

# Leveraging Mental Health Dollars Into Your District

By Robert Kilkenny, Ed.D.; Nechama Katz, M.A., and Lisa Baron, Ed.D.



**T**he U.S. Surgeon General reports that 20% of American children have a diagnosable mental disorder, and only 20% of those children receive treatment. In a classroom of 25 students, this translates into five students with mental health disorders serious enough to cause impairment, but only one student receiving treatment.

An untreated mental health or behavioral disorder in even one child in the class often diminishes teaching and learning for every child in the classroom. Yet, in schools, most teachers are left alone to address multiple mental health issues that they were never trained to address—but for which they end up being responsible.

So why don't more schools do more?

It's not because they don't understand the problem or because they wouldn't welcome more school-based mental health supports. The institutional failure is the result of the systemic separation between education and mental health in terms of both funding and culture. These "silos" artificially separate treatment for children's emotional problems from their academic and social environments, preventing a unified response from the important adults in a child's life.

Across the United States, in spite of the systemic obstacles, some school districts have developed innovative school-based mental health models. However, such programs are relatively few in number and often are vulnerable to changes in leadership, shifting institutional priorities, and vagaries of funding.

Every principal knows about the buck-passing, cost-shifting, and dysfunctional communication that can occur between social service agencies, local education agencies, and medical insurers when a child is in need of mental health services. What is missing is a way to blend funding to give schools access to on-site mental health services that address children's untreated behavioral and emotional disorders. For students dealing with behavioral health challenges, as well as for their teachers and classmates, mental health services are necessary to promote students' success in learning and in life.

## Connecting With Care

Three years ago, with funding from the Robert Wood Johnson Foundation, Amelia Peabody Foundation, Blue Cross Blue Shield of Massachusetts Foundation, and The Boston Foundation, a group of schools and private agencies in Boston joined together to address these challenges. After identifying financial and other barriers to school-based mental health care, the partners designed Connecting With Care (CWC), a mental health collaboration that places full-time clinicians in schools in the city's most under-served urban neighborhood.

Connecting With Care was initiated by the Alliance for Inclusion and Prevention (AIP), a local non-profit that operates full-service school partnerships with two Boston public schools. AIP operates an array of student and school supports, including therapeutic after-school and summer programs, before-school programs, and Saturday programs,

that are integrated with the core culture, operations, and academic mission of the host schools.

Along with the Alliance for Inclusion and Prevention, the CWC collaboration includes five Boston institutions: The Home for Little Wanderers, MSPCC, Family Service of Greater Boston, Children's Hospital Boston, and the Boston Public Schools.

Connecting With Care responds to the specific needs of its schools by providing school-based individual counseling with a specialization in trauma treatment. In addition, to ensure that families can participate fully in treatment, Connecting With Care runs a weekly Evening Family Clinic. Child care and transportation for families are available when needed.

Building on AIP's comprehensive integrated service model at Boston's Lilla G. Frederick Pilot Middle School, the partners launched CWC to develop and test alternative means for supporting school-based mental health services. The goal was to offer new strategies for addressing the barriers to integration of mental health services and public education. Now operating in five schools, grades K–12, Connecting With Care demonstrates how districts can collaborate with mental health agencies to place full-time clinicians in schools, at relatively little additional cost to the district.

Connecting With Care's approach focuses on one core service delivery node: financially sustainable school-based counseling delivered by community-based mental health providers. The primary purpose of this program is to "crack the code" of sustainable partnerships between schools and mental health providers by addressing the key components of finance and infrastructure.

Connecting With Care shows that the district can leverage third-party insurance to provide needed school-based services, with high levels of staff productivity and expert clinical supervision, at a small fraction of what it would cost the district to provide these services on its own.

## The Challenge for Schools

The U.S. Substance Abuse and Mental Health Services Administration estimates that this country spends \$121 billion annually on mental health services. Even though most school principals and superintendents recognize the need, very few children's mental health dollars flow through school districts. Most children's behavioral health services are paid for by Medicaid or private health insurance, but school districts are rarely licensed as mental health clinics, so they cannot bill for these services. While some special education students receive IEP-mandated behavioral health services, funded in some cases by Medicaid, the majority of the student population is not eligible for this support.

Many schools invite local mental health agencies into the school building to treat children on site. In most cases, an outside agency sends a fee-for-service clinician into a school for a few hours a week to provide one-on-one counseling to identified children who have health insurance coverage. The agency bills the insurance to pay for the treatment. The clinician has relatively little interaction with people at the school and little impact on school climate or culture as a whole because no one is paying for these activities. Most time spent outside of the "therapeutic hour" is not reimbursable. While the part-time, fee-for-service approach is helpful in providing some services to some children, as a whole, neither schools nor mental health providers consider it sufficiently comprehensive or collaborative.

Mental health providers typically operate on thin margins. While public education spending has more than doubled in the past 15 years, insurance reimbursement rates for mental health services have been severely constricted. The result is that clinics are reluctant to place full-time, salaried clinicians in schools. A primary reason for reliance on fee-for-service clinical staff for school-based counseling is the 12 to 14 weeks of

school vacation each year. It is difficult for any employer to pay full-time salary and benefits when employees are not productive for three or more months each year. In addition, most mental health clinics cannot afford the risk that schools' limited existing referral infrastructures might not produce the number of billable hours that clinics require to break even.

The Connecting With Care model reorganizes the way school-based services are delivered in order to address these issues. With its emphasis on clinical staff who are full-time and salaried, with benefits, CWC avoids the high rates of turnover and lower levels of experience and professional licensure often associated with fee-for-service clinicians. It allows the clinicians to become fully integrated into the daily life of the school and to develop personal relationships with teachers that can be very helpful when consulting about students who are in treatment.

## Infrastructure and Finance

How can schools and local mental health providers collaborate to embed on-site mental health services as a core school service? How can two unaligned service systems—education and mental health—develop deep partnerships that work for both partners?

When schools work with mental health partners to identify infrastructure needs and then maintain an infrastructure that meets those needs, mental health clinics and schools can collaborate successfully. Three key conditions that must be met by this infrastructure are:

**1. Refer a sufficient number of clients:** Because billing provides the revenue stream that supports the clinical staff placed in the school, clinics rely on their school partner to refer enough children to treatment to enable the clinic to maximize third-party reimbursement.

The clinic partner and school should jointly determine how many referrals will be needed over the course of a year to keep the clinician's

caseload at a level that will sustain the position. The number will vary by school or district, by clinic, and by region, depending on variations in insurance rates and guidelines, collection rates, specific clinic and school policies, and prevailing salaries, benefits costs, and clinic overhead. These are all questions for school districts to discuss with mental health partners. One option for schools where fewer children need services is to share one clinician across several schools.

After evaluating the partners' expenses and available insurance revenue streams, Connecting With Care developed a formula for how many billable hours its clinicians need to provide weekly to cover the costs to the clinic over a 12-month period. These numbers, which were agreed to by all the partners, are useful for monitoring referral and billing rates over the year and for evaluating the amount of any subsidy needed to fill the gap at the end of the year.

**2. Provide private counseling space:** Counseling requires a calm,

private space where the child and clinician can meet, uninterrupted. Schools must provide a guaranteed, consistent, private space, with telephone and Internet access, where the therapist can meet regularly with children and families and make confidential phone calls.

**3. Develop a Memorandum of Agreement that specifies the school's infrastructure commitments and the agency's service commitments:** The mental health agency and the school or district should make formal commitments to each of the infrastructure elements needed for effective school-mental health partnerships. By providing this infrastructure, the district can expect the provider to tailor services to meet the specific needs of each school. The key infrastructure elements are discussed below. Table 1 summarizes the cost implications of this infrastructure:

- **School-based Coordination of Referrals:** A referral coordinator in each school is critical for maintaining the flow of referrals to the

school-based clinician. This function often is filled by an existing administrator inside the school.

- **Central Project Manager:** When the partnership is at the district or multi-school level or involves multiple providers, the school district or a mental health partner should assign a clinically knowledgeable staff person to oversee the collaboration. This position provides important oversight to the institutional partnership infrastructure, to the mental health clinicians working in the schools, and to the school-based referral coordinators.
- **Partner Liaison:** If the school district has employed the central project manager, the mental health clinic should assign an individual to serve as liaison to the project. If the manager is employed by the mental health agency, the school district must assign one position whose responsibilities include serving as liaison. In either case, this will require only a small amount of staff time.

**Table 1.** Key Elements of Needed Infrastructure:  
The Costs for Integration of Mental Health Services and Schools

Infrastructure Support Needed	Discussion of Role in the School/District	Description of Cost
Referral Coordinator at each school	Many schools already have student support staff, so this may not be an added cost. This responsibility may be assigned to an existing staff person.	Professional staff, 1 per school (small part of an FTE)—typically 40–80 hours per year. Usually would not be an additional expense.
Central Project Manager	Position serves as liaison between mental health providers and schools, overseeing the School-Based Referral Coordinators. In most cases it would be an additional responsibility for an existing position. Larger districts or multiple mental health partnerships may need this level of central administration; individual schools may not.	Mid-level position, 1 per district (part of an FTE—amount depends on number of schools and partners involved). May be preferable for the district’s clinical provider partner to employ this individual, rather than the district.
Partner Liaison	The entity that does not hire the Central Project Coordinator must assign a staff person to serve as liaison to the project.	Mid-level or managerial position, 1 per district (small part of an FTE)
Potential subsidy	May be necessary to offset mental health partner’s unreimbursed costs	Estimated at \$8,000 or less per full-time clinician

- Potential Subsidy to Finance Integrated School-Based Services:** With well-designed infrastructure inside the school, insurance reimbursement generally will cover most or all of the expense to the agency for placing a full-time mental health clinician in a school. The district or school may need to offset ramp-up costs through a subsidy to the mental health clinic. This subsidy would be a small fraction of what it would cost the district to provide similar services on its own.

These costs sometimes decline in subsequent years, once referrals are consistently adequate. Depending on local conditions and the particular services the school wants, a district that can guarantee infrastructure and sufficient numbers of referrals may or may not need to provide an ongoing subsidy.

In Connecting With Care, a detailed review of expenses and reimbursement across three agencies over three years, coupled with strong ongoing school-based infrastructure

supports, yielded an unreimbursed amount that typically was less than \$8,000 per clinician per year. In some cases, the needed subsidy was significantly less. It is reasonable for the district to ask the agency for a transparent explanation of costs not covered by insurance before agreeing on a subsidy amount. Salaries, benefits, insurance reimbursement rates, collection rates, and agency overhead all figure into the equation. The size of the subsidy also can be negotiated if the school would like additional services from the partner agency that are not covered by insurance, such as staff training, case consultation, free care, assessment or testing, crisis intervention, or various prevention programs. The district can subsidize the unreimbursed costs, or the collaboration has the option of seeking outside funding.

### Implications for Schools and Districts

School-based mental health partnerships offer the opportunity to lever-

age a wide array of supports for children, paid for largely by third-party reimbursement for individual treatment. For example, help to address school violence, bullying, substance abuse, or school climate issues may be high priorities for some schools. Once schools create the infrastructure to provide their mental health partners with sufficient billable hours, schools can then enlist these partners to help them address broader prevention efforts as well.

The schools in the Connecting With Care network requested specialized trauma services as part of the service delivery package. This led to a partnership with a teaching hospital that includes intensive training for partner school staff and CWC clinicians, as well as a weekly interdisciplinary, inter-agency trauma roundtable where cases are discussed and supervised. Districts should consider establishing partnerships that can provide specialized clinical expertise and training in one or more areas of high need for their schools.

School-based mental health services bring treatment into the children's daily life context and facilitate collaboration between the clinician and the school staff. School-based counseling also is a significant convenience for parents, because they do not have to take responsibility for getting their child to weekly appointments. At the same time, the standard of care in children's mental health necessitates significant parental involvement in treatment, so schools should work with their mental health partners to engage parents and families in their child's treatment. This may mean home visits, flexible hours, transportation vouchers, or on-site childcare. For example, Connecting With Care requires its clinicians to be available to see parents and children two evenings per week in CWC's school-based Evening Family Clinic. The goal is to keep parents just as engaged in their child's treatment as they would

be if they had to bring their child to a clinic or a therapist's office for regular counseling appointments.

### In Sum

By addressing common reasons that schools and mental health partners often cannot sustain sufficient school-based mental health services, Connecting With Care is demonstrating how schools and districts can leverage significant mental health dollars and marshal them into services that meet schools' and children's needs. The key elements for successful collaborations include the creation of school-based infrastructure to support an efficient and steady referral flow, memoranda of agreement to outline detailed mutual expectations and responsibilities, and coordination of these partnerships at high levels of management across the partners.

There is a natural convergence of mission and need between schools

and mental health providers. Systemic obstacles to more collaborative and sustained partnerships can and must be resolved if the clinical, emotional, behavioral, and social problems that children present in school are to be successfully addressed. Integration of mental health services in schools results in healthier children and better schools—at far less expense to districts than the cost of providing these services themselves.

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**Robert Kilkenny** is executive director of the Alliance for Inclusion and Prevention in Boston, Massachusetts, and a founder of Connecting With Care. Email: [bkilkenny@aipinc.org](mailto:bkilkenny@aipinc.org)

**Nechama Katz**, an independent consultant, is a founder of Connecting With Care and its Planning Coordinator. Email: [nekatz@comcast.net](mailto:nekatz@comcast.net)

**Lisa Baron**, a licensed psychologist, is the Connecting With Care program director. Email: [lbaron@aipinc.org](mailto:lbaron@aipinc.org)