

CHALLENGE AND OPPORTUNITY

**AN ANALYSIS OF CHAPTER 26.5 AND THE
SYSTEM FOR DELIVERING MENTAL HEALTH SERVICES
TO SPECIAL EDUCATION STUDENTS IN CALIFORNIA**

**YOUTH AND EDUCATION LAW CLINIC
STANFORD LAW SCHOOL
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EXECUTIVE SUMMARY

Children with disabilities are entitled to a free appropriate public education (FAPE) in the least restrictive environment (LRE) under state and federal law, including any “related services” necessary for a child to benefit from special education. Among children with disabilities, those with emotional disabilities and mental health issues have historically been among the most poorly served of all disabled children. They are often segregated from their non-disabled peers as “behavior problems,” or misunderstood or marginalized because of the “invisibility” of their disability. Too frequently, children with mental health issues do not receive the related services that may be necessary to meet their individual educational needs, including case management services, individual counseling and therapy, family therapy, therapeutic day programming or, in some instances, residential treatment.

California provides mental health services to special education students through AB 3632, adopted in 1984 and codified at Chapter 26.5 of the Government Code. Chapter 26.5 establishes a unique interagency approach to mental health service delivery, sharing the responsibility for such services between Local Education Agencies (LEAs) and County Mental Health (CMH) agencies. This allocation of responsibility between LEAs and CMH agencies promised to provide children with the mental health services that would be required to meet their educational needs

from the most qualified, well-trained professionals.

Twenty years later, it is clear that Chapter 26.5 and the provision of mental health services to children with disabilities require renewed legislative attention. Across the state, the system is in fiscal shambles. The state—in the midst of an epic budget crisis—recently reduced significantly financial support for such services, passing the cost of the program on to counties, which are increasingly unable to bear the added financial strain. This fiscal crisis has already prompted several lawsuits, a complaint to the United States Department of Education, and the threat of discontinuing services by cash-strapped CMH agencies.

At the same time, it is clear that the challenges facing school-based mental health service delivery are broader than questions of adequate funding alone. Parents, students, advocates, teachers, administrators and mental health professionals have long recognized “street-level” barriers to providing mental health services to children under the Individuals with Disabilities Education Act (IDEA). These barriers are encountered at all stages of the process, from identification and referral of students with potential mental health problems to eligibility determinations to service delivery to more foundational questions of interagency collaboration and accountability.

This report is based on research conducted by students and faculty of the Stanford Law School, under the direction of the Youth and Education Law Clinic at the law school. The research sought to identify the specific barriers that affect the delivery of mental health services in California through the special education system. In particular, the research focused on local-level constraints that impede more effective service delivery under the Chapter 26.5 framework, within the context of state-level constraints, including legal, fiscal and policy concerns.

Our research is based on a review of previous reports on the Chapter 26.5 system, analysis of the legal framework for mental health service delivery to special education students, analysis of relevant data at the state and local levels, and, most of all, more than 70 interviews we conducted with state and local stakeholders representing diverse perspectives in the school-based mental health system. At the heart of the report are three in-depth county level case studies, analyzing the implementation of Chapter 26.5 at the local level in San Mateo, Santa Clara and Alameda Counties.

Our research revealed substantial gaps in the provision of mental health services under the existing Chapter 26.5 framework. Despite requirements that LEAs exhaust local treatment options before turning to Chapter 26.5, many LEAs provide no mental health services whatsoever. As a result, the mental health needs of many students go unnoticed until their problems reach a crisis level, requiring intensive, higher-cost interventions. This organization of service delivery, focusing on a “crisis approach” to mental health issues, comes at the expense of prevention and early intervention strategies, which are not only more cost-effective, but also less disruptive to students with mental health needs.

Our case studies suggest that the fiscal crisis and the shortage of adequate funding are already having a direct and detrimental effect on students with mental health needs. In all three counties, stakeholders reported perceptions that eligibility criteria have been “narrowed” as resources have become more scarce and that fewer students are being found eligible for Chapter 26.5 services. Service delivery options have also been reduced, resulting in a shortage of appropriate placements and services for students already determined to be in need of such services.

At the implementation level, our research revealed a surprising number of barriers for students to access services included in their IEPs. Counseling appointments may be scheduled at inconvenient times, at inconvenient places and without effective means of transportation, meaning that many students and families are unable to fulfill scheduled appointments. Our case studies found that LEAs and CMH agencies often operate under different procedures and practices, including different eligibility criteria. This often results in confusion, lack of transparency, unnecessary delays and, in some cases, even denial of services. We found that parents and teachers are relied upon as the frontline in identifying students with potential mental health problems, yet they are often unfamiliar with mental health issues, with the services available under Chapter 26.5, and with the procedures and practices for accessing those services.

Our state-level consultations and our county case studies confirmed significant challenges in the areas of interagency collaboration and accountability. Data collection at the state level has improved, but still does not capture some of the more relevant and interesting aspects of the system. Students still fall through the cracks

in the Chapter 26.5 system, and parents often feel left out of the informal decision-making processes that increasingly determine eligibility and services. Many stakeholders are frustrated by the effective “veto” held by CMH agencies over eligibility and service delivery determinations, while others are concerned that schools often do not treat potential mental health problems with sufficient seriousness. Tension between LEAs and CMH agencies often results from a lack of understanding between the agencies of their respective mandates and procedures, as well as resource constraints and improper incentives created by particular funding mechanisms.

While there is much room for improvement, we also found that Chapter 26.5 has been fairly effective in providing services to students with the most urgent or most obvious mental health needs. Despite the shortcomings of the Chapter 26.5 system, stakeholders consistently expressed serious concerns over any reforms that would transfer primary responsibility for providing mental health services to any agency whose primary business is not mental health. We agree with these stakeholders that the original rationale for AB 3632 remains sound: ***Mental health***

services are best provided by trained, qualified mental health professionals and, given the current and foreseeable fiscal and staffing realities in LEAs, such services are best provided by mental health professionals in CMH agencies.

This is not to say that we would categorically oppose an adequately funded proposal to abolish AB 3632 and return mental health “related services” to LEAs. Indeed, aligning the LEAs’ legal obligation to provide IDEA related services with the programmatic responsibility to provide mental health services holds much appeal. But such a proposal would require rigorous planning for funding, capacity-building, and mental health staffing in schools, as well as a phase-in period so that current mental health service provision is not disrupted. To date, we have not seen such a proposal.

The current fiscal crisis provides an opportunity to make broad reforms to the Chapter 26.5 framework, which can improve the quality and cost-efficiency of mental health service delivery to special education students in California. In an effort to contribute to ongoing state dialogue on these questions, we offer the following recommendations:

Recommendation #1: Increased, early involvement of mental health professionals in the special education process and a mental health presence in every school

Our first recommendation is for increased involvement of mental health professionals at all stages of school-based mental health service delivery. CMH agencies should seek to have a presence in every school and on every IEP team. This involvement should begin at the initial multi-disciplinary team assessment of students with suspected disabilities. To the greatest extent practicable, CMH personnel should be fully integrated into the school community. Such a presence can bring more consistency and expertise to the process of identifying students with potential mental health needs and can shift the focus from high-cost crisis interventions to more cost-efficient prevention and early intervention. While this may not have been the original design of the Chapter 26.5 framework, this shift in focus is appropriate given the history of the program to date. Clearly, this recommendation poses significant challenges, among them funding, staffing, determination of lines of authority, and accountability. Yet, anecdotal

evidence collected during our research suggests that such models are being employed in certain counties across the state to the benefit of the students served in those counties.

Recommendation #2: Remove obvious barriers to access that prevent students from benefiting from mental health services

Our second recommendation is to remove obvious access barriers. As local interagency agreements provide, schools must provide adequate on-site office space for mental health professionals. Wherever possible, mental health services should be delivered on-site at a student's school in appropriate settings at appropriate times. Similarly, mental health agencies and LEAs should review current practices and identify other logistical barriers that prevent or impede access by students to services included in their IEPs.

Recommendation #3: Streamlining of procedures and practices

Our third recommendation is to streamline procedures and practices between mental health and special education agencies. Agencies should align eligibility criteria, as well as criteria for determining when such services should be terminated, to eliminate inconsistencies. Agencies should eliminate other administrative obstacles that create unnecessary delay, such as double timelines. Local practices and procedures should be audited to ensure that eligibility and service delivery decisions are made as efficiently as possible. The presence of CMH personnel on the IEP team from the outset, as we recommend above, should also help to achieve this recommendation.

Recommendation #4: Expanded case management services to increase accountability and responsibility

Our fourth recommendation is to expand the use and role of case managers for every student with mental health needs. Ideally, this case manager would not be the service provider, but rather a separate individual in the LEA with overall responsibility for making sure that the system is working for the student—that the process is moving forward during the eligibility phase, that timelines are being met, that services are being provided, and that the student is able to access those services. A case manager would also provide a clear point of contact and accountability for parents when questions or concerns arise. Significantly, the case manager would ensure that all students recommended for mental health services by an IEP team are provided those services regardless of whether the student is found eligible for Chapter 26.5 services. Many CMH agencies already employ a case manager model, particularly for students with more severe mental health issues and more costly or intensive services. We recommend that LEAs employ case management and that case management services are expanded to include all students with mental health needs at all stages of the process.

Recommendation #5: Training and information for parents, teachers and agency personnel

Our fifth recommendation is for increased training, outreach and information. While our recommendation for a CMH presence in every school will shift some responsibility for identification of mental health problems, parents and teachers will no doubt continue to serve as

the front-line in identifying students who may require mental health services. Parents should be provided with training on the availability of services, their rights, and how to access those services. In particular, resource parents provided to assist parents in navigating the system should be fully trained on the Chapter 26.5 system. Teachers should receive more substantial training on identification and eligibility for mental health services. Agencies should also participate in cross-training on legal mandates, eligibility criteria, and transparency of funding. Finally, all LEA and agency personnel involved with Chapter 26.5 should be trained to recognize potential mental health needs across cultural and linguistic groups and to conduct outreach to underserved communities.

Recommendation #6: Better data collection, monitoring, and oversight at the state level

Our sixth recommendation is for enhanced monitoring and oversight by the California Department of Education (CDE) and better data collection and analysis by both the CDE and the Department of Mental Health (DMH) at the state level. Ultimate legal responsibility for ensuring that students receive a free, appropriate education, including mental health related services when necessary, lies with the state educational agency, *i.e.*, the CDE. Our research revealed, however, that the CDE currently does very little to collect data on and monitor the delivery of mental health services. The data already being collected -- largely by the DMH -- should be supplemented by county- and LEA-level statistics, including the number of Chapter 26.5 referrals, the number of denials or rejections and the reasons why, the types of services offered, and the frequency and duration of services. Data collection should also include an inventory of programs and services developed and employed across the state, as well as the collection at the state level of local interagency agreements. With data in hand, the CDE will better be able to monitor local education agencies, engage in more focused monitoring, and institute corrective actions where systemic non-compliance exists.

Equally important, best practices should be collected, analyzed and disseminated across the state. Our research uncovered a variety of interesting models – from local interagency working groups to unique approaches to service delivery. Sharing these best practices—particularly during a time of fiscal crisis—may help struggling counties and LEAs to find more effective, more efficient ways to provide services to students.

Recommendation #7: Adequate funding for school-based mental health services

Our last recommendation is for adequate state funding for school-based mental health services. Such funding is first of all necessary to prevent an even larger crisis in school-based mental health. Many of the recommendations we have put forward above will require some amount of additional funding. No doubt, this is a tall order at a time of state fiscal crisis. At the same time, however, it is inescapable. As a matter of policy, students with mental health needs deserve the services that will help them to benefit from their education; as a matter of law, the state and LEAs are obligated to provide such services. Moreover, we believe that an initial investment by the state can result in dramatically improved school-based mental health services, not to mention substantial savings down the road.

ACKNOWLEDGMENTS

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We would also like to thank the many parents, advocates, teachers, education and mental health professionals, and agency representatives who generously shared their time and perspectives with us. In particular, we are grateful to key staff at the Department of Mental Health and the California Senate who, in addition to sharing their experience and expertise, provided relevant documentation and data for our research.

We emphasize that the findings and recommendations contained in this report are made by the Youth and Education Law Clinic and may or may not reflect the opinions and recommendations of any other participant in this study. Similarly, any errors are those of the Youth and Education Law Clinic.

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Part I

Introduction

Under the Individuals with Disabilities Education Act (IDEA), children with disabilities are entitled to a free appropriate public education (FAPE) in the least restrictive environment (LRE). To ensure that children with disabilities are served, the IDEA requires state and local education agencies to identify such children, ensures that identified children receive special education and related services that meet the children's unique educational needs, and protects those rights by providing parents and guardians with substantive and procedural rights to participate fully in their children's educational planning.

Among children with disabilities, those with emotional disabilities have historically been among the most poorly served of all disabled children. Often segregated from their non-disabled peers because they are "behavior problems," frequently misunderstood or marginalized because of the "invisibility" of their disabilities, and all too infrequently provided with therapeutic services and behavioral programming that would ensure their access to a FAPE, students with mental health needs require our attention.

The IDEA mandates that all disabled children receive those "related services" that are necessary for such children to benefit from special education. For children with mental health needs or serious emotional disturbances, such related services may include case management services, individual counseling and therapy, family therapy, therapeutic day programming, or, in certain instances, residential treatment. No doubt that many of these services require specialized training and expertise to deliver. No doubt also that schools may be ill-equipped to provide such services.

Recognizing IDEA's mandate regarding related mental health services, yet understanding the need for expertise, the State of California passed AB 3632 in 1984, which was codified at Chapter 26.5 of the Government Code (this report uses "Chapter 26.5" and "AB 3632" interchangeably). AB 3632 permits county offices of education and special education local plan areas (SELPAs) to develop inter-agency agreements through which county or community mental health agencies (CMH agencies) would provide certain mental health services under the IDEA to qualified children. In turn, local education agencies (LEAs) would be permitted to refer children to CMH agencies for service. This allocation of responsibility between LEAs and CMH agencies promised to provide children with high-quality mental health services that would be required to meet their educational needs.

Twenty years later, it is clear that Chapter 26.5 and the provision of mental health services to children with disabilities require renewed legislative attention. Funded at the state level by a small amount of categorical monies and long-delayed state-mandates reimbursements to counties, the system is in a fiscal shambles. Indeed, many counties have been waiting several years to receive millions of dollars in reimbursements from the state, while the state – in the midst of an epic budget crisis – cannot find uncommitted funds to support the program. As a result, counties are forced to bear the costs of the program at a rate that is simply not sustainable. That fiscal crisis has already prompted two lawsuits, a complaint to the United States

Department of Education, and the threat of discontinuing Chapter 26.5 services by cash-strapped CMH agencies.

Beyond the fiscal crisis of Chapter 26.5, parents, children, advocates, teachers, administrators, and CMH officials have long recognized “street-level” and procedural barriers to providing mental health services to children under the IDEA. Those barriers range from the mundane – *e.g.*, lack of space in facilities to provide services, inappropriate referrals, and bureaucratic delay – to the philosophical – *e.g.*, differing standards for eligibility for mental health services and differing views regarding the need for such services.

This report seeks to identify the specific barriers that affect the delivery of mental health services in California through the special education system. In particular, the report focuses on those “street-level” constraints that impede more effective service delivery under the Chapter 26.5 framework, placing this inquiry within the context of state-level constraints, including legal, fiscal and policy concerns. While the focus of our inquiry is on Chapter 26.5, the report is not only an analysis of the implementation of Chapter 26.5, it also looks more broadly to how LEAs serve (or don’t serve) children with mental health needs.

This report proceeds with a description of our methodology and its limitations. In Part III, we review several other reports undertaken of Chapter 26.5 and provide a summary of the findings and recommendations of those previous reports. Part IV provides an overview of the legal framework for mental health service delivery under the IDEA and California state law. In Part V, we offer a “bird’s eye” view from the state level of the Chapter 26.5 program. Specifically, we provide data on the children served by Chapter 26.5, an overview of the current fiscal crisis facing the program, and an analysis of the legal and political responses to that crisis. In Part VI, we present three in-depth county case studies, investigating the local implementation of the school-based mental health systems in San Mateo, Santa Clara, and Alameda Counties. We summarize our findings and offer a set of recommendations in Part VII of the report.

At bottom, we hope that our work will contribute to an ongoing dialogue aimed at reforming the fiscal – and, hopefully, service delivery – challenges facing the Chapter 26.5 program. Most importantly, we hope that any such reforms are designed to best serve California’s children.

Part II **Methodology**

Our research sought to identify specific barriers that continue to prevent more effective delivery of mental health services through the special education system under the Chapter 26.5 framework. The original research design was based on the premise that these barriers arise from the combination and interaction of: state and federal legal mandates on special education and mental health; the state-level policy and budget context; and local-level implementation issues. While by no means comprehensive, our research intends to provide an updated, coordinated analysis of these factors and a more comprehensive look at how services are delivered at the local level.

The research team consisted of students and faculty involved with the Youth and Education Law Clinic of Stanford Law School and Disconnected Youth, a year-long interdisciplinary course for Stanford graduate students in law and education, working in consultation with Protection and Advocacy, Inc. (PAI). The Youth and Education Law Clinic provides legal representation in connection with education-related matters, such as special education and school discipline, to students and their families from low-income backgrounds in San Mateo and Santa Clara Counties. PAI is a non-profit agency that advocates for the legal rights of disabled persons.

Components of Research Design
<ul style="list-style-type: none">▪ Literature Review▪ Analysis of State and Federal Legal Mandates▪ Review of State Policy and Budget Context▪ Data Collection and Analysis▪ County Case Studies

Research began with a review of previous studies of California’s school-based mental health programs. In Part III of the report, we summarize the major findings and recommendations of these reports, which provided the foundation for our own efforts. We also conducted an analysis of the legal framework governing the provision of mental health services to special education students under state and federal law. Relevant elements of this framework that factor into the analysis include the IDEA, AB 3632, and accompanying administrative regulations. The legal analysis was also informed by the pertinent case law affecting relevant legal rights and responsibilities.

At the state level, a series of key informant interviews were conducted with relevant stakeholders. Primarily, these interviews focused on state-level policy issues, funding challenges and the current budget crisis, assessments of the overall structure and effectiveness of Chapter 26.5, and different policy proposals for systemic reforms. Represented among these stakeholders were staff from the Department of Mental Health, leaders of statewide SELPA and CMH

associations, state level advocacy organizations, mental health service providers, key staff at the California legislature, and a number of local-level heads of agencies, many of whom are actively involved in regional or statewide interagency working groups. State level data on funding and service delivery were collected and analyzed, although relevant data were not always available.

The research also investigated a number of more recent responses within the state to the challenges of providing AB 3632 services, which collectively demonstrate the urgency of the crisis. These include the lawsuits filed by Tuolumne and San Diego counties over their legal obligation to provide such services in the face of inadequate funding and the complaint filed by the state SELPA directors' association with the compliance division of the federal Office of Special Education Programs (OSEP) over state use of federal IDEA money. Primarily, this consisted of reviewing court and other official documents, although a limited number of interviews were also conducted.

At the heart of the study are three in-depth county-level case studies. These case studies investigate local-level implementation of the Chapter 26.5 program in San Mateo, Santa Clara and Alameda Counties. The case studies are based primarily on interviews with key local-level stakeholders in the Chapter 26.5 system representing diverse perspectives, supplemented by review of local interagency agreements, administrative policies, training materials, and county-level data. In all cases, county-level interviews included: students, parents and advocates who have directly experienced the Chapter 26.5 system, local mental health service providers and professionals, local County Mental Health (CMH) agencies, SELPA and LEA administrators, and school district and County Office of Education personnel.

Researchers for the case studies used a semi-structured interview methodology, focusing on issues in three primary areas: access to services, delivery of services, and interagency collaboration. Interviews investigated the processes for identifying students with mental health needs, referral and assessment procedures, and eligibility criteria. Information was collected on the continuum of services available and provided within each county, including how, where, and by whom such services are provided. Analysis focused on identifying the barriers to more effective service delivery, including fiscal, political, philosophical, institutional, and implementation barriers; community awareness and education; staff training and capacity; and accountability and collaboration issues.

In total, the project team conducted more than 70 interviews with state and local stakeholders as part of our research. No doubt, our research would have benefited from even more consultations with many other state and local leaders with whom we were unable to arrange interviews. Resource constraints curtailed initial plans to conduct additional case studies with wider geographic representation. However, we expect that the barriers identified within the report are representative of many of the challenges faced by counties and school districts across the state.

Part III

Previous Reports on the Chapter 26.5 Program

Our research and analysis of California’s school-based mental health service delivery system builds upon the work of several previous studies. In this section, we briefly summarize the findings, conclusions and recommendations of the most recent and relevant reports. Overall, these earlier reports conclude that the basic interagency approach of Chapter 26.5 promises to be an effective model for providing school-based mental health services. However, at the same time, they identify a number of specific barriers that prevent more effective service delivery under the existing framework, including issues related to organizational structure, practices and procedures, resources, collaboration, service delivery and accountability.

The Little Hoover Commission reported in 2001 that more than one million children in California will experience an emotional or behavioral disorder each year and that more than 600,000 of these children will not receive adequate treatment.¹ According to the Commission’s findings, 0.3% of California’s school-age population in special education receive mental health care through programs for emotionally disturbed youth – less than one third of the national average. Ann Levine reported similar findings² in her analysis of data from a 1997 review of Chapter 26.5 services conducted on behalf of the California Department of Mental Health and the California Department of Education.³ Levine reported that only between 7-9% of California children with severe emotional disturbance (SED) received special education services through Chapter 26.5 programs, and that the majority of California’s children with the most serious emotional disabilities receive no mental health services at all. The Little Hoover Commission concluded that the way in which California organizes and provides mental health services at the state level unnecessarily complicates and, in some cases, may even prevent students from receiving the services they require.

While all student populations may be underserved by Chapter 26.5 programs, earlier studies have noted that certain minority groups may be particularly underserved by existing procedures and practices. Data collected for the DMH-CDE Report revealed that Chapter 26.5 services were disproportionately accessed by students of different ethnic or racial backgrounds.

Ethnic/Racial Background for Different Populations				
	Special Education Enrollment	Pupils Classified as Severely Emotionally Disabled	Chapter 26.5 Caseload	Children Receiving Residential Care Under Chapter 26.5
White	46.0%	54.0%	61.1%	73.0%
African American	12.6%	25.1%	17.1%	12.1%
Hispanic	35.5%	17.6%	18.0%	11.7%
Other Groups	5.9%	3.2%	3.8%	3.2%
<i>Data collected for 1994-95 Reproduced from DMH-CDE Report, Table 7</i>				

¹ Little Hoover Commission, “Young Hearts and Minds: Making a Commitment to Children’s Mental Health,” October 2001 (Little Hoover Commission Report).

² Ann Levine, “An Evaluation of California’s Faulty but Hopeful System, Chapter 26.5,” May 1998 (Levine Report).

³ “Mental Health Services for Special Education Pupils: A Report to the State Department of Mental Health (DMH) and the California Department of Education (CDE),” March 1997 (DMH-CDE Report).

Several studies note fundamental organizational and operational differences between CMH agencies and LEAs that have impeded more effective service delivery under the interagency framework. While the majority of studies have focused primarily on the state level, the DMH-CDE study conducted county level research regarding local implementation of Chapter 26.5. The review included field visits to 12 counties and interviews with local CMH agencies and SELPAs, supplemented by consultations with state and local program staff.

In its overall assessment of the interagency framework, the DMH-CDE Report concludes that, “[b]y all accounts, services for pupils with mental illness and emotional problems have improved significantly since the enactment of Chapter 26.5.” Nevertheless, the report identifies a range of operational challenges that impede more effective program operations – in terms of philosophical approach, eligibility criteria, operating procedures, and the legal frameworks under which each agency operates. For instance, special education law grants students a legal entitlement to required mental health services which must be provided according to strict timelines and at no cost to the student. By contrast, mental health agencies often ration mental health services to the most urgent needs, due to limited resources, and patients are required to contribute to the cost of services. A table from the report highlighting several of the most important program divergences between mental health and special education is reproduced below. Both Levine and a 2001 report by the Disability Rights Education and Defense Fund (DREDF)⁴ provide comprehensive summaries of the legal framework for Chapter 26.5, much of which is captured in our analysis of the legal context in Part IV.

While the DMH-CDE Report included interviews of education and mental health professionals, the DREDF Report focused on the performance of the Chapter 26.5 system from the perspective of parents, students and advocates. Generally, parents reported that they were denied assessments when requested; they encountered long delays and waiting lists for referrals, assessments and services; timelines were often not met; parents were not informed of their rights under special education law; and parents without legal representation and parents who spoke a primary language other than English were at a serious disadvantage in navigating the system and securing mental health services under Chapter 26.5.

The DREDF Report also found that, despite local interagency agreements and legal requirements to coordinate services, interagency collaboration was weak. The report concluded that LEAs were “passing the buck” to mental health agencies, despite their own obligations under AB 3632. Similarly, Levine’s analysis found that LEAs had primarily shifted, rather than shared, responsibility for the mental health needs of special education students, as the law seems to envision. Levine reported that, although AB 3632 requires LEAs to provide services for less severe mental health issues, many LEAs provide no counseling services at all. Many AB 3632 referrals are therefore considered inappropriate by local mental health agencies, and services are denied until problems reach a crisis state.

⁴ Disability Rights Education and Defense Fund (DREDF), “Final Report to the California Endowment,” March 2001 (DREDF Report).

DMH-CDE Report: Table 1 Program Differences Mental Health and Special Education	
Mental Health	Special Education
Targeted to severely disabled adults and “seriously emotionally disturbed” children; not an entitlement	Serves pupils with a variety of disabilities, including “seriously emotionally disturbed” pupils; entitlement program
Definition of serious emotional disturbance can encompass a broad range of symptoms and settings; requires clinical diagnosis and substantial impairment or risk	Definition of serious emotional disturbance focuses on functioning in school
Children’s services generally go to age 18; after age 18 clients are considered adults	Serves pupils up to age 22
Clients must pay costs of services based on ability to pay	No cost to parents
Serves county clients, even when placed outside the county	Serves pupils who live in area, regardless of origin
Services provided year-round	Services provided during the school year and school day, for the most part
Local flexibility in determining how to serve clients	Mandated service configurations, extensive procedural requirements
Minimal state or federal oversight	Heavily regulated by the state and federal governments
<i>Reproduced from the DMH-CDE Report, page 14.</i>	

All earlier reports have noted the importance of resource constraints on the effectiveness of the Chapter 26.5 framework. More than the overall amount of funding available to children’s mental health services, several studies have found that the particular mechanisms through which funding has been provided have proved detrimental to the provision of required mental health services. The Little Hoover Commission suggested that the overall level of funding provided to mental health programs may already be sufficient; however, the complex, uncoordinated and restrictive funding mechanisms prevented optimization of available resources. Local agencies reported in the DMH-CDE review that the MediCal and mandate reimbursement processes, which provided a substantial proportion of AB 3632 funds, were administratively burdensome, created unpredictable funding streams that impeded proper planning and efficient resource utilization, and provided the wrong incentives to agencies. Both the DMH-CDE Report (from the agency perspective) and the DREDF Report (from the parent and advocate perspective) noted that battles between agencies over which agency should bear financial responsibility created unnecessary conflict and, at times, prevented the delivery of needed services to students.

Earlier studies also found significant challenges and gaps in the area of service delivery. Several reports noted that AB 3632 services may be effective at serving children whose mental health situations have reached crisis levels. However, the interagency framework may have disserved children with less acute mental health needs. The Little Hoover Commission Report notes that AB 3632 funding mechanisms and eligibility requirements create a focus on crisis

management, often at the expense of approaches that emphasize more cost efficient prevention and early intervention strategies. The DMH-CDE Report found that a limited range of services in a given area often meant either that an appropriate placement was not available for a particular student, or a student was not served in the “least restrictive environment,” as required by law. DREDF and Levine also raise questions about compliance with legal mandates under existing practices.

All of the reports found significant challenges in the area of accountability. The DMH-CDE Report concluded that there was “no systematic program of state oversight,” while Levine noted “a complete lack of federal or state oversight.” Levine also pointed to a 1995 investigation by the federal Office of Special Education Programs (OSEP), which reported that “CDE did not ensure that all public agencies provide “mental health services” as related services if needed to assist a student to benefit from special education.” At the local level, special education agencies, while being held accountable for services provided by mental health agencies, have limited ability to require compliance with procedural or substantive requirements. As a result, Levine concludes, “The complete lack of accountability over county mental health agencies wholly undermines the effectiveness of Chapter 26.5, rendering it both impractical and illogical.”

As a related matter, several of the earlier studies noted problems with data collection practices at the state level. DREDF’s study had initially planned to analyze state funding, service delivery, referral and assessment data for Chapter 26.5 services; however such data were found to be unavailable at the state level. At the same time, the DMH-CDE study reported that local agency personnel found existing data collection practices to be unnecessarily burdensome. The study provided funding and service delivery data for certain Chapter 26.5 services through 1996.

These earlier reports are similar in the recommendations they offer. Both the DMH-CDE Report and Levine recommended that the basic interagency approach of Chapter 26.5 be retained. All of the reports suggested changes to the way Chapter 26.5 services are funded, arguing that funding should be less restrictive, more predictable, simplified, and streamlined. DREDF suggested that specific fiscal barriers that prevent integration of children’s mental health service delivery be identified and that agencies should investigate the potential for pooling funds more effectively. Similarly, all of the reports recommended steps to strengthen interagency collaboration, including increased information exchange among counties, the creation of interagency working groups at the state and local levels, and interagency cross-training among agency personnel regarding the mandates and procedures of various children’s service agencies. Levine recommended earlier involvement of CMH personnel in the IEP process, more on-site counseling services, and enhanced case management.

The reports also recommended outreach and awareness campaigns targeting underserved low-income and minority communities. DREDF recommended that local interagency agreements be collected at the state level and that data collection practices be revisited. In particular, the state should monitor the frequency of assessments, adherence to timelines, the content of IEPs, and the types of services provided, as well as their frequency and duration. DREDF also recommended that specific implementation barriers that prevent more effective service delivery at the local level be identified. More broadly, the Little Hoover Commission Report argued for a radical and fundamental re-thinking of how mental health services are

organized and provided in California, including more of a focus on early intervention and prevention through integrated, coordinated service delivery.

Summary of Recommendations	
(1)	Retain the basic structure of Chapter 26.5
(2)	Resources: stable, simplified, streamlined, less restrictive
(3)	Strengthen interagency collaboration: agency cross-training, information sharing, interagency working groups
(4)	Outreach and education: particularly targeting underserved communities
(5)	Data collection
(6)	Greater focus on prevention and early intervention

This previous research on Chapter 26.5, and more generally, school-based mental health services in California, provided a substantial foundation for our own efforts, highlighting potential areas for investigation and inquiry. Our research attempts to bring together important elements from each of these earlier studies and then to build upon them by recapturing the legal analysis of earlier reports and providing an updated assessment of the state political and budget context, more current data on funding and service delivery, and, most importantly, three county-specific case studies that explore specific implementation at the local level.

Part IV
The Legal Context for Mental Health
Service Delivery to Special Education Students

The Federal Mandate to Provide Special Education and Related Services

Prior to the mid-1970s, children with disabilities, particularly those with severe physical, cognitive, and emotional disabilities, were seldom provided with appropriate educational services in our public schools and frequently excluded from school altogether. In 1975, Congress passed the Education for All Handicapped Children Act, later renamed the Individuals with Disabilities Education Act (IDEA), in an effort to address the educational needs of children with disabilities. That legislation guarantees that children with disabilities are entitled to a free appropriate public education (FAPE) in the least restrictive environment (LRE); that is, children are entitled to special education and related services and shall receive that education with their non-disabled peers to the maximum extent appropriate.

The IDEA provides not only the substantive right to a FAPE, but also grants parents and non-minor children procedural protections to enforce those rights. Specifically, the IDEA requires parental consent and involvement in most decisions affecting a child's educational program. These procedural protections are infused in the entire special education process of (1) referral, assessment, and identification; (2) development of an individual educational program (IEP); and (3) placement. Equally important, the IDEA's LRE provisions reflect a national trend toward integration of people with disabilities into all aspects of modern life by emphasizing the need for all children to be educated in non-segregated settings.

To be eligible for services under the IDEA, a child must be between the ages of three and twenty-one (until the end of the semester in which the child turns twenty-two) and must meet certain disabling conditions. The qualifying conditions must further (1) adversely affect the student's educational performance and (2) require special education.⁵ The qualifying categories of disability are:

- Hearing impaired
- Visually impaired
- Both hearing and visually impaired
- Speech or language impaired
- Severely orthopedically impaired
- Impaired in strength, vitality, or alertness due to chronic or acute health problems ("other health impaired")
- Exhibiting autistic-like behaviors
- Mentally retarded
- Seriously emotionally disturbed
- Learning disabled

⁵ 20 U.S.C. § 1402(3)(A)(i); 34 C.F.R. § 300.7; Cal. Code Regs. Tit. 5, § 3030.

Ultimately, the IEP team (made up of qualified professionals and the parent) makes the actual determination of the eligibility for special education and related services based upon assessment reports, observations of the student, and other information presented at the IEP team meeting.

As mentioned above, a student eligible for special education is entitled to a FAPE. FAPE means “special education and related services that (A) have been provided at public expense . . . ; (B) meet the standards of the state educational agency; (C) include an appropriate preschool, elementary, or secondary school education in the State involved; and (D) are provided in conformity with the individualized education program. . . .”⁶ The IDEA further defines the terms “special education” as “specially designed instruction, at no cost to the parents or guardians, to meet the unique needs of a child with a disability,”⁷ and “related services” as “transportation, and such developmental, corrective, and other supportive services . . . as may be required to assist a child with a disability to benefit from special education.”⁸ Such services include speech and language services, audiological services, mental health counseling (individual, group, family), physical and occupational therapy, adaptive physical education, therapeutic recreation, rehabilitation counseling, health services (specialized health care plan), home or hospital instruction, specialized driver training instruction, and social worker services, to name just a few.

Under the IDEA, a “full and individual evaluation of the child’s educational needs” must be conducted before placing a child with disabilities in a special education program.⁹ This evaluation must be in “all areas related to the suspected disability, including, if appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities.”¹⁰ No assessment can be conducted, however, without the signed consent of a parent on an assessment plan that describes the areas and methods of assessment and the professionals responsible for such assessment. Once the LEA receives the signed assessment plan, it has 50 days (excluding school vacation days in excess of five days and days that school is not in session) to complete the assessment and develop an individualized educational plan (IEP) for the student.¹¹

The IEP is an essential component of the special education process. The IEP is a document that sets forth the instruction and services that a child will be receiving for up to a year. Creating the IEP is a team effort among the parents, student (whenever appropriate), teachers, evaluators and administrators. This team jointly considers all of the information regarding the child’s present levels of performance, including work samples, evaluations, and observations; develops goals and objectives for the child to meet in the upcoming year; and determines the appropriate services and placement in the LRE in which the child will attain the goals and objectives. Ideally, this process is completed with mutual respect and maximum cooperation in the best interests of the student.

Significantly, the IDEA places the responsibility of providing special education and all related services (including mental health services) in the IEP squarely on the LEA at no cost to

⁶ 20 U.S.C. § 1401(8); 34 C.F.R. § 300.8.

⁷ 20 U.S.C. §1401(25).

⁸ 20 U.S.C. § 1401(22).

⁹ 34 C.F.R. § 300.531.

¹⁰ 34 C.F.R. § 300.532(g).

¹¹ Cal. Educ. Code § 56344.

the parent.¹² The LEA may provide those services through other agencies, non-profit organizations, or private service providers, but the ultimate responsibility for provision of those services rests with the LEA. In other words, although the State of California, special education local plan areas (SELPAs), and LEAs may choose to provide services through arrangements with non-LEA providers, the IDEA does not shift the mandate of providing those services to the non-LEA providers; rather, it remains with the LEA. If the LEA fails to provide appropriate special education and related services, the state educational agency (SEA), i.e., the California Department of Education, is required to monitor and ensure provision of those services.

Mental Health Services as a Related Service in California¹³

Consistent with the federal IDEA, California has adopted a comprehensive statutory scheme that governs the provision of special education and related services to our children with disabilities. Cal. Educ. Code §§ 56000 *et seq.* Among those related services (called “designated instruction and services” in California), the following mental health services are identified:

- Counseling and guidance
- Psychological services, other than assessment and development of the IEP
- Parent counseling and training
- Health and nursing services, and
- Social worker services.¹⁴

Prior to 1984, California’s plan for providing mental health services paralleled the approaches of other states: California relied on the state and LEAs to provide *all* related services, including mental health services, needed by children with disabilities. With the passage of AB 3632,¹⁵ California’s approach to mental health services was restructured with the intent to address the increasing number of emotionally disabled students who were in need of mental health services. Instead of relying on LEAs to acquire qualified staff to handle the needs of these students, the state sought to have CMH agencies – who were already in the business of providing mental health services to emotionally disturbed youth and adults – assume the responsibility for providing needed mental health services to children who qualified for special education. Moreover, it was believed at the time that such mental health services would be most cost-efficiently provided by CMH agencies

Shortly after the passage of AB 3632, emergency regulations were adopted in 1986 to implement the shift in mental health service delivery from LEAs to CMH agencies. The emergency regulations required the adoption of local interagency agreements to detail local working procedures. Additionally, the emergency regulations delineated referral criteria, timelines for the development of assessment plans and completion of assessments, procedures

¹² 20 U.S.C. §§ 1401(22) and 1414(d)(7)(A)(iii).

¹³ This section relies heavily on the work of DREDF (2001) and Levine (1998).

¹⁴ Cal. Educ. Code § 56363(b)(9)-(13). The California Code of Regulations, Title 2, Section 60020 also identifies the following as mental health services: (1) mental health assessments; (2) psychotherapy; (3) collateral services; (4) medication monitoring, including all medication support services: prescribing, administering, dispensing and monitoring of psychiatric medication or biologicals necessary to alleviate symptoms of mental illness; (5) day rehabilitation; (6) intensive day treatments; and (7) case management services.

¹⁵ Cal. Gov’t Code §§ 7570 *et seq.*

for the consideration and provision of residential care, and financial responsibility for out-of-state mental health services. In 1996, most of these emergency regulations were effectively codified by AB 2726, particularly those dealing with the referral criteria and procedures. A flowchart that lays out the general Chapter 26.5 referral and assessment process is provided on page 26 of this report.¹⁶

Under federal and state law, once a child with a qualifying disability has been found in need of mental health services to benefit from her education, LEAs are obligated to provide mental health services, which may include on-site counseling, group therapy, and/or family therapy, in accordance with the child's IEP. According to Chapter 26.5, if it appears that the LEA's provision of counseling, guidance, and psychological services are not adequately meeting the needs of the child, then the child must be referred to the CMH agency. As depicted in the flowchart, Chapter 26.5 requires that referral packages include copies of the current IEP, all current assessment reports, and other relevant information, as well as a copy of the parent's consent, a summary of the child's emotional or behavioral characteristics, and, significantly, a description of the services provided to the child by the LEA.

The CMH agency must then determine whether the referral packet is complete and/or whether a mental health assessment is warranted within 5 days of the receipt of the referral packet. If the CMH agency determines that the referral is inappropriate or an assessment is unnecessary, the CMH agency must document the reasons and notify the parent and the LEA within one working day. If the packet is complete and an assessment is necessary, the CMH agency must provide to the parent within 15 days of the referral from the LEA an assessment plan for the parent's review and consent. Upon receipt of parental consent to the assessment, the CMH agency has 50 days to complete the assessment and participate in an IEP team meeting to discuss eligibility for Chapter 26.5 services and, if eligible, the type and scope of those services. The CMH agency must make a copy of the mental health assessment available to the parent at least two days prior to the IEP and must discuss the results of the assessment with the parent. Perhaps more significant, the CMH assessor's recommendation regarding services and eligibility must be adopted as the LEA's recommendation, thereby giving CMH effective plenary power over the mental health related services decision, unless the parent disagrees with the CMH recommendation and prevails in a fair hearing on the issue.

This complicated referral and assessment process may be expedited on the basis of preliminary assessment results performed by the LEA. If a child demonstrates the emotional and behavioral characteristics described in the following paragraph *and* if the LEA's counseling, guidance and psychological services are "clearly inappropriate" in meeting the child's needs, then concurrent referrals for special education and county mental health services may be made.

Eligibility under Chapter 26.5 is not automatic merely because an IEP team refers a student to CMH. A child is eligible for Chapter 26.5 services if she has emotional or behavioral characteristics that: (1) are observed by qualified educational staff in the classroom and other settings; (2) restrict or prohibit the pupil from benefiting from educational services; (3) are significant, as observed by their rate of occurrence or intensity; and (4) are associated with a condition that cannot be defined as solely a social maladjustment problem and that cannot be

¹⁶ See Cal. Gov't Code §§ 7570-7576; Cal. Code Regs. Tit. 2, §§ 60030-60100.

resolved with short-term counseling. As a practical matter, children who are considered “behavioral problems” or suffer from “conduct disorders” are frequently denied Chapter 26.5 services as being “socially maladjusted.” Additionally, a child may only qualify for Chapter 26.5 if the child’s functioning is at a level sufficient to enable the child to benefit from mental health services. In practice this means that very young children, developmentally delayed children, and low-functioning autistic children are frequently denied Chapter 26.5 services.

Part V
A State-Level View of Chapter 26.5 Services

The Chapter 26.5 system is in a state of fiscal crisis. Since 2001, the state has withdrawn its annual support for Chapter 26.5 services, which had totaled as much as \$100 million annually. Counties and their mental health agencies across the state, which had relied on this funding to provide mental health services to special education students, are unable to continue providing these services at their own expense. Policymakers and other stakeholders have responded to this crisis with action in three primary arenas: the state budget and the allocation of federal special education funds; legal challenges to the existing funding levels and framework; and policy reform proposals that call the entire Chapter 26.5 system into question.

This section begins by presenting the most current available statewide data on the use and delivery of mental health services under Chapter 26.5. We also review the history, mechanisms, and current state of funding for these services across the state. We then address the budgetary actions, legal disputes and policy reform proposals that have arisen in response to the fiscal crisis. These include recent decisions by the state government to allocate federal IDEA funds directly to the Department of Mental Health to pay for Chapter 26.5 services; still-pending court challenges filed by stakeholders in Tuolumne and San Diego counties that challenge existing interagency relationships and responsibilities; and state-level stakeholder positions on policy reform proposals.

Chapter 26.5 in California: Service Delivery Data and Monitoring

The CDE reported that 663,220 students were eligible for special education services in 2001-02. Of this total population of special education students, 24,554 students were classified as “emotionally disturbed” (ED). The same year, according to data collected by the DMH from county mental health agencies, 29,486 special education students in California received mental health services as part of their IEPs through Chapter 26.5. In total, however, including community mental health programs not delivered through the special education system, DMH reports that CMH agencies served as many as 223,193 youth between the ages of 0-21 during the same year. According to these data, about 13.2% of youth between the ages of 0-21 served by CMH agencies received their services pursuant to an IEP and through the Chapter 26.5 framework. A separate DMH report found that CMH agencies, again during 2001-02, treated as many as 106,243 children between the ages of 0-17 for “serious emotional disturbance” (SED).

Summary Data: Chapter 26.5 Service Delivery (2001-2002)	
Total # of Special Education Students (CDE)	663,220
Classified as ED (Emotionally Disturbed) by LEAs	24,554
Total Youth Served by CMH agencies (aged 0-21)	223,193
Youth Served by CMH through IEP (via 26.5)	29,486
Youth (aged 0-17) served by CMH for SED (Serious Emotional Disturbance), IEP and non-IEP	106,243

The large discrepancy between the total number of youth served by CMH agencies, as opposed to the number served through Chapter 26.5, raises questions. Four times as many youth

are treated for “serious emotional disturbance” as are identified by the special education system as “emotionally disabled,” while an untold number of additional youth with mental health needs may be receiving no services at all. Differing eligibility criteria between mental health and special education cannot alone account for this large discrepancy. While we recognize that not all mental health problems will adversely impact a student’s education, it seems unlikely to us that so few students diagnosed as SED would exhibit symptoms that detrimentally affect their ability to benefit from their education and thereby qualify them for Chapter 26.5 services. Rather, the data may reflect either the ineffectiveness of the special education system at identifying and providing treatment to students in need of mental health services or the “steering” of students away from Chapter 26.5 services and toward other services provided by CMH agencies that are not documented in IEPs and do not come with the protections of the IDEA. For those students already receiving alternative mental health services from CMH agencies, accessing those services through the Chapter 26.5 would provide significant legal and procedural protections unavailable to students who receive their services under other mental health programs.

Demographic data collected by the DMH on the students receiving Chapter 26.5 services provide a picture of the program’s population. These data echo the findings of earlier studies, which found disproportionate use of and access to Chapter 26.5 services by various populations. For instance, Latino and Asian/Pacific Islander students are significantly under-represented in the Chapter 26.5 caseload, as compared with their representation in the general school population and the special education population. By contrast, white students are significantly over-represented, while African-American students are slightly over-represented, as compared to their general school and special education populations. As compared to the overall mental health caseload, all minority students are under-represented in the Chapter 26.5 caseload. DMH data suggest that minority students are significantly more likely to receive mental health services outside of the special education framework, and without the accompanying legal protections. Similarly, the data reveal significant service disparities based on gender, as only 1 in 4 students receiving Chapter 26.5 services are girls, though these disparities are also reflected to a lesser extent in the overall population of youth served by mental health agencies.

As noted in the “diagnosis” data presented in the chart below, the DMH reports that 4,975 students are receiving mental health services through their IEPs even though they lack a formal mental health diagnosis. Such practice appear to be consistent with federal special education law, which premises eligibility for services on the determination of the IEP team and not an official mental health diagnosis. This may account for the difference between the number of students classified by CDE as “emotionally disturbed” in the special education system and the slightly greater number of students reported by DMH as receiving Chapter 26.5 services.

Despite the demographic data available on the population of students served by AB 3632 services, significant gaps in the available data prevent a more comprehensive picture of school-based mental health in California. For instance, no data are available at the state level on the number of students who are referred for Chapter 26.5 services, the number assessed by mental health agencies, and the numbers found ineligible for those services. Moreover, the demographic data do not account for the overwhelming majority of students receiving mental health services in California, whose services are delivered through mechanisms outside of the special education framework.

Demographic Snapshot: The Chapter 26.5 Population (2001-2002)				
Ethnicity	% of Total Student Population	% of Special Education Population	% of Total Mental Health Caseload	% of Chapter 26.5 Caseload
White	35.00%	38.83%	35.9%	52.38%
Latino	44.20%	42.41%	31.5%	22.25%
African-American	8.30%	12.28%	18.9%	14.31%
Asian / Pacific Islander	8.80%	4.41%	3.6%	2.81%
Primary Language				
Primary Language	% of Total Student Population	# of Students Receiving Chapter 26.5 Services	% of Chapter 26.5 Caseload	
English	74.6%	26,218	88.92%	
Spanish	21.2%	1,452	4.92%	
Other	4.2%	1,247	4.23%	
Gender				
Gender	% of Total Student Population	% of Total Mental Health Caseload	% of Chapter 26.5 Caseload	
Boys	51.37%	61.8%	73.24%	
Girls	48.63%	38.1%	26.71%	
Age				
Age	# of Students Receiving Chapter 26.5 Services	% of Chapter 26.5 Caseload		
0-4	278	0.94%		
5-11	10,037	34.04%		
12-17	17,356	58.86%		
18-21	1,881	6.38%		
Diagnosis*				
Diagnosis*	# of Students receiving Chapter 26.5 Services	% of Chapter 26.5 Caseload		
ADHD/ADD	6,070	20.59%		
Anxiety Disorder	2,503	8.49%		
Bipolar / Mood Disorder	1,987	6.74%		
Conduct Disorder	3,633	12.17%		
Depressive Illness	4,753	15.93%		
No Axis I or II Mental Diagnosis	4,975	16.67%		
* A smaller number of Chapter 26.5 services are provided for additional diagnoses not represented here.				
<i>Source: DMH</i>				

One consequence of the limited data collection at the state level is that the CDE, the state educational agency ultimately legally responsible to ensure that LEAs are providing FAPE – including mental health services – to students, cannot adequately monitor compliance with the IDEA. In recent years, CDE has developed a data-driven system of “focused monitoring” to ensure special education compliance among LEAs. Yet there is still only modest data collected

regarding mental health services and such data are insufficient to indicate systemic non-compliance at the local level. Such data collection would be a first step toward more intensive oversight and, ultimately, stepped-up compliance investigations and corrective actions when necessary.

Nor does California’s unique interagency framework draw favorable comparisons to other states in terms of identifying and serving the mental health needs of special education students. In comparison to other states, California’s special education system identifies and serves a smaller percentage of special education students, a smaller percentage of special education students with “emotional disturbance” (ED), and the population of students served demonstrates greater demographic disparities than some comparable states.

State Comparisons: Identifying and Serving ED Students							
	Children Served by IDEA (as % of student population, by age group)			ED Students (as % of Special Education)	Subgroups of ED population ('X' times more likely to be identified)		
	3-5	6-17	18-21		Black (vs. White)	Hispanic (vs. White)	Male (vs. Female)
California	0.9%	9.2%	0.4%	4.3%	2.0	0.3	3.5
New York	1.9%	12.7%	0.8%	10.8%	2.8	1.5	3.3
Texas	0.9%	10.4%	0.5%	7.7%	1.3	0.5	2.8
Florida	1.3%	13.2%	0.7%	10.5%	1.7	0.5	3.8
Illinois	1.4%	12.8%	0.6%	10.8%	1.7	0.5	3.8
Ohio	1.0%	11.3%	0.7%	7.5%	2.1	1.1	4.8
Washington, DC	1.2%	10.3%	0.5%	4.6%	2.2	0.5	4.3
National Average	1.3%	11.6%	0.6%	8.1%	1.7	0.6	3.4

Source: Education Week, Volume XXIII, Number 17, January 8, 2004

Funding of Chapter 26.5 Services

When first adopted in 1984, AB 3632 was expected to impose only minimal costs on CMH agencies. The interagency approach was perceived primarily as shifting responsibility for provision of existing services from education agencies to mental health agencies, rather than expanding the scope of services to be delivered. The 1986-87 state budget initially allocated \$2.1 million in state categorical funding, later increased to \$4.7 million, to mental health agencies to cover the added cost imposed by AB 3632 of participation in IEPs, additional assessments required by the legislation, and case management of special education students.

Statewide, the annual cost of providing Chapter 26.5 services is now estimated to range from \$100 million to as much as \$140 million. Historically, the state has allocated significant fiscal resources to cover the lion’s share of this amount. Categorical funding under the Assessment, Treatment and Case Management of Special Education Pupils program increased to approximately \$12 million annually, totaling \$12.4 million in 2000-01. In addition, counties have relied extensively on financial reimbursement from the state under the state-mandate claims process (also known as the SB 90 process). In 1990, the Commission on State Mandates determined that AB 3632 imposed a state mandate on local counties and that counties were therefore entitled to reimbursement for costs incurred in providing these services. In 1991-92,

mandate reimbursement claims totaled \$41.2 million, increasing to a total of \$82.7 million by 2001-02.

In theory, the mandate claims process offered counties full reimbursement for the cost of providing Chapter 26.5 services. In practice, however, the mandate claims process has been problematic. The State has been slow to grant these payments and regularly defers state reimbursements until the following fiscal year. In 2003, the California Mental Health Directors Association (CMHDA) estimated that counties were advancing more than \$8 million per month to maintain Chapter 26.5 services and were owed more than \$130 million in overdue claims submitted through the SB 90 process. Moreover, a dispute over the proper interpretation of the Parameters and Guidelines from the State Mandate Commission (whether reimbursement should be made at 10% or 100% of the cost of certain services) was only recently resolved.¹⁷

More generally, utilization of the mandate claims process has varied tremendously by county. The Legislative Analyst Office found that the mandate reimbursement process provided no mechanism for the legislature to ensure the equitable distribution of resources across the state or to direct resources to specific parts of the state. For instance, while San Diego County has seven times the enrollment of San Francisco County, San Francisco County's average annual claim was 25 times that of San Diego County. (As the chart on page 23 demonstrates, San Diego's reimbursement claims rose dramatically from 2000-01 through 2002-03).

AB 3632 Mandate County Claims 1995-96 Through 1999-00			
County	Average Annual Claim	1999-00 Enrollment	Annual Cost Per Pupil
San Francisco	\$4,750,380	62,041	\$76.57
San Mateo	2,439,592	92,285	26.44
Orange	8,836,597	483,360	18.28
Sonoma	815,624	72,034	11.32
Riverside	3,301,597	307,055	10.75
Stanislaus	1,016,505	95,090	10.69
Alameda	2,123,015	217,080	9.78
Santa Clara	2,151,389	254,782	8.44
Los Angeles	8,644,835	1,650,948	5.24
San Diego	193,490	480,017	0.40

Source: Legislative Analyst Office

Counties have supplemented state resources provided for AB 3632 services with realignment funds and reimbursement from third-party insurance, both private and public programs. We were unable to find statewide data tracking the level of relevant funding from these sources; however, it is clear that these resources are extremely limited in comparison to the state funding that has historically been provided. County realignment funds no doubt contribute to Chapter 26.5 funding, particularly in those counties that have made less ambitious use of the mandate claims process. However, realignment funds are specifically intended to target low-

¹⁷ AB 2781 was adopted by the legislature in 2002, definitively stating that counties are entitled to 100% of the cost of providing all AB 3632 services and providing for the settlement of past partial reimbursement to counties.

income communities. Redirection of these resources to Chapter 26.5 correspondingly reduces the resources available for community mental health access.

While private health insurance may be billed for the cost of mental health services, federal law prohibits this practice without the consent of the policyholder. Chapter 26.5 services must be available as part of the “free appropriate public education” guaranteed by special education law. Public health insurance programs, such as MediCal, can be billed for AB 3632 services, and CMH data report that 51.8% of students receiving Chapter 26.5 services are MediCal eligible. The MediCal billing practices of CMH agencies are not tracked at the state level by the DMH. Many stakeholders suggest that counties might be able to make better use of MediCal billing to subsidize the cost of Chapter 26.5 services.

As of July 1, 2002, however, in the face of state budget challenges, the state has nearly completely withdrawn its financial support for AB 3632 services, contributing to the current fiscal crisis surrounding the school-based mental health system. The 2002 Budget Act eliminated the annual \$12 million of categorical funding and at the same time imposed an indefinite moratorium on the mandate reimbursement claims process. Counties, still owed reimbursements from prior years, were left to fend for themselves in making up the almost \$100 million shortfall. While counties continued to provide AB 3632 services in the 2002-03 school year at their own expense, they informed state and local education agencies that they would be unable to continue to do so in 2003-04.

Budgetary Response: Shift of IDEA funds

In response to the fiscal crisis created by the elimination of AB 3632 funding, the 2003-04 state budget allocated \$69 million of federal IDEA, Part B funds directly to mental health agencies to offset the cost of providing Chapter 26.5 services. This amount represented approximately half of the annual increase in federal IDEA, Part B funds from the prior year; the total amount of these federal funds for 2003-04 was anticipated to be \$972.7 million. The legislature concluded that this use of federal IDEA funds was appropriate, given that these mental health services were required as “related services” under the IDEA.

The proposed shift of federal funds to mental health agencies was extremely controversial within the special education and mental health communities. To begin, \$69 million represented only approximately half of the total funding necessary to maintain AB 3632 services. However, counties and their mental health agencies saw this as an improvement from the total lack of financial support they had been receiving for AB 3632 services. Many stakeholders, however, objected vociferously to this response from the state legislature. Replacing historical state support for AB 3632 services with federal funds would result in an overall decrease in funding for special education and mental health of almost \$100 million. Moreover, state Special Education Local Plan Areas (SELPAs) would not see their budgets increased by the \$69 million of new federal funds now directed to mental health agencies.

This budgetary response raises legal concerns that may have an impact on future federal special education funding to California. Several agencies and individuals – including the state SELPA Administrators association, school district administrators and a U.S. Congressman – filed complaints with the U.S. Office of Special Education Programs (OSEP) in June and July

2003. The complaints allege that the state’s budgetary practice violates “supplanting” and “maintenance of efforts” provisions of IDEA and seek definitive rulings from OSEP on the issue.

To be eligible for federal IDEA, Part B funds, states must provide annual assurances to the federal government that these federal funds will be used to supplement—and not to supplant—state and local funding for special education. The complaints filed with OSEP argue that, by using federal funds to pay for AB 3632 services that had previously been funded by the state, California was in violation of the supplanting provision. The Senate Budget Committee considered this issue in endorsing the shift of federal funds and relied upon legislative provisions in the IDEA that allow a significant portion of federal funds to be used for state-level activities without triggering the “supplanting” provision. Moreover, a determination that federal funds had been used to “supplant” state and local support would likely be made at the aggregate special education funding level, as opposed to the provision of mental health services alone.

Of greater concern in California’s case, however, are the statutory provisions requiring a “maintenance of effort” in California’s overall funding of special education. These provisions have been interpreted to require that annual state funding for special education not result in an overall decrease from the prior year. The loss of \$100 million in state funding for AB 3632 services, not counterbalanced by an equivalent increase in overall state special education funding in the 2003-04 budget, could lead to a finding that California has failed to meet its “maintenance of effort” requirement. Such a finding could result in a corresponding reduction of \$100 million in federal funds the following year.

While recognizing these concerns, the state prioritized its ability to continue to provide some level of mental health services to special education students over the maintenance of effort concerns. The Senate Budget Committee noted that failure to provide some level of funding for AB 3632 services could cause counties to cease to provide these services at all, jeopardizing the entire amount of federal IDEA funding the following year, more than \$972 million. Among the state assurances required to be eligible for federal IDEA funding, California must certify its ability to provide a FAPE to all special education students. The inability of the state to meet the mental health needs of special education students could certainly prevent California from providing such assurances.

In August 2003, OSEP forwarded these complaints to the CDE, and asked that the CDE resolve them as state complaints. Initial proposals of the 2004-05 state budget propose a similar shift of \$69 million of federal IDEA funds to mental health agencies to fund AB 3632 services.

Legal Response: Tuolumne and San Diego County Lawsuits

The fiscal crisis surrounding Chapter 26.5 services has been most severe at the county level, where funds must ultimately be found to pay for mental health services. While federal IDEA funds have no doubt lessened the burden on counties, many counties have determined that they are financially unable to continue to provide AB 3632 services under present funding arrangements. In two counties, Tuolumne and San Diego, pending lawsuits may dramatically alter current interagency relationships under which AB 3632 services are provided.

In January 2003, the Tuolumne County Board of Supervisors unanimously approved a measure to cease providing mental health services to special education students through Chapter 26.5. The Board cited the lack of state funding and the excessive cost of providing these services. One county official estimated that the county was regularly incurring \$300,000 to \$400,000 in annual costs to fund AB 3632 services, but was receiving only \$13,000 to \$14,000 in state reimbursements. The county's share of the costs had placed the county in severe financial distress. Under the measure adopted by the Board, CMH agency would continue to provide existing AB 3632 services, but would not provide new services added to IEPs in the future.

The Tuolumne County SELPA and special education unit filed a claim with the state Interdepartmental Dispute Resolution body in February 2003. When the administrative body failed to hear the complaint, the School District and SELPA filed suit against the County in State Superior Court. The complaint alleged that the Board's decision, ordering the County to refuse to provide for and fund mental health services, violated both the IDEA and California state law. The School District and SELPA sought injunctive relief requiring the County to continue to provide services until resolution of the dispute, and declaratory relief confirming the obligations and responsibilities of both parties in providing mental health services to students.

The court dismissed the lawsuit without creating a full evidentiary record. The primary basis for the decision was that the School District and SELPA had failed to exhaust their administrative remedies. Essentially, the court sent the parties back to the Interdepartmental Dispute Resolution process. Although it was not required to do so, the court went on to hold that the County was not obligated to provide services or funding for an unfunded state mandate. An appeal by the special education unit and SELPA of this decision is now pending before the California Appellate Court.

In a second set of lawsuits, the County of San Diego filed claims on February 3, 2004 against the State of California, the State Controller, the State Treasurer, and the Director of the State Department of Finance. The lawsuits, now pending before State Superior Courts in Sacramento and San Diego, were prompted by the failure of the state to fund or reimburse county expenses incurred in the delivery of Chapter 26.5 services. The County seeks declaratory relief confirming that the State's failure to fund Chapter 26.5 services creates an unfunded state mandate, in violation of the State Constitution's prohibition against unfunded mandates, and that the County is therefore not obligated to provide such services. The County also seeks injunctive relief, directing the State to reimburse the County for current and prior unreimbursed expenses incurred in the delivery of Chapter 26.5 services. According to San Diego County, these prior year costs total almost \$20 million, with a further estimate that the cost of providing Chapter 26.5 services in 2003-04 will exceed an additional \$9 million.

San Diego County Data: AB 3632 and AB 2726 Reimbursement Claims 1996-97 through 2002-03					
Fiscal Year	AB 3632 Claim	Reimbursement from State	AB 2726 Claim*	Reimbursement from State	Balance Owed by State
1996-97	\$ 177,139	\$ 177,139	N/A	N/A	\$ 0
1997-98	232,447	232,447	\$ 87,634	\$ 7,441	80,193
1998-99	189,973	195,986	435,797	29,033	400,751
1999-2000	599,716	159,268	903,042	43,395	1,300,095
2000-01	1,296,338	438,763	1,171,667	35,875	1,993,367
2001-02	5,993,431	591,998	1,691,153	0	7,092,586
2002-03	6,864,335	0	2,149,203	0	9,013,538
TOTAL	15,353,379	1,795,601	6,438,496	115,744	19,880,530
*AB 2726, adopted in 1996, requires CMH agencies to pay for the cost of out-of-county residential placements.					
Source: <i>Co. of San Diego v. State of CA</i> , Plaintiff's Complaint					

The situations in Tuolumne and San Diego Counties are not unique, but are reflective of the dire financial situations in the great majority of counties across the state. In 2003, as many as 13 CMH agencies refused to sign their “performance contracts” with the DMH, citing “significant concerns” with their ability to meet their obligations to provide AB 3632 services. Ideally, these lawsuits will encourage a political settlement in which the state restores significant levels of funding for Chapter 26.5 services. However, such an outcome seems unlikely in the current political and budget climate. Short of that, and short of a court ruling directing the state to fully fund these services, more and more counties are likely to declare themselves unable to continue to provide Chapter 26.5 services.

Policy Responses: Stakeholder Positions

Much of the debate among stakeholders at the state level has focused on efforts to resolve the current financial crisis surrounding AB 3632 services. However, today’s funding crisis has cast the spotlight on longstanding, underlying tensions within the Chapter 26.5 framework. Indeed, many policymakers have been prompted to call into question the fundamental interagency approach of AB 3632. As policymakers consider the future of the AB 3632 program, the stakeholder community is divided and polarized.

Among the most serious calls for reform are calls to repeal AB 3632. The California Mental Health Directors Association (CMHDA) now supports this position and advocates the reassignment of responsibility under state law to school districts for providing IEP-related mental health services. The CMHDA points to the tremendous financial strain on counties and fundamental flaws in the design and funding of the program. School districts, meanwhile, generally support the continued role of mental health agencies in the IEP process, but fiercely guard against perceived encroachment on limited resources to fund AB 3632 services. A handful of school districts have suggested that they would prefer to provide mental health services themselves, rather than share federal IDEA funds with mental health agencies.

Such proposals, in general, raise serious concerns for other constituencies in the mental health community. Some advocacy and provider organizations oppose the repeal of AB 3632 and support the continued role of CMH agencies in school-based mental health programs, with

full state funding restored for the program. They note that the original reasons that prompted the adoption of AB 3632 still hold true: a general perception that mental health professionals, as opposed to education professionals, are better qualified to identify and treat the mental health needs of students. They expressed the concern that many education professionals do not perceive many mental health issues as real disabilities, but rather, as primarily behavioral issues. Under the current framework, students with mental health needs are already treated as “second-class citizens.” Others observed that the special education system has essentially “disowned” these students and does not perceive this class of special education students as “their kids.” Given this, many perspectives in the mental health community are concerned that treatment for students with mental health needs would deteriorate without the further involvement of mental health agencies in the IEP process.

The majority of the state-level stakeholders we interviewed asserted that the problems facing Chapter 26.5 go beyond the lack of funding. Stakeholders bemoan the lack of accountability in the interagency framework, the absence of any meaningful oversight or monitoring, and the deficiency of relevant data at the state level. The complex interagency funding mechanisms often create perverse incentives for agencies that may affect referral, assessment and treatment decisions. Others pointed to fundamental tensions arising from the role of CMH agencies in a sometimes adversarial IEP process, poisoning the relationship between client and provider.

Beyond the basic questions about the future of the AB 3632 program, state-level leaders proposed several other reforms that would improve school-based mental health service delivery. Some policymakers propose a greater focus on prevention, early identification, and early intervention. Several respondents, for instance, pointed to the potential of the Early Mental Health Initiative to address mental health problems before they require more extensive and costly interventions later on. Others have suggested more streamlined funding procedures, which would need to be careful to create the appropriate incentives for schools and mental health agencies to identify and treat mental health needs in the most effective way possible.

Several policymakers cited the need for more collaborative and effective programs employed at the local level, which might serve as models for programs throughout the state. Similarly, leaders called for more rigorous data collection practices, in order to assess which programs were having the most positive impact. The fundamental need identified, however, was for a constructive and collaborative dialogue to take place at the state level among all stakeholders. Such a dialogue could replace the current polarized debate with an alignment of underlying interests between mental health and special education.

Part VI
A Ground-Level Look at
Chapter 26.5 Service Delivery in Three Counties

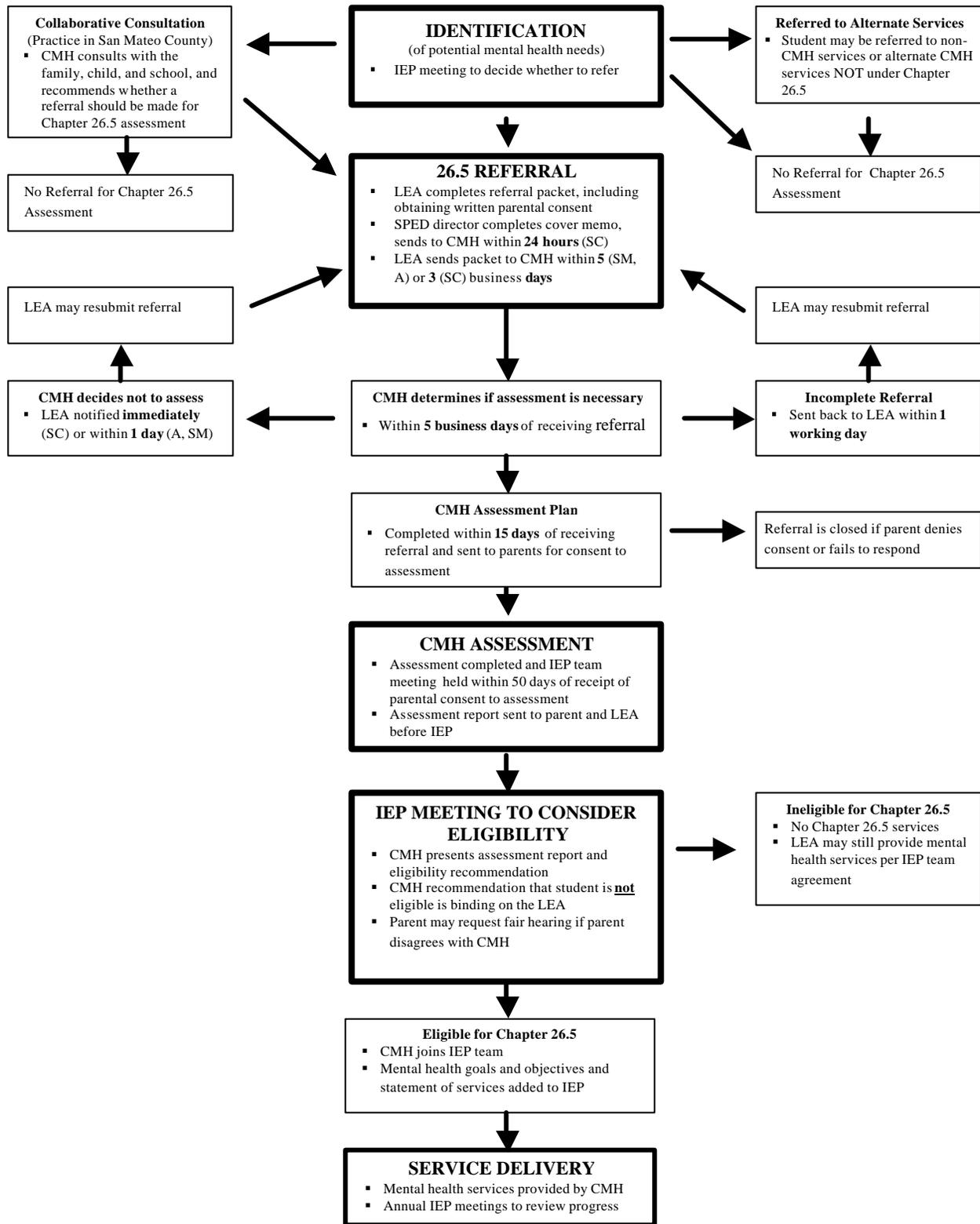
While the state-level perspective presented in the previous section no doubt raises the potential of legal, fiscal, and policy barriers, of at least equal importance are the “street-level” barriers that arise at the local level in the implementation of the Chapter 26.5 framework. In this next section of the report, we present three county-level case studies that sought to analyze implementation of Chapter 26.5 at the local level and identify barriers, if any, that prevent more effective delivery of mental health services to special education students.

Case studies were conducted in San Mateo, Santa Clara and Alameda Counties. San Mateo County is a mid-sized, primarily suburban county in northern California, with a general population of 707,161 residents and student population of 88,991 students, the latter of which is predominantly white and Latino, with a smaller population of students of other ethnicities. Santa Clara County is a larger county of approximately 1.7 million residents, with a mix of urban (San Jose) and suburban areas, and a student population of 250,435 students, which is predominantly Latino, white, and Asian. Alameda County has a general population of 1,443,741 residents, dominated by Oakland as the major metropolitan area, with a student population of 218,041 that is primarily white, Latino and African-American. Demographic data on each of the counties, including relevant education and mental health data for each county, are presented in a table on pages 27 and 28.

Each case study reports stakeholder perspectives on how the Chapter 26.5 system works in practice and the implementation barriers that arise at various stages of the process. The case studies begin with issues of access to the Chapter 26.5 system, including the processes of identification, referral, assessment, and determination of eligibility for services. The case studies next address issues of service delivery, including the continuum of services provided by programs in the county, the location of services, evaluation of services and other challenges encountered in service delivery. Finally, the case studies address questions of interagency collaboration and accountability in each county. Each case study concludes with a summary of the findings from our county-level research.

Common among the case studies is the general process for access and service delivery under Chapter 26.5. Much of this process is dictated by the state regulations discussed in Part II above, as well as strikingly similar interagency agreements adopted at the local level between LEAs and the CMH agency. This general process is presented in the flowchart on the following page. The case studies make particular note of instances in which county practices and procedures deviate from this common general process.

Accessing Services Under Chapter 26.5 ¹⁸



¹⁸ 'A' denotes 'Alameda County,' 'SC' denotes 'Santa Clara County,' and 'SM' denotes 'San Mateo County.'

A Snapshot of the Schools in Each County

General County Information						
	County Population		Student Population		# of Schools	# of SELPAs
San Mateo County	707,161		88,991		171	1
Santa Clara County	1,682,585		250,435		390	7 (organized into 2 Admin. Offices)
Alameda County	1,443,741		218,041		356	5
School District Information						
	Elementary Districts # (Enrollment)		High School Districts # (Enrollment)		Unified Districts # (Enrollment)	County Office of Education (Enrollment)
San Mateo County	17	(53,086)	3	(21,305)	3 (13,571)	(1,029)
Santa Clara County	21	(116,666)	5	(47,210)	6 (84,319)	(2,240)
Alameda County	1	(47)	1	(321)	17 (216,546)	(636)
Student Population Information						
	Student Population		Free / Reduced Lunch (%)		English Language Learners (%)	Special Education Population (%)
San Mateo County	88,991		24,005 (27.3%)		20,844 (23.5%)	10,182 (11.4%)
Santa Clara County	250,435		79,119 (30.6%)		61,643 (24.6%)	26,331 (10.5%)
Alameda County	218,041		75,044 (34.8%)		47,146 (21.6%)	23,003 (10.5%)
Student Demographic Information						
	Total Student Population		Special Education Population		Emotional Disturbance Population	
San Mateo County	88,991 (total)		10,182 (total)		405 (total)	
White	37.1%		41.4%		48.9%	
Hispanic or Latino	32.7%		35.6%		20.2%	
Asian	11.1%		6.5%		5.9%	
Filipino	9.4%		5.3%		4.7%	
African-American	4.5%		7.7%		17.5%	
Pacific Islander	3.1%		3.0%		2.0%	
American Indian or Alaska Native	0.3%		0.4%		0.7%	
Multiple or No Response	2.0%		-----		-----	
Santa Clara County	250,435 (total)		26,331 (total)		849 (total)	
White	31.5%		37.8%		60.7%	
Hispanic or Latino	34.2%		41.2%		24.4%	
Asian	23.3%		11.5%		4.1%	
Filipino	5.1%		2.8%		2.4%	
African-American	3.5%		5.1%		6.9%	
Pacific Islander	0.8%		0.7%		0.6%	
American Indian or Alaska Native	0.7%		0.9%		1.3%	
Multiple or No Response	1.0%		-----		-----	
Alameda County	218,041 (total)		23,003 (total)		1,058 (total)	
White	28.8%		35.4%		39.5%	
Hispanic or Latino	25.6%		24.2%		10.9%	
Asian	18.2%		9.1%		3.7%	
Filipino	5.0%		2.8%		0.9%	
African-American	18.6%		26.8%		43.7%	
Pacific Islander	1.5%		0.9%		0.5%	
American Indian or Alaska Native	0.7%		0.8%		0.8%	
Multiple or No Response	1.6%		-----		-----	

Source: California Department of Education

County Mental Health Caseload by County

	Total Mental Health Caseload (Age 0-21)	Total Chapter 26.5 Caseload (Clients age 0-21 w/ IEP)	% of Caseload Served Through Chapter 26.5
Statewide	223,193	29,486	13.2%
San Mateo County	3,122	614	19.7%
Santa Clara County	6,951	852	12.3%
Alameda County	8,056	951	11.8%

Chapter 26.5 Demographics

	By Gender		MediCal Eligibility	Primary Language		
	Boys	Girls		English	Spanish	Other
Statewide	26.7%	73.2%	51.18%	88.9%	4.9%	4.2%
San Mateo County	24.6%	75.4%	35.99%	92.5%	6.2%	1.1%
Santa Clara County	28.1%	71.9%	34.74%	95.9%	0.8%	3.2%
Alameda County	22.8%	77.0%	56.68%	94.6%	1.2%	2.5%

Chapter 26.5 by Ethnicity

	Statewide	San Mateo County	Santa Clara County	Alameda County
Total Chapter 26.5 Students	29,486	614	852	951
White	52.4%	48.7%	62.9%	41.1%
Hispanic or Latino	22.3%	25.2%	20.9%	9.5%
Asian	2.3%	1.6%	4.5%	3.4%
Filipino	0.6%	1.8%	1.3%	0.6%
African-American	14.3%	12.4%	7.0%	41.1%
Pacific Islander	0.5%	1.0%	0.4%	0.3%
Native American	0.9%	0.3%	1.5%	0.5%
Multiple, Other or No Response	6.7%	8.6%	1.5%	3.5%

Source: California Department of Mental Health

San Mateo County

Introduction

Chapter 26.5 is many things to the stakeholders in San Mateo County. To CMH, in the words of one of its administrators, “overall, it’s a good thing,” allowing the agency to reach children with mental health problems who might not otherwise receive the services they need but also requiring it to collaborate with education agencies that have different ideas regarding by whom and for how long mental health services are needed. To educators, it is another resource to help the subset of their special education students who have qualified as emotionally disturbed—one for which their responsibility is usually limited but potentially enormous. To advocates, it is a program that has promise and helps many students but that also places—intentionally or unintentionally—a variety of barriers in the way of access to and delivery of school-based mental health services. To parents, borrowing a phrase from one of them, “it’s just a number”—if it even is that; the program’s availability and details are largely unknown to parents. Finally, to all categories of stakeholders, it is an under-funded program, which limits its scope in a variety of ways.

This case study explores the ideas above as they play out in the components and procedures of the Chapter 26.5 program, as it is implemented in San Mateo County. It begins with some basic demographic information for San Mateo County and then proceeds to highlight areas of interest and concern in various areas of the program.

Demographic information for San Mateo County

San Mateo County is a mid-sized county in northern California with a population of 707,161 residents.¹⁹ In the 2002-03 school year, the county’s 88,991 students²⁰ attended one of its 171 schools, which are divided into 23 LEAs and the County Office of Education. The three largest racial and ethnic groups among students are non-Hispanic white (37.1%), Hispanic or Latino (32.7%), and Asian (11.1%). San Mateo County has only one SELPA. The county had 10,182 students enrolled in special education during the 2002-03 school year; while County Mental Health served 614 students with IEPs in 2001-02 and 595 students with IEPs in 2002-03.

Access to Services

Identification

Most stakeholders in San Mateo County probably would agree with the CMH administrator who stated that, by the time a student reaches the level at which he clearly qualifies for the Chapter 26.5 program, it “should not be a surprise to anyone” that he is eligible, because his mental health needs should have been identified earlier by people in the system. However, it is not as clear who would have made that initial identification and on what basis. The case study participants named no less than a dozen different categories of people who could identify

¹⁹ This figure is from the 2000 U.S. Census.

²⁰ Unless otherwise indicated, all education-related data in this section are from the 2002-03 school year.

potential mental health problems in students, ranging from school personnel to advocates to probation officers. The two most commonly mentioned categories were teachers and parents. At the same time, several stakeholders highlighted the problems with relying on either of these individuals to make the initial identification, as neither is sufficiently trained to recognize mental health problems, and one advocate believes that educators are acting under a “tacit instruction” not to make identifications that might lead to referrals—except in “egregious” circumstances—because of fiscal constraints.

Moreover, there do not appear to be any formal identification criteria in San Mateo County. Some stakeholders described a range of vague factors that might raise suspicion of mental health problems, such as “emotional difficulties,” “behavioral problems,” and “strange” behavior. Other stakeholders expressed concern that those same factors might be ignored by educators who do not pay adequate attention to students’ mental health needs or misidentified as willful misbehavior (and not only go untreated but possibly even be punished). If a student has a “clear emotional disturbance or mental health problem,” he seems to stand a better chance of being identified, but, on the flip side, several stakeholders lamented that students whose special education eligibility is not based on emotional disturbance (ED) face a significant barrier to being identified and that even known mental health problems may be ignored by both the IEP team and CMH.

Collaborative consultation

In Alameda and Santa Clara Counties, the next step after a student’s potential mental health problems have been identified is a referral for mental health assessment. However, in San Mateo County, a procedure called a “collaborative consultation” may be used prior to that step to obtain CMH’s recommendation on whether a referral should be made. After the student’s parents have given their written consent, CMH observes the student, reviews relevant records, and speaks to the student’s parents and/or teachers in order to gather enough information to provide advice for addressing the student’s problems, which may or may not include a referral for mental health assessment. Although this procedure technically is optional and is not a necessary first step toward a referral, both CMH administrators and educators reported that there usually is a collaborative consultation before a referral is made, and one advocate stated that CMH “insists” on using this procedure. If, as a result of the collaborative consultation, CMH recommends against a referral, the student’s parents still may request and obtain one at another IEP meeting.

CMH and educators on the one hand and advocates on the other appear, for the most part, to have very different views about the purposes and effects of collaborative consultations, with the former focusing on the benefits of the procedure and the latter pointing out what they see as potential and actual barriers the procedure puts in the way of access to school-based mental health services. According to many of the CMH administrators and educators interviewed, collaborative consultations improve the referral process by, for instance, “ferreting out” cases in which referral would be inappropriate; helping stakeholders determine the most appropriate level and source of services to address students’ problems, which may or may not be mental health services from CMH; increasing flexibility in dealing with students’ mental health problems; by providing assistance to educators through information and support; and/or serving a “triage function” – reserving CMH’s limited resources for the “most needy” and “most disturbed” students. In contrast, advocates’ strong criticism of collaborative consultations is leveled

primarily at their perception that CMH does not seem to view itself as being under any particular obligations under this procedure and the fact that, although potential mental health problems already have been identified, a collaborative consultation might never result in a formal assessment, provision of mental health services, or “anything really beneficial.” One advocate characterized collaborative consultations as a “big obstacle to getting full-fledged 26.5 services.”

Referral

Regardless of whether there was a collaborative consultation, the official decision to make a referral for mental health assessment is made by the IEP team at an IEP meeting, and it is written into the IEP. While it is possible for a student to be assessed concurrently for special education eligibility and Chapter 26.5 eligibility, according to CMH administrators, typically the student should have been served by special education for some time before a referral is made. Similarly, according to County Office of Education administrators, it is CMH’s “recommendation” that a student either be placed in a County-run special day class or referred for mental health assessment—but not both at the same time—on the theory that the combination of the new placement and Chapter 26.5 services might be “more than the child needs to stabilize.”

To make a referral, the LEA prepares a referral packet, which contains, among other things, written parental consent for a mental health assessment and documentation that school services to address the student’s needs have been exhausted. The LEA is required, under the Interagency Agreement, to send the completed referral packet to CMH within five business days after it has obtained written parental consent. In the eyes of several stakeholders, once the LEA has sent the packet to CMH, it seems to think its responsibility for the case, at least as far as mental health issues are concerned, is finished.

Stakeholders described three major barriers to accessing school-based mental health services at the referral stage, all of which echo difficulties mentioned with regard to identification. First, parents may be relied upon to start the process themselves, either by asking for a referral or by obtaining a private assessment and then using it to request mental health services from the LEA. However, advocates, parents, and even some educators repeatedly stressed that most parents do not know that mental health services are available through special education, so they would be unlikely to ask for them. Second, some stakeholders expressed concern that LEA personnel are not adequately trained about the mental health services available through the Chapter 26.5 program or about the process for obtaining those services for students.²¹ Third, comments from several stakeholders suggested that the ED designation, which some educators identified as the LEAs’ criterion for making a referral, may be used as a prerequisite for receiving school-based mental health services, thus excluding students who qualify for special education under other disability categories but who nonetheless have mental health problems that affect their ability to benefit from their education.

²¹ In December 2003, one education administrator stated that revisions were being made to the Interagency Agreement at that time to address training for staff people who work at the IEP level so that they understand what the Interagency Agreement is and what the requirements are for referrals and exit criteria.

Assessment

Within five days of receiving a referral packet, CMH is supposed to determine whether a mental health assessment is necessary. While CMH administrators reported that they “screen” referrals quickly and make an “immediate” decision (or return incomplete referral packets), two advocates stated that this timeline is violated in a number of cases. CMH’s decision that a mental health assessment is not necessary is based on its judgment that the referral packet does not describe a mental health problem, though CMH administrators also expressed that LEAs, not being aware of the full range of mental health services available outside of the Chapter 26.5 program, might make a referral when another program (e.g., services through Medi-Cal) would be “more appropriate.” Two advocates found fault with the system for giving CMH the power, without conducting an assessment, essentially to “veto” the IEP team’s determination that mental health services definitely or probably are needed.

If CMH determines that a mental health assessment is necessary, it has fifteen days to develop an assessment plan, which it then sends to the student’s parents for written parental consent. One educator was particularly bothered by the way CMH handles obtaining parental consent, arguing that using the mail to obtain consent (instead of obtaining this consent at the same IEP meeting at which the parents consent to the referral) is very inefficient, causing delays in assessing students and providing them with needed services, during which “oftentimes kids go down in flames.” This same educator also pointed out that he has seen “many” cases in which students are not assessed at all because the parents have failed to return the forms and, to his knowledge, CMH has not followed up with the parents by phone or informed the LEA until after it has closed the case.

Once CMH receives written parental consent, it has fifty days to complete its mental health assessment. Several educators praised CMH for “generally” responding quickly to referrals, for “usually” completing the assessment within the fifty-day timeline, and for expediting the assessment process when a student is in serious need of a therapeutic placement. On the other hand, advocates and a couple of other educators stated that CMH violates the fifty-day timeline with a frequency perceived to range from “sometimes” to “routinely” to “nearly always.”²² One educator said that she never had gotten a clear answer from CMH about what is causing the delays, while advocates variously attributed the delays to CMH’s “crushing caseload,” CMH’s failure to treat mental health services as “entitlements,” and the use of “double timelines” for students who are being assessed concurrently for special education eligibility and Chapter 26.5 eligibility (i.e., allowing fifty days for the LEA to complete its initial assessment and hold an IEP meeting and another fifty days for CMH to complete the mental health assessment).

Eligibility determination

Following the completion of the mental health assessment and also within fifty days of CMH’s receipt of written parental consent for the assessment, another IEP meeting is held to

²² Violation of the fifty-day timeline for assessment necessarily means that the IEP meeting to discuss eligibility is not held within the mandated timeframe either.

determine whether the student is eligible for the Chapter 26.5 program.²³ At this meeting, the IEP team is expanded to include one or more CMH personnel, who present the results of the assessment and CMH's recommendations regarding eligibility, services, and mental health goals and objectives.

What is most notable at this stage is that LEAs and CMH operate under different criteria governing eligibility. From an educational perspective, LEAs view eligibility for the Chapter 26.5 program as equivalent to qualifying for special education under the category of emotional disturbance (ED). From a clinical perspective, CMH's criteria, as described by various categories of stakeholders, appear to require a *DSM-IV* diagnosis, require that the student have the "cognitive ability" to benefit from treatment, and exclude young students and students who have developmental disabilities (e.g., autism), conduct disorders, or substance-abuse problems. The LEAs' criterion, in the words of one educator, "glosses over" the definition of mental illness used by CMH and, in the words of another educator, "oftentimes" makes what school personnel regard as a mental health issue not "fit" within CMH's view of its "target population." (A substantial number of stakeholders stated that they were not aware of or had not seen written out the agencies' eligibility criteria.)

Despite the differences in the criteria used by LEAs and CMH, stakeholders reported few disputes or disagreements over eligibility. When there are disagreements, they appear to be resolved informally at or outside of the IEP meeting. One advocate suggested that the reason there may be so few open disputes over eligibility is that a "huge" amount of deference is shown to CMH's determinations of eligibility, in part because LEAs do not have staff qualified to second-guess CMH's recommendations, effectively making CMH the "gatekeeper" to the Chapter 26.5 program. One educator said that LEAs rely on CMH's expertise, which could support the advocate's argument, while another educator stressed that CMH makes only recommendations and that eligibility is the IEP team's decision.²⁴

Perhaps a more daunting barrier stems from the tightening of eligibility criteria in response to inadequate funds and resources for the Chapter 26.5 program. A few LEA and CMH stakeholders acknowledged that, when there is less funding, the "guidelines" for who "might benefit" from Chapter 26.5 services are narrowed and that, if there were more resources, the criteria could be broadened, there could be "more flexibility" in the guidelines, and more students could be served. The burden of this institutional reaction to fiscal constraints seems to fall most heavily on students who do not exhibit the most clearly serious mental health needs.

If the student is found eligible for the Chapter 26.5 program, the IEP team proceeds to determine the type and frequency of services and the student's mental health goals and objectives. As with the eligibility determination, stakeholders reported few disagreements among the IEP team members about these topics and informal resolution of any disagreements that do arise.

²³ This timeline is reduced to thirty days when residential placement is being considered for a student qualified for special education as emotionally disturbed.

²⁴ Two stakeholders mentioned that more weight is given to CMH's recommendation when the IEP team is considering residential placement. One stakeholder described the difference as a "shift" in the balance that still involves negotiation among the agencies' directors, while the other said that CMH's recommendation is deemed to be the IEP team's recommendation.

Other barriers to accessing the Chapter 26.5 program

In addition to the obstacles mentioned above, stakeholders also described various barriers that interfere with students' access to school-based mental health services at more than one stage of the process. Rather than being listed repeatedly in the preceding sections, they are summarized below.

The first such barrier is the funneling of Chapter 26.5 services to the most seriously disturbed students with clear mental health problems, which leaves those students with legitimate but less serious or less obvious mental health needs either underserved or not served at all. Types of students observed to be underserved included “depressed or anxious children,” “withdrawn” students, and students who do not injure themselves or others. Stakeholders' comments suggested two potential causes for this phenomenon. The first is that CMH has had to prioritize its interventions and direct its services to the “most needy” and “most disturbed” students in the face of the inadequate funding for the Chapter 26.5 program recognized by most stakeholders. One CMH administrator acknowledged that what ends up happening is that the students with the most significant psychiatric problems are most likely to be treated, while the less serious problems may go untreated or be addressed with services from places other than the “overburdened” CMH agency. The second possible reason is that CMH's philosophy—which may or may not be influenced by fiscal constraints—seems to be that its target population is the most seriously disturbed students. For example, one advocate said that CMH's attitude towards students with less severe cases is that they are “not the population it was set up to serve.” In addition, one educator said that CMH has identified its “core constituency” as severely emotionally disturbed (SED) children who are eligible for Medi-Cal.

A second overarching barrier to access to the Chapter 26.5 program, which also is related to insufficient funding, is that CMH, at various stages of the process, tries to get families to access mental health services through their private insurance, through other agencies or organizations, or through CMH's community access services instead of through the Chapter 26.5 program. According to one CMH administrator, because of the inadequacy of resources for the Chapter 26.5 program, it is necessary to take an “exhaustive look” at all of the available resources, including “community-level resources,” that might be the “best match” for the student. (This administrator added that, if a student's mental health services are provided by CMH through its community access program, they can be “broader” and more focused on ameliorating the mental health condition and not merely its interference with the student's education, than services obtained through the Chapter 26.5 program). Several stakeholders mentioned that CMH has a practice of asking families about their private insurance coverage; one educator said that it is the “first question” CMH asks and that, because of its finite resources, CMH encourages parents to “access what they're already paying for.”

A third barrier, which can have detrimental effects throughout this process, is that, because parents do not know that school-based mental health services are available—much less what specific service options there are—or understand how the Chapter 26.5 process works, they are unable to act as effective advocates for their children. All four of the parents interviewed for this case study were distressed that their LEAs never volunteered information about the Chapter

26.5 program. Stakeholders suggested several possible reasons for that failure, including avoidance of extra costs, conformance with an instruction not to open new Chapter 26.5 cases, and school personnel's own insufficient knowledge of the Chapter 26.5 program. Particularly striking is that even SELPA Resource Parents, who are held out by the San Mateo County SELPA as being trained volunteers who can assist parents of students receiving special education, are not trained about the Chapter 26.5 program; in fact, two of the three Resource Parents interviewed for this case study had not heard about the Chapter 26.5 program until we asked them questions regarding their experiences with it. Six stakeholders, including educators, advocates, and parents, specifically recommended that training be provided to parents to remedy these problems.

In contrast, one of the barriers to access discussed by some CMH administrators results from what might be cast as parental advocacy that is "too effective." From CMH's perspective, in some cases, access to high-end services, such as out-of-state residential placements, can be driven more by the motivation and means of the student's parents (sometimes assisted by an advocate) than by the mental health needs of the student, as determined by CMH. When parents push for services that, in the professional judgment of CMH, are unnecessary (e.g., by placing their children unilaterally and then filing due process complaints, which they win on minor technicalities, according to CMH administrators), it takes CMH's already limited resources away from other students with more serious disabilities. CMH administrators perceive this problem as a grave one that is growing not only in San Mateo County but in other "urban, affluent areas."

Finally, there may be barriers to accessing the Chapter 26.5 program that are attributable to individual, family, or cultural factors rather than institutional or systemic factors. Educators listed a number of such barriers, including a desire to avoid the stigma associated with mental health problems, a lack of interest in receiving mental health services, family dysfunction, and a cultural avoidance of counseling services.

Service Delivery

Service options

There is a continuum of services available through the Chapter 26.5 program, ranging from outpatient services to residential placement. On one end of the spectrum is outpatient therapy, which can be provided on an individual, group, or family basis (or some combination of the three). Medication monitoring provided by CMH psychiatrists is another outpatient service. The most intensive outpatient service is placement in a "milieu classroom" at the County Office of Education, which is a special day class that includes a therapist a couple of days per week. Taking another step toward the other end of the spectrum, two day-treatment placements are available. One option is placement in a non-public school that includes intensive mental health rehabilitative day treatment.²⁵ The second option is placement in a therapeutic day school (TDS). TDSs, which are run in conjunction with the County Office of Education on high school campuses and are staffed by a teacher and a mental health therapist, provide treatment five days a week for five hours each day. Finally, residential placement is available for the most serious cases; last summer, San Mateo County opened its own residential facility, called Canyon Oaks.

²⁵ To avoid placement in a non-public school, CMH may provide extensive wraparound services.

Many of these services can be accompanied by consultation to parents and/or to school personnel.

Several stakeholders shared their perception that the primary service provided through the Chapter 26.5 program is individual therapy; a few of them were even more specific, stating that students typically receive only one counseling session per week.

A handful of stakeholders, including school and CMH personnel, reflected on the impact of insufficient funding on the availability of Chapter 26.5 services, explaining that it reduces not only the number of open slots but also the types of services that are offered. Moreover, a couple of stakeholders stated that there are waiting lists for some services. Stakeholders seemed to be most troubled by the fact that the TDSs are “always full,” particularly because they are considered to be so successful. Service gaps noted by some advocates included practices for formally addressing behavioral problems, social skills classes, and services directed toward conflict resolution, anger management, and gang prevention.

Individualization of services

Educators and advocates differ dramatically in their perceptions of the extent to which Chapter 26.5 services are individualized for each student. All but one of the educators who commented on the issue stated emphatically that Chapter 26.5 services, like all services in students’ IEPs, are individualized based on each student’s specific needs. The remaining educator said that the only Chapter 26.5 service available in that district is one-on-one therapy at a CMH clinic, suggesting minimal tailoring to students’ individual mental health needs, which might call for more than a single form of outpatient therapy. Advocates went much further, criticizing CMH for what they see as its lack of flexibility and creativity, its failure to “easily accommodate” individual needs, and its use of “one-size-fits-all” approaches. While one advocate took the view that any flexibility that exists usually happens outside of the Chapter 26.5 program and the IEP process, such as through wraparound services, another advocate stated that the only “individualization” occurs within the existing system—that is, the agencies try to “plug kids into the right place” in the existing framework, which usually depends on where there is an open slot.

Location of service delivery

Most stakeholders identified two locations where Chapter 26.5 services are provided: at the school site and at a CMH clinic. A few stakeholders also mentioned that some services, such as family therapy, might be provided in the student’s home. The stakeholders who estimated how often services are provided at the school site versus at a CMH clinic were split almost evenly among three perspectives; several educators perceived that services are provided more often at school sites than at CMH clinics, another educator and several CMH administrators estimated the breakdown to be about half and half, and a couple of educators and an advocate opined that services more commonly are provided at CMH clinics than at school sites.

Numerous stakeholders expressed a preference for increasing the number of cases in which services are provided at the school site. Among the benefits of on-site service delivery they mentioned were convenience to students, elimination of transportation and scheduling

difficulties, reduction of the time students are taken away from their academic curriculum, enhancement of school personnel's ability to ensure that students are receiving their services, and avoidance of CMH clinics that are not child-friendly in appearance or atmosphere. Several educators observed that CMH clinics lack a strong "connection" to the schools and that their physical distance from and weak presence at school sites, especially when many services are provided off campus, seem to undermine their level of commitment to those students. However, several stakeholders pointed out that there is not appropriate, private space available at some school sites for service delivery.

Ensuring that students receive their services

CMH is the provider of Chapter 26.5 services in San Mateo County. However, several educators mentioned that, if CMH does not provide the services specified in a student's IEP, the ultimate responsibility for ensuring that the student receives those services falls on the LEA. In the words of one educator, the LEA, unlike CMH, cannot say, "No." This responsibility has made some educators especially nervous in light of the funding crisis that has plagued the county for the last couple of years.

Putting aside the issue of ultimate financial responsibility for Chapter 26.5 services, though, there seems to be little in the way of a formal structure to ensure that students are receiving their services on a daily or weekly basis. Several advocates said that there are no formal checks to ensure that students do not fall through the cracks or get lost between agencies, pointing out, in the words of one advocate, that "parents are the cops here." For their part, educators listed a number of possible checks, such as the engagement of and case management by CMH professionals, case management by teachers, and parent-teacher conferences, many of which were described as though they tend toward informality and rely heavily on one individual involved in the case—be it a teacher, therapist, school psychologist, or secretary—to notice that something is wrong. A number of educators also stated that problems are fixed when they are reported by parents. The apparent weakness in confirming on a regular basis that students are receiving their services seems to be exacerbated in some cases by the varying—and sometimes uncertain—frequency and extent of communication among CMH personnel, school personnel, and parents described by stakeholders once service delivery begins.

The mechanism for ensuring that students do not fall between the cracks that was mentioned by the most educators is the annual IEP meeting.²⁶ This meeting is supposed to be used, among other things, to discuss the student's progress toward his mental health goals and objectives and to decide whether to continue, discontinue, or alter the student's Chapter 26.5 services. However, CMH's attendance at IEP meetings subsequent to the one at which eligibility initially is determined is inconsistent, which obviously interferes with discussion of mental health issues. Several stakeholders attributed CMH's absence to problems with getting notice of IEP meetings from LEAs.

²⁶ The Interagency Agreement provides that the student's mental health outcome goals are to be reviewed every six months, unless IEP meetings are scheduled less frequently by the IEP team. Every stakeholder who mentioned the frequency of IEP meetings following the one at which eligibility initially is determined said that they typically occur annually.

Evaluation of the effectiveness of services

Echoing the observations directly above regarding procedures for ensuring that students receive their Chapter 26.5 services, the only formal mechanism stakeholders mentioned for evaluating the effectiveness of students' Chapter 26.5 services was the annual IEP meeting. Evaluation criteria seem to be centered around the student's progress toward his mental health goals and objectives. Stakeholders also mentioned that the IEP team considers the student's educational progress, the degree to which the problems that triggered the referral are being ameliorated, and the student's social interactions and relationship with the school environment. In addition, several educators described informal evaluation of the effectiveness of services in the form of teachers' checking to see whether students' mental health goals and objectives are being met and conversations between CMH and school personnel about students' progress, though two stakeholders noted that confidentiality protections might interfere with discussion of students' mental health treatment. Finally, two educators supposed that CMH must be conducting its own evaluation of the effectiveness of services, while a handful of advocates and educators said that they do not know if or how services are evaluated.

Termination of services

As mentioned above, one of the decisions made by the IEP team at IEP meetings is whether to discontinue the student's Chapter 26.5 services. With regard to termination of services, some CMH administrators called attention to the tensions that can arise from the "conflicting perspectives" of CMH on the one hand and parents and LEAs on the other regarding how long Chapter 26.5 services should be provided. From CMH's perspective, Chapter 26.5 services are supposed to enable students to benefit from special education, so it may request to remove them from a student's IEP if the student's mental health condition no longer is interfering with his education, if the services have been provided for a long time but the student has not started benefiting from his education, or if the student repeatedly misses appointments. However, in the experience of those CMH administrators, parents and LEAs often want Chapter 26.5 services to be provided for "the life of special education" (i.e., for as long as the student continues to receive special education). Thus, CMH finds it difficult to end provision of Chapter 26.5 services in some cases where it feels termination would be appropriate. One educator actually agreed with the view expressed by these CMH administrators, asserting that "too many students are in therapy for way too long" and that there needs to be a "more efficient way to drop dead wood from the caseload" so that getting Chapter 26.5 services is not a "life sentence."

Interagency Collaboration and Accountability

By and large, CMH and school personnel expressed a relatively high level of satisfaction with how interagency collaboration is working in San Mateo County, describing good relationships among staff, a mutual problem-solving orientation, and a cooperative approach to resolving disagreements. However, one education administrator acknowledged that interagency collaboration is "spotty sometimes" and that collaboration does not work as well in some areas of San Mateo County as it does in others. A vivid example of poor collaboration is provided by the remarks of one educator who complained that CMH "oftentimes" acts like a "separate entity;" when that educator has asked CMH about certain practices believed to be interfering with the provision of Chapter 26.5 services, CMH personnel have replied curtly, "This is the way

we do things in San Mateo.” Focusing on service areas rather than geographical areas, two advocates observed that collaboration seems to work considerably better when it comes to providing higher-level services, such as TDSs, and services for students who are experiencing crises than when it comes to providing counseling; in the latter scenario, the agencies were described as not being “cooperative” or “well coordinated.”

With regard to the quality and frequency of information-sharing and interagency communication, responses were mixed. Some educators reported “lots of back and forth” between agency staff, characterized the movement of information between agencies as “very efficient and effective,” and applauded personnel on both sides for “always” being open to discussing issues. On the other hand, three advocates asserted that CMH and LEAs share information with each other only at IEP meetings, and one educator said that the agencies get together to talk only every six months to a year. A different educator stated that she does not feel that much information moves between agencies, and another one said that it is not always easy to keep the lines of communication open.

Summary of Findings

This case study of Chapter 26.5 in San Mateo County supports a number of findings as to how Chapter 26.5 operates on the ground, from the earliest stages of identification through the delivery of services. Although parents and teachers are looked to as the primary stakeholders responsible for identification and referral for Chapter 26.5 services, they may be ill-equipped to do so. Most parents are unable to participate fully in the Chapter 26.5 process or otherwise act as effective advocates for their children because they do not know how to identify potential mental health problems, they may not know that school-based mental health services are available through special education, or they may be unfamiliar with the process for accessing and obtaining those services. Some education personnel are also insufficiently trained on how to identify potential mental health problems, what services are available through the Chapter 26.5 program, and referral and other procedures.

Once a student has been identified, a number of administrative and procedural barriers may stand in the way of timely determinations of eligibility and delivery of services. In most cases, collaborative consultations add an extra step on the path to accessing Chapter 26.5 services, which may help or hinder students’ access to the most appropriate services to address their needs. Delays at all stages may result from violations of timelines, the use of “double timelines” for concurrent special education and Chapter 26.5 eligibility determinations, and methods of obtaining parental consent. CMH and LEAs have different criteria for determining whether students ought to be eligible for the Chapter 26.5 program and different perspectives on the length of time Chapter 26.5 services should be provided, which may result in denial or delay of services. In some cases, service delivery is impeded by a shortage of appropriate school-site locations for therapy, failure to provide transportation to off-site services, and inconvenient scheduling of appointments.

Stakeholder perceptions raised serious questions regarding accountability and responsibility under Chapter 26.5. Outside of the annual IEP meeting, there generally does not appear to be clear and consistent assignment of responsibility for ensuring that all of the services in a student’s IEP, including Chapter 26.5 services, are provided and that they are effective. The

extent and quality of interagency collaboration varies in different parts of the county and with regard to different levels of Chapter 26.5 services.

Of particular concern is the impact that the current fiscal crisis seems to be having on the provision of mental health services to special education students in San Mateo County. In the face of inadequate funding, eligibility criteria for Chapter 26.5 services are “narrowed” and the number of open slots and the types of services available are reduced. As a result, those students with less serious and/or less obvious mental health problems may go without any services at all, while others may receive services that are not appropriately tailored to individual needs. The fiscal crisis also seems to be creating some tension among agencies. LEAs bear ultimate responsibility for ensuring that students receive the services in their IEPs, including mental health services, and many county stakeholders fear that CMH may respond to the inadequate funding for the Chapter 26.5 program by ceasing to provide school-based mental health services.

Santa Clara County

Introduction

Although Chapter 26.5 is not the only mechanism of school-based mental health service delivery in Santa Clara County, it provides the focal point for policy and practice. CMH is the effective gatekeeper of Chapter 26.5 services. CMH's view and approach dominate services and perceptions, in part because the Interagency Agreement grants CMH the authority to make all final eligibility and service delivery decisions, and in part because of CMH's strong presence throughout the county. However, there are several alternate approaches to school-based mental health, many of which developed in reaction to dissatisfaction or disagreement with CMH's model and methods.

In recent years, CMH has worked hard to develop more consistent practices and policies, and to share its view of Chapter 26.5 more clearly with educators and other stakeholders. The result is CMH and LEAs are increasingly on the "same page" regarding school-based mental health services, but not everyone agrees this page is best for students with mental health needs. Disagreements arise, particularly over eligibility and services, and are sometimes contentious. In the give-and-take between LEAs and CMH, the mental health needs of students are at risk of getting lost in the shuffle.

Santa Clara County Demographics

Santa Clara is a large county in northern California with approximately 1.7 million urban and suburban residents. San Jose is its largest metropolitan area, with more than 800,000 residents. 250,435 students were enrolled in Santa Clara's 390 schools in 2001-2002. The three largest ethnic groups among students are Caucasian (31.5%), Hispanic (34.2%), and Asian (23.3%). There are seven SELPAs in Santa Clara, organized into two administrative units: Santa Clara County SELPA Administrative Unit and the South East Consortium for Special Education Administrative Unit. There are 32 LEAs.

Chapter 26.5 in Santa Clara County

There are approximately 800 students currently receiving Chapter 26.5 services in Santa Clara County. According to CMH, Chapter 26.5 cost the county \$11 million in 2002-2003. The Local Interagency Agreement between Santa Clara Valley Mental Health Family Services Division, Santa Clara County Public School LEAs, and Santa Clara County Office of Education was last revised April 15, 1999. According to CMH and SELPA officials, it is currently under revision.

Access to Services

Identification

School psychologists are the primary source of identification of students with mental health needs in Santa Clara County. Most students identified are already in Special Education, and often designated emotionally disturbed (ED). A student's IEP team typically raises the issue of mental health. If a student is not already in Special Education, an IEP or Student Support Team (SST) meeting may be called, and an IEP developed if necessary. The Department of Social Services, the Probation Department, and CMH may also identify students for Chapter 26.5 services.

There are no formal mechanisms for identification of mental health problems within the IEP process, and most stakeholders do not view one individual or agency as responsible for identification. One advocate described the process of identification for school-based mental health services as “patchwork, at best.” Multiple stakeholders, including parents, report it is very rare for parents to identify mental health problems to the school. School counselors are also potential identification sources, but they are primarily focused on academic needs, and therefore less likely to raise mental health concerns. Teachers may also make identifications, most frequently by referring the student to the school psychologist. However, teachers report they do not always feel they have the information or experience needed to identify a mental health problem.

Many educators and advocates perceive that identification, or at least first bringing the concern to the school psychologist or the IEP team, is largely left to individual educators. However, there is little, if any, training, information or support available for educators on how to identify mental health issues. Several parents and advocates sense IEP teams frequently do not see mental health as part of a comprehensive evaluation for education-related services. Several stakeholders believe that no one at schools raises mental health issues until a crisis occurs, and this “wait and see” attitude is detrimental to the student. A few stakeholders feel schools deny or disregard mental health issues altogether out of concern that if they raise them the LEA must bear the cost of services.

Many stakeholders believe that within this identification process certain students are more likely to be identified than others. Educators, advocates, and CMH generally perceive four groups of students to be more likely to be identified. First, Special Education students with a pre-existing IEP. Second, students with behavior problems, although a few educators report a referral will not be made if there is a genuine belief that the issue is behavioral, and not mental health related. Third, students who exhibit symptoms of more commonly known disorders such as Bipolar. Fourth, students with an active parent or advocate. Conversely, several stakeholders sense students who are depressed, not disruptive in class, and have non-English speaking parents are less likely to be identified.

Referral

Santa Clara County LEAs make the bulk of Chapter 26.5 referrals.²⁷ The decision to refer a student through the LEA for Chapter 26.5 services is made by the IEP team. Typically, the school psychologist handles the referral process, including obtaining parental consent for the 26.5 referral and collecting the materials necessary for the referral packet. In more involved cases, the LEA Program Specialist or Director of Special Education or Pupil Services may initiate and supervise the referral process.

After a referral packet is completed, it is forwarded to the LEA Special Education Administrator, who reviews the packet and completes the standardized cover memo used by CMH in Santa Clara County. The cover memo includes basic information, such as the student's special education classification, and a checklist of items to be included in the packet. The LEA administrator must send the packet to CMH within 24 hours of receiving it, which can be no more than three working days from the LEA's receipt of parental consent.

The Interagency Agreement spells out the required elements of the referral packet prepared by the LEA to be reviewed by CMH. Each packet must include, among other things, recent reports and assessments, an IEP, observations from school staff, and a form indicating parental consent to the referral. A referral packet must document the student's history of mental health problems; CMH will not conduct an initial assessment absent this showing. Packets for students who are described as aggressive, violent, or a danger to self must include a Functional Analysis plan.

The IEP requirement may theoretically be bypassed to allow concurrent assessment – for Special Education and Chapter 26.5 at the same time – but CMH training material clearly states this “requires justification.” Several parents and advocates report that, in practice, they are told that concurrent assessments are either not allowed or severely discouraged. This poses a problem for students who exhibit mental health problems suddenly, move from another LEA without complete records, or were not previously identified as disabled. These students with serious mental health problems may be forced to endure a “double timeline.”

Stakeholders identified several barriers that may arise during the referral process. Several educators feel assembling the referral packet is time consuming, and some stakeholders perceive the added work can be a disincentive for making a referral. Also, many educators are not familiar or comfortable with the Chapter 26.5 referral process. Some advocates believe understaffed LEAs cannot properly identify or assess mental health problems because school psychologists are not available to conduct the baseline testing required to make a complete referral. A few stakeholders believe reluctance about Chapter 26.5 referrals may be due to a fear that if a referral is made and services are denied the LEA will be responsible for providing services. Several stakeholders perceive financial concerns lead to a hesitancy to suggest or initiate the referral process.

²⁷ Group home residents are referred for 26.5 services by the County Office of Education (COE). CMH, Social Services, and the Probation Department are also able to make Chapter 26.5 referrals for students involved in other systems.

Once an LEA has sent out a referral packet, the matter is often considered by educators, parents, and advocates to be almost entirely in the hands of CMH. Many parents expect services to be forthcoming automatically, based on the LEA referral, without understanding a second agency with the authority to deny eligibility is now involved in the process. Several advocates and parents perceive that some LEAs do not follow-up with CMH, and there is sometimes no one at the LEA actively tracking the progress of the referral. As a result, delays occur. Many educators and advocates report bureaucratic delays may go unnoticed or un-addressed for a period of time due to poor communication between the two agencies. For example, the Interagency Agreement states “incomplete packets are returned to the referring LEA within four calendar days, with a request by telephone, for missing information.” Two educators report that in their experiences this procedure is not followed, and packets are returned, for reasons such as supposedly missing information, without an accompanying phone call or explanation.

Educators and CMH report another source of delay in the referral process is lack of cooperation from parents or trouble contacting parents in order for CMH to obtain the necessary parental consent to begin the assessment. If parents do not consent or cooperate, the referral is closed. The Interagency Agreement does not describe how or how often CMH attempts to contact parents to obtain their consent. In practice, CMH typically calls parents two or three times to follow-up. Several advocates and educators report some families are difficult to contact, and the need for a second consent from parents is a frequent obstacle to referrals. One advocate notes that parents may not understand that more is required of them after signing the initial consent to referral from the LEA, and therefore do not realize they should expect to be contacted by CMH.

Assessment

After receiving the referral packet CMH may determine an assessment is inappropriate or unwarranted for several reasons. In these cases, the referral packet is returned and the assessment does not begin. For instance, a packet that does not, in the judgment of CMH, demonstrate sufficient prior interventions by the LEA is returned. No official time frame is given for the LEA interventions prior to making a Chapter 26.5 referral, but CMH describes three to six months as the typical minimum period. Several educators and advocates agreed that this is their understanding of CMH’s requirements. In addition to returning incomplete or insufficient packets, which may be resubmitted, CMH may also determine a student should not be assessed at all. CMH may decide not to assess a student if CMH sees another explanation for the reported mental health problems, which it believes makes the student ineligible for Chapter 26.5 services. For example, if the referral packet indicates a primary substance abuse problem, e.g. a failed drug program, or a primary behavior problem, CMH might not assess the student.

The assessment process in Santa Clara is standardized, although each CMH clinician has some flexibility. There are three main outpatient clinics in Santa Clara, which conduct assessments, and the main clinic at Coyote Creek has four clinicians on staff as full-time Chapter 26.5 assessors. An assessment typically includes a face-to-face interview with parent and child, a review of information from collaborative sources, and a mental health assessment. According to CMH, middle and high school students are not usually observed in the classroom because they are too reactive to an adult watching them. When the CMH assessment is completed, a summary

report with a statement of eligibility and recommendation for treatment is sent to the LEA administrator.

The general consensus among stakeholders is that CMH complies with the 50-day timeline to complete the assessment report. Several educators report this is a marked improvement from a few years ago. Multiple educators also note that if there is a case that requires an expedited decision, they contact CMH officials directly and receive a timely response. Many parents and educators note that parents are not often informed enough to be an effective check on the assessment process, and some parents are unclear about the involvement of a second agency (CMH).

The assessment report completed by the CMH clinician typically includes a discussion of the student's medical and psychiatric history, education history, and family and social situation, and the presenting problem. Assessors are cautioned by CMH to "stick to symptoms" and eligibility determinations, and not to recommend the type or level of services. If mental health services are denied, the reasons are stated in the report. CMH notes a student's diagnosis is also not typically included in the assessment report out of confidentiality concerns about access to the student's cumulative file. Instead, the CMH clinician describes the symptoms at the IEP and will tell the parent and child the diagnosis, if requested.

Eligibility

The Chapter 26.5 legislative and administrative eligibility criteria provide only a basic framework for eligibility, and leave much open to interpretation on the county level. As a result, eligibility is one of the most contentious issues in Santa Clara County. CMH exercises wide discretion in deciding individual cases and exerts considerable influence on the understanding among county LEAs of the purpose and practices of Chapter 26.5. Indeed, the language of the Interagency Agreement demands wholesale acceptance of CMH recommendations regarding eligibility. "The IEP team shall accept the recommendation of the mental health representative regarding the need for related mental health services." The result is CMH operates as an effective veto on therapeutic mental health services, and is perceived by many educators and advocates to control the eligibility criteria, which are the foundation of the entire Chapter 26.5 process.

The potentially divisive effect of the perceived ambiguity and CMH's almost unilateral power is multiplied because of the significance of the eligibility determination. As one educator puts it, there are "needy, expensive, and complicated kids" who require lots of resources from multiple agencies and providers. Several stakeholders feel that LEAs and CMH both feel the expectations and demands on their agency's capacities are too high, and this breeds resentment. The interagency discord is particularly stark when an LEA refers a student for Chapter 26.5 services and she is found ineligible by CMH. The implications of the finding of ineligibility are large for the student, and also the LEA, which is now responsible to provide the mental health services it deemed necessary but CMH will not provide. According to many stakeholders, the high stakes, including funding responsibilities, sometimes fuel disagreements and tension between the agencies.

Philosophical differences and divergent views of Chapter 26.5 add to the potential for disputes. Most educators, parents and advocates view Chapter 26.5 as a support service that should be available to any student who cannot benefit from his education without mental health services. Many are frustrated when CMH finds a student ineligible for mental health services, when the IEP team already found a need. CMH, in contrast, takes a markedly more limited view of its role, and expects LEAs to provide mental health services to many more students than most LEAs currently do or expect to. CMH and at least one educator believe LEAs depend too heavily on CMH to provide mental health services to every student, and are too quick to refer cases to CMH in order to gain resources and services LEAs are responsible to provide.

Eligibility disputes

The vast majority of stakeholders sense CMH has the final word regarding eligibility, and several advocates and parents note that open disagreements between CMH and the LEA at the IEP meeting are rare. However, differences of opinion appear more frequently outside of IEP meetings. Many educators, parents, and advocates are unhappy because they sense CMH is restricting eligibility through explicit criteria and stricter scrutiny of referrals. The majority believes budget concerns are the impetus for CMH's narrowing eligibility criteria, and the result that more students found ineligible.

Most stakeholders perceive that the most contentious eligibility determinations involve students with behavior or conduct problems. Clinicians and educators both admit the distinction between behavior issues and mental health problems can be difficult, but the effects are major. Students designated as Oppositional Defiant, "socially maladjusted," or with another "conduct disorder" are markedly less likely to be found eligible for Chapter 26.5.

In addition to students with behavior problems, another source of eligibility disagreements frequently cited by educators is the lack of transparency in CMH's eligibility criteria and determinations. CMH and some LEA administrators feel CMH administrators are very clear in verbal and written communications regarding the agency's interpretation of eligibility for services under Chapter 26.5. In spite of these efforts at clarity, many educators, parents, and advocates report they do not understand eligibility, or indicate they operate under shared misunderstandings. For instance, several LEA administrators incorrectly believe that a student must be labeled ED to receive Chapter 26.5 services. Some stakeholders believe CMH is intentionally vague about the basis for its decisions. An experienced MFT says, "It is always clouded in mystery. It is very hard to pin CMH down, they don't want to say who is eligible because they are worried that magically all of these students will start fitting those criteria." Several stakeholders point to instances where CMH and LEAs use different or hard to reconcile vocabulary and designations, and report this leads to frustration, and sometimes mistrust of CMH by educators.

There is very little understanding of any formal resolution process for disputes over eligibility or services, although the Interagency Agreement provides for the fair hearing process used in special education disputes. Several educators report using informal mechanisms to resolve eligibility disputes between CMH and LEAs. Most CMH and LEA interviewees cite personal contacts or individual approaches as the most useful tools to resolve disagreements between agencies. CMH, in many instances, tries to collaborate with the LEA prior to the IEP

meeting at which CMH presents the eligibility determination. The Interagency Agreement advises “every effort will be made to resolve any disagreement between the mental health assessor and LEA, IEP team members.” CMH and many educators feel this is justified because it avoids open disputes in front of parents. A few perceive that avoiding formal disputes helps maintain good working relationships between the agencies who are repeat players in the Chapter 26.5 process.

Several parents and advocates are concerned that the informal process leaves them out of decision-making. They report parents rarely challenge the apparent agreement about eligibility between the agencies. Parents also sometimes do not understand or agree with CMH’s eligibility determination. The Interagency Agreement calls for the written assessment to be shared with the parent prior to an IEP. However, one advocate says all reports are pulled together at the last moments, denying parents an opportunity to review the materials before the IEP, and further alienating them from the entire process. If a student is found ineligible the Interagency Agreement requires CMH to attend an IEP to notify parents of CMH’s finding. This meeting may involve an explanation of the basis of the eligibility determination. However, some parents, advocates, and educators report they are sometimes left to guess the basis of a particular student’s eligibility determination.

Ineligibility for Services

CMH is fairly rigid about several populations it considers highly unlikely to be eligible for Chapter 26.5 services. For instance, students with a confirmed IQ below 70 are referred to San Andreas Regional Center and do not receive Chapter 26.5 services. Other students who are too young, developmentally delayed, Autistic, or otherwise believed to be unable to benefit from talk therapy – the only method used by CMH – are similarly ineligible. Students with drug and alcohol problems are also almost entirely excluded from Chapter 26.5. However, it is not an irrefutable presumption of ineligibility in all cases, and some stakeholders sense CMH is now more willing to assess certain students, such as Autistic students with Asperger’s syndrome, than in the past.

Service Delivery

Process of service delivery

If a student is found eligible through the assessment process for Chapter 26.5 services, CMH joins the IEP team. A description of the mental health services to be provided, including date of initiation, frequency, and duration of services, must also be prepared by CMH and included in the IEP. CMH emphasizes that it only makes recommendations regarding mental health services, not educational placements. For instance, CMH trains its staff not to say a student “needs an NPS” because that is an educational decision and might create unwanted financial obligations for at least one of the agencies.²⁸ A CMH training memo advises, “It is important we keep our roles clear and separate. Mental health should not make educational recommendations and Education should not make mental health recommendations. THIS CAN BE DANGEROUS.” A CMH administrator states CMH is very concerned not to bind the

²⁸ CMH also advises clinicians not to recommend Wraparound services, because a county committee, not CMH, determines eligibility for Wraparound.

agency to providing any particular services by including them on the IEP. Several educators, advocates, and parents perceive CMH's resistance.

Types of services available

Chapter 26.5 does not include the full panoply of mental health services provided by CMH, and many students receive services from CMH that are not covered by Chapter 26.5. Chapter 26.5 services are provided by CMH clinicians and by outside service providers who contract with CMH. The largest contractor is Eastfield Ming Quong (EMQ), which provides a wide range of therapeutic services for CMH under Chapter 26.5. At least four LEAs and the COE also contract with EMQ to provide school-based mental health services outside of the Chapter 26.5 framework. The Chapter 26.5 services available in Santa Clara generally fit into four main categories.

i. Case Management

At a minimum, CMH provides case management services for every student receiving Chapter 26.5 services. For many students, case management is the only service CMH provides. If possible, the CMH clinician who conducted the initial assessment remains on the IEP team as the case manager, and attends the on-going IEP meetings.

ii. Outpatient therapy

CMH outpatient therapy is not typically provided at the school site or during school hours, but more commonly in the afternoon and evening. Students are occasionally given school passes to attend therapy off-site during school, although a few educators note this disrupts the school day. CMH clinicians may visit clients at home. All four of the CMH clinics are open until at least 7 p.m. on weekdays, but none of the clinics are open on weekends. Some clinicians arrange to meet parents during the parent's lunch break. Clinicians are encouraged to accommodate the schedules of the student and the family as much as their caseloads allow.

iii. Special Day Classes and ED classrooms

CMH provides therapists for some SDCs and ED classrooms, often through a contract with a particular LEA. An LEA may also contract with the county to pay directly for a student's placement in the COE's programs, including its Adolescent Day Treatment and ED classrooms. Lastly, several LEA's contract with outside service providers for mental health and behavioral staff in ED classrooms.

iv. Residential placements

The requirements and process for a residential placement are stricter and more elaborate than other Chapter 26.5 services, and are described in detail in the Interagency Agreement. If residential placement is considered, an expanded IEP team meeting is held, at which CMH must be present, and an expanded IEP is drafted.

Service Gaps and alternatives or supplements to Chapter 26.5 services

Most stakeholders mention at least one gap in services offered under Chapter 26.5. The most commonly cited unmet needs include crisis counseling, substance abuse treatment, therapy appropriate for students with cognitive difficulties or who otherwise do not respond to talk therapy, and ED classrooms with therapy-in-the-milieu. Some LEAs are unable to fill some of these deficiencies. Many LEAs provide mental health services outside of Chapter 26.5, as acknowledged in the Interagency Agreement and confirmed in practice. Some LEAs directly employ counselors and psychologists who offer individual counseling and group therapy on school sites, contract with outside providers for these services, or contract with CMH, outside of Chapter 26.5. These services are typically open to all students, including general education students and special education students who are not eligible for Chapter 26.5 and not ED. There are also other non-Chapter 26.5 mental health services throughout the county that students may be able to access and to which LEAs refer students, such as community access clinics and psychiatric medications through Medi-Cal. An LEA may fund a student's non-Chapter 26.5 placement in an NPS, although several educators and advocates note LEAs' resistance to taking on this additional cost.

A few educators report their LEA provides its own services in lieu of CMH services because of past dissatisfaction with CMH and Chapter 26.5 services. One of the most significant alternatives to Chapter 26.5 is the Psychoeducational Support Team (PST) run by the South East Consortium SELPA to provide school-based mental health services. PST is comprised of an experienced special education teacher and an MFT. It provides support services and guidance for schools regarding the students in the program, and also provides direct mental health services for the students.

Inconsistent Services and Quality

The majority of stakeholders in Santa Clara County perceive the quality of the services under Chapter 26.5 to be unpredictable, and largely dependant on the abilities, experience, commitment, character, and training of the particular individuals involved. Several educators recall CMH workers who provided incredible services, and were integral to preventing a more restrictive placement. However, other educators cite cases in which exceptional CMH workers were removed from cases or stopped working with an LEA altogether.

CMH therapists are often student interns, working toward the practical hours needed to complete their degrees. Interns are typically supervised by a licensed therapist. Many educators, parents and advocates comment that the interns are inexperienced and sometimes poorly trained or supervised. They perceive that the range of quality among therapists is pronounced. Some educators complain that some clinicians are not involved enough, while other clinicians are so involved that it interferes with what the educators believe are their roles.

Several educators and parents report frequent personnel changes wreck havoc on the relationship between CMH and LEAs, and create substantial obstacles and setbacks in individual cases. One educator reports that in the past four school years there have been eight different therapists assigned to work with students in the ED classroom, and there were also months when there was no therapist at all for the classroom due to delays in assigning a new therapist.

Role of CMH Clinicians

Tension develops around the role of CMH clinicians who attend IEP meetings, particularly related to information shared between agencies about a student receiving Chapter 26.5 services, according to several educators and parents. CMH operates under different confidentiality regulations than LEAs, which prevent clinicians from violating therapist-patient confidences by sharing information learned during a therapy session or related to therapy. Educators and parents sometimes perceive the withholding of this information as counter-productive and an obstacle to the IEP team's full understanding of the mental health issues as they relate to education. Teachers and parents feel particularly left out, because the communication between agencies is often limited to administrators from each, and little is shared during IEP meetings. CMH may discuss issues regarding the student's work and progress in therapy more generally, and may offer techniques for addressing the student's mental health needs in school. However, several teachers complain they are given little or no guidance by CMH regarding students receiving Chapter 26.5 services in their classrooms.

Some educators, advocates, and parents sense CMH clinicians do not consistently attend IEP meetings for students receiving Chapter 26.5 services, or that getting CMH to attend on-going meetings can be difficult. According to a few advocates and educators, the clinician is not always prepared to report on goals and objectives that must be included and updated in the IEP. Several advocates, educators and parents perceive that the more involved CMH is in the services provided, and particularly the more services CMH is funding, the more active the CMH therapist or case manager is likely to be. Many educators, especially teachers and principals, express frustration that CMH does not see itself as a related support service for schools. Moreover, a few educators feel the medical/therapy model of CMH and other mental health service providers is essentially at odds with the education model, and no amount of regulations or interagency agreements can overcome that divide.

Parents

At times, parents can cause or add to delays or problems in service delivery. Parents may be hard for CMH to reach, they may resist the services offered, or they may experience difficulties supporting their child in therapy for a variety of reasons. Some programs, such as therapeutic classrooms, require active parent participation. If the parent is not willing or able to be involved, the student may not be eligible for the service or the service will be less successful. Parents may resist services in part because of lack of information about mental health and/or cultural barriers. One educator believes some parents resist mental health services because the parents are made to feel that they are to blame for the child's issue, or resist the stigma they associate with mental health problems. Other parents have their own mental health or other emotional issues that prevent them from being able to support their child. For some families, managing the appointments and the multiple agencies in their lives, of which the LEA and CMH are only two, can be overwhelming. The paperwork and transportation alone can be overwhelming. A few advocates, parents, and non-government service providers note LEAs and CMH require several seemingly redundant forms, such as the consent to assessment, background information, and exchange of information forms.

Conflicts over termination of services

Most stakeholders report that once services are in place, there are few conflicts. However, conflicts may arise regarding termination of Chapter 26.5 services. One advocate believes it is typically not an IEP team decision when to bring a student back from an NPS, and it often causes tension when CMH wants to return the student to the LEA school before the parent and the LEA believe she is ready. Many educators perceive one source of the tension is LEAs are left to figure out replacement and transition services after Chapter 26.5 services are terminated. Several stakeholders report the shifting of responsibility back to LEAs can create contentious IEPs regarding termination of services. A few parents feel they are sometimes caught in the middle because they do not know which agency has the student's best interests at heart.

Interagency Collaboration and Accountability

A working partnership between LEAs and County Mental Health (CMH) is foundational to Chapter 26.5. However, many stakeholders report fundamental tensions seemingly inherent in the relationship as established by Chapter 26.5 may at times overwhelm the collaborative intentions. The Interagency Agreement itself alternately promotes the team-based IEP process and yet grants one agency total control over a decision. Each agency wants to work together in some circumstances, particularly when the other agency is a source of professional expertise, funding streams, and additional resources. Many educators, in particular, are concerned that CMH does not become a true part of the IEP team, and CMH clinicians are not integrated into the student's education. At other times, each agency is concerned with demarcating divisions in order to shift responsibility for certain services and decisions to the other agency.

The budget constraints of each agency only further the friction, and stakeholders report each agency feels the demands on its capacity are too great given the patently insufficient funding. As one county official explained, "LEAs are really strapped, there are few resources, and they look to 26.5 as a last resort. When they are denied that, there is a lot of frustration because ultimately, the schools are responsible for making the services happen." On the other hand, CMH feels under siege by LEAs looking to the mental health agency to fill LEA service gaps not intended to be covered by Chapter 26.5. CMH insists Chapter 26.5 is not designed to provide general support to LEAs for all students with mental health or behavioral problems.

Many educators sense that the biggest barrier to true cooperation between CMH and LEAs is that LEAs remain ultimately responsible and liable for services, even those provided by CMH. Several educators expressed, with frustration, the idea that CMH can walk away from the IEP table at any time, but LEAs do not have that option. The frustration is exacerbated because the vast majority of educators feel there is no constructive way to formally challenge a CMH decision about eligibility, service delivery, or termination of services. Several parents and advocates also report that they typically turn to the LEAs regarding concerns about all related services, including Chapter 26.5, and do not hold CMH accountable.

Summary of Findings

Overall, this case study of school-based mental health studies in Santa Clara County revealed a lack of mutual understanding between education and mental health agencies. CMH has not been able to integrate itself into schools and IEP teams, while educators may not view mental health issues as an important component of education. CMH and LEAs disagree about eligibility criteria, and disagree about the appropriate role of Chapter 26.5 and the target population the program is intended to serve.

Operationally, redundant elements of the process create the opportunity for unnecessary bureaucratic delays and hurdles in accessing Chapter 26.5 services. The vast majority of services are provided off-site. As a result, logistical constraints such as limited clinic hours, location and transportation may create obstacles for students and families. Parents often have limited understanding of mental health issues or the Chapter 26.5 process, while teachers do not feel qualified to identify mental health needs or support students receiving Chapter 26.5 services.

Each agency is constrained by insufficient resources, and current practices and procedures create inappropriate incentives regarding provision of services, engendering interagency mistrust and at times resentment. As in San Mateo County, financial constraints are seen to result in a “narrowing” of CMH eligibility criteria for Chapter 26.5 services. Educators, parents and advocates perceive that CMH is not ultimately accountable for the services it provides, yet CMH is given an effective “veto” over whether or not to provide services. Formal mechanisms of dispute resolution are not well understood and are rarely used. CMH determinations are infrequently challenged, and informal decision-making often leaves parents and advocates out of the decision-making process.

Alameda County

Introduction

This case study reveals the various opinions regarding the effectiveness of Chapter 26.5 in practice in Alameda County from the main stakeholders involved in the process. CMH administrators generally view Chapter 26.5 as necessary to provide students with adequate mental health services that could not be delivered by an LEA alone. On the other hand, Chapter 26.5 forces CMH to cooperate with LEAs which frequently do not regard mental health issues as a high priority. Removing students with behavioral problems from the classroom is a high priority for school districts, and either a Chapter 26.5 referral and therapeutic placement or a juvenile detention center is the easiest and cheapest way to achieve this goal. The LEAs also consider Chapter 26.5 as a mechanism to shift many of the high costs of mental health services to CMH, but do not always recognize the importance of early detection and intervention in long term cost reduction. When CMH provides programs on the school site, the LEAs feel CMH is intruding into their space and adding even more costs to an already financially burdened system. Parents are not given sufficient information about the process and feel overwhelmed by the bureaucratic chaos they encounter when CMH steps into the picture. Advocates generally are frustrated by how little they believe the LEAs value mental health services and believe the districts are purposefully dragging their feet to identify and make referrals. Advocates on the whole are satisfied once services are provided by CMH, though they agree that a greater range of services are needed to meet the individualized needs of students.

This case study describes the course of a Chapter 26.5 referral implemented in Alameda County from the view of the major stakeholders of the process. The study leads from identification of a student in need of services, to referral, and finally to delivery of services. The case study highlights reoccurring issues presented by the stakeholders existing throughout all levels of the process, practical barriers to successful implementation, and recommendations to improve the process in the future.

Alameda County Demographics

Alameda is a large county with a population of 1,443,741 dominated by Oakland as its main metropolitan area. There are five SELPAs and twenty-two school districts in Alameda County, with Oakland having its own SELPA. It was reported that Oakland has more referrals countywide for Chapter 26.5 services than all of the other four SELPAs combined. The number of students enrolled in Alameda County schools in 2002-2003 was 218,041, with the largest ethnic groups amongst the students being white (28.8%), Hispanic or Latino (25.6%), and African American (18.6%).

Access to Services

Identification

Advocates, school administrators, and CMH administrators all reported that usually the student is identified as needing mental health services through Chapter 26.5 when the student is assessed for mental health needs as a related service pursuant to a pre-existing IEP. There is no single person or process responsible for identification throughout the county. One stakeholder stated “Alameda has 17 districts with their own identification procedures so it is mind boggling.” Usually the school psychologist would identify the need for an assessment at this level, though parents sometimes request an assessment. Some stakeholders feel parents are not likely to report mental health issues to the school because they are not aware that services are available through the school and the potential stigma from the community once their child is identified as having mental health problems.

If the student does not have a pre-existing IEP, stakeholders report that students are identified as needing mental health services when they have behavioral problems in school. A school administrator reported that it is uncommon for a student to be identified this way, and that most times, the student already has an IEP when they are identified. One advocate stated, “teachers only identify when there is a behavioral problem in the classroom.” Another advocate suspected that, “non-violent students with mental health problems probably don’t get identified.”

Several stakeholders revealed that school staff, including some special education staff, were usually not trained to identify mental health problems. One interviewee reported that in her experience there was no training of teachers and that many “don’t even know what 26.5 is.” One stakeholder stated that principals also needed to be better educated regarding mental health issues, “since their leadership sets the tone for the school.” Alternatively, school administrators believe that training of teachers and school site staff on mental health and identification was not necessary because there is a school psychologist at every school. One school administrator stated that because there was a school psychologist at school, “they didn’t miss anything.” Another school administrator stated, “the school psychologist brings their expertise to the IEP team.”

As noted, one area of concern in identifying students with mental health needs is how behavioral issues should be handled. Most stakeholders perceive a difference of opinion between the school administrators and the CMH administrators, advocates, and parents regarding behavioral problems in school. School administrators interviewed found behavioral disruptions in school to be more likely linked to discipline issues as opposed to mental health. One school administrator stated that discipline problems are about “behavioral issues more than DSM disorders,” and that children with discipline problems will receive appropriate services in juvenile detention centers.

On the other hand, parents, advocates and CMH administrators believe that the discipline issues are many times linked to mental health disorders and that students with behavioral problems should therefore be identified as needing to be assessed for Chapter 26.5 services. One parent stated, “services [for their child] were hard to get in the beginning because the school was

focusing on discipline issues instead of mental health.” One advocate stated, “schools would rather arrest students than refer [for Chapter 26.5 services] or have a behavioral plan.”

Finally, resource constraints reveal themselves at the identification stage, as some believe that identification must be limited due to resources. Several stakeholders reported that they believed teachers were at risk of losing their job or being disciplined if they identified a student as needing mental health services or offered services to parents. One school administrator reported that he/she felt pressure not to spend money. “Special ed is seen as a program that doesn’t pay for itself and an encroachment to the general ed budget.... [There is a] backlash for a behavioral disorder kid or NPS kid because that is \$35,000 that other students don’t get. If it takes a teacher and a social worker and an aide for one kid, that means the more mental health kids, the more money we spend.”

Referral

i. Referral Process

Once the IEP team determines that a Chapter 26.5 referral is necessary for the student to benefit from her education, the LEA case carrier, typically the school psychologist or resource specialist, initiates a referral to CMH and obtains parental consent. Before being referred for Chapter 26.5 services, the interagency agreement requires the school to attempt other interventions, such as counseling or guidance services. In cases in which the student has not been previously identified for special education services, the LEA case carrier may determine that these services are not appropriate and the school does not need to provide them as a precursor to Chapter 26.5 services. As one CMH administrator stated, “a student with mental health issues that has behavioral problems would not benefit from a behavioral plan.”

The interagency agreement requires the referral packet to contain reports and assessments from the past 3 years, school observations records, and a form indicating parental consent to the referral. The LEA case carrier will submit the referral packet to the LEA Director, along with the student’s latest IEP and referral face sheet form. The face sheet contains the student’s demographic information, such as immigration status, county of origin, and place of birth. The LEA Director will review, sign and forward the referral packet to Alameda CMH within five calendar days of parental consent.

Once CMH receives the referral packet from the LEA Director, it is reviewed and determined within five calendar days whether an assessment is necessary and whether the referral is complete. A county administrator reported that a very low percentage of referrals are rejected during this initial screening process and, when the referral is rejected, a referral receipt is sent out identifying the missing information or the reasons the assessment was denied.

After CMH determines an assessment is required, an assessment plan including a parental consent form is produced within fifteen days of receiving the referral. If no parental consent for assessment is received within 30 days, CMH will send a reminder to the parents with a copy to the LEA. If sixty days passes with no parental consent, the LEA is informed and the case is usually closed. One CMH administrator stated that in the past, CMH has placed tape flags in the spaces the parent should sign in order to make the process easier for parents with learning or

developmental disabilities. CMH would also occasionally show the parent a generic cover sheet at an IEP meeting to show them where they would sign. Despite these efforts, one CMH administrator reported that there are instances in which the parents cannot be reached and the referral is sent back to the LEA.

Following receipt of parental consent, an assessor is assigned to complete an evaluation of the student within 50 days. A pool of twenty independent assessors is on-call with CMH. Typically the assessor conducts a home visit and school observation and contacts the school, parents, and other providers. The assessor then completes an assessment report, typically two pages long, which reports eligibility and recommended services and goals. One of two managers (one supervises residential case managers and one supervises day treatment) reviews the report and signs off before sending to the school district, LEA case carrier, and parents.

ii. Referral Timelines

Stakeholders had varied responses as to whether the timelines set for the referral process by the regulations and the interagency agreements are usually met. One CMH administrator stated that “the timelines are usually met, but that the process just seemed slow to the school and parents.” One advocate stated that timelines are met more than people allege. In contrast, one CMH administrator stated that timelines are at times hard to meet because there are 17 school districts and many referrals to deal with. One advocate reported that in his opinion, Alameda had a particular problem with delay. A parent stated that she was not informed at any time what the timelines were. Several stakeholders felt the timelines were too long and that many times parents give up on the process.

Some offered explanations for delays. CMH administrators found that the large number of referrals contributed to the delay, along with incomplete packets sent by LEAs. Furthermore, one CMH administrator stated that “disorganized parents slowed down the process” when they did not sign off on assessment plans.

Several stakeholders reported that there is a backlog of referrals at the end of the year because behavioral problems typically emerge at that time. These late spring referrals interrupt the timeline requirements. One CMH administrator said that the referrals that backlog at the end of the year get done over the summer, but that is hard to contact school district administrators, teachers or staff at this time of the year, slowing down the process further. Another CMH administrator stated that when there is a backlog at the end of the year, they aren’t able to send the student to the best fit among placement options.

iii. Stakeholder Participation in the Referral Process

Parents and advocates interviewed felt that many parents feel powerless and confused during the referral process. One parent reported that CMH did not follow up with them after the referral and that the forms given to them were unclear. This parent felt the need to eventually hire a lawyer to navigate the system. Several advocates reported that the process can be confusing for parents with a disability or non-English speaking parents and that at times advocates or lawyers were necessary to obtain services for students.

Several stakeholders reported that, to ensure efficiency in the referral process, school case managers are assigned to each referral to keep track of its progress. The case carrier usually serves as the case manager, which is most times the school psychologist. If the student is sent to an NPS, usually a program specialist is assigned from the LEA to manage the case. Other stakeholders reported that there was a lack of adequate case management and that no single person was responsible for keeping track of a referral's progress.

Despite participation from many stakeholders, the County Mental Health agency has final say as to whether and what services are recommended. The interagency agreement states "the IEP shall accept the recommendation of the mental health professional as their own." Several stakeholders reported that there are rarely disagreements between the county and the LEA regarding services to be provided. When there are disagreements, they "very rarely go to fairness hearings or mediation." In the end, "the county always wins, but parents have the right to due process."

Assessment and Eligibility

One striking finding of this study is that the criteria employed by CMH for eligibility for Chapter 26.5 mental health services appear to differ from the standard that LEAs and IEP teams employ when making referral decisions. The IEP team determines whether services are necessary for the student to benefit from his education, while CMH determines whether the student has a DSM-IV diagnosis and needs mental health services. One CMH administrator stated that they usually don't turn away students that are in need of some mental health care, even if they don't feel that the condition warranted Chapter 26.5 coverage. Such students are steered into non-Chapter 26.5 mental health services. Of course, this begs the question of what those non-Chapter 26.5 services are and whether the student is entitled to them under the IDEA.

Several interviewees stated that while the criteria for eligibility are set by "law," these criteria have a range of interpretations depending on the assessor. It should be noted that no interviewees articulated those "legal" standards. One school administrator stated that the criteria "were as consistent as the assessor." One CMH administrator stated that because assessors must place students in pre-determined levels of service, this creates the sense of rigid criteria to be followed.

Funding responsibilities

The county mental health department is funded by the California Department of Mental Health, which channels money to the County of Alameda. The County of Alameda only runs a few special education programs and basically acts as funnel through which money is passed. As with other counties, a complete moratorium on funding for Chapter 26.5 services has left the mandate unfunded in the recent past. Moreover, state reimbursements due pursuant to the mandate reimbursement process have been effectively frozen. Notwithstanding these fiscal constraints, one CMH administrator stated that efficient departments in Alameda gain some savings that help with funding concerns. Last year Alameda CMH dipped into "rainy day funds" in order to fund mental health services.

Recently, additional federal money has been distributed to the County Office of Education, but the Alameda CMH had not received the money when personnel were interviewed. A county mental health administrator reported that the process of obtaining the federal money was unclear and that there is a “lack of information or resources on getting funding.” Though the money has not yet been distributed, most stakeholders reported that CMH is not currently running differently because of funding. One CMH administrator stated that they haven’t lost any staff yet.

Service Delivery

Types of Services

There are several levels of services available to students eligible for Chapter 26.5 services. The first level is outpatient services, which involves counseling provided either at the school or at a clinic. In this scenario, the student could remain in the general education classroom, and could also be assigned a resource specialist or a 1:1 aide. The next level is a special day classroom or an ED classroom. The ED class mental health services are usually provided by the County through Chapter 26.5. The third level is the counseling enriched class (also dubbed “therapy in the milieu”), which has a social worker or therapist involved with the class. The next level of treatment is non-public school day treatment, in which a student receives services at a non-public school with a major counseling component. The last level of services is residential treatment, in which the student lives out of the home and receives mental health treatment.

There were several stakeholders interviewed that reported that two large districts in the county had no counseling enriched special day class approved by CMH. This leaves a gap of services between special day class and non-public school day treatment, resulting in students possibly being assigned to a level of services more or less than intensive desired. One CMH administrator reported that the classrooms offered by these districts as counseling enriched classes were not run by clinicians and therefore the county would not approve them for Chapter 26.5 referral. These stakeholders believe these districts continue to run these classrooms as a non-Chapter 26.5 funded option.

There are also several other non-Chapter 26.5 options provided by LEAs through the IEP process. The Oakland SELPA has several counseling programs generally geared towards general education students with mental health needs or used as a preventative intervention prior to Chapter 26.5 services. The services available in Oakland are outpatient care, a counseling enriched program and a school-based day treatment program staffed by teachers and non-public mental health service providers. Berkeley has a school clinic in which a therapist comes to the school. One parent reported that this arrangement was convenient for parents and students. Pleasanton also has counselors and high-risk counselors available to students.

Several stakeholders reported a lack of available services for high-needs children. One CMH administrator reported that there are not enough locked facilities in California and that students therefore must cycle in and out of juvenile justice halls in order to be protected from themselves or others. Several people reported that there are not enough day treatment facilities available, causing the referral process to be slowed down considerably. Others reported that

placements were frequently not available and students were placed in a holding pattern. Students waiting for placement sometimes cycle in and out of juvenile detention centers unless they are lucky enough to receive an interim placement.

Service Quality Issues

CMH administrators, advocates and parents reported issues with staff training and adequacy. One CMH administrator reported that “ED classrooms aren’t adequately staffed so they have to move students to a higher level of treatment to get them out of an inappropriate class.” Stakeholders also reported that some schools don’t have social workers or counselors on staff, only a school psychologist who is trained in assessment and not counseling. Several stakeholders reported that the turnover rate of mental health workers and therapists is a huge problem. One parent reported that the therapist for their child left without adequate transition after graduating from school. This abrupt transfer sidetracked the student’s progress and could have been prevented with proper transition planning.

CMH administrators, parents and advocates also reported a lack of adequate training for teachers, counselors and other school site staff regarding mental health issues. This training would be helpful for mainstreaming students and avoiding stigma for students with mental health needs.

Several stakeholders believe that Chapter 26.5 and the least restrictive environment (LRE) requirements of the IDEA are at times at odds with each other. For example, day treatment rules don’t allow students to be mainstreamed in a regular classroom while receiving continuous therapeutic therapy, even if the general classroom would be the best fit for the student. Stakeholders report that not being able to leave day treatment hurts the students’ social and academic skills. Also, in most instances, residential treatment does not allow the student to transition back to the general classroom while in treatment. If the student requires residential treatment solely as a means of removing the student from her home (which is not necessarily an educational decision), a general classroom could be an appropriate educational placement. Oftentimes, however, such students are enrolled in non-public day treatment programs. One stakeholder reported this was because residential treatment facilities sell their programs as a package of both residential and school services because group homes would not make enough money only providing residential treatment.

Accessibility of Services

Accessibility of services was a common concern among stakeholders. One parent stated that the psychiatrist his child was assigned was not in his community, requiring them to travel far away to receive outpatient services. Another CMH administrator stated “transportation is the biggest problem in outpatient services.” Though a school bus service can transport the student after school to a clinic, there is no funding for transportation from the clinic to the student’s home. One stakeholder reported that there are outpatient clinics filled with appointments but no patients because of transportation issues, wasting valuable resources for the county.

Most stakeholders believe Chapter 26.5 services provided on-site at schools are the most effective because of convenience and accessibility for parents and students. Alameda County is

currently working to provide more school-site services through Chapter 26.5. But many stakeholders reported problems of adequate space and cooperation from schools. One CMH administrator reported that at one point counseling sessions had to be given on the playground, or if it was raining, in the hallway. The school in this case did not provide an office or even a desk for the counselor to use. Stakeholders believe that the school doesn't value the services provided by the county enough to even give them space on campus, regardless of the fact that the interagency agreement requires them to do so.

Interagency Collaboration and Accountability

This case study revealed varying opinions as to the level of cooperation between CMH and LEAs in Alameda County. Both CMH administrators and school administrators reported that the relationship was productive and that both sides accept CMH service recommendation without arguments. One CMH administrator said that at one time, the relationship was more adversarial and that both sides "would pick on who was not following the rules and who was spending money," but that now cooperation among agencies is working well. One school administrator reported that Alameda interagency cooperation was faring better than other counties he had been employed with in the past. Though cooperation seems to be working well, one CMH administrator reported that "now that times are harder financially, it will probably be harder to come to mutual agreements. For example, if a school wants an NPS but the school doesn't want to pay."

On the other hand, several advocates expressed that CMH and LEAs do not get along at times. One school administrator believed that the county just advocates for the parents. Another advocate stated that in her opinion, "the school doesn't like CMH coming to the school and changing things."

There are varying opinions among stakeholders regarding accountability among the agencies during the referral and service delivery process. School administrators feel there is sufficient accountability for the LEA because they share responsibility with CMH financially and for oversight of the programs. Another school administrator reported that the LEA and county mental health have regular meetings with CMH in which they keep each other aware of problems to keep each side accountable. Yet several advocates believe that the power structure allows for too much autonomy among agencies and districts and not enough accountability to parents. One advocate stated that "with more agencies, there are inevitably more complications and more scapegoats."

Summary of Findings

This case study of school-based mental health services in Alameda County supports several of our findings regarding the implementation of Chapter 26.5. As with San Mateo and Santa Clara Counties, budget constraints are beginning to have a significant and detrimental effect on the provision of required mental health services to special education students. Stakeholders report pressure on the system not to identify students who might need expensive Chapter 26.5 services, and both LEAs and CMH are unable to provide the full range of services needed to meet the individualized needs of students.

Similar to the other counties, the Chapter 26.5 system in Alameda relies upon parents and teachers to identify students who might need mental health interventions. Yet, parents are not adequately informed about mental health issues, the services available under Chapter 26.5, or the process for accessing those services. Similarly, the case study revealed a lack of adequate training for teachers or school-site staff regarding mental health identification or mainstreaming. Moreover, education personnel tended to approach behavioral issues as matters of discipline, rather than as possible mental health issues.

At the level of implementation, services are not made adequately accessible to students and parents. Mental health professionals report that space is not made available on-site at schools. Services are frequently provided at inconvenient locations and a substantial number of appointments are not met due to transportation problems. As a result, the system bears the full cost of providing the services, but students often do not receive or benefit from the services being provided.

Part VII

Findings and Recommendations

Our research sought to identify the barriers that impede effective mental health service delivery to special education students in California. Towards this end, we reviewed the state level context, including legal, fiscal and policy constraints, as well as local level implementation of Chapter 26.5 services in three counties. Our research supports a number of findings and recommendations, which we present below. We offer these recommendations in the hope that they can contribute to future reforms of the Chapter 26.5 system.

Recommendation #1: Increased, early involvement of mental health professionals in the special education process and a mental health presence in every school.

Our research supports the finding that mental health services are best provided by mental health professionals. Despite the shortcomings of the Chapter 26.5 system, stakeholders consistently expressed concerns over any alternative that would transfer primary responsibility for mental health issues to any agency whose primary business is not mental health. Mental health professionals respect and understand mental health issues in a way that other stakeholders cannot.

At the same time, our research clearly revealed substantial gaps in the provision of mental health services under the existing framework. Chapter 26.5 services have been effective in providing services to students with the most acute and obvious mental health needs. However, this focus on high-cost, high-intensity crisis interventions for the most severe cases has come at the expense of prevention and early intervention strategies, which are also more cost-efficient in the long run. Despite requirements that schools exhaust local treatment options before turning to Chapter 26.5, many LEAs provide no mental health services whatsoever. Many times, students with mental health needs go unnoticed until their problems reach a crisis level, when they might have been effectively addressed with early intervention.

Our first recommendation is for increased involvement of mental health professionals at all stages of school-based mental health service delivery. CMH agencies should seek to have a presence in every school and on every IEP team. This involvement should begin at the initial multi-disciplinary team assessment of students with suspected disabilities. To the greatest extent practicable, CMH personnel should be fully integrated into the school community. Such a presence can bring more consistency and expertise to the process of identifying students with potential mental health needs and can shift the focus from high-cost crisis interventions to more cost-efficient prevention and early intervention. While this may not have been the original design of the Chapter 26.5 framework, this shift in focus is appropriate given the history of the program to date. Clearly, this recommendation poses significant challenges, among them funding, staffing, and determination of lines of authority and accountability. Yet, anecdotal evidence collected during our research suggests that such models are being employed in certain counties across the state, to the benefit of the students served in those counties.

Recommendation #2: Remove obvious barriers to access that prevent students from benefiting from mental health services

Our research revealed a surprising number of access barriers that prevent students from benefiting from the mental health services provided as part of their IEPs. Counseling appointments are often scheduled at inconvenient times, at inconvenient places, and without effective means of transportation. As a result, many students and families are unable to fulfill scheduled appointments, services are wasted, and students remain without services.

Our second recommendation is to remove these obvious access barriers. As local interagency agreements provide, schools must provide adequate on-site office space for mental health professionals. Wherever possible, mental health services should be delivered on-site at a student's school in appropriate settings at appropriate times. Similarly, mental health agencies and LEAs should review current practices and identify other logistical barriers that prevent or impede access by students to services included in their IEPs.

Recommendation #3: Streamlining of procedures and practices

At the level of implementation, LEAs and mental health agencies often operate under different procedures and practices that may result in delay or denial of services, or at the very least, confusion and a lack of transparency. The county case studies revealed that CMH agencies and LEAs often use differing criteria to determine eligibility for Chapter 26.5 services. Similarly, the agencies may have differing views as to the duration or termination of services. Other bureaucratic hurdles such as the potential for "double timelines," ineffective means of seeking parental consent, or, in the case of San Mateo County, the Collaborative Consultation phase, may create unnecessary time delays.

Our third recommendation is to streamline procedures and practices between mental health and special education agencies. Agencies should align eligibility criteria, as well as criteria for determining when such services should be terminated, to eliminate inconsistencies. Agencies should eliminate other administrative obstacles that create unnecessary delay, such as double timelines. Local practices and procedures should be audited to ensure that eligibility and service delivery decisions are made as efficiently as possible. The presence of CMH personnel on the IEP team from the outset, as we recommend above, should also help to achieve this recommendation.

Recommendation #4: Expanded case management services to increase accountability and responsibility.

Our research revealed underlying structural challenges of accountability and responsibility in the operation of the Chapter 26.5 system. Across the board, stakeholders reported the perception that LEAs take no responsibility for students once a referral is made for Chapter 26.5 services. At the same time, stakeholders were frustrated by the effective veto power of CMH. Parents and advocates reported that, more and more, decisions are being made by LEAs and CMH outside of the IEP process, to the exclusion of parents and advocates. Students can easily fall through the cracks, or may face logistical challenges in accessing their

services as noted above, or may simply not benefit from the services being provided. Our research found little in the way of organized systems of evaluation and accountability.

Our fourth recommendation is to expand the use and role of case managers for every student with mental health needs. Ideally, this case manager would not be the service provider, but rather a separate individual in the LEA with overall responsibility for making sure that the system is working for the student -- that the process is moving forward during the eligibility phase, that timelines are being met, that services are being provided, and that the student is able to access those services. A case manager would also provide a clear point of contact and accountability for parents when questions or concerns arise. Significantly, the case manager would ensure that all students recommended for mental health services by an IEP team are provided those services regardless of whether the student is found eligible for Chapter 26.5 services. Many CMH agencies already employ a case manager model, particularly for students with more severe mental health issues and more costly or intensive services. We recommend that LEAs employ case management and that case management services are expanded to include all students with mental health needs at all stages of the process.

Recommendation #5: Training and information for parents, teachers and agency personnel

The county case studies revealed that the Chapter 26.5 system depends upon teachers and parents for initial identification of students with potential mental health problems. At the same time, parents and teachers reported that they were unfamiliar with mental health issues, often unaware of the services available under Chapter 26.5, and either uninformed or misinformed about how the Chapter 26.5 system operates. Data analysis confirmed that Chapter 26.5 programs continue to disproportionately under-serve minority communities. Our interviews confirmed a belief among many educators that behavioral issues are best addressed through discipline, rather than perhaps signaling an underlying mental health problem. Similarly, the different legal and organizational mandates and a lack of understanding among LEAs and CMH agencies seem at least in part responsible for tension between agencies where it exists.

Our fifth recommendation is for increased training, outreach and information. While our recommendation for a CMH presence in every school will shift some responsibility for identification of mental health problems, parents and teachers will no doubt continue to serve as the front-line in identifying students who may require mental health services. Parents should be provided with training on the availability of services, their rights, and how to access those services. In particular, resource parents provided to assist parents in navigating the system should be fully trained on the Chapter 26.5 system. Teachers should receive more substantial training on identification and eligibility for mental health services. Agencies should also participate in cross-training, on legal mandates, eligibility criteria, and transparency of funding. Finally, all LEA and agency personnel involved with Chapter 26.5 should be trained to recognize potential mental health needs across cultural and linguistic groups and to conduct outreach to underserved communities.

Recommendation #6: Better data collection, monitoring, and oversights at the state level

Our research suggests that data collection practices regarding 26.5 services have improved in the past several years. Much of that data is presented in the earlier sections of this

report. At the same time, stakeholders consistently pointed to the absence of meaningful data at the state level. This suggests three things: first, that the data already being collected should be disseminated more effectively to stakeholders; second, some of the most relevant data remain uncollected and unavailable; and third, the CDE's compliance monitoring and enforcement efforts are necessarily hampered by insufficient data collection and analysis.

Our sixth recommendation is for enhanced monitoring and oversight by the CDE and better data collection and analysis by both the CDE and the DMH at the state level. Ultimate legal responsibility for ensuring that students receive a free, appropriate education, including mental health related services when necessary, lies with the state educational agency, *i.e.*, the CDE. Our research revealed, however, that the CDE currently does very little to collect data on and monitor the delivery of mental health services. The data already being collected -- largely by the DMH -- should be supplemented by county- and LEA-level statistics including the number of Chapter 26.5 referrals, the number of denials or rejections and the reasons why, the types of services offered, and the frequency and duration of services. Data collection should also include an inventory of programs and services developed and employed across the state, as well as the collection at the state level of local interagency agreements. With data in hand, the CDE will better be able to monitor local education agencies, engage in more focused monitoring, and institute corrective actions where systemic non-compliance exists.

Equally important, best practices should be collected, analyzed and disseminated across the state. Our research uncovered a variety of interesting models -- from local interagency working groups to unique approaches to service delivery. Sharing these best practices -- particularly during a time of fiscal crisis -- may help struggling counties and LEAs to find more effective, more efficient ways to provide services to students.

Recommendation #7: Adequate funding for school-based mental health

One clear finding from our research is that the challenges facing the Chapter 26.5 system are about more than money. Yet, it is equally obvious that the current fiscal crisis poses an insurmountable challenge to counties and LEAs in their efforts to provide mental health services to special education students. Legal challenges in Tuolumne, San Diego, and Contra Costa Counties, among others, signal that the current situation is simply unsustainable. Counties have increasingly found that they are unable to continue to provide services without increased levels of state support.

Our last recommendation is for adequate state funding for school-based mental health services. Such funding is necessary to prevent an even larger crisis in the school-based mental health system. Many of the recommendations we have put forward above will require some amount of additional funding. No doubt, this is a tall order at a time of state fiscal crisis. At the same time, however, it is inescapable. As a matter of policy, students with mental health needs deserve the services that will help them to benefit from their education; as a matter of law, the state and LEAs are obligated to provide such services. Moreover, we believe that an initial investment by the state can result in dramatically improved school-based mental health services, not to mention substantial savings down the road.