelists presenting at the "Understanding the Implications of Infant Brain Development" policy briefing include: Dr. Steven Pavlakis, Director of Developmental Medicine and Child Neurology, Maimonides Infants and Children's Hospital and Chief Scientific Officer, Maimonides Medical Center; Dr. Gilbert M. Foley, Associate Professor of School, Clinical Child Psychology, Ferkauf Graduate School of Psychology, Yeshiva University; and Evelyn J. Blanck, Associate Executive Director, New York Center for Child Development.

120 Panelists presenting at the "School-Based Health Services and Academic Outcomes" policy briefing include: Margaret Rogers, Training and Education Coordinator, Montefiore Medical Center's School Health Program; Charles E. Basch, March Hoe Professor of Health Education, Teachers' College, Columbia University; and Roger Platt, MD, Chief Executive Officer, OSH.

121 DOE SY 2009-10 School Progress Report, *supra* note 35. The scope of CCC's data analysis is limited to schools categorized by the DOE Progress Reports as "Elementary," which most often enroll students in grades pre-kindergarten (or kindergarten) through the fifth grade. A handful of schools categorized by the DOE as "Elementary" also enroll students up through the sixth grade. Schools enrolling other ranges of elementary school-aged children, such as K-2, K-3, K-8 and K-12, are excluded from this analysis.

122 Information supplied by the DOE Office of School Health, which is reported online periodically.

123 "Figure 13: Risks to Child Well-Being by Community District." *Keeping Track of New York City's Children, Tenth Edition*, Citizens' Committee for Children of New York. 2010. (Hereinafter, "Risk Ranking Map – Keeping Track 9th Ed.")

CCC's *Keeping Track of New York City's Children*.¹²⁴ In this analysis and report, risk to child well-being is used as a proxy for assessing the level of need within a given community (e.g., the higher the risk to child well-being, the higher the needs of that community). Accordingly, this map illustrates service gaps based on expected need. To illustrate change over the past three years, an updated map overlaying existing services against need during the 2012-13 school year¹²⁵ can be found on page 58 under *Appendix 1: Additional Maps and Tables*.

CCC also identified elementary schools using behavioral intervention programs including, Positive Behavioral Interventions and Support and Turnaround for Children. At the time of CCC's analysis, the presence of this service delivery model in elementary schools was sparse, with only fourteen elementary schools administering these programs.

B) DEMOGRAPHIC INDICATORS

CCC conducted a demographic indicator analysis to determine whether there were notable demographic similarities or differences between children in schools with and without on-site clinical mental health services and/or school-wide behavioral intervention programs. CCC examined race/ethnicity, test scores, attendance and suspension rates, as well as a whole host of student characteristics (e.g. enrollment, individualized education program for special needs instruction, free lunch, English Language Learners and limited English).

C) PRINCIPAL SURVEY

CCC anonymously¹²⁶ surveyed elementary school principals to learn about the following: (1) their beliefs about the mental health needs of children in their schools; (2) the roles and responsibilities of their school staff with regard to addressing students' mental health needs; (3) their use of crisis intervention services, including the police and emergency medical services; (4) their views about the benefits and barriers to providing school-based clinical mental health services and school-wide behavioral intervention programs; and (5) their desire to establish clinical mental health services and/or a school-wide behavioral intervention program in their schools.

CCC placed a link to its anonymous online survey in the April 27, 2010 principals' weekly newsletter in the hopes of reaching the greatest number of principals with and without on-site clinical mental health services and behavioral health programs. Very few principals responded to the initial online survey. On May 19, 2010, CCC e-mailed the link to 392 NYC school principals across all grade levels. The survey was completed by June 2, 2010.

124 The level of risk to child well-being is based on a composite of nearly 30 indicators reported at the community level spanning the domains of economic conditions, health, youth (adolescent risks), housing, community life, safety, education and environment. Indicators in the risk ranking are first standardized by using Linear Scaling Technique, which calculates the difference between the value of a given Community District and that of the lowest value Community District, and divides this number by the difference between the highest value Community District and the lowest value Community District (Value-Min./Max.-Min.). Standardized values are then adjusted so that they are all scaled from high to low with regard to increasing well-being. Category values are then ranked to identify the highest and lowest levels. Within each of the categories, the Community Districts are listed in order of their CD number in each block. Categories are averaged to obtain overall risk rank for map. "Figure 12: Ranking New York City's Communities by Risks to Child Well-Being." *Keeping Track of New York City's Children, Tenth Edition*, Citizens' Committee for Children of New York. 2010. (Hereinafter, "Risk Ranking Chart – Keeping Track 9th Ed.")

125 "Figure 1.15: Ranking New York City's Communities by Risks to Child Well-Being." *Keeping Track of New York City's Children, Tenth Edition*, Citizens' Committee for Children of New York. 2013. (Hereinafter, "Risk Ranking Chart – Keeping Track 10th Ed.") "Figure 1.16: Risks to Child Well-Being by Community District." *Keeping Track of New York City's Children, Tenth Edition*, Citizens' Committee for Children of New York. 2013. (Hereinafter, "Risk Ranking Map – Keeping Track 10th Ed.") DOE School Search Tool, *supra* note 28.

126 CCC administered the surveys anonymously to encourage greater candor among respondents.

Thirty-five elementary school principals completed the entire survey, comprising CCC's sample of surveyed principals. Twenty-five elementary school principals reported that their schools had on-site clinical mental health services via a health or mental health clinic. Ten of the elementary school principals reported that their school did not have on-site clinical mental health services. In addition, school-wide behavioral intervention programs were reported at six of the represented schools with and four without on-site clinical mental health services.

D) CLINICIAN INTERVIEW

CCC also administered an in-person survey interview of mental health clinicians providing on-site clinical mental health services to elementary school students in schools. The survey asked the clinicians for their opinions on the following: (1) the mental health needs and diagnoses of elementary school age children; (2) the social and emotional stressors that they believe impact elementary school children; (3) the staffing structure of their school-based clinics; (4) the clinician's role and responsibilities in their school; (5) the types of mental health and crisis intervention services available on-site in their schools; and (6) the perceived benefits and barriers to providing school-based clinical mental health services.

From April 2010 through June 2010, CCC administered the in-person survey to randomly selected mental health clinicians from school-based health and mental health clinics. As of January 2010, there were a total of 101 elementary school-based clinics that had a mental health component (81 SBMHCs, fifteen SBHCs with a mental health component and five with both) across the five boroughs. CCC aimed to survey 25 percent of these schools (approximately 25 clinics). CCC identified the share of elementary school on-site clinical mental health services in each borough and applied a proportionate share to each borough sample size. For example, 27.7 percent of the total school-based mental health programs in DOE elementary schools were located in the Bronx.¹²⁷ Accordingly, CCC took 27.7 percent of the sample size of 25 and set a goal of interviewing seven school-based mental health clinicians in the Bronx.¹²⁸ Ultimately, CCC successfully interviewed 22 school-based clinicians across the City, representing about a fifth of on-site clinics in DOE elementary schools. Nineteen of these clinicians worked in SBMHCs and three worked in SBHCs that provided direct clinical mental health services.¹²⁹

E) DATA COLLECTION LIMITATIONS

There are a few limitations to CCC's data collection efforts:

- The location of school-based clinical mental health services was derived from spreadsheets available on the New York City DOE's website, a source of information that is not frequently updated; and
- CCC samples sizes for principals and school-based mental health clinicians were not large enough to be statistically representative.

127 Please consult "Table 4" in *Appendix 1: Additional Maps and Tables* on page 60 herein for the complete borough distribution.

128 Clinics were selected at random for the sample. Names of each school-based clinic sponsoring agency were separated by borough and type of clinic (school-based mental health or school-based health centers with mental health services), placed into a box and drawn individually drawn at random. To safeguard against over-representation of any one sponsoring agency within the sample size, CCC interviewed a number of clinicians proportionate to their sponsoring agency's borough representation. (For example, if an agency sponsored 38 percent of all programs in Manhattan, CCC would have capped clinician interviews at 38 percent of the sites under that program's supervision). Letters and emails were mailed to the randomly selected clinics in May 2010 and CCC follow-up with telephone calls and emails to confirm participation in the survey, secure the site for interviews and began to schedule one on one survey administration in May 2010 and completed by June 2010 just before the end of the school year.

129 Please consult "Table 4" in *Appendix 1: Additional Maps and Tables* on page 60 herein for the complete borough distribution.

FINDINGS

CCC's surveys covered a wide range of topics and generated insightful responses. CCC's survey results show there is widespread support for greater investments in school-based clinical mental health services and behavioral intervention programs in New York City.

The responses of surveyed principals and school-based mental health clinicians documented the benefits of school-based mental health services at the schools they work in. Surveyed principals and clinicians noted that classroom learning environments can be adversely impacted by the unmet mental health needs of students; and that conversely, students, classrooms, teachers and families all benefit when those needs are better met. Most believed that the availability of on-site mental health services had a mitigating effect on classroom order, student performance and overall school environment.

Survey findings also showed that there were challenges facing not only those providing school-based mental health services, but also as the schools in which they were co-located. Notably, there was much discussion about the need to stabilize clinic financing in order to sustain existing programs and then to eventually expand them to other schools. In addition, responses indicated that there was additional work that could be done to reduce emergency room referrals, foster more collaboration between DOE school staff and mental health professionals and to better engage families in the child's treatment plan.

A) LOCATION OF SCHOOL-BASED CLINICAL MENTAL HEALTH SERVICES

Finding: School-based clinical mental health services and school-wide behavioral interventions are scarce and must be expanded upon.

According to data supplied by the DOE at the time of CCC's survey (spring 2010), 101 of New York City's 612 traditional elementary¹³⁰ schools delivered clinical mental health services through an SBHC or an SBMHC and 14 elementary schools engaged in school-wide behavioral intervention programs. Of the fourteen schools administering a school-wide behavioral intervention, 13 administered these interventions concurrently with school-based clinical mental health services. More than four-fifths of all DOE elementary schools (497 sites) offered neither an on-site clinic nor administered a school-wide behavioral intervention program. For details, see "Table 1" on page 31 for and "Table 3" in *Appendix 1: Additional Maps and Tables* on page 59.

The maps on the next few pages illustrate the limited presence of mental health clinical services available in DOE elementary schools during the 2009-10 school year. Services appear to have been largely concentrated in most of the City's reportedly highest risk/highest needs communities.¹³¹ This includes the Manhattan communities of East Harlem, Central Harlem, Washington Heights and the Lower East Side; Hunts Point, Morrisania, Unionport/Soundview, Williamsbridge and East Tremont in the Bronx; East New York in Brooklyn; and St. George in Staten Island.

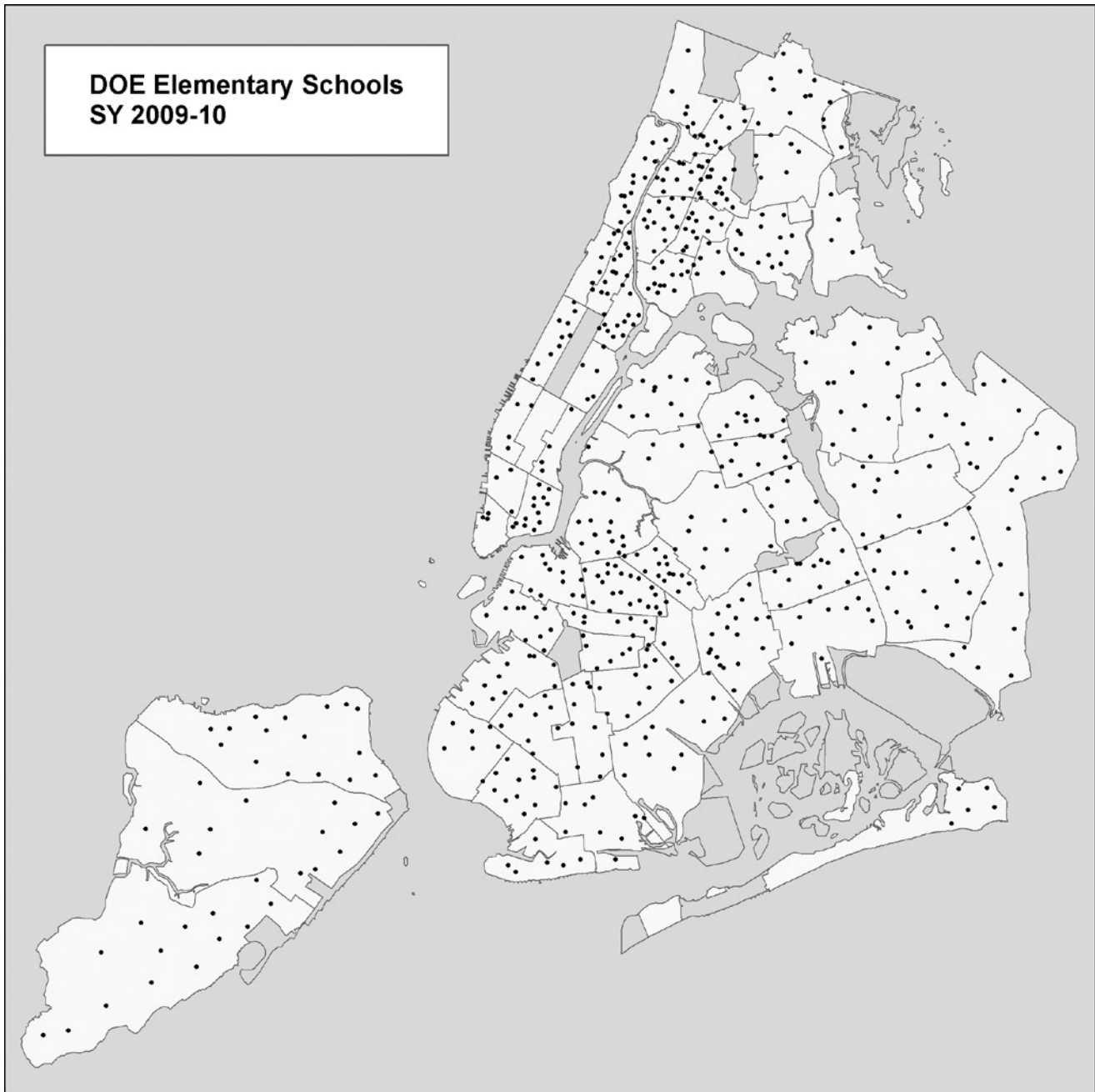
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¹³⁰ The scope of CCC's data analysis is limited to schools categorized by the DOE Progress Reports as "Elementary," which most often enroll students in grades pre-kindergarten (or kindergarten) through the fifth grade. A handful of schools categorized by the DOE as "Elementary" also enroll students up through the sixth grade. Schools enrolling other ranges of elementary school-aged children, such as K-2, K-3, K-8 and K-12, are excluded from this analysis.

¹³¹ Identified in CCC's risk-ranking index to be within the top eight highest risk communities to child well-being out of all 59 NYC Community Districts.

Per “Map 5” in *Appendix 1: Additional Maps and Tables* on page 58 herein, three years later, many medium-to-high needs communities are still showing a limited presence of elementary school-based mental health services including the Bronx communities of Mott Haven, Fordham/Bedford Park and Unionport/Soundview; Williamsburg/Greenpoint, East Flatbush, Crown Heights South, Borough Park, Flatbush/Midwood and Brownsville in Brooklyn; Central Harlem in Manhattan and Jackson Heights in Queens.

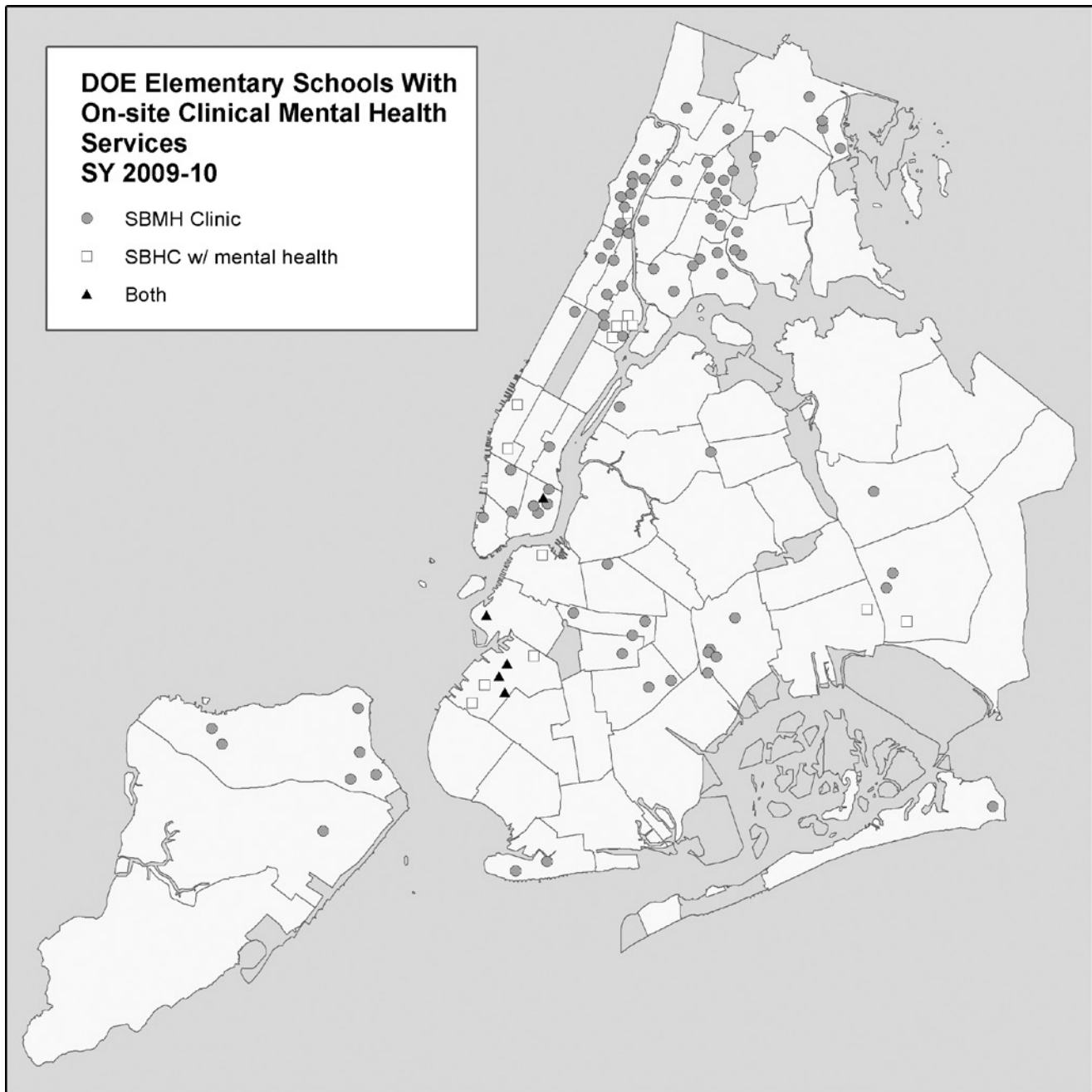
**Map 2:
All SY 2009-10 DOE Elementary Schools.**



There were 612 elementary schools operating within the DOE system during School year 2009-10. The scope of CCC's data analysis is limited to schools categorized by the DOE School Progress Reports as "Elementary," which most often enroll students in grades pre-kindergarten (or kindergarten) through the fifth grade. A handful of schools categorized by the DOE as "Elementary" also enroll students up through the sixth grade. Schools enrolling other ranges of elementary school-aged children, including K-2, K-3, K-8 and K-12, are excluded from this analysis.

Source: DOE SY 2009-10 School Progress Report, *supra* note 35.

**Map 3:
All SY 2009-10 DOE Elementary Schools Offering On-Site
Clinical Mental Health Services.**

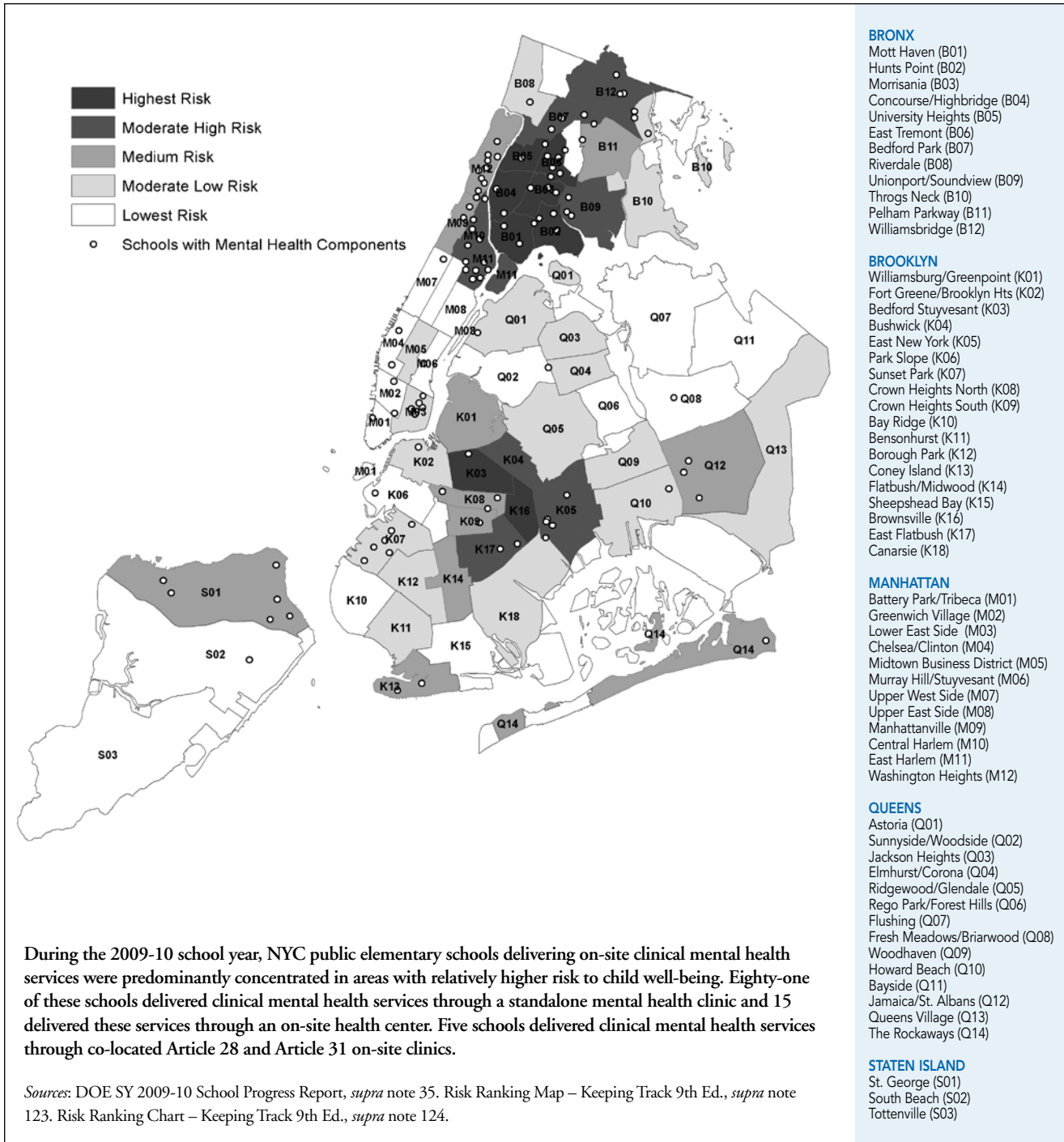


During School Year 2009-10, one-hundred-one schools delivered on-site clinical mental health services. Eighty-one of these schools delivered clinical mental health services through a standalone mental health clinic and 15 delivered these services through an on-site health center. Five schools delivered clinical mental health services through co-located Article 28 and Article 31 on-site clinics.

The scope of CCC's data analysis is limited to schools categorized by the DOE School Progress Reports as "Elementary," which most often enroll students in grades pre-kindergarten (or kindergarten) through the fifth grade. A handful of schools categorized by the DOE as "Elementary" also enroll students up through the sixth grade. Schools enrolling other ranges of elementary school-aged children, including K-2, K-3, K-8 and K-12, are excluded from this analysis.

Sources: DOE SY 2009-10 School Progress Report, *supra* note 35. SY 2009-10 SBMH Program Listing, *supra* note 35.

Map 4: All SY 2009-10 DOE Elementary Schools Offering On-Site Clinical Mental Health Services Measured Against Risk to Child Well-Being.



Finding: The data from the demographic indicator analysis suggests that school-based clinical mental health services and/or school-wide behavioral intervention programs served high-needs populations.

The data from CCC’s demographic indicator analysis below suggests that DOE elementary schools **with** mental health clinical services and/or school-wide behavioral intervention programs on-site served higher needs populations, which is aligned with findings from “Map 4” on page 30. For example, schools **with** on-site mental health clinical services and/or a school-wide behavioral intervention program had a higher rate of English Language Learners rate, lower test scores and a greater percentage of children who qualified for free lunch.

TABLE 1. DEMOGRAPHIC INDICATOR ANALYSIS

Demographic Indicator Analysis NYC Public Elementary Schools, SY 2009-10 (as a percentage of enrollment)					
Elementary School Demographic Indicators	On-Site Clinical	Behavioral Intervention	Both Incl./ Behav.	Neither Incl./ Behav	Total Elementary Schools
Student Enrollment in Schools	53,161	2,807	8,793	312,938	377,699
Student Characteristics					
IEP*/Special needs education	18.9%	21.1%	22.3%	15.6%	16.3%
Free Lunch	77.7%	88.3%	90.7%	68.2%	70.3%
Limited English	22.0%	29.6%	15.6%	18.0%	18.6%
Race/Ethnicity					
White	7.6%	1.0%	3.6%	18.4%	16.4%
Black	27.9%	33.4%	46.6%	24.9%	25.9%
Hispanic	55.3%	63.6%	47.3%	38.4%	41.2%
Test Scores					
ELA*	41.2%	24.5%	30.0%	49.2%	47.4%
Math*	53.6%	35.0%	36.7%	60.9%	59.2%
Other School Characteristics					
Attendance Rate	92.8%	91.5%	91.4%	93.7%	93.5%
Suspension Rate	1.9%	4.2%	2.8%	1.6%	1.7%
Stability Rate**	78.4%	72.3%	77.5%	82.1%	81.4%
<p>* For these categories, data were not available for all schools in our sample. Of the 612 DOE elementary schools operating during SY 2009-10, data were available for 595 schools. Within this sample, 98 schools offered on-site clinical mental health services, four administered a behavioral intervention, 14 offered a combination of both, and 479 offered neither.</p> <p>** Stability Rate refers to the percent of students in the highest grade who were also enrolled at any time during the previous year.</p> <p>Sources: “2009-10 Database (ZIP).” School Report Card Data: SY 2009-10. New York State Department of Education n.d. https://reportcards.nysed.gov/counties.php?year=2010 (accessed on January 4, 2010). SY 2009-10 SBMH Program Listing, <i>supra</i> note 35. DOE SY 2009-10 School Progress Report, <i>supra</i> note 35.</p>					

B) ELEMENTARY SCHOOL CHILDREN'S MENTAL HEALTH NEEDS AND DIAGNOSES

Since school-age children spend many of their waking hours in school, school personnel and on-site clinic staff often serve as a key component of the frontline for observing children's behavior, identifying children's potential mental health needs and connecting them to the appropriate supports. This section explores the perceived need for clinical mental health services for elementary school students by surveyed principals and clinicians, as well as the extent to which existing programs in surveyed schools were meeting children's mental health needs. Accordingly, CCC asked principals and mental health clinicians to estimate the share of children in their schools presenting mental health and/or behavioral health needs, to identify those needs and to gauge the extent to which those needs influenced a child's experience in school.

Finding: All surveyed principals of schools with and without on-site clinical mental health services were aware of students in their schools presenting a mental health or behavioral needs that impeded their learning or disrupted the learning of other children.

When asked to estimate the share of children in their school presenting mental health or behavioral needs that impeded their learning or disrupted the learning of other children, all of the surveyed principals stated at least "a few" to "almost all" children presented a mental health or behavioral need (35/35). The majority of surveyed principals of schools **with** (19/25) and more than half of those **without** (7/10) on-site clinical mental health services reported that this described "some" to "many" children in their schools.

Finding: Many surveyed clinicians reported observing social emotional stressors in almost every child they treated over the past six months and that the most frequently observed stressors were single parent households and severe economic stress in the home.

When asked to estimate the share of students they treated over the past six months impacted by various social and emotional stressors, nine out of the 22 (9/22) surveyed clinicians said single parent households and severe economic stress in the home were present in "almost every child" they treated. Eight out of the 22 (8/22) surveyed clinicians said experiencing community violence was present in "almost every child" they treated. Ten out of the 22 (10/22) surveyed clinicians surveyed stated that in the last six months, experience with divorce/parental separation or bullying were present in "many children" they treated.

Finding: Many surveyed clinicians reported that in the six months prior to the survey, attention deficit disorder/attention deficit hyperactivity disorder, disruptive/conduct disorder or adjustment disorder were observed in almost every child they treated.

When asked to estimate the share of the children they had treated over the prior six months that had a mental health diagnosis, slightly more than half (13/22) of the surveyed clinicians said "many" or "almost every child" they treated had Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder ("ADD/ADHD"). Eleven out of the 22 surveyed clinicians reported that "many" or "almost every child" they treated had a disruptive/conduct disorder. Nine out of the 22 clinicians said that "many" or "almost every child" they treated had an adjustment disorder.

C) DOE ELEMENTARY SCHOOL STAFF ROLES AND RESPONSIBILITIES IN PROVIDING CLINICAL MENTAL HEALTH SERVICES

This section reports the principals' perceptions of DOE staff roles and responsibilities regarding the delivery of mental health services to students. It also explores whether DOE staff adjust their roles and responsibilities based on whether or not there are of on-site clinicians. To solicit this information, CCC asked school principals to rank the top three most critical functions performed by the DOE guidance counselor, social worker and psychologist from a pre-determined list.

Finding: “Counsel students on a scheduled basis” and “provide crisis management to students” were identified by most surveyed principals as critical functions performed by the DOE guidance counselor.

When asked to rank the top three most critical functions performed by the DOE guidance counselor, nearly all (24/25) surveyed principals of schools **with** on-site clinical mental health services and nine out of the 10 principals of schools **without** on-site clinical mental health services selected “counsel students on a scheduled basis” as a critical function performed by the DOE guidance counselor. Additionally, a majority of surveyed principals of schools **with** (21/25) and most **without** (9/10) on-site clinical mental health services selected “provide crisis management and intervention to students” as a critical function performed by the DOE guidance counselor.

Finding: “Work with parents on special education issues” and “participation in Individualized Education Program meetings” were identified by most surveyed principals as critical functions performed by the DOE social worker.

When asked to rank the top three most critical functions performed by the DOE social worker, nearly three-fourths principals of schools **with** (18/25) and many **without** (7/10) on-site clinical mental health services selected “work with parents on special education issues” as a critical function. Additionally, almost half (12/25) of the surveyed principals of schools **with** on-site clinical mental health services and seven out of the 10 principals of schools **without** on-site clinical mental health services reported “participation in Individualized Education Program meetings” as a critical function performed by the DOE social worker.

Finding: “Ensuring the effective management of the special education evaluation process” and “administering psycho-educational assessments” were identified by most principals as critical functions performed by the DOE psychologist.

When asked to rank the top three most critical functions performed by the DOE psychologist, nearly all surveyed principals of schools **with** (24/25) and most **without** (8/10) on-site clinical mental health services indicated “ensuring the effective management of the special education process” as a critical function. Additionally, many of the surveyed principals of schools **with** (17/25) and most **without** (9/10) on-site clinical mental health services reported “administering psycho-educational assessments” as a critical function performed by the DOE psychologist.

There was variation among principals’ priorities regarding mental health/psychosocial evaluations. Fifty percent (5/10) of the surveyed principals of schools **without** on-site clinical mental health services reported that “conducting mental health/psychosocial evaluations” was a critical function of the DOE psychologist. Roughly a quarter (6/25) of surveyed principals of schools **with** on-site clinical mental health services reported that “conducting mental health/psychosocial evaluations” was a critical function of the DOE psychologist.

Finding: The majority of surveyed principals reported regularly scheduling meetings with staff members to discuss response strategies for students presenting acute mental health/behavioral needs. Schools with on-site mental health clinicians did not always include the clinicians in these meetings.

When asked if staff members regularly meet to discuss response strategies for children who present mental health/behavioral health needs, many surveyed principals of schools **with** (17/25) and most **without** (8/10) on-site clinical mental health services reported holding regularly scheduled meetings. While the meetings always included the principal and DOE staff, only one in 22 (1/22) clinicians reported spending a great deal of the time participating in school-based meetings to determine response strategies for students presenting these needs. Nineteen (19/22) reported spending some to very little time in such meetings, and two (2/22) did not spend any time in these meetings.

While most clinicians reported a minimal level of involvement in school-based meetings, most clinicians reported meeting separately with teachers about particular students. Specifically, nine clinicians (9/22) reported spending a great deal of time and eleven (11/22) reported spending some time meeting with teachers separately while two clinicians (2/22) reported spending no time in clinician-teacher meetings.

D) STAFFING STRUCTURE AND CLINICAL MENTAL HEALTH SERVICES DELIVERED BY SCHOOL-BASED CLINICIANS

This section explores the staffing structure of school-based health centers and mental health clinics, clinicians' credentials, the types of psychiatric supports available, supervision, caseloads and clinical mental health services provided. Clinicians also reported on the referral process, mental health assessments, the timing and duration of treatment sessions and the trainings they provided.

Finding: Data from surveyed clinicians suggested there were common mental health staffing patterns in both school-based health centers and mental health clinics.

The majority of the surveyed clinicians staffed in either school-based Article 28 or 31 clinics held a social work degree. Sixteen out of the 22 (16/22) surveyed clinicians had a social work degree and four out of the 22 (4/22) clinicians surveyed had a psychology degree (either a Psyc.D or PhD). All of the surveyed clinicians reported that they were supervised by a psychiatrist. Nearly three-fourths (16/22) of the clinics' psychiatrists were located at the main clinic site rather than in the school-based clinic. Most community based clinics staff a single mental health clinician on school grounds while colleagues and supervisors are located at other sites – both in other schools and at the main clinic site. Many of the clinicians stated that they traveled to the main clinic site for weekly meetings and supervision.

Finding: Surveyed clinicians reported a caseload average that ranged from 5 to 25 students.

When asked to estimate the average caseload in their school-based clinic, almost half (10/22) of the clinicians estimated 11 to 20 students, six estimated 25 and five estimated five to 10.

Finding: Surveyed clinicians reported that assessment/evaluations, individual psychotherapy and collateral sessions were the most common services provided to elementary school students in their schools.

When asked to estimate the share of children receiving various clinic services, all clinicians (22/22) reported that “almost every child” or “many children” receive an assessment/evaluation. This was followed by individual psychotherapy (20/22) and collateral sessions (19/22), which are therapeutic sessions with a child's family members or other significant persons in the child's life.

Finding: Surveyed clinicians reported receiving referrals from various sources.

When asked to indicate common sources of referrals, most (20/22) surveyed clinicians reported that they received referrals from teachers. This was followed by parents (19/22) and principals and guidance counselors (both, 18/22).

Finding: Surveyed principals reported that teachers are the most likely professionals to refer children presenting behavioral/mental health needs for an assessment.

When asked to identify the school-based professionals who typically refer children presenting behavioral/mental health needs for an assessment, most surveyed principals of schools **with** (21/25) and all **without** (10/10) on-site clinical mental health services identified teachers as the most likely to make a referral. This was followed by the DOE guidance counselor and principal. Twenty-one out of the 25 surveyed principals of schools **with** on-site clinical mental health services reported that parents are able to make referrals directly to the school-based clinic for their child to receive a mental health assessment.

Finding: The majority of the surveyed clinicians reported often referring students they assess for clinical mental health services.

When asked to estimate the share of children referred for clinical mental health services after receiving a mental health assessment, nearly three-quarters (16/22) of the clinicians selected “90-100%.”

Finding: The majority of the surveyed clinicians reported that the typical length of time for a treatment session in school settings is less than 30 minutes, which is shorter than a full class period.

When asked to estimate the typical length of a time for a treatment session with students, almost half (12/22) of the clinicians selected 30 minutes, which is less than one class period.¹³² Clinicians noted that the allotted session time builds in non-treatment time to escort the children to and from the classroom, which limits the length of actual treatment within a given session.

Finding: Most of the surveyed clinicians noted that treatment sessions typically occurred during non-academic class periods, avoiding conflict with student learning.

When asked when the clinician typically sees the child, most (19/22) reported that the psychotherapy sessions took place during non-academic class periods. This was followed by lunch time (17/22), academic class periods (14/22) and after-school (11/22).

Finding: The majority of the surveyed clinicians reported that the average duration of treatment within the school-based clinic lasted six months or longer.

When asked what the average duration of treatment was within the school-based clinic, more than half of the surveyed clinicians (13/22) selected “over one school year.” Seven clinicians selected “six months to a year.” This suggests that a majority of children treated by on-site mental health clinicians require and receive ongoing treatment.

Finding: Most surveyed clinicians reported training parents and students on mental health topics; however, very few of the clinicians reported extending trainings to school staff.

When asked if they provide group trainings on mental health topics, slightly more than half (12/22) of the surveyed clinicians stated that they provided trainings to students and parents. On the other hand, only seven of the 22 surveyed clinicians stated that they trained school staff on mental health topics. Surveyed clinicians reported that the two most frequent topics for parent trainings were parenting skills and an overview of mental health. Surveyed clinicians reported most frequently training students on conflict resolution and bullying prevention. The two most frequent topics reported for staff trainings were an overview of mental health and classroom management.

Finding: Surveyed clinicians reported balancing their time between billable and non-billable services.

When asked how much of their time during an average week was spent on various tasks, the surveyed clinicians most frequently reported that a “great deal of my time” or “most of my time” was spent on regular appointments (20/22). Fifteen out of the 22 surveyed clinicians reported that “a great deal of my time” or “most of my time” was spent on administrative work (15/22). Other tasks frequently performed by clinicians included “parent outreach” and “managing disruptive children” (both, 10/22) and “consulting with teachers” (9/22). Aside from regular appointments (or, student therapy sessions), none of the other services are billable.

¹³² A typical class period in the NYC DOE system is 42 minutes.

E) CRISIS INTERVENTION SERVICES AND PROTOCOL

This section explores the use of crisis intervention services, including those provided by a school-based mental health clinician and emergency room usage.

Finding: Surveyed principals reported referring students to the emergency room within the year prior to being interviewed by CCC.

When asked how many of their students were referred to the emergency room last year, the majority of principals reported “a few” children. Three quarters of surveyed principals of schools **with** (19/25; 76%) and more than half of those **without** (6/10) on-site clinical mental health services reported referring “a few” children to the emergency room in the past year in response to either disruptive behaviors or unmet social emotional needs. None of the surveyed principals reported referring no children to the emergency room.

Finding: The majority of the surveyed clinicians rarely referred students for psychiatric hospitalization.

When asked to estimate the frequency of clinic referrals for student psychiatric hospitalization, twelve out of the 22 surveyed clinicians selected “rarely”. This was followed by “occasionally” (6/22) and “never” (4/22).

Finding: Surveyed clinicians reported that all students that experienced a psychiatric crisis received follow-up counseling at the clinic.

When asked about post-crisis follow-up with students, parents and school staff after a crisis situation occurs, all of the clinicians (22/22) reported that the child would receive counseling at the clinic. Eighteen out of the 22 clinicians reported participating in a meeting with the student, parent and teacher.

F) BENEFITS OF SCHOOL-BASED CLINICAL MENTAL HEALTH SERVICES AND SCHOOL-WIDE BEHAVIORAL INTERVENTION PROGRAMS

This section explores the perceived benefits by principals and clinicians of school-based clinical mental health services; school-wide behavioral intervention programs; and the presence of DOE guidance counselors, social workers and psychologists.

“The mental health clinic has made a tremendous difference to our school climate since it’s been located on-site. Students get the help they need and it makes a difference in their lives,”
—Surveyed principal

Finding: The majority of surveyed clinicians reported that having clinical mental health services available on school grounds moderately or significantly benefitted students by reducing suspensions and referrals to special education.

Most (20/22) surveyed clinicians reported that the availability of on-site clinical mental health services has a “moderate” or “significant” benefit to reducing student suspensions. Sixteen out of the 22 surveyed clinicians reported that on-site clinical mental health services provided a “moderate” or “significant” benefit to referrals to special education. This was followed by student expulsions and student grades (both, 15/22).

Finding: Almost all of the surveyed principals of schools with on-site clinical mental health services reported observing similar benefits to students.

When asked if the availability of on-site clinical mental health services in the school provided a benefit to students, the majority of surveyed principals of schools **with** on-site clinical mental health services reported that these services have a “moderate” to “significant” impact on student attendance (22/25) and referrals to special education (22/25) and student grades (21/25).

Finding: The majority of the surveyed clinicians reported that on-site clinical mental health services moderately or significantly benefitted classroom order and the school environment.

When asked if having on-site clinical mental health services had benefitted the school, most (20/22) surveyed clinicians reported that they have a “moderate” or “significant” benefit to both classroom order and the school environment. Eighteen out of the 22 surveyed clinicians said that on-site clinical mental health services provided a “moderate” or “significant” benefit to parent engagement. Fewer emergency room visits for psychiatric care and improved teacher morale were also reported benefits (both, 17/22).

Finding: Almost all of the surveyed principals of schools with on-site clinical mental health services reported that the availability of on-site clinical mental health services benefitted the school environment.

When asked if the availability of on-site clinical mental health services benefitted the school, nearly all (22/25) surveyed principals of schools **with** on-site clinical mental health services reported that they have a “moderate” to “significant” impact on the school environment. This was followed by benefits to parent engagement and incident reports (both, 21/25).

Finding: All surveyed principals of schools without on-site clinical mental health services believed their students, and the overall school, would benefit from bringing such services to school grounds.

All surveyed principals of schools **without** on-site clinical mental health services (10/10) reported that they believed that on-site clinical mental health services could have a beneficial impact on referrals to special education, classroom order, teacher morale, incident reports, emergency room visits for psychiatric care and the school environment. Additionally, most (9/10) of those principals believed school-based clinical mental health services could benefit student suspensions, expulsions, grades and parent engagement.

Finding: All surveyed principals of schools administering a school-wide behavioral intervention program reported benefits to classroom order, teacher morale and the school environment.

When principals of schools administering a school-wide behavioral intervention program (Positive Behavioral Intervention Supports, Turnaround for Children or other) were asked if the availability of these programs benefitted the students and school, all of the surveyed principals whose schools had these programs (10/10) reported that they have a “moderate” to “significant” impact on classroom order, teacher morale and the school environment.

“I partnered with Turnaround for Children last year. As a result of this partnership, we have decreased suspensions and increased attendance. Additionally, we went from a ‘B’ on our Progress Report to an ‘A.’ Providing teachers with training and tools to manage difficult students has been instrumental.”
—Surveyed Principal

G) PERCEIVED BARRIERS TO PROVIDING COMPREHENSIVE SCHOOL-BASED CLINICAL MENTAL HEALTH SERVICES

This section explores the range of barriers to establishing and preserving clinical mental health services in New York City’s public elementary schools that were reported by surveyed principals and clinicians. Financial and regulatory barriers can create a structural operating deficit for school-based clinics, which threatens their long-term viability. Even if a school is able to bring clinical mental health services on-site, parent-oriented barriers (e.g., concerns about stigma and limited parental engagement) and child-related barriers (e.g., limited child access) can impede a student’s access to care.

Finding: Surveyed principals of schools with on-site clinical mental health services reported that the most significant child-related barriers to providing clinical mental health services were the child's prior negative experience with clinical mental health services and the child's insurance or lack thereof.

When asked to select from a list of potential barriers related to the child in providing clinical mental health services, a little more than half (13/25) of the surveyed principals of schools with on-site clinical mental health services selected a child's prior experience with clinical mental health services as a "moderate" to "significant" barrier. This was followed by the child's insurance or lack thereof (12/25). Notably, a child's health insurance status as a reported barrier to providing clinical mental health services should be inconsistent with the school-based clinics mandate to serve every child presenting for service regardless of their health insurance coverage status.¹³³

Finding: Surveyed clinicians cited parental barriers and access to the child as the most significant child-related barrier.

When asked to select from a list of potential barriers related to the child in providing clinical mental health services, almost half (10/22) of the surveyed clinicians selected parental barriers as a "moderate" to "significant" barrier. This was followed by restricted access to the child due to special events such as testing days and the school's vacation schedules (9/22).

Finding: Surveyed principals of schools with on-site clinical mental health services reported that the parent's prior experience with clinical mental health services and concerns about stigma to their child were the most significant parent-related barriers to students' access to clinical mental health services.

When asked to select from a list of potential parent-related barriers to providing clinical mental health services to children, more than two-thirds (17/25) of surveyed principals of schools **with** on-site clinical mental health services selected parent's prior experience with clinical mental health services as a "moderate" to "significant" barrier. This was followed by parental concern about stigma to his or her child (16/25).

Finding: Surveyed clinicians reported that the most significant parent-related barriers to providing clinical mental health services to children were parental concerns about stigma, mental health counseling appearing on a child's permanent record and the parent's denial of his or her child's unmet needs.

When asked to select from a list of potential barriers related to the parent in providing clinical mental health services to the students, more than three-quarters (17/22) of the surveyed clinicians identified parent concern about stigma as a "moderate" to "significant" barrier. They also identified parent concerns that mental health counseling would be reflected on their child's permanent record and parent's denial of a problem as top barriers (both 16/22).

Finding: Competing demands for student time and school space were cited as major school-related barriers by almost half of the surveyed principals of schools with on-site clinical mental health services.

When asked to select from a list of potential school-oriented barriers to delivering mental health services to students, almost half (12/25) of the surveyed principals of schools **with** on-site clinical mental health services selected that the space for the clinic was not always adequate and competing demands within the school so that access to the child was restricted to limited hours/days as "moderate" to "significant" barriers.

¹³³ OSH SBHC Description, *supra* note 85.

Finding: Some of the surveyed clinicians reported that the most significant school-related barriers delivering on-site mental health services were competing educational demands, DOE staff insensitivity to the child and the lack of adequate space.

When asked to select from a list of potential school-related barriers to delivering mental health services to students, more than a third (8/22) of the surveyed clinicians selected competing demands within the school and DOE staff insensitivity to the child as “moderate” to “significant” barriers. This was followed by the lack of available adequate space (6/22). Notably, space issues are likely a larger barrier in schools without clinics than those that found space.

“It is complicated working in the schools. DOE staff is charged with the responsibility of educating students. In many ways the schools are not efficient in making sure kids’ mental health needs are met.”
– Surveyed Clinician

Finding: Some of the surveyed clinicians reported that the most significant clinic-related barriers were funding constraints, a shortage of clinic staffing and the inability to see every parent.

When asked to select from a list of potential barriers clinicians face in providing clinical mental health services to students, nine (out of 22) surveyed clinicians selected funding constraints as a significant barrier. Six out of the 22 surveyed clinicians selected shortage of clinic staffing and the inability to see every parent as a significant barrier.

Finding: The majority of the school-based clinics remained open during school academic year vacations, while only a slight majority of them remained open during July and August.

When asked if the school-based clinic remained open during school-year vacations and/or summer break the (July and August), more than half (14/22) of the clinicians reported that the clinic remained open during school-year vacations, while a similar number (12/21) reported that the clinics remained open during July and August. Some of the clinicians reported that clinics close when the school is closed, including during school year vacations and summer breaks. Clinics’ inability to operate year-round obstructs access to care for children and their families who rely on these clinic services to meet most of their basic health and mental health care needs. Ten out of the 22 surveyed clinicians reported that if the clinic is not open during July and August the children typically go to the main clinic site or another mental health provider to receive treatment.

H) ESTABLISHING AND/OR EXPANDING CLINICAL MENTAL HEALTH SERVICES, SCHOOL-WIDE BEHAVIORAL INTERVENTION PROGRAMS AND DOE SCHOOL PERSONNEL IN ELEMENTARY PUBLIC SCHOOLS

This section explores the principals’ willingness to establish and/or expand on-site clinical mental health services, school-wide behavioral intervention programs and/or increase the number of DOE school staff (guidance counselors, social workers and psychologists). It also explores reported barriers to increasing the capacity of these services and increasing the number of DOE school staff.

Finding: The majority of surveyed principals of schools supported increasing the capacity of clinical mental health services in their schools.

When asked if they wanted to increase the capacity of clinical mental health services in their schools, a majority of principals **with** (16/24) and **without** (8/10) responded to this question in the affirmative.

Finding: The majority of surveyed principals wanted to increase the capacity of school-wide behavioral intervention programs in their schools.

When asked, “Would you like to increase the capacity of school-wide behavioral intervention in your school?” almost three-quarters (18/25) principals of schools **with** and most (9/10) **without** on-site clinical mental health services wanted to increase the capacity of school-wide behavioral intervention programs in their schools.

Finding: The majority of surveyed principals wanted to increase the number of on-site DOE social workers, guidance counselors and psychologists.

When asked if they favored increasing the number of DOE school personnel on their staff, a majority of principals of schools **with** (17/25) and **without** (8/10) on-site clinical mental health services and reported they would like to increase the number of DOE school personnel. These principals indicated they wanted to increase the number of DOE social workers, guidance counselors and psychologists.

Finding: The biggest barriers to establishing or expanding clinical mental health services, school-wide behavioral intervention programs and/or DOE school personnel identified by surveyed principals included the lack of supplemental financing to stabilize operations and students’ educational needs competing for limited DOE resources.

When asked to identify barriers to establishing and/or expanding services in their schools, many surveyed principals of schools **with** (19/24) and **without** (7/10) on-site clinical mental health services cited the lack of supplemental financing and competing DOE-supported educational needs as the biggest barriers.

RECOMMENDATIONS

School-based clinical mental health services are proven to bridge access gaps for children with mental health needs while improving their academic experience. CCC's survey results affirm that principals highly value on-site clinical mental health services and would likely bring those services to their schools, if given the necessary resources.¹³⁴

In a city where one in five children have undiagnosed mental health needs, one in 10 children suffer from a serious emotional disturbance impairing their daily functioning and only a fifth of children have their mental health needs met, more must be done.

Since these satellite clinics are not self-sustaining and outside funding opportunities are few and far between, this condition often presents an insurmountable climb for schools that are unable to shoulder new spending needs. Securing these resources is arguably the most difficult obstacle to expanding, let alone preserving, school-based clinical mental health services in NYC public schools.

Likewise, while about one-sixth of NYC public elementary schools currently offer on-site mental health services,¹³⁵ their reach is limited and their fate is uncertain. The existing landscape is largely supported by one-time and limited-time funding opportunities that temporarily cover clinic operating shortfalls.¹³⁶ As these opportunities retract, so eventually could the presence of these satellite clinics in NYC public schools.¹³⁷ Evidence of this attrition is captured in both CCC's data analysis¹³⁸ and in school clinic closure data disclosed by the OSH.¹³⁹ This is movement in the wrong direction – services are contracting at time when extensive research and demonstrated need suggest they should be expanding.

The City must move beyond triaging school-based clinics' chronic financing needs with stopgap solutions and pursue a more proactive, cross-systems solution to making school-based mental health services more permanent fixtures in all NYC public schools. To start, financing for school-based clinic care must become self-sustaining and action must be taken to correct the regulatory and financial challenges threatening clinic solvency. Until these challenges are resolved, the State and the City must better protect and leverage existing financial, community and social supports that stabilize these institutions, promote innovation, combat stigma, improve mental health literacy and timely connect all school-aged New Yorkers presenting mental health needs to appropriate levels of direct and wraparound care. Finally, New York City must improve upon existing clinic data collection, reporting, and information sharing efforts to promote accountability, improve quality and better target existing resources.

CCC is confident that this agenda is actionable in the current fiscal climate. Below, CCC has developed a series of recommendations that are designed to guide policymakers toward maximizing the value of the public mental health care dollar by investing in approaches that will yield better health outcomes, improve quality of life and lower costs to taxpayers. Altogether, CCC hopes these recommendations will serve as a roadmap toward increasing elementary school student access to clinical mental health services in school and in community settings throughout New York City.

134 SBMH Committee Paper on Barriers to Fiscal Sustainability, *supra* note 79.

135 For details, see "Table 2" in *Appendix 1: Additional Maps and Tables* on page 59 herein for details.

136 NYC Fiscal 2014 Supporting Schedules, *supra* note 43. NYS 2013-14 Enacted Budget, *supra* note 83.

137 May 1, 2012 Testimony of the School-Based Mental Health Committee, *supra* note 27. Transcript to the May 1, 2012 City Council Oversight Hearing on SBMH, *supra* note 51.

138 See "Table 3" in *Appendix 1: Additional Maps and Tables* on page 59 herein for details.

139 Bronx Legal Services Preliminary Analysis of DOE Student EMS Referrals, *supra* note 56.

A) STABILIZE AND EXPAND SCHOOL-BASED MENTAL HEALTH SERVICES

Recommendation: Integrate school-based mental health into the DOE's academic philosophy and create dedicated funding streams to support those efforts.

School-based clinic service models have proven to bridge access gaps for school-aged children.¹⁴⁰ More importantly, they are also linked to improvements in student academic outcomes.¹⁴¹ They are not support services; rather, they are integral to the academic experience. The City should recognize this important distinction and adopt school-based mental health as part of its larger academic philosophy. Just as the New York City budget is a reflection of local priorities, the DOE budget should be reflective of that philosophy.

Recommendation: Expand clinical mental health services to all DOE elementary schools.

The DOE should expand the availability of on-site clinical mental health services to all interested elementary schools. There is no close substitute to comprehensive mental health care offered by full-time on-site mental health clinicians in school settings. This model of care for school-aged mental health consumers has been proven to reduce barriers to care and help students get the right amount of care at the right time, which in turn, promotes optimal classroom learning environments. School-based clinical care offers a sound return on investment,¹⁴² delivering a range of benefits to society that help strengthen human capital, promote social cohesion, improve quality of life and prevent against avoidable costly interventions.

Despite its ambition, this expansion is actionable. Understanding that most school-based clinics are not financially self-sustaining and resources to support them are extremely limited, the DOE should adopt a gradual approach to expanding its network of school-based clinical mental health services as resources become available, strategically targeting expansion efforts.

Expansion priority should first be given to elementary schools. Establishing on-site clinical mental health services in elementary schools enables students first engaging with the school system to better reach their academic potential by connecting them to care in an accessible setting at a time in their lives when their mental health needs may first be detected and they are most responsive to treatment.¹⁴³

Priority should also be given to geographic areas where services are scarce and community need is greatest.¹⁴⁴ According to CCC's 2012-13 geocoding results (per "Map 5" in Appendix 1: Additional Maps and Tables on page 58) these areas include, but are not limited to, including the Bronx communities of Mott Haven, Fordham/Bedford Park and Unionport/Soundview; Williamsburg/Greenpoint, East Flatbush, Crown Heights South, Borough Park, Flatbush/Midwood and Brownsville in Brooklyn; Central Harlem in Manhattan and Jackson Heights in Queens.

**"Full service, all day mental health clinics are critically needed in high needs inner city public schools. They should be fully integrated into school's operations providing clinical services to children and their families, professional development and training for school staff and an information repository/resource for the community."
—Surveyed principal**

140 Catron et al., *supra* note 23. Kaplan et al., *supra* note 23.

141 Jennings et al., *supra* note 25.

142 Heckman, James J. "The Case for Investing in Disadvantaged Youth." *In Big Ideas for Children; Investing in our Nation's Future*, edited by First Focus, 49-58. Washington, D.C., 2009.

143 National Scientific Council on the Developing Child, *supra* note 1. Hogan, Michael E., *supra* note 5.

144 Risk Ranking Chart – Keeping Track 10th Ed., *supra* note 125. Please see "Map 5" in Appendix 1: Additional Maps and Tables on page 58 herein for details.

To ensure the delivery of comprehensive mental health services in school settings, expansion efforts should prioritize bringing more school-based mental health clinics to elementary schools. These satellite clinics guarantee students access to a range of comprehensive mental health care on school grounds. Alternatively, school-based health centers have the option to either offer clinical mental health services on-site or refer out for care. Also, SBMHCs are on average faster and less expensive to start up since they require less clinic space and outfitting needs than SBHCs.¹⁴⁵

Recommendation: Correct regulatory barriers embedded within the DOE Chancellor's Regulations.

Several regulations imposed by the DOE Chancellor impede DOE schools' ability to attract and sustain Article 28 and Article 31 satellite clinics on-site because they exacerbate the financial burden to the school-based clinic providers. To help bring more of these services to NYC schools, the DOE Chancellor should amend the following regulations:

- 1. DOE Chancellor's Regulation A-610**, which prohibits "outside organizations," including school-based clinics, from collecting payments from students on-site.¹⁴⁶ This fee does not apply to DOE-staffed health professionals delivering primary and preventive services. To bring greater parity to the treatment of health and mental health services delivered in schools, the DOE Chancellor should exclude school-based clinics from the existing definition of "outside organization."
- 2. DOE Chancellor's Regulation D-180**, which imposes a fee on school-based health and mental health providers operating after school hours, on the weekend and when the school is not in session. The DOE Chancellor should amend this policy to waive the fee imposed on school-based clinics operating outside the regular hours of school operation. The fee is already waived for other jointly operated DOE programs bringing wraparound and direct services to schools like Beacon Programs and Out-of-School Time after-school programs.¹⁴⁷
- 3. Chancellor's Regulation A-701(B)(1)(a)**, which is intended to require schools to collect all students' health insurance information.¹⁴⁸ School-based clinics need complete student health insurance information in order to successfully processing claims; however, the information collected by schools is often incomplete. CCC suggests that the DOE Chancellor strengthen the language in this regulation to ensure that schools collect complete health insurance coverage information. The Chancellor could also require schools to follow-up on collecting outstanding information until it is complete and relay it to on-site health and mental health care providers.

Recommendation: Address financial challenges threatening school-based Article 28 and Article 31 clinic solvency.

In addition to regulatory barriers, financial barriers also discourage Article 28 and Article 31 providers from establishing satellite clinics in schools. School-based clinic models are not self-sustaining and more often than not, their sponsoring agencies can't afford to prop them up indefinitely. These school-based clinics cannot achieve financial independence until insufficient payments for reimbursable services and nonpayment for non-reimbursable services are addressed. The State has the jurisdiction to not only mitigate several of these barriers, but to also bring greater Medicaid financing parity to school-based mental health providers.

The State should set the floor for Medicaid managed care reimbursement rates for all school-based mental health clinicians basing payment floors on government-set rates or another appropriate measure.

The State's APG (or, "government") rates for the delivery of clinical mental health services are more generous than most mainstream Medicaid managed care rates and better cover the cost of care. Since September 2012, Medicaid managed care providers have been required to pay Article 31 providers using these higher payment thresholds. The State can bring

¹⁴⁵ According to State guidelines, Article 28 SBHCs must have a fully operational medical room, which requires internal constructions, plumbing and electricity; Article 31 SBMHCs, on the other hand need to secure a confidential space of at least 70 square feet of space with floor to ceiling walls to host counseling sessions. Principles and Guidelines for SBHCs, *supra* note 39. Part 599 Clinic Treatment Programs, *supra* note 40, section 599.12.

¹⁴⁶ Chancellor's Regulation A-610, *supra* note 107.

¹⁴⁷ Chancellor's Regulation D-180, *supra* note 109.

¹⁴⁸ Chancellor's Regulation A-701, *supra* note 111.

greater Medicaid financing parity to school-based mental health providers by preserving this requirement and expanding it to include Medicaid managed care plan payments to qualified Article 28 providers delivering clinical mental health services at schools. The State has already set a precedent for this approach by applying it toward the treatment of Medicaid and supplemental payments to Article 31 providers.

The State should sufficiently finance preventive and essential administrative services not covered by insurers.

Aside from addressing insufficient reimbursement for Medicaid-billable clinical mental health services, CCC recommends that the State also create a funding mechanism to compensate school-based mental health providers for delivering non-billable preventive and essential administrative services. These services are integral to mental health recovery and examples include workshops/trainings for school staff, consultation with teachers regarding children who lack parental consent to be treated, crisis services for children who are not already admitted to the clinic, case management, referrals and parent outreach. Outcomes include facilitating student access to mental health treatment, promoting treatment adherence, protect against crisis situations, improving school learning environments and offering a whole host of other benefits. Despite their great value, third party payers do not reimburse providers for these services. Mental health clinicians delivering these uncompensated services to students in need unfortunately risk compounding their clinics' financing struggles, which further jeopardizes their future presence in schools.

“Financially it is very hard to keep school-based clinics alive. So much of what clinicians do and is good practice, classroom observation for example, is not reimbursable.”
—Surveyed clinician

To encourage these important activities, providers must be appropriately compensated for their work. To finance these services, the State could apply for a waiver of federal Medicaid statute (commonly known as a “Medicaid Waiver”) permitting Medicaid to cover these preventive services using the State’s federal match rate of 50 percent. If approved, the State would only be financially responsible for half the cost; the federal government would cover the remaining half.

Understanding that the State may not currently possess the political capital necessary to successfully secure Medicaid waiver funds, there are other alternatives the State can pursue in the interim. The State could form a dedicated pool to finance a prescribed set of preventive mental health and related services delivered by Article 28 and 31 school-based providers to Medicaid-eligible students. Since these services promote recovery in community settings, this pool could be supported with a portion of redirected savings generated by recent State efforts to right-size its inpatient psychiatric facilities (including those serving children) and strengthen its community-based infrastructure.

The State could also form a dedicated pool (i.e., fund) offering rate enhancements to Article 28 and Article 31 school-based providers serving a disproportionately high share of students from low-income families. Qualifying providers would be serving schools reporting an enrollment meeting or exceeding a pre-determined threshold of Medicaid-eligible students. This pool could be modeled after the State’s Vital Access Provider program,¹⁴⁹ which offers enhanced payments to qualifying financially challenged hospitals located in high-needs, low-resourced communities. Similar to other State-sponsored safety-net pools, New York could also levy a small fee on select categories of providers and/or localities to help fundraise for the pool.

¹⁴⁹ Following a recommendation by the Medicaid Redesign Team, the State established in April 2012 a Vital Access Program Pool, which is a dedicated pool of funds intended to provide long-term support to qualifying financially challenged hospitals located in high-needs, low-resourced communities. Medicaid Redesign Team Waiver Amendment, 2012, *supra* note 91.

The State should allow students to self-refer¹⁵⁰ to their school's clinic for a prescribed set of covered clinical mental health services once the Article 28 SBHC Medicaid Managed Care carve-out is discontinued.

CCC believes that the State needs to address the planned discontinuation of the Article 28 SBHC carve-out. Currently, this carve-out guarantees SBHC providers access to APG reimbursement rates, which promotes their fiscal solvency. Assuming this carve-out will not be permanently extended, SBHCs will eventually need to negotiate rates with each managed care plan or assume the risk of providing out-of-network, and likely uncompensated, care. SBHCs once dependent upon the carve-out may lose a substantial amount of third party revenue, increasing their financial risk. Many struggling clinics could be brought to the verge of financial collapse and almost certain closure.

To ensure patient access is maintained once the carve-out ends, CCC recommends allowing students to self-refer to their school's Article 28 and/or Article 31 clinic (which may or may not be an in-network provider) for a prescribed set of covered clinical mental health services. Medicaid managed care plans, in turn, would be required to reimburse school-based clinics (Article 28s and 31s) for delivering those pre-authorized out-of-network care services. To ensure adequate payment, the State would also need to set the floor for reimbursements using APG rates or another appropriate measure.

By requiring the student's health plan to pay the clinic for the care it delivers regardless of whether that provider is in the student's health plan network, the financial risk to both school-based Article 28s and 31s is mitigated and greater Medicaid financing parity is achieved between the two models. Health plans benefit by promoting less costly care delivery that prevents against more costly interventions (e.g., emergency medical services and concomitant health condition onset). New York could look to Maryland, a state that has pioneered this option, for guidance.¹⁵¹

Recommendation: Sustain State and local dedicated funding for SBHCs and create equivalent funding opportunities for SBMHCs until financial and regulatory challenges that currently jeopardize school-based clinic operations are resolved.

As previously noted herein, the City¹⁵² and State¹⁵³ each grant a handful of awards to stabilize select valued Article 28 school-based clinics at-risk for closure (similar dedicated funding is not available to these clinics' Article 31 counterparts). Incidentally, the very institutions granting these awards maintain policies that drive many of the regulatory and financial challenges currently confronting their grantees.

The future of these dedicated supports remains uncertain and without these lifelines, these grantees may be forced to scale back on – or even shut down – operations. In recent years, the City¹⁵⁴ and State¹⁵⁵ have considered trimming these supports in order to meet reduced spending targets within their respective jurisdictions. These budget actions are ill-advised and counterproductive. Not only do school-based clinics add immense value to the communities they serve, but they also save taxpayers money by reducing dependence on more costly public supports and by aiding their beneficiaries

150 Used in this context, self-referral describes the process by which a student enrolled in Medicaid managed care can seek care from his or her school-based provider without gaining prior authorization (or, advance approval) from the managed care plan. Harvey, Jennel, Lissette Vaquerano, Lea Noal, and Colleen Sonosky. "The Triple Aim: Care, Health, and Cost." *School-Based Health Centers and Managed Care Arrangements: A Review of State Models and Implementation Issues*. Center for Health Services and Research Policy July 2002.

151 Medicaid managed care organizations in Maryland are required by state law to reimburse SBHCs for four self-referred acute care visits and four follow-up visits, per student. *Id.*

152 Fiscal 2014 Supporting Schedules, *supra* note 44.

153 NYS 2013-14 Enacted Budget *supra* note 83.

154 In an effort to close the City's budget deficit, Mayor Bloomberg's Fiscal 2014 Executive Budget recommended discontinuing subsidies valued at \$1.2 million to four SBHCs serving the Bronx, Manhattan, Queens and Brooklyn. *New York City Office of Management and Budget*. "Financial Plan Reconciliation: May 2013." New York City Office of the Mayor. May 3, 2013. http://www.nyc.gov/html/omb/downloads/pdf/exec13_fprecon.pdf (accessed on May 13, 2013).

155 This past January, the Governor proposed in his SFY 2013-2014 budget actions that would have jeopardized the State's existing dedicated budget lines supporting SBHCs. This subsidy could have become whittled down to the point where SBHCs dependent upon these subsidies may have had to eventually close. Fortunately, the enacted State budget preserves the dedicated general fund line items for SBHC subsidies with only slight funding reductions. New York State Division of Budget. *2013-14 Article VII Bills: Health and Mental Hygiene (HMH) Bill*. New York State Executive Office. January 22, 2013. http://publications.budget.ny.gov/eBudget1314/fy1314artVIIbills/HMH_ArticleVII.pdf (accessed on January 23, 2013).

in becoming more productive, more fully engaged members of society. In fact, as CCC suggests throughout this report, the City and the State would more successfully curb spending in the long-run through maintaining (if not enhancing) targeted investments in school-based clinics. Moving forward, these grants and other related financial support for Article 28 SBHCs should be held harmless and equivalent funding opportunities should be made available to their Article 31 school-based counterparts.

As mentioned earlier herein, there is recently heightened interest by elected and appointed officials to bring more clinical mental health services to schools. CCC applauds this sentiment and resulting efforts, but also cautions that these services must be sufficiently funded. Similarly, any new capital investments building school-based clinic infrastructure should be accompanied by budgeted baseline expense funding to meet the clinics' anticipated operating needs. Otherwise, these efforts will likely be short-lived and fail to deliver on their full potential.

I *Recommendation: Optimize new financing and grant opportunities offered through the ACA and MRT.*

Aside from mitigating regulatory and financial challenges confronting school-based clinics, CCC recommends that the State include a focus on school-based mental health in its implementation of primary and preventive services per the ACA and Medicaid Redesign. For example, to date, \$8.6 million in combined capital and expense funding made available through the ACA has been awarded to 20 SBHC grantees serving New York City.¹⁵⁶

B) COMBAT STIGMA AND IMPROVE THE MENTAL HEALTH LITERACY OF PARENTS, STUDENTS AND SCHOOL STAFF

Stigma is a powerful, and often overlooked, barrier to mental health care – especially for children. The stigma attached to mental illness and treatment can lead those with unmet mental health needs (and their loved ones) to turn a blind eye to their symptoms and forgo care. While public attitudes have shifted immensely over the past few decades toward greater understanding and support, many individuals' perceptions of public attitudes partially diminish these gains. A recent survey by the U.S. Centers for Disease Control shows that while the general public is largely sympathetic to those suffering from mental illness, most people with symptoms are unaware of that support.¹⁵⁷ These same misperceptions help perpetuate the stigma surrounding mental illness and treatment.

In turn, adults may either consciously or subconsciously project their personal concerns about stigma onto their children, influencing their child's individual attitudes toward mental illness and treatment. Moreover, parents can obstruct their child's access to care by denying their child's apparent mental health needs, refusing to grant their consent to use a school's on-site mental health provider (if available) and by failing to act on their children's referrals to community-based care.

Since misinformation largely shapes negative social attitudes toward mental illness and treatment,¹⁵⁸ educational efforts to raise awareness can help break down the barriers to care that are built by stigma.

156 Health Resources and Services Administration. "News Release." *U.S. Department of Health & Human Services*. December 8, 2011. <http://www.hhs.gov/news/press/2011pres/12/20111208a.html> (accessed on January 26, 2013).

157 According to a 2007 survey, nearly three out of every five all adults believed that people are caring and sympathetic to persons with mental illness; however, only a quarter of adults with mental health symptoms shared that belief. "Stigma of Mental Illness." Centers for Disease Control and Prevention. July 1, 2011. http://www.cdc.gov/mentalhealth/data_stats/mental-illness.htm (accessed on April 5, 2013).

158 Knifton, Lee, et al. "Community conversation: addressing mental health stigma with ethnic minority communities." *Social Psychiatry and Psychiatric Epidemiology* (Springer-Verlag) 45 (2010): 497-504.

Recommendation: Launch a citywide anti-stigma mental health awareness messaging campaign.

The NYC Department of Health and Mental Hygiene (“DOHMH”) is the City’s public health agency. The DOHMH has a long and effective history of using public health messaging campaigns to catapult public health threats into the mainstream of public discourse. In recent years, the DOHMH has waged public messaging campaigns covering a wide and diverse range of topics relating to population health such as anti-smoking, obesity, dog licensing, breastfeeding, safe sex and binge drinking.

CCC recommends that the DOHMH launch a citywide messaging campaign to help combat the stigma of mental illness and treatment and raise awareness of existing local mental health supports. Mental health awareness is a fitting addition to the DOHMH’s public messaging portfolio since the stigma attached to mental illness and treatment arguably meets the major criteria of public health interventions: it remains extremely widespread, it is rooted in misinformation and misperceptions and it endangers population health. A campaign of this caliber has the potential to normalize attitudes toward mental health, strengthen engagement with mental health service system, and in turn, promote mental health recovery.

This action had been recommended to accompany OMH’s Child and Family Clinic-Plus program, but was never executed. Many from within the provider community speculate that the program would have been more widely used if grantees were given the tools necessary to engage parents and principals and address their concerns about the program. In the absence of anti-stigma supports, grantees’ constrained performance failed to justify future funding for the program.

Understanding that resources supporting these activities are limited, the DOHMH should actively pursue outside grant opportunities and leverage its existing network of intra-city and community-based partnerships to disseminate messaging materials at a reduced cost. Since peers are often the best messengers, the DOHMH could execute a peer-to-peer media campaign for parents and relayed by parents.

To reach youth and adolescents, the DOHMH can also disseminate existing messaging material targeting this age group. For example, CCC’s youth advocacy program, YouthAction, recently developed a public service announcement (“PSA”) to promote teen mental health awareness.¹⁵⁹ This PSA was created by teens to help their peers identify their mental health needs and connect to available supports, and it already has been well-received by key stakeholders including the DOHMH Bureau of Children, Youth and Families, the NYC School-Based Mental Health Committee and the Campaign for Effective Behavioral Supports for Students.

Recommendation: Launch a series of targeted trainings to improve the mental health literacy of parents, students and school staff.

DOE school staff, including guidance counselors, social workers, psychologists and mental health clinicians uniquely contributes to student mental health. These school-based staff should collaborate to identify culturally competent and age appropriate training opportunities on identifying children’s mental health needs and accessing services available on-site and in the community. Similarly, students can more proactively address their own mental health needs through participating in targeted, age-appropriate mental health literacy trainings and learning about available supports. The DOE, through collaborations with child-serving mental health providers, could develop and administer separate trainings and education workshops addressing certain core topics while tailoring material to each target audience, including DOE administrators, principals and school staff, students and parents.

“Mental health is considered very private and personal. Until parents are educated and are willing to accept that counseling is accepted and beneficial for their children as well as family members, our students will not receive the assistance that they need to address issues that will certainly continue in their adult life if not addressed.”
—Surveyed principal

¹⁵⁹ CCC’s YouthAction public service announcement can be accessed at: <http://youtu.be/KcqVr8mSNoM>.

Activities improving mental health literacy require investments of time and money. The DOE should explore grant opportunities to support these efforts, such as “Typical or Troubled?”¹⁶⁰ a grant program that funds schools to implement a variety of culturally appropriate mental health educational tools targeting teens and their parents. To better secure the level of resources necessary to timely implement system-wide change in NYC, CCC suggests that the DOE could also strengthen efforts to form long-lasting public-private partnerships with stakeholders.

Educate parents of elementary school students on benefits and availability of school-based clinical mental health services.

School-based clinics are only permitted to provide ongoing care to students who are enrolled in the school and have parental consent to receive services.¹⁶¹ Unfortunately, CCC’s survey results show that some parents are hesitant to give consent for their children’s mental health care. Parents’ negative attitudes toward mental illness can deter parents from connecting their children to the mental health supports they need.

“There is a real opportunity to improve the focus on parent engagement and family work – to reduce conflict between students and parents and improve student outcomes.”
– Surveyed clinician

To achieve parental buy-in, CCC suggests that schools offer parents mental health literacy information sessions. These sessions would create a forum for parents and mental health professionals to address concerns, debunk common mental illness myths and validate mental health facts. These sessions could also provide parents with the tools to detect their child’s unmet mental health needs and apprise them of available school- and community-based supports. Parent coordinators and organizations such as Parent-to-Parent NYS and the Parent Teacher Association (“PTA”) can participate by encouraging family/parent advocates to engage parents about their concerns with the children’s mental health system. These education sessions could be incorporated into regularly scheduled parent meetings to better accommodate the schedules of working parents.

Educate elementary school students on benefits and availability of school-based clinical mental health services.

CCC’s survey results indicate that students’ prior negative experience(s) with mental health care (e.g., medically unnecessary hospitalization, overcrowding in community settings etc.) deters children from seeking future care. To ease their fears, CCC recommends that all elementary school students participate in age-appropriate information sessions that teach students techniques to recognize and self-manage some of their social and emotional stressors. These sessions should also help students identify sources of on-site support that they can comfortably access when they are in need (e.g., mental health clinicians, if available, and DOE guidance counselors, social workers, psychologists and so on).

Increase mental health education and training opportunities for DOE administrators, principals and school staff.

School administrators, principals and teaching staff frequently interact with students and, accordingly, are well-positioned to link students to care. CCC’s survey results show, however, that while most surveyed clinicians provided informal trainings to parents and students on mental health topics, very few of them extended their trainings to school staff. CCC recommends training DOE elementary school staff on the following:

160 Rural Assistance Center. “Typical or Troubled? School Mental Health Education Grants.” *American Psychiatric Foundation*. 2013. <http://www.raonline.org/funding/3114/> (accessed on April 5, 2013).

161 OSH SBHC Description, *supra* note 85.

1. How to recognize the signs and symptoms of common social and emotional stressors in children;
2. Techniques to address and manage students with social and emotional disturbances and disruptive behaviors;
3. The protocol for student mental health crisis de-escalation, intervention and follow-up;
4. Sensitivity training on the stigma attached to mental health care and strategies to reduce stigma;
5. The benefits of mental health and behavioral health interventions available on-site and how to access the full range of services;
6. The roles and responsibilities of school-based mental health clinicians (if applicable); and
7. How to link children to community-based clinical mental health services and supports.

“There is an increased demand on the teacher to provide behavioral management strategies to the students. Teachers need professional development on how to de-escalate crises and how to manage them within the classroom setting.”
—Surveyed principal

CCC suggests that the DOE partner with other experienced New York City-based providers, such as Samaritans of New York, to connect DOE staff to free and reduced cost trainings on evidence-based approaches to psychiatric crisis management.¹⁶² The DOE should bundle these trainings into larger staff trainings to reduce administration costs. Additionally, the DOE could apply a portion of accruals from its newly enhanced training budget toward financing these recommended teacher trainings on mental health.¹⁶³

Recommendation: The DOE Chancellor should integrate training on children’s mental health and behavioral needs into the Principal Leadership Academy curriculum.

The DOE Chancellor should require the NYC Leadership Academy¹⁶⁴ trainings to cover mental health and behavioral needs of students and their interplay with academic outcomes. These trainings should emphasize that all students are entitled to available on-site mental health services, regardless of immigration or health insurance status. To ensure all principals receive this training, CCC recommends including it in the continuing professional development requirements.

Recommendation: Give DOE elementary school nurses the option to train in STARS.

Screening the At-Risk Student (“STARS”) is a DOE pilot program training middle school nurses to screen students for depression and suicidal ideation and to refer students for further psychological assessments, as needed.¹⁶⁵ Unmet mental health needs often underlie and/or co-occur with many medical conditions. School nurses are well-positioned to discover these emerging symptoms while treating a student primarily for physical ailments. Giving elementary school nurses the tools to screen for these needs offers a more holistic approach to student wellness and can help connect students to appropriate levels of care. Since elementary school children are developmentally different from their middle school peers, STARS training should be modified to ensure screenings are age-appropriate.

162 Samaritans of New York, the City’s only confidential suicide prevention hotline, in partnership with OMH, released an *NYC Guide to Suicide Prevention, Services and Resources in the Fall of 2011* that is free and publicly available online at <http://www.samaritansnyc.org/files/NYCSuicidePreventionResourceGuide.pdf>.

163 Beginning in June 2013, the DOE more than doubled funding available for teacher training. While this funding enhancement is dedicated toward preparing teachers for more rigorous Common Core Learning Standards and a new teacher evaluation, it is possible some budgeted funds may be leftover once these training have been completed. Walcott, Dennis M. “Testimony of NYC Schools Chancellor Dennis M. Walcott on the Fiscal Year 2014 Executive Expense Budget before the NYC Council Committees on Education and Finance.” *New York City Department of Education*. June 4, 2013.

164 The NYC Leadership Academy aims to prepare and support visionary, passionate educators who lead schools that orient all their activities around accelerating student learning and academic growth. *NYC Leadership Academy*. 2013. <http://www.nycleadershipacademy.org/> (accessed on April 3, 2013).

165 NYC OSH SBMH Programs, *supra* note 41.

C) REDUCE UNNECESSARY EMERGENCY ROOM ADMISSIONS

In New York City, schools are required by the DOE Chancellor's regulations to administer a same-day risk assessment of students posing a risk to themselves or others.¹⁶⁶ Consequently, the acute mental health needs of DOE students in psychiatric crisis are likely met with medically unnecessary, costly, and usually avoidable, interventions such as EMS referrals and ER admissions.¹⁶⁷ More often than not, these interventions are a disproportionate response to students' psychiatric needs and fail to promote recovery for those with unaddressed needs.¹⁶⁸

CCC's survey results suggest a lack of uniformity in EMS referrals prescribed by DOE school crisis intervention protocol. Results also show that, irrespective of the availability of on-site services, schools are highly dependent on ER referrals for psychiatric crisis response, underscoring the disconnect between school officials and on-site mental health clinicians.

Recommendation: Advance recommendations by the Campaign for Effective Behavioral Health Supports for Students¹⁶⁹ to mandate protocols and standard operating procedures for the use of EMS services by DOE school officials.

Existing crisis intervention protocol, per Chancellor's Regulations A-755 and A-412, offers schools broad guidance on addressing student behavioral, social and emotional disturbance and gives principals discretion in developing a site-specific protocol.¹⁷⁰ In theory, these regulations enable schools to tailor crisis response strategies to the unique needs of the school; in practice, however, they are also a key driver of unnecessary EMS referrals by schools. In the absence of well-coordinated and appropriate on-site resources, principals disproportionately defer to emergency medical referrals in response to students' psychiatric crises.¹⁷¹

Accordingly, CCC recommends that the DOE, in partnership with the NYC School-Based Mental Health Committee,¹⁷² form a workgroup comprised of school-based mental health professionals and school principals. This workgroup would be charged with revisiting the DOE Chancellor's regulations to include a uniform set of protocols connecting students to the right amount of psychiatric care at the right time, while protecting school safety.

There should be explicit guidance on policy and procedure for school EMS referrals, specifying when to involve on-site medical and mental health professional staff, when to contact emergency responders and when to refer students to comparable, non-medical emergency alternatives for acute psychiatric needs. It should also clarify protocol for post-crisis follow-up for schools to ensure students that are referred to emergency medical services while in their custody are successfully connected to treatment in the school and community, where applicable. To ensure compliance, enforcement mechanisms should be built into these regulations.

Once approved, these protocols should be uniformly implemented in all NYC public schools. Lastly, each principal should periodically host trainings on the student psychiatric crisis intervention protocol for all involved school staff to review their roles and the chain of command that becomes triggered when a psychiatric crisis situation emerges. More on this recommendation follows under this section's subheading: "E) Improve Data Collection, Information Sharing and Dissemination of Performance and Utilization Data on DOE School-Based Mental Health Services."

166 Chancellor's Regulation A-755, *supra* note 55.

167 Winerip, Michael, *supra* note 53. Bronx Legal Services Preliminary Analysis of DOE Student EMS Referrals, *supra* note 56.

168 According to preliminary figures released by the Campaign for Effective Behavioral Health Supports for Students, a total of 13,967 EMS calls were made by NYC schools during SY 2010-2011. About a quarter of these calls (3,630 calls) were made in response to students' disruptive related behaviors. A separate report found psychiatric emergencies where students required hospitalization constituted only a small fraction of the mental health EMS referrals that schools are making. Lorschbough, Erika. "Making the Wrong Call: Why EMS Removal of Students Exhibiting Disruptive Behavior Is An Unacceptable Substitute for Positive School-Based Mental Health Practices." *Legal Services NYC – Bronx*. 2012.

169 Reducing School Usage of EMS Referrals, *supra* note 70.

170 Chancellor's Regulations A-755 and A-412, *supra* note 55.

171 For details, see subheading "School-Based Mental Health Services" under the *Background* section.

172 The NYC School-Based Mental Health Committee is an advisory body to the DOHMH on school-based mental health matters. May 1, 2012 testimony of the School-Based Mental Health Committee, *supra* note 27.

| Recommendation: Create an HHC liaison position within the OSH.

The NYC Health and Hospitals Corporation (“HHC”) should formally liaise with the DOE Office of School Health.¹⁷³ HHC not only sponsors several SBHCs throughout the City,¹⁷⁴ but it also offers a continuum of care in the City’s underserved communities through its network of clinics, diagnostic and treatment centers and hospitals. For years, HHC has reduced inefficiencies within its system by preventing unnecessary hospital admissions by promoting community-based primary and preventive care. Through proactively connecting students presenting mental health needs to the HHC network, OSH and HHC could similarly help to keep students in school and the community and out of hospitals.

D) INVEST IN PROGRAMS AND SERVICES THAT IMPROVE SCHOOL CLIMATE AND INCREASE CONNECTIONS TO COMMUNITY-BASED SUPPORTS

Schools can also benefit from several other alternatives to improving student mental health status. These models tend to be less costly, but also more limited in scope or reach. They innovate the delivery of mental health care and prevention to achieve some basic level of service in schools while overcoming some major cost barriers. Consequently, they could be administered in lieu of, or in addition to, comprehensive on-site clinical mental health services.

| Recommendation: Expand behavioral intervention programs to more NYC elementary schools.

Behavioral intervention programs, such as Turnaround and Positive Behavioral Intervention Solutions, promote a positive school climate conducive to learning while safeguarding against student behavior-related crisis situations. Many schools across the City have already benefitted from these approaches. Unlike school-based clinical care, these interventions only require short-term investments in order for schools to reap long-term benefits. The DOE should create a dedicated funding stream to expand the reach of these interventions across the five boroughs, prioritizing elementary schools and schools serving high-needs populations.

| Recommendation: Expand NYC’s Mobile Response Team pilot to DOE elementary schools.

Support for Mobile Responses Teams in New York City schools continues to grow since they were first piloted in select NYC middle schools in the beginning of 2012.¹⁷⁵ OSH, in partnership with the DOHMH Bureau of Children, Youth and Families, released a Request for Proposals in March 2013 to expand the Mobile Responses Teams program to an additional 30 middle/junior high schools throughout the five boroughs, starting this fall.¹⁷⁶ CCC recommends including elementary schools as eligible sites in the next Mobile Responses Teams expansion.

Mobile Responses Teams is an OSH pilot program in NYC comprised of three teams¹⁷⁷ of multi-disciplinary professionals delivering select clinical mental health services to clusters of five public middle schools each in the Bronx and Brooklyn. Each team is charged with spearheading psychiatric crisis intervention for all schools within its cluster, immediately responding (either in person or over the phone) at any cluster school as psychiatric crises emerge.¹⁷⁸

173 The New York City Office of School Health is housed within the Department of Education, but is jointly administered with the New York City Department of Health and Mental Hygiene. OSH Description, *supra* note 42.

174 Grimm May 1, 2012 Testimony, *supra* note 48.

175 Each team is comprised of three full-time interdisciplinary clinical staff: one Masters level social work supervisor or psychologist, one social worker and one family advocate. NYC Department of Health and Mental Hygiene. “Request for Proposals for the Provision of the Mobile Response Teams (MRT) Program for New York City Public Schools.” March 29, 2013. <http://www.nyc.gov/html/doh/downloads/pdf/acco/2013/acco-rfp-13AO001200R0X00.pdf> (accessed on April 8, 2013). (Hereinafter, “MRT RFP, 2013.”)

176 *Id.*

177 New York City Office of School Health. “Amendment to Annex A: Intra-City Agreement between the New York City Department of Health and Mental Hygiene and the New York City Department of Education: Mobile Response Team.” *New York City Office of School Health*. July 5, 2012. <http://www.nyc.gov/html/doh/downloads/pdf/about/coop-agreement-011812.pdf> (accessed on October 24, 2012). New York City Office of School Health. “Intra-City Agreement between the New York City Department of Health and Mental Hygiene and the New York City Department of Education: Mobile Response Team.” *New York City Office of School Health*. December 26, 2011. <http://www.nyc.gov/html/doh/downloads/pdf/about/coop-agreement-011812.pdf> (accessed October 24, 2012).

178 MRT RFP, 2013, *supra* note 175.

In addition to mental health crisis response services, these teams also take preventive actions against future crises. Each team regularly spends one day a week at each school within its cluster, conducting mental health assessments for referred students and, when necessary, making referrals for treatment in the community.¹⁷⁹ The teams conduct school-wide assessments, tailoring intervention strategies to the unique needs of each school population. They also offer training and consultations to parents and staff. Notably, these teams do not deliver clinical treatment services in school settings.

With an annual price tag of less than \$50,000 per school,¹⁸⁰ this program is at least half as expensive to operate as a full-time on-site comprehensive model of care and may be a palatable option to cash-strapped schools seeking to implement some form of on-site mental health support system. While this model is not a comparable alternative to comprehensive school-based clinical mental health services, it adds immense value to schools by preventing against and defusing destructive crisis situations. Moreover, Mobile Responses Teams augment the impact of many other actions recommended herein. They also benefit students, families, emergency responders and taxpayers by reducing the frequency of school EMS referrals.

Recommendation: Expand the Bronx Children's Mobile Crisis Team Pilot Citywide.

In 2013, the DOHMH will pilot a new Children's Mobile Crisis Team ("CMCT") service model that is an extension of the City's existing Mobile Crisis Team model¹⁸¹ and targets youth under 18 years of age residing or attending school in Bronx Community Districts seven through 12.¹⁸² CMCTs are hospital-based providers that respond to the location of the child within two hours of a referral,¹⁸³ delivering rapid crisis response and management services in settings like the home and in schools. Unlike Mobile Response Teams, whose reach is each confined to a designated cluster of schools, CMCTs are designed to serve entire communities and a range of settings. Accordingly, this CMCT is designed to respond to children's acute psychiatric needs at a time and place when it is needed the most and families are most receptive to intervention.

These teams can serve as another alternative to medically unnecessary student emergency medical service referrals and hospitalizations.¹⁸⁴ If the pilot demonstrates success, it should be expanded citywide.

Recommendation: Expand NYC Project LAUNCH Citywide.

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) is a federally funded five-year demonstration program bringing early childhood mental health services to primary care, early care and education settings.¹⁸⁵ Project LAUNCH aims to promote school readiness by targeting at-risk children from birth through age eight and offers a wide range of services that focus on the social and emotional development of children and their families.¹⁸⁶ Social-emotional screenings and mental health consultations in public schools are among the many services supported by Project LAUNCH.¹⁸⁷

179 *Id.*

180 *Id.*

181 The Mobile Crisis Team model traditionally requires Teams responds within 24-48 hours of a referral from LifeNet, the City's premiere mental health referral hotline, to a client's home. Mental/Behavioral Health: Visiting Nurse Service Of New York: VNS Queens Mobile Crisis Team: Queens, Borough Wide." *Mental Health Association of New York City*. April 17, 2013. http://newyorkcity.ny.networkofcare.org/mh/services/agency.aspx?pid=VisitingNurseServiceofNewYorkVNSQueensMobileCrisisTeamQueensboroughwide_754_2_0 (accessed on April 5, 2013). LifeNet is a 24/7 toll-free, multi-lingual, mental health and substance abuse information, referral, and crisis prevention hotline available to New York City residents. "LifeNet." *New York City Department of Health and Mental Hygiene*. January 12, 2012. <http://home.nyc.gov/html/doh/html/mental/lifenet.shtml> (accessed April 5, 2013).

182 Lily Tom, e-mail message to Pamela Corbett (co- author), April 23, 2013. Bronx Community Districts seven through 12 comprise the following the neighborhoods: Fordham, Riverdale, Unionport, Soundview, Throgs Neck, Pelham Parkway and Williamsbridge.

183 *Id.*

184 *Id.*

185 "NYC Project LAUNCH." *National Center for Children in Poverty*. Mailman School of Public Health. Columbia University. 2012. http://www.nccp.org/projects/launch_nyc.html (accessed on June 12, 2013). (Hereinafter, "NYC Project LAUNCH Description.")

186 "News from NYC Project LAUNCH." *Project LAUNCH Newsletter*, Issue No. 1. New York City Department of Health and Mental Hygiene, Issue#1. March, 2012. <http://www.fphny.org/UserFiles/File/NYC-Project-LAUNCH-Newsletter.pdf> (accessed on June 12, 2013). (Hereinafter, "NYC Project LAUNCH March 2012 Newsletter.")

187 NYC Project LAUNCH Description, *supra* note 185.

In NYC, Project LAUNCH was first funded in 2010 and currently serves the high needs communities of Hunts Point in the South Bronx and East Harlem. As Project LAUNCH enters its third program year in New York City, the program is already demonstrating success¹⁸⁸ and is bringing much-needed mental health resources to the City's high-risk children. CCC recommends that City officials collaborate with members of the NYC Congressional Delegation to renew the federal grant supporting this program and to increase the funding award to expand this program to other high-needs communities across the five boroughs. CCC also recommends that the City explore creating a dedicated funding stream of its own to ensure the program continues in the event federal financial support becomes discontinued.

Recommendation: Scale-up OMH's performance-based Early Recognition Coordination and Screening program.

Although OMH's Early Recognition Coordination and Screening program does not directly target resources toward school settings, its services benefit school-age children and youth.

ERS is funded with up to \$5 million a year for five years¹⁸⁹ and supports 37 awards, with nine awards granted to NYC providers. Since ERS requires each grantee to screen at least 1,000 unduplicated children each year for mental health needs,¹⁹⁰ in theory, a total of 45,000 discrete children will be screened in NYC over the next five years. There are approximately 1,772,000 youth under the age of 18 living in New York City as of 2011.¹⁹¹ Assuming all nine NYC providers are able to meet their screening targets every year, they will screen about a half percent of the City's youth each year. ERS brings much needed resources to early childhood mental health screening activities, but its reach barely begins to scratch the surface when at least on in every five children are suspected of having a diagnosable mental health need.

Each \$120,000 ERS grant supports 1,000 screenings a year, spending \$120 for each child screened. There are approximately 4,270,000 New Yorkers under the age of 18.¹⁹² To only screen a tenth of these children each year, resources for ERS would need to increase ten-fold. If ERS continues to demonstrate success throughout the initial grant period, CCC recommends that the State reward that success by infusing the program with funding that enables ERS to substantially expand its reach across the State, including in New York City.

Recommendation: Expand the continuum of care available to students presenting mental health needs through strengthening school linkages to community supports.

Strong, formal partnerships between schools and local community supports expand the continuum of care available to children presenting mental health and behavioral needs in schools. These community linkages actively connect students to the right level of care at the right time within the school and surrounding community. They also reduce dependence on EMS services.

CCC recommends that the State continue to invest in proven school-community linkage models, like Community Schools. Through active involvement with parents and community stakeholders, Community Schools can build formal partnerships with community-based providers to bring direct care and wraparound supports on-site and/or connect students to nearby services off-site.¹⁹³ The New York State Fiscal Year 2013-14 Enacted Budget allocates \$15 million to develop Community Schools. To reach students statewide, the State should make this appropriation recurring and increase the funding levels.

188 NYC Project LAUNCH March 2012 Newsletter, *supra* note 186.

189 ERS RFP, 2011, *supra* note 98.

190 *Id.*

191 U.S. Census Bureau. American FactFinder. *American Community Survey 1-Year Estimates (2011)*. <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml> (accessed on April 2, 2013).

192 *Id.*

193 Coalition for Community Schools. "Making the Difference: Research and Practice in Community Schools." *Institute for Educational Leadership*. 2003. <http://nationalcenterforcommunityschools.childrengivingsociety.org/system/files/making-the-difference.pdf> (accessed on April 5, 2013).

E) IMPROVE DATA COLLECTION, INFORMATION SHARING AND DISSEMINATION OF PERFORMANCE AND UTILIZATION DATA ON DOE SCHOOL-BASED MENTAL HEALTH SERVICES

Data collection and analysis helps to better target future investments, promote accountability and lay a foundation for program improvement and expansion.

Recommendation: Mental health clinicians should regularly collaborate with school staff to improve the social and emotional well-being of students.

CCC's survey results show that on-site mental health clinicians were frequently excluded from DOE staff conferences regarding mental health/behavioral needs of individual students. These meetings often form in response to poor student social and emotional behavior, and intuitively, would benefit from mental health clinicians' expertise. Unlike any other staff serving schools, school-based mental health clinicians are the only professionals who are qualified to diagnose mental health conditions and prescribe an accompanying plan of treatment. Schools with on-site mental health clinicians should take full advantage of their presence and involve them in student conferences whenever unmet student mental health needs are suspected. This proactive approach can connect students to care before their unmet needs present on impediment to their learning or majorly disrupt the classroom environment.

Moreover, mental health clinicians should enhance their visibility among students, teachers and parents. They should actively participate in school-based events involving parents such as information fairs, open houses, parent-teacher conferences (e.g. set up an information table for parents to learn more about mental health need and supports) and school tours.

Recommendation: Create opportunities and vehicles to report, analyze and share information among DOE principals and across DOE schools on existing school-based clinical mental health services and school-wide behavioral intervention programs.

The OSH and Office of School Safety should work with the DOE Division of Academics, Performance and Support to create a forum for school officials to share information on children's mental health needs, school-based clinical mental health services and school-wide behavioral intervention programs. In this forum, for example, principals interested in establishing on-site clinical mental health services would have opportunities to speak with principals benefiting from these services in their schools. Furthermore, principals should use newsletters, regularly scheduled meetings and forums to share recommended best practices and lessons learned.

Recommendation: Advance the recommendation by the Campaign for Effective Behavioral Health Supports for Students to require all school districts to individually collect and annually report individual school usage data for emergency medical services and mental health referrals.

NYC needs a robust analysis of child psychiatric emergency room referrals by schools. This data should be able to identify the correlation, if any, to the presence of school-based clinical mental health services and administration of school-wide behavioral intervention programs.

Ideally, this information would help inform DOE psychiatric crisis prevention protocol while validating the need for expanding on-site clinical mental health services to more schools. This data can also help policymakers better identify and direct services to schools reporting disproportionately high incidences of behavioral disturbances. Over time, this data could also help document the impact of both school-based clinical mental health services and school-wide behavioral intervention programs. Furthermore, the data may help identify opportunities for targeted expansions and improvements in DOE staff crisis response practices. The DOE should build upon existing reporting tools to better achieve economies of scale in DOE-led data collection efforts.

Recommendation: The NYC DOHMH and the DOE should consider following a cohort of students or schools to document the impact of school-based clinical mental health services on City schools and students over time.

Data-driven approaches can help drive positive outcomes and mobilize advocacy efforts. CCC's study involved a small cohort of clinicians and elementary school principals expressing their opinions. A more comprehensive, DOE-led effort to document the short-term and long-term impact of school-based services on children, classrooms, schools and communities could help inform outreach, expansion and programmatic improvements over time.

Recommendation: Expand the scope of locally collected and reported data on children's utilization of community-based mental health services.

Data collection and analysis is integral to documenting need and direct service delivery. Very little data on children's mental health needs and service utilization in New York City exists, and utilization is by no means, an accurate measure of need. Without this information, New York City has no way of knowing how successful it is in meeting these needs at the citywide level, limiting the City's ability to strategically target existing and future resources.

Information collected annually by OMH only offers a one-week snapshot of clients utilizing services delivered by OMH-licensed providers. This methodology compromises the City's ability to generalize findings or accurately estimate existing capacity because of the cyclical nature of children's mental health service utilization – which is tied to the school year. The one-week window of OMH reporting runs the risk of conflating utilizations peaks and valleys with utilization averages.

To complement OMH efforts, CCC recommends that the DOHMH annually collect and make publicly available demographic and service utilization data on all clients receiving DOHMH-contracted services. The DOHMH is already required to collect some basic level of information to measure provider performance; however, metrics appear to vary across bureaus and offices and cannot be aggregated in any way that meaningfully informs macro-level policy decisions. A more uniform reporting tool for collecting data on all of its mental hygiene contracted services, that also standardizes the collection of demographic indicators, can help policymakers better understand who is being served, how often and where. Over time, this data can be used to ensure that taxpayers are getting the maximum value out of the public mental health care dollar and that New Yorkers with mental health needs are better served.

Recommendation: Add mental health prevalence to Take Care New York's new child- and youth-focused agenda.

Take Care New York¹⁹⁴ (“TCNY”) is a Citywide health strategy developed by the DOHMH and HHC in collaboration with community partners, which identifies priorities and measurable goals to improve the health of all New Yorkers. TCNY is reconfiguring its agenda to create a separate category of indicators to measure child and adolescent health and mental health in New York City.

CCC believes this new child- and adolescent-oriented category offers a perfect opportunity for including a measure of diagnosable mental disorder prevalence among children and youth within its epidemiology portfolio. To collect this information, the DOHMH could reinstate the administration of the 2009 Child Health Survey¹⁹⁵ annually moving forward. This one-time survey collected information on a variety of child mental health and related indicators. Its findings offer a snapshot of NYC children's mental health circa 2009 and have been used to inform policy. Collected annually, these indicators would help the DOHMH more regularly measure its (and the City's existing mental health care delivery

194 “A Strategic Plan to Improve the Health of all New Yorkers: A presentation by the New York City Department of Health and Mental Hygiene.” May 2013. <http://www.nyc.gov/html/doh/downloads/pdf/tcny/listening-session-presentation.pdf> (accessed on May 15, 2013).

195 “Mental Health Conditions among Children Aged Six to 12 in NYC.” *Epi Data Tables*. New York City Department of Health and Mental Hygiene. March 2013, no. 25. <http://www.nyc.gov/html/doh/downloads/pdf/epi/databrief25.pdf> (accessed on June 5, 2013).

systems) progress on meeting key mental health priority goals for children, just as various measures collected annually in the DOHMH's Community Health Survey help to inform the DOHMH on its progress toward meeting its major public health priority goals for adults (e.g., asthma, obesity, etc.).

Since resources are already made available for public health measures, priority should be given to the allocation of resources needed to better collect and report data on children's mental health. Arguably, information on children's health and mental health status would be equally as valuable to the City. The DOHMH should seize upon this opportunity presented by the TCNY reconfiguration to request the resources necessary to finance this endeavor.

CONCLUSION

CCC's research largely echoes existing literature and anecdotal evidence regarding the impact of school-based clinical mental health services. CCC's survey results show that there is widespread support among surveyed principals for greater investments in school-based clinical mental health services. Principals acknowledge that classroom learning environments are adversely affected by the unmet mental health needs of students; and conversely, principals also acknowledge the benefits to students, classrooms, teachers and families when those needs are better met.

CCC recommends repairing and unifying New York City's underdeveloped, underappreciated and underutilized public resources through a series of actions to stabilize and expand school-based clinical mental health services; combat stigma and improve the mental health literacy of parents, students and school staff; reduce medically unnecessary emergency room admissions; invest in programs and services that improve school climate and increase connections to community-based supports; and improve data collection and dissemination of information on NYC public school-based clinical mental health services.

While CCC's recommendations offer an action plan for gradual improvements in student access to appropriate levels of care to better meet their mental health needs, they can also serve as a platform or guidelines for the next NYC mayoral administration. In fact, CCC offers one additional recommendation that is the sine qua non to making all other proposals herein a reality: **New York City's next Mayor must prioritize expanding student access to mental health supports and reflect that priority in his or her budget.**

The next mayor will likely exercise the greatest influence in shaping the future of New York City's school-based mental health care infrastructure. The New York City Charter affords the Mayor discretion over tens of billions of dollars in City-funded 'controllable' agency spending. He or she has the jurisdiction, in partnership with the New York City Council, to re-direct a share of these resources toward meaningfully developing child-serving mental health programs in DOE schools and in the community.

This is no small task in a City filled with competing needs, limited resources and vocal advocates representing causes and constituents from all walks of life. While mental health needs by no means trump other needs of New Yorkers, they are far from being met and cannot be until the City's mental health care infrastructure is better resourced. As the City's 2013 Mayoral campaign wagers on, any candidate expressing support for these priorities on the campaign trail should be held accountable to take action starting in January 1, 2014.

In the meantime, like the events of 9/11 twelve years ago, the Newtown tragedy recently inspired efforts at the local, state and national levels to expand access to mental health services in schools and the community. Nearly all of these proposals require additional investments at a time when mobilizing support for increased spending initiatives is a hard sell. Accordingly, while New York State and City elected officials should take advantage of this momentum to facilitate smart and measurable change, CCC urges them to maintain their commitments to supporting these efforts, especially as that nationwide momentum eventually recedes.

Despite these demands, stakeholders must persevere, continuing to explore new opportunities and innovative funding mechanisms to support these initiatives. CCC is hopeful that New York State and City government, policymakers, clinical providers and the advocacy community can work together to find ways in which to proactively expand children's access citywide to school-based clinical mental health services, school-wide behavioral intervention programs and community supports.

APPENDIX 1: ADDITIONAL MAPS AND TABLES

**Map 5:
All SY 2012-13 DOE Elementary Schools Offering On-Site Clinical Mental Health Services
Measured Against Risk to Child Well-Being.**

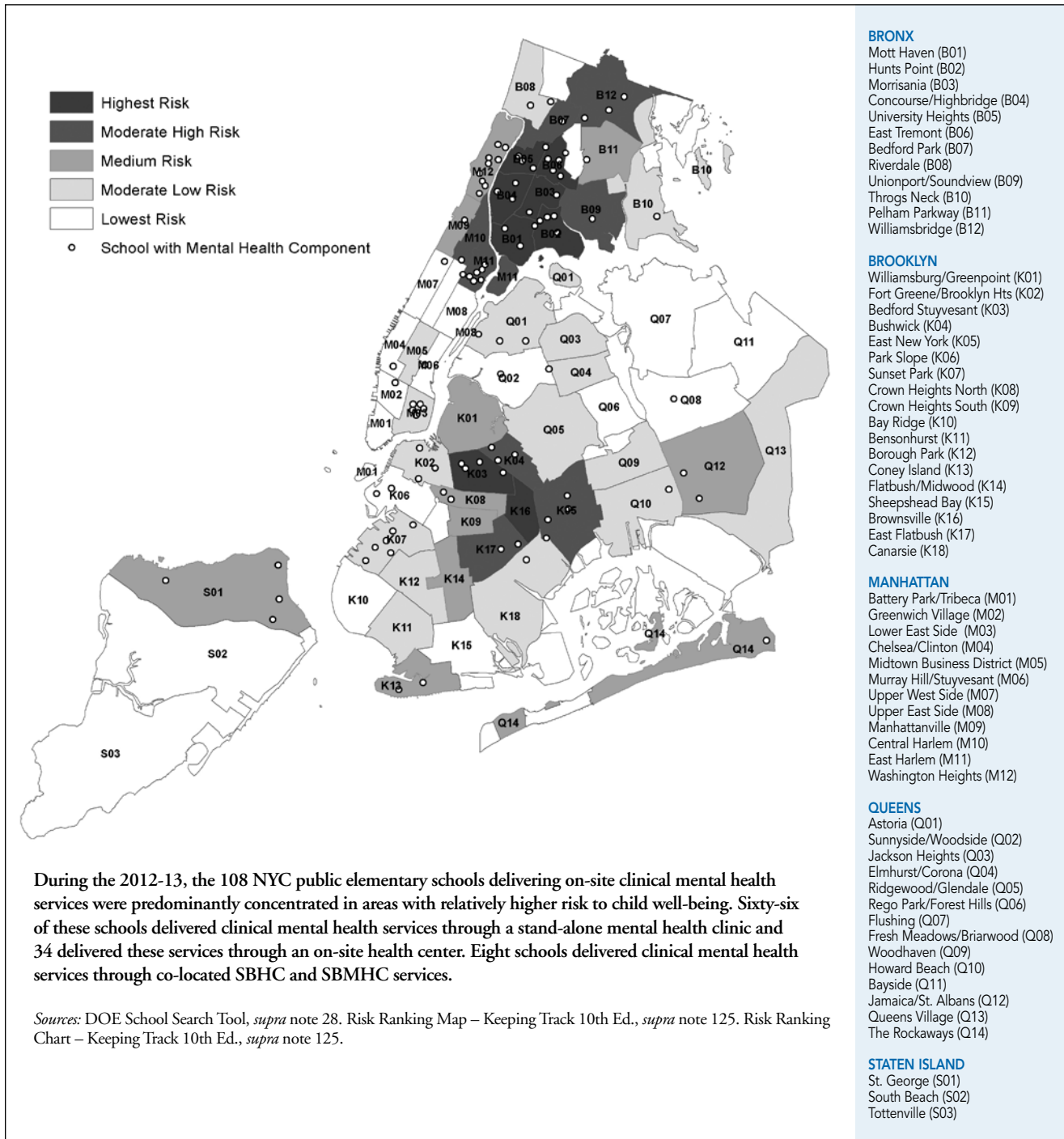


TABLE 2. NYC PUBLIC ELEMENTARY SCHOOLS OFFERING ON-SITE CLINICAL MENTAL HEALTH SERVICES

NYC Public Elementary Schools Delivering On-Site Clinical Mental Health Services SY 2012-2013				
	Sites		Enrollment	
	N	Pct.	N	Pct.
All DOE Schools*	1,700	n/a	1,041,500	n/a
All DOE Schools Reporting On-Site Mental Health	399	23.5%	224,191	21.5%
All DOE Elementary Schools**	626	36.8%	376,321	36.1%
All DOE Elementary Schools Reporting On-Site Mental Health***	108	17.3%	66,693	17.7%
On-Site Mental Health Clinic Only	66	61.1%		
On-Site Health Center with Mental Health Component	34	31.5%		
With Both On-Site Mental Health Clinic and Health Center	8	7.4%		

*Estimates reported in the Fiscal 2013 Preliminary Mayor's Management Report.
 ** Total elementary school count reflects all elementary schools submitting progress reports to the DOE for SY 2011-12, including District 75 elementary schools. Source: DOE SY 2009-10 School Progress Report.
 ***These estimates are a snapshot in time derived from an April 11, 2013 scan of all NYC DOE schools reported as delivering on-site mental health services on the List of Mental Health Program Locations and then cross-walked against results generated from DOE online school search tool. Given student enrollment and school opening fluctuations throughout the year, they are subject to change.
 Sources: SY 2012-13 SBMH Program Listing, *supra* note 28. DOE School Search Tool, *supra* note 28.

TABLE 3. CHANGE IN NYC PUBLIC ELEMENTARY SCHOOLS OFFERING ON-SITE CLINICAL MENTAL HEALTH SERVICES

NYC Public Elementary Schools Delivering On-Site Clinical Mental Health Services Change from SY 2009-10						
	SY2009-10*		SY2012-13**		Change	
	N	Pct.	N	Pct.	N	Pct.
Total Elementary Schools	612	n/a	626			
Total Elementary Schools with On-Site MH Svcs.	101	16.5%	108	17.3%	7	6.9%
On-site SBMHC	81	80.2%	66	61.1%	(15)	-18.5%
On-site SBHC with a mental health component	15	14.9%	34	31.5%	19	126.7%
With both on-site SBMHC and SBHC	5	5.0%	8	7.4%	3	60.0%

*Data on all DOE elementary schools delivering on-site mental health services during the 2009-10 school year. Sources: DOE SY 2009-10 School Progress Report, *supra* note 35. SY 2009-10 SBMH Program Listing, *supra* note 35.
 **Data on all DOE elementary schools delivering on-site mental health services during the 2012-13 school year. Sources: SY 2012-13 SBMH Program Listing, *supra* note 28. DOE School Search Tool, *supra* note 28.

TABLE 4. BOROUGH DISTRIBUTION OF NYC PUBLIC ELEMENTARY SCHOOLS OFFERING ON-SITE CLINICAL MENTAL HEALTH SERVICES, SY 2009-10

NYC Public Elementary Schools Delivering On-Site Clinical Mental Health Services Borough Distribution SY 2009-10		
	Sites	
	N	Pct.
All DOE Elementary Schools Reporting On-Site Mental Health	101	27.7%
Bronx	28	22.8%
Brooklyn	23	34.7%
Manhattan	35	7.9%
Queens	8	6.9%
Staten Island	7	27.7%

Sources: DOE SY 2009-10 School Progress Report, *supra* note 35. SY 2009-10 SBMH Program Listing, *supra* note 35.

APPENDIX 2: PRINCIPAL SURVEY

Next page.

Principal Survey

*** In which borough is your school located?**

- Bronx
- Brooklyn
- Manhattan
- Queens
- Staten Island

*** In which School District is your school?**

*** Which grades are in your school? Select all that apply.**

Pre- K 1 2 3 4 5 6 7 8 9 10 11 12

*** Average number of students per grade:**

*** Average number of students per class**

*** Approximately what percentage of students are eligible for free/reduced price school meals?**

Principal Survey

*** Does your school employ a DOE guidance counselor?**

Yes

No

How many DOE Guidance Counselors are at your school:

Full Time

Part Time

In your opinion, what are the top three most critical functions performed by the DOE Guidance Counselor? Please rank the top three most critical functions performed by a DOE Guidance Counselor.

	First Most Critical	Second Most Critical	Third Most Critical
Counsel students who see the guidance counselor on a scheduled basis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide crisis management and intervention to students	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide crisis management and intervention for school personnel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conduct staff workshops	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conduct community workshops	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Observe classrooms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ensure the rights of Students in Temporary Housing (STH).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide support services to parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide support services to school personnel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Principal Survey

* Does your school employ a DOE Social Worker?

Yes

No

How many DOE Social Workers are at your school:

Full time

Part time

In your opinion, what are the top three most critical functions performed by the DOE Social Worker? Please rank the top three most critical functions performed by a DOE Social Worker.

	First Most Critical	Second Most Critical	Third Most Critical
Work with parents on special education issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work with parents on non-special education issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work with students on special education issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work with students on non-special education issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide support services to students	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide crisis intervention services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Participate in IEP meetings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Observe Classrooms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide support services to students	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide support services to school personnel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Principal Survey

*** Does your school employ a DOE psychologist?**

Yes

No

How many DOE psychologists are at your school:

Full time

Part time

In your opinion, what are the top three most critical functions performed by the DOE Psychologist Please rank the top three most critical functions performed by a DOE Psychologist.

	First Most Critical	Second Most Critical	Third Most Critical
Ensure effective management of the special education evaluation process	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Establish linkages with community mental health resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Administer psycho-educational assessments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Observe classrooms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consult with school staff on behavioral management issues and concerns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consult with parents on behavioral management issues and concerns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consult with students on behavioral management issues and concerns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Formulate Behavioral Intervention Plans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Conduct mental health/ psychosocial evaluations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Principal Survey

*** Does your school have a school-based mental health clinic (SBMH)?**

[A school based mental health clinic is a clinic that is on site at your school and provides therapy and support to students who present mental health or emotional/behavioral health needs].

Yes

No

How many children (meaning slots/caseload) can be served in the school based mental health clinic at any one time?

Enter number

If you don't know, place an

"x" in box

Principal Survey

*** Does your school have a school based health (SBH) clinic?**

[Definition: school based health clinics are multi-disciplinary, primary medical care programs located in schools].

Yes

No

*** Are mental health services provided on the school premises as part of your school based health clinic?**

Yes

No

How many children (meaning slots/caseload) can be served in the school based health clinic with mental health at any one time?

Enter number

If you don't know, place an

"x" in box

Principal Survey

*** How easy or difficult was it to identify a mental health service provider with which to work?**

	Easy	Somewhat difficult	Very difficult	Was already on site when I became principal	Not applicable because school does not have this service
School based <u>health clinic with mental health services</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School based <u>mental health clinic</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Principal Survey

If you do not have a clinic providing on site mental health services at your school, to what agency or community resource do you refer students with mental health concerns? Please list all or write none if your school does not refer children for mental health services to community providers.

*** Is your school participating in Child and Family Clinic-Plus?**

[Definition: Child and Family Clinic-Plus is a confidential, early recognition and intervention program funded by the New York State Office of Mental Health and operated at a local level by a Clinic Treatment Provider. The program is designed to assist with the early identification and treatment of mental health issues by performing school-wide assessment of students with parental consent. It also allows clinic treatment providers to make home visits to students.]

Yes

No

Principal Survey

*** Is your school engaged in behavioral change programming? [Definitions: behavioral change programs work with the students and school to improve the individual and the school environment for all. Positive Behavioral Interventions and Supports (PBIS) is a school wide decision-making model to improve student academics and behavior and school environment. Turnaround is a non-profit organization that helps schools develop tools for working with the most challenging students, while improving the school environment].**

Yes

No

Which behavioral change programming is in your school?

PBIS

Turnaround

Other (please specify)

How easy or difficult was it to identify a behavioral change program service provider with which to work?

	Easy	Somewhat difficult	Very difficult	Was already on site when I became principal	Not applicable (because school does not have this service)
<u>PBIS</u> (a school wide decision-making model to improve student academics and behavior and school environment)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Turnaround</u> (a non-profit organization that helps schools develop tools for working with the most challenging students, while improving the school environment)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Other</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please specify which behavioral intervention program you referred to as "other"

Principal Survey

*** Approximately how many children in your school currently present a mental health or behavioral issue that impedes their learning or disrupts learning for other children?**

- Almost all the children
- Many children
- Some children
- A few children
- No children

*** In your school, do staff members meet to discuss the needs of children who present mental health/behavioral health issues?**

- Yes
- No

Please identify all staff who regularly participate in that meeting (please select N/A if that staff person is not in your school).

	Yes	No	N/A
DOE Social Worker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DOE Guidance Counselor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DOE Psychologist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Principal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School based health clinician	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School based mental health clinician	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please specify)	<input type="text"/>		

How frequently do these types of meetings typically take place?

- Daily
- Weekly
- Monthly
- As needed
- Other (please specify)

Principal Survey

*** In your school, who are the professionals who typically make a referral for an assessment when a child is displaying behavioral/ mental health issues?**

	Yes	No
Principal	<input type="checkbox"/>	<input type="checkbox"/>
Teacher	<input type="checkbox"/>	<input type="checkbox"/>
DOE Guidance Counselor	<input type="checkbox"/>	<input type="checkbox"/>
DOE Social Worker	<input type="checkbox"/>	<input type="checkbox"/>
DOE Psychologist	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

*** How are parents notified when your school believes there is a need to refer a student for an assessment of mental health/behavioral health issues? (check all that apply)**

Phone call

E-mail

Mail

In person

Do not regularly notify parents

*** Are parents also able to make referrals to your school based clinic for an assessment of their children's mental health/behavioral health issues?**

Yes

No

N/A

Principal Survey

*** Approximately how many children in your school were referred for mental health/ behavioral health assessments in the last 6 months?**

of children referred

*** Approximately what percentage of mental health/ behavioral health assessments performed of the children in your school are on site versus off-site?**

What percentage were performed on site:

What percentage were performed off site:

*** What is the approximate percentage of mental health/ behavioral health assessments performed by the following different professionals on site at your school in the last six months. If your school does not have the professional listed, please enter "N/A" in the appropriate box.**

DOE School Personnel
(i.e., DOE Social Worker, DOE Psychologist or DOE Guidance Counselor)

Mental Health Clinic Personnel (from an on-site mental health or health clinic with mental health or Child Family Clinic Plus)

Don't know

*** Over the past 6 months, approximately how long has it typically taken to secure off-site mental health / behavioral health assessments for students in your school? Please check one.**

- Not applicable
- 1-3 school days
- 4-7 school days
- 8-14 school days
- 15+ school days

Principal Survey

*** How many of your students were referred to the emergency room last year due to mental health/behavioral issues?**

- Almost all the children
- Many children
- Some children
- A few children
- No children

Principal Survey

*** To what extent do you believe that the availability of on site mental health services in your school has (or, if you do not have such services in your school, could have) a beneficial impact on each of the following:**

	None	Minimal	Moderate	Significant
Student Attendance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Student Suspensions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Student Expulsions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Student Test Scores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Student Grades	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Referrals to Special Education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Classroom Order	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Teacher Morale	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parent Engagement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Incident Reports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emergency Room Visits for Psychiatric Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School Environment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*** To what extent do you believe that the availability of on site school personnel (DOE Social Worker, DOE Guidance Counselor, DOE Psychologist) in your school has (or, if you do not have these staff in your school, could have) a beneficial impact on each of the following:**

	None	Minimal	Moderate	Significant
Student Attendance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Student Suspensions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Student Expulsions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Student Test Scores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Student Grades	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Referrals to Special Education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Classroom Order	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Teacher Morale	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parent Engagement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Incident Reports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emergency Room Visits for psychiatric care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School Environment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Principal Survey

*** To what extent do you believe that the availability of on site behavioral health programming (PBIS, Turnaround or Other) in your school has (or, if you do not have such programming in your school, could have) a beneficial impact on each of the following:**

	None	Minimal	Moderate	Significant
Student Attendance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Student Suspensions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Student Expulsions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Student Test Scores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Student Grades	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Referrals to Special Education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Classroom Order	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Teacher Morale	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parent Engagement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Incident Reports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emergency Room Visits for psychiatric care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School Environment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Principal Survey

*** To what extent are any of the following items barriers to providing mental health services/ behavioral health programming on site at your school?**

	Significant	Moderate	Minimal	Not a barrier
Parent's primary language was other than English and communication was difficult	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parental concern about stigma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obtaining Parental Consent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parent's Prior Experience with Mental Health Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child's Immigration Status	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child's Insurance or Lack Thereof	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child's Prior Experience with Mental Health Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child's Primary Language is other than English and Communication is Difficult	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child's Concern about Stigma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Competing Demands within the School so that Access to Child is Restricted to Limited Hours/Days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Space Provided for Clinic is not Always Available or is Considered Inadequate by Clinic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relationship between School Staff and Mental Health Providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Length of Time it Takes from Referral to Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cultural Competency of the Mental Health Providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Principal Survey

*** Would you like to increase the capacity of the mental health services in your school?**

Yes

No

For which of the following mental health services are you interested in increasing capacity?

	Yes	No
School based health clinic with mental health staff	<input type="radio"/>	<input type="radio"/>
School based mental health clinic	<input type="radio"/>	<input type="radio"/>
Child and Family Clinic Plus	<input type="radio"/>	<input type="radio"/>

Other (please specify)

What are the barriers to expansion or establishment of mental health services in your school?

	Barrier	Not a barrier
Physical Space	<input type="radio"/>	<input type="radio"/>
Inability for clinic to obtain external financing	<input type="radio"/>	<input type="radio"/>
Shortage of Professionals	<input type="radio"/>	<input type="radio"/>
Competing educational needs that need funding with DOE funds	<input type="radio"/>	<input type="radio"/>

Other (please specify)

Principal Survey

*** Would you like to increase the capacity of the behavioral health programming in your school?**

Yes

No

For which of the following behavioral health programs are you interested in increasing capacity?

	Yes	No
PBIS	<input type="radio"/>	<input type="radio"/>
Turnaround	<input type="radio"/>	<input type="radio"/>
Other (please specify)		
<input type="text"/>		

What are the barriers to expansion or establishment of behavioral health programming in your school?

	Barrier	Not a barrier
Physical space	<input type="radio"/>	<input type="radio"/>
Inability for program to obtain external financing	<input type="radio"/>	<input type="radio"/>
Shortage of professionals	<input type="radio"/>	<input type="radio"/>
Competing educational needs that need funding with DOE funds	<input type="radio"/>	<input type="radio"/>
Other (please specify)		
<input type="text"/>		

Principal Survey

*** Are you interested in increasing the number of school personnel (DOE social workers, DOE guidance counselors and/or DOE psychologists) on your staff?**

Yes

No

Which of the following staff would you like to expand or increase capacity for in your school:

	Yes	No
DOE guidance counselors	<input type="radio"/>	<input type="radio"/>
DOE social workers	<input type="radio"/>	<input type="radio"/>
DOE psychologist	<input type="radio"/>	<input type="radio"/>

Other mental health professional (please specify)

What are the barriers to expansion or initial hiring of DOE staff (social work staff, psychologists or guidance counselors) in your school?

	Barrier	Not a barrier
Physical Space	<input type="radio"/>	<input type="radio"/>
Inability for clinic to obtain external financing	<input type="radio"/>	<input type="radio"/>
Shortage of Professionals	<input type="radio"/>	<input type="radio"/>
Competing educational needs that need funding with DOE funds	<input type="radio"/>	<input type="radio"/>

Other (please specify)

Principal Survey

*** Please rank the three items that, within these choices, constitute the largest percentage of your school budget.**

	First Largest Percentage of Budget	Second Largest Percentage of Budget	Third Largest Percentage of Budget
School based health clinic (with or without mental health staff)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School based mental health clinic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child and Family Clinic Plus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PBIS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Turnaround	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DOE Guidance Counselors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DOE Social Workers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DOE Psychologist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Principal Survey

Are there any other comments or thoughts you would like to share about improving mental health and behavioral health programming for school children?

APPENDIX 3: CLINICIAN SURVEY

ELEMENTARY SCHOOL MENTAL HEALTH TASK FORCE CLINICIAN SURVEY

Date of Interview: _____

Name of Clinician interviewed: _____

Clinic name: _____

Type of clinic: _____

School based health clinic with mental health services

School based mental health clinic

School name & location: _____

CCC Volunteers: _____ & _____

CCC Staff: _____

INTRODUCTION:

Thank you for taking the time to meet with us and talk about the mental health services in this school clinic. I am _____ and this is _____. We are volunteers/board members with Citizens' Committee for Children of New York. As you may know, CCC is a 66-year-old multi-issue child advocacy organization dedicated to ensuring that every child is healthy, housed, educated and safe. We are meeting with clinicians in elementary schools to gain a better understanding about what you see as the mental health needs of elementary school-aged children. We want to understand the population you are serving, the stressors impacting the children you serve and to find out what resources are available in the schools. We are also surveying principals so that we have different perspectives. We hope to use the information collected to inform our advocacy efforts.

Please know that CCC keeps all survey results confidential. No clinician, parent, child, staff person, elementary school or program name is ever identified by name in any CCC publication or advocacy effort.

GENERAL QUESTIONS:

1. **How long** has the clinic been at this site? ____ years or _____ months

Don't know

2. Is there **more than one** school in this building?

No

Yes

If yes, how many schools are in the building? _____

If yes, how many schools do you serve? _____

3. How long have you been employed at this clinic? _____

4. Do you work here full time or part time?

Full time

Part time

5. What is your professional certification?

Masters of Social Work

Clinical Social Worker

Licensed Clinical Social Worker

Psychologist (Psy.D / PhD)

Psychiatrist

Other: _____

6. How many mental health clinicians, including you, work in this school-based clinic?

Full Time: _____ (*write in number*)

Part Time: _____ (*write in number*)

Total: _____ (*write in number*)

7. We are interested in **when your school-based clinic is open**. Which days is the clinic open and what are your hours of operation during the school week (Monday through Friday)?

8. If applicable, which days is the clinic open and what are your hours of operation over the **weekend** (Saturday and Sunday)?

9. What is your **average caseload** in this school based clinic? _____

10. In an average week, approximately **how many children** does **this** school-based clinic work with? _____

11. Is there a **waiting list** for mental health services at this clinic?

No

Yes

a) If yes, on average, approximately how many children are on the waiting list? _____

b) Are there other mental health provider(s) to whom you refer children on the wait list?

No

Yes

c) If yes, to where? _____

12. Does the school-based clinic remain open during **school-year vacations**?

Yes

No

a) If no, where do children typically go if they need continuing mental health treatment during the school-year vacation?

The clinic's main site

We refer to another mental health provider

Treatment is discontinued

I don't know

Other: _____

13. During **July and August**, does the school-based clinic remain open?

Yes

No

a) If no, where do children typically go if they need continuing mental health treatment during July and August?

The clinic's main site

We refer to another mental health provider

Treatment is discontinued

I don't know

Other: _____

14. What type of **psychiatric support**, if any, does the clinic have?

- Psychiatrist on staff at main clinic
- Psychiatrist on staff at this school clinic
- Psychiatrist comes to the school weekly
- Psychiatrist comes to the school bimonthly
- Psychiatrist comes to the school monthly
- Other: _____
- None

15. Is the clinic part of **Child and Family Clinic Plus**? [*Note to Interviewers, you may want to read the clinician this definition.* Child and Family Clinic-Plus is a confidential, early recognition and intervention program funded by the New York State Office of Mental Health and operated at a local level by a Clinic Treatment Provider. The program is designed to assist with the early identification and treatment of mental health issues by performing school-wide assessment of students with parental consent. It also allows clinic treatment providers to make home visits to students.]

- Yes
- No
- Don't know

16. Are any of the following **DOE staff** in this school?

(Check all that apply - Note to Interviewer read each one)

- DOE Social Worker
- DOE Psychologist
- DOE Guidance Counselor
- Other Mental Health professional (*write in*) _____
- None of the above

17. Does this school have **behavioral programming** such as Positive Behavioral Interventions and Supports (PBIS) or Turnaround?

- Yes
- No

If yes, which behavioral program is in this school? (*Check all that apply Note to Interviewer read each one*).

- Positive Behavioral Interventions and Supports (PBIS)
- Turnaround
- Other

18. I am going to read through a list and then ask you to tell us approximately how much of your time during an average week is spent on each one: most of your time, a great deal of time, some time, not a lot of time, no time.

	(1) Most of my time	(2) Great deal of my time	(3) Some of my time	(4) Not a lot of my time	(5) None of my time
a) Seeing students for regular appointments					
b) Managing crisis situations					
c) Managing disruptive children					
d) Classroom observation					
e) Telephone calls					
f) Training school staff					
g) Consulting with teachers on specific cases					
h) Parent outreach					
i) Participating in school based committees or Interdisciplinary team meetings					
j) Participating in IEP (Individualized Education Plan) meetings					
k) Administrative tasks/ paper work:					
l) Consulting with other mental health professionals					
m) Providing clinical supervision to staff					
n) Receiving clinical supervision					
o) Arranging transition mental health services for children who are graduating or transferring out of the school					
p) Other (<i>write in</i>)					

Referrals

19. Is there an **official protocol** for referrals to this clinic?

No

Yes

a) If yes, what is the protocol for referrals to be made to this clinic? _____

20. From whom does your clinic **receive referrals** (*check all that apply - Note to Interviewer read each one*):

Principal

Teachers

Parents

DOE Guidance Counselor

DOE Social Worker

DOE Psychologist

Student (Self-refer)

Other: please specify: _____

21. Approximately **how many referrals** for mental health assessments does this school-based clinic typically receive per month? _____

22. On average, if there is no waitlist, how long does it take from the time you receive a referral for a mental health assessment to initiate the assessment?

Immediately

Less than a week

Between 1-2 weeks

Between 3 to 4 weeks

More than a month

Other: _____

23. On average, if there **is** a waitlist, how long does it take from the time you receive a referral for a mental health assessment to initiate the assessment?

- Immediately
- Less than a week
- Between 1-2 weeks
- Between 3 to 4 weeks
- More than a month
- Not applicable, we do not have waitlists
- Other: _____

24. Who performs the **on-site** mental health assessments? (*Check all that apply - Note to Interviewer read each one*)

- N/A – children are sent off-site for assessments
- Clinician (person being interviewed)
- Other social worker from this clinic
- Other psychiatrist from this clinic
- Other psychologist from this clinic
- Other: _____

25. Of all children assessed, approximately what percentage are then referred to mental health services? _____

26. How many hours on average does it take to complete an assessment? _____

27. What is the protocol for obtaining **parental consent** for an assessment or for mental health treatment? (*Please write down exactly what the clinician states*) _____

28. What is typically included in an assessment? *Check all that apply:*

- Interview with parent(s)
- Interview with child
- Interview with sibling(s)
- Interview with teacher
- Psychiatric Evaluation
- Psychological Evaluation
- Classroom Observation
- I.E.P. Review, if applicable

29. How long does it take from the time you receive a **referral** for mental health services to starting such services if there is **no** waitlist?

- Contemporaneous with evaluation
- Immediately
- Less than 2 weeks
- Between 2 to 4 weeks
- 1 to 3 months
- More than 3 months but less than 6 months
- Other: _____

30. How long does it take from the time you receive a **referral** for mental health services to **starting such services** if there is a waitlist?

- Contemporaneous with evaluation
- Immediately
- Less than 2 weeks
- Between 2 to 4 weeks
- 1 to 3 months
- More than 3 months but less than 6 months
- Not applicable, we do not have waitlists
- Other: _____

Children and Needs

31. I am going to read through a list of **mental health diagnoses**. We are interested in finding out approximately how many of the children that you personally have treated in the past six months have had the following diagnoses? (*Note to interviewers: no actual number is needed, you can simply **check** the boxes.*)

Diagnosis	(1) Almost every child	(2) Many children	(3) Some children	(4) A few children	(5) No Children
a) Attention Deficit Disorder					
b) Other disruptive behavior disorders (conduct disorder, oppositional defiant disorder)					
c) Mood & anxiety disorders (bi-polar disorder, depressive disorder, anxiety disorder, stress disorders including post traumatic stress disorder)					
d) Adjustment disorders					
e) Elimination disorders (encopresis, enuresis)					
f) Psychotic disorders (schizophrenia and others)					
g) Primary substance abuse disorders					
h) Autism spectrum disorders (including Aspergers)					
i) Other developmental disabilities					
j) Other (write in)					
k) Approximately how many of the children you see have multiple diagnoses?					

32. Which of the above are the **three most critical** diagnoses that children have in this elementary school?

- a) _____
- b) _____
- c) _____

33. Do you believe that the most critical diagnoses, selected above, are the same for all grade levels or are there variances in needs by grade?

Same for all grades

Variance by grade

a) Please describe the differences:

Don't know

34. I am going to read through a list of **social and emotional stressors**. We are interested in finding out approximately how many of the children served by you in the last six months in this school-based clinic are being impacted by the following list of social or emotional stressors: *(Note to interviewers: no actual number is needed, you can simply **check the boxes**).*

Social/Emotional Stressor	(1) Almost every child	(2) Many children	(3) Some children	(4) A few children	(5) No Children	(6) Don't know
a) Bereavement						
b) Immigration						
c) Foster Care						
d) Sexual Abuse of a Child						
e) Physical Abuse of a Child						
f) Substance Abuse by a Parent/ Guardian						
g) Parent Mental Illness						
h) Divorce/ Parent Separation						
i) Single Parent Household						
j) Severe Economic Stress in the Home						
k) Hunger						
l) Homelessness						
m) Child Physical Illness						
n) Parent/ Guardian/ Family Member Physical Illness						
o) Domestic Violence						
p) Community Violence						
q) Bullying						
r) Learning Disabilities						
s) Other						

35. Of the above list, which are the **three most critical** social/emotional stressors children have in this elementary school?

- 1) _____
- 2) _____
- 3) _____

36. Do you believe that the most pressing social/emotional stressors, selected above, are the same for all grade levels or are there variances in needs by grade?

- Same for all grades
- Variance by grade _____
 - a) Please describe the differences:

- Don't know

37. Approximately how many children served by you in this school-based clinic receive the following services in or through this clinic? (*Note to interviewers: no actual number is needed, you can simply **check** the boxes*).

Type of Service	(1) Almost every child	(2) Many children	(3) Some children	(4) A few children	(5) No Children	(6) Don't know
a) Assessment/Evaluation						
b) Case Management						
c) Collateral Session						
d) Crisis intervention						
e) Family Therapy						
f) Group Therapy						
g) Home Based Services						
h) Individual Psychotherapy						
i) Medication Management						
j) Skills Training for Child's Parent						
k) Psychiatric Evaluation						
l) Psychological Testing						
m) Other						

38. What is the typical length of a treatment session **with a child** within the school-based clinic?
- 30 minutes
 - As long as one class period (42 minutes)
 - Other: _____
39. What is the typical length of a treatment session with a child and parent together within the school-based clinic?
- 30 minutes
 - As long as one class period (42 minutes)
 - Other: _____
40. When do you typically see children (*check all that apply Note to Interviewer read each one*):
- During academic class time
 - During child's lunch period
 - During non-academic class time (e.g., art, gym)
 - After school
 - Other: _____
41. What is the **average duration** of treatment within this school-based clinic:
- One session
 - Less than 3 months
 - 3 to 6 months
 - More than 6 months up to one full school year
 - More than one school year
42. Besides parental consent requirements, what are the **typical role(s) of the parent(s)** in their child's mental health treatment within this school-based clinic? (*Check all that apply. Note to Interviewer read each one*)
- Attending family therapy
 - Ensuring they are home for home visits
 - Attending special training workshops
 - Conference calls
 - Participating in child's therapy through learning to do suggested behavioral and/or mental health interventions
 - None
 - Other: _____

43. Approximately how many children in this school needed crisis intervention services during this school year?

Number: _____

Don't know

a. If you know the number of children who needed crisis intervention services, can you please tell us what percentage of those crisis situations were addressed within the school/clinic and which ones needed emergency room intervention or some other type of outside assistance.

Crisis situation handled in an emergency room _____ %

Crisis situation handled in the clinic/school _____ %

Crisis situation handled in – Other _____ %

Please specify other: _____

Don't know _____

44. How often does this clinic **refer a child for hospitalization** for mental health reasons?

Often (at least once a month)

Occasionally

Rarely (once or twice a school year)

Never

We are interested in what type of follow up is done by the clinic after a crisis situation occurs.

45. What follow up is typically done with the **student**? (*Check all that apply. Note to Interviewer- if clinician responds "no follow up" you do not need to read each one*)

No follow up

Telephone call to student

Home visit

Counseling at clinic

Parent-teacher-student-clinician meeting

Classroom observation

Other: _____

46. What follow up is typically done with the **parents**? (*Check all that apply. Note to Interviewer- if clinician responds "no follow up" you do not need to read each one*)

No follow up

Telephone call to parent

Home visit

Family counseling at clinic

Referrals for handling any family social/emotional stressors (e.g., lack of food, homelessness)

Other: _____

47. What follow up is typically done with the **school staff**? (*Check all that apply. Note to Interviewer- if clinician responds “no follow up” you do not need to read each one*)

- 1 No follow up
- 2 Developing strategies with staff for the child
- 3 Classroom observation
- 4 Staff training
- 5 Other: _____

48. I am going to read through a list of items and would like to know if you think having **on-site mental health services** has provided an **overall** significant benefit, moderate benefit, minimal benefit, or no benefit to students and the school.

1 = a significant benefit

2 = a moderate benefit

3 = minimal benefit

4 = not a benefit from providing services

Note to Interviewers: You may need to say after each potential benefit, “From your perspective was this benefit to students from providing mental health services significant, moderate, minimal or none.”

Check the appropriate box.

	(1) Significant benefit	(2) Moderate benefit	(3) Minimal benefit	(4) Not a benefit
Benefits to Students				
a) Student Attendance				
b) Student Suspensions				
c) Student Expulsions				
d) Student Test Scores				
e) Student Grades				
f) Referrals to Special Education				
<i>Note to Interviewers: for the next set you may need to say after each potential benefit, "From your perspective, was the benefit to the school from providing mental health services significant, moderate, minimal or none."</i>				
Benefits to the school				
g) Classroom Order				
h) Teacher Morale				
i) Parent Engagement				
j) Incident Reports				
k) Emergency Room Visits for Psychiatric Care				
l) School Environment				

49. Do you provide any **group parent trainings** on mental health topics?

- No (*note to interviewer, if no, skip column 1 below*)
- Yes

50. Do you provide any **group student trainings** on mental health topics?

- No (*note to interviewer, if no, skip column 2 below*)
- Yes

51. Do you provide any **group school staff trainings** on mental health topics?

- No (*note to interviewer, if no, skip column 3 below*)
- Yes

52. Which of the following trainings do you offer?

Check the appropriate box.

Training	(1) Parent	(2) Students	(3) School Staff
a) Overview of Mental Health	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes
b) Conflict Resolution	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes
c) Domestic Violence: an overview	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes
d) Violence Prevention	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes
e) Substance Abuse Education	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes
f) Bereavement Counseling	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes
g) Bullying Prevention	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes
h) Classroom Management	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes
i) Parenting Skills	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes
j) Peer Mediation	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes
k) Other	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes	<input type="checkbox"/> _a No <input type="checkbox"/> _b Yes

Challenges/ Barriers

We realize that all collaborations have **challenges and benefits**. We want to ask you about some of the challenges and benefits you have experienced as a mental health clinician in an elementary school. We will ask you first about challenges with parents, then with the children, then with school staff and finally about those challenges that are specific to the clinic.

53. Below is a list of potential barriers **for parents** in engaging them and their children in mental health services. Please think about the children and families you have served and then tell us how much of a challenge/barrier these have been in providing mental health services.

1 = a significant barrier

2 = a moderate barrier

3 = a minimal barrier

4 = not a barrier to providing services

Notes to Interviewers: You may need to say after each potential challenge, “Was this a significant, moderate, minimal or not a barrier to providing mental health services.”

Check the appropriate box.

	(1) Significant	(2) Moderate	(3) Minimal	(4) Not a barrier
a) Parent’s primary language was other than English and communication was difficult				
b) Parental concern about stigma				
c) Parent refusal to consent				
d) Parent delay in consenting				
e) Parental resistance to family therapy				
f) Parental concerns that mental health counseling goes on a child’s permanent record				
g) Cultural barriers				
h) Parent’s work hours interfered with engaging in family therapy				
i) Parental denial of a problem				
j) Inability to make contact with the parent				
k) Other				

54. Below is a list of potential barriers for **children** in engaging them in mental health services. Please think about the children you have served and then tell us how much of a challenge/barrier these have been in providing mental health services.

1 = a significant barrier

2 = a moderate barrier

3 = a minimal barrier

4 = not a barrier to providing services

Notes to Interviewers: You may need to say after each potential challenge, “Was this a significant, moderate, minimal or not a barrier to providing mental health services.”

Check the appropriate box.

	(1) Significant	(2) Moderate	(3) Minimal	(4) Not a barrier
a) Access to child restricted by inability to get child released from class				
b) Access to child restricted by special events such as testing days, vacation schedules				
c) Access to child restricted by after school activities				
d) Cultural barriers				
e) Child’s primary language was other than English and communication was difficult				
f) Child’s concern about stigma				
g) Parental barriers				
h) Other				

55. Below is a list of potential barriers you may face with **the school and with school personnel** in providing mental health services. [Note to Interviewer: *If the clinician serves more than one school, please ask them to refer to the school which is listed on the front of this survey*]. Please think about the school staff you have interacted with and then tell us how much of a challenge/barrier these have been in providing mental health services.

1 = a significant barrier

2 = a moderate barrier

3 = a minimal barrier

4 = not a barrier to providing services

Note to Interviewers: You may need to say after each potential challenge, “Was this a significant, moderate, minimal or not a barrier to providing mental health services.”

Check the appropriate box.

Barriers	(1) Significant	(2) Moderate	(3) Minimal	(4) Not a barrier
a) Space provided is not always available or is inadequate				
b) DOE regulations (<i>please ask the clinician to specify if possible</i>)				
c) Terminology differences between mental health professionals and school professionals				
d) Competing demands within the school				
e) Difference in privacy laws (<i>Note to interviewers: school is governed by FERPA (Family Educational Rights and Privacy Act) and mental health privacy falls under HIPAA (Health Insurance Portability and Accountability Act)</i>)				
f) Staff resistance to mental health services for children				
g) Lack of principal support				
h) Cultural barriers				
i) DOE staff concern about stigmatizing the child				
j) DOE staff insensitivity to the child				
k) Other				

56. Below is a list of potential barriers you may face as **a clinician** in providing mental health services. Please think about the children and families you have served and school staff you have interacted with and then tell us how much of a challenge/barrier these have been in providing mental health services.

1 = a significant barrier

2 = a moderate barrier

3 = a minimal barrier

4 = not a barrier to providing services

Notes to Interviewers: You may need to say after each potential challenge, “Was this a significant, moderate, minimal or not a barrier to providing mental health services.”

Check the appropriate box.

	(1) Significant	(2) Moderate	(3) Minimal	(4) Not a barrier
Clinic				
a) Inability to see every child who needs services				
b) Inability to schedule sufficient treatment sessions				
c) Time constraints for school staff training				
d) Inability to see every parent				
e) Inability to do sufficient classroom observation				
f) Shortage of clinic staffing				
g) Funding constraints				
h) OMH or DOE regulations. <i>Please specify</i>				
i) Other				

57. Are there any issues you would like to see addressed by the **Department of Education’s Office of School Health, the State Office of Mental Health or the City Department of Health and Mental Hygiene** related to meeting the mental health needs of elementary school children? If so, please be specific and please describe. (*Interviewers, please use reverse if needed*)

58. We thank you for taking the time to answer all of our questions today. Is there **anything you would like to add** about providing mental health services or meeting the mental health needs of elementary school children?
(Interviewers, please use reverse if needed)

Thank you very much for your time.

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Since 1944, Citizens' Committee for Children of New York, Inc. (CCC) has convened, informed and mobilized New Yorkers to make the city a better place for children. CCC's approach to child advocacy is fact-based and combines the best features of public policy advocacy with a tradition of citizen activism. Our focus is on identifying the causes and effects of vulnerability and disadvantage, recommending solutions to problems children face and working to make public policies, budgets, services and benefits more responsive to children. Our mission is to ensure that every New York City child is healthy, housed, educated and safe.

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