



Testimony to House K-12 Budget Committee on HB 2395

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Madam Chair and members of the Committee, my name is Kyle Kessler. I am the Executive Director for the Association of Community Mental Health Centers of Kansas, Inc. The Association represents the 26 licensed Community Mental Health Centers (CMHCs) in Kansas that provide behavioral health services in all 105 counties, 24-hours a day, seven days a week. In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. As part of the licensing regulations, CMHCs are required to provide services to all Kansans who need them, regardless of their ability to pay. This makes the community mental health system the “safety net” for Kansans with behavioral health needs.

We appreciate the opportunity to testify in support of the school mental health program provisions in HB 2395. Through the School Mental Health Pilot established by the 2018 Kansas Legislature, many lessons have been learned that support the need for the program to be expanded on a statewide basis.

Our initial goal as it related to working with schools was to provide treatment and track the behavioral health needs of two groups of youth.

The first group consists of youth who are Children in Need of Care (CINC) in state custody. They may have multiple placements that may range from one end of the state to another or one end of a school district to the other. These children are often unintentionally forgotten but pose significant challenges to education and health systems in the communities where they reside through no fault of their own.

The second group consists of youth who may move from time to time but just as likely may reside in one school district throughout their education. These are youth who need more behavioral health treatment outside of the normal school day, whether that is after 5:00 PM on a weekday, on the weekend, or during the summer.

Both of these groups could have their behavioral health needs met by CMHCs in coordination and cooperation with the school districts. The formula for establishing funding and tracking student needs and progress in the Pilot was achieved by establishing the geographic boundaries that currently exist for school districts and CMHCs. Once the program boundaries were established, the identified workforce was established. Simply stated, we do not have the workforce capacity to set up parallel behavioral health systems in our state, which would add inefficiencies and break the

continuity of care. With this project, schools can focus on education, and CMHCs can focus on treatment and improving care. CMHCs also have crisis services available 24 hours a day, seven days a week, year-round. Wrap-around case management services are part of the array as well.

The data will be compelling, but the stories and experiences with the Pilot have been inspiring. From numerous interventions with students who had suicidal ideation, up to and including a plan and date for attempting suicide, to reports of abuse or neglect on youth in foster care that resulted in the need for a change in placement. Those working in the Pilot are not just improving lives, they are saving them.

As the Pilot launched, it became clear that students who may not be part of the aforementioned priority groups might need services as well. Even prior to the launch, a superintendent mentioned that a kindergarten teacher could spend 90 percent of her or his time, working with the behaviors of one student. This creates a strain on the teacher as well as the overall learning opportunities for other students in the classroom.

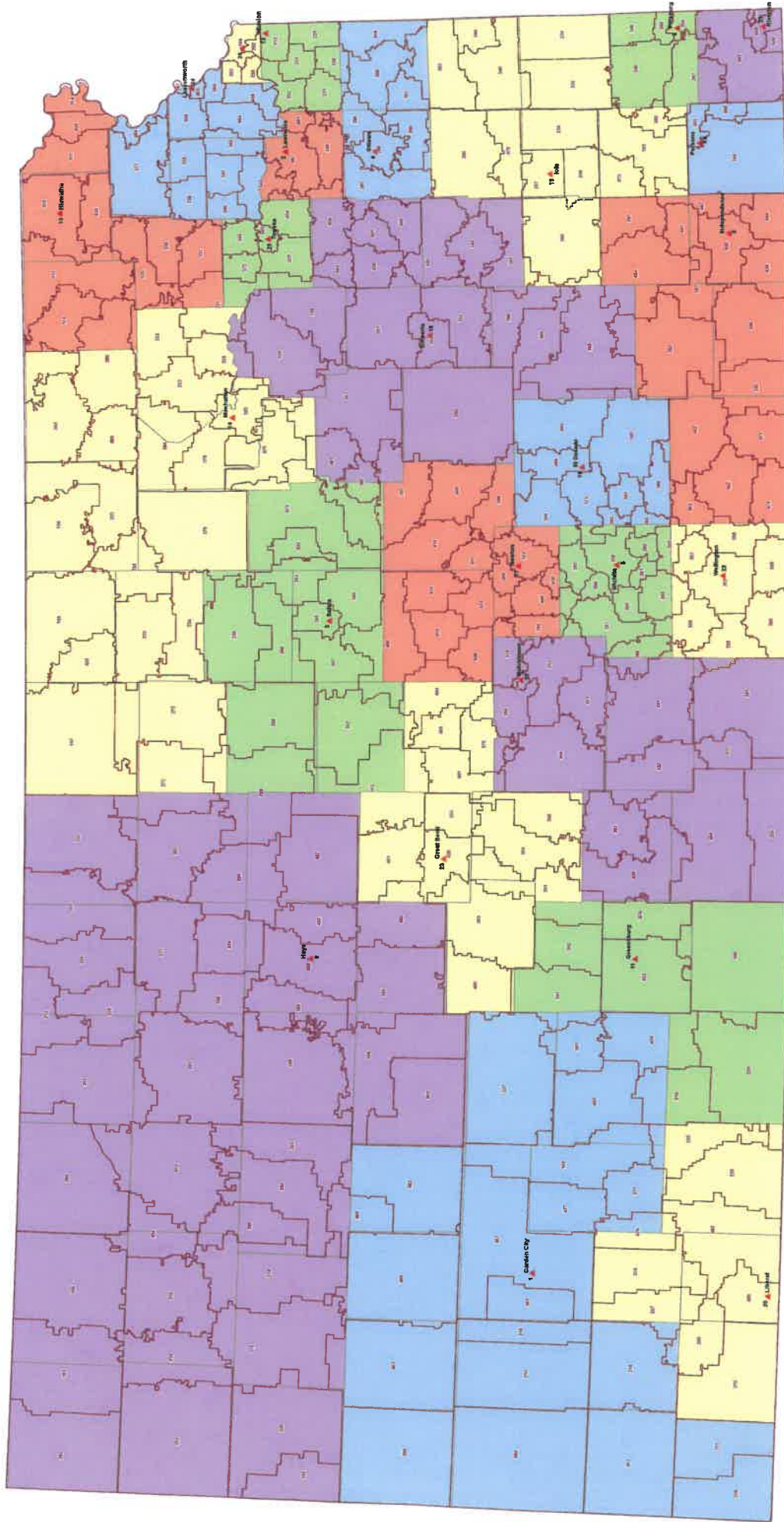
Part of the work in the Pilot has been working out the mechanics such as the federal Health Insurance Portability and Accountability Act (HIPAA) that governs privacy on the health care side and the federal Family Educational Rights and Privacy Act (FERPA) on the education side. When a parent consents, this allows information to flow between the school district and CMHC. CMHCs have a long history of working with students, especially providing case management, and the difference in the Pilot is the MOU and release to share information among the professionals working with the students.

We believe that we are seeing and will continue to see improvements in the behavioral health of students and the collective classroom cultures of the respective school districts while lowering stress and burnout of teachers resulting both in improvement of the Kansas education system and the Kansas behavioral health system. Based on the latest data, 75 percent of students involved with the pilot have improved attendance reports, 74 percent have shown improved behavior, and 61 percent have improved academic performance. Over 2,000 students have been referred to the program in the six pilot districts during the 2018-2019 school year thus far. We believe that we can conservatively estimate that over 8,000 students would be referred to the program if it is expanded as intended in HB 2395.

We would recommend that the weighting be corrected in HB 2395 to the amount of 0.015 in order to accurately reflect what we believe was the intent of the bill.

Thank you for the opportunity to appear before the Committee today in support of the school mental health program provisions of HB 2395, and I will stand for questions at the appropriate time.

Community Mental Health Centers of Kansas Kansas School Districts



▲ Main Centers
□ School District Boundary

JOHNSON COUNTY
Date of 2018 Reapportionment
February 15, 2019

