Intentional teaching and planning for California's diverse learners to allow each child an opportunity to achieve

The EDge newsletter

Volume 34, No. 1, Spring 2020

Social-emotional and Behavioral Health

What's Inside . . .

Letter from the State Director 3

Behavioral Health in Schools 4

California PBIS Coalition 8

Inside PBIS 11

UDL and PBIS 12

School-based Services:

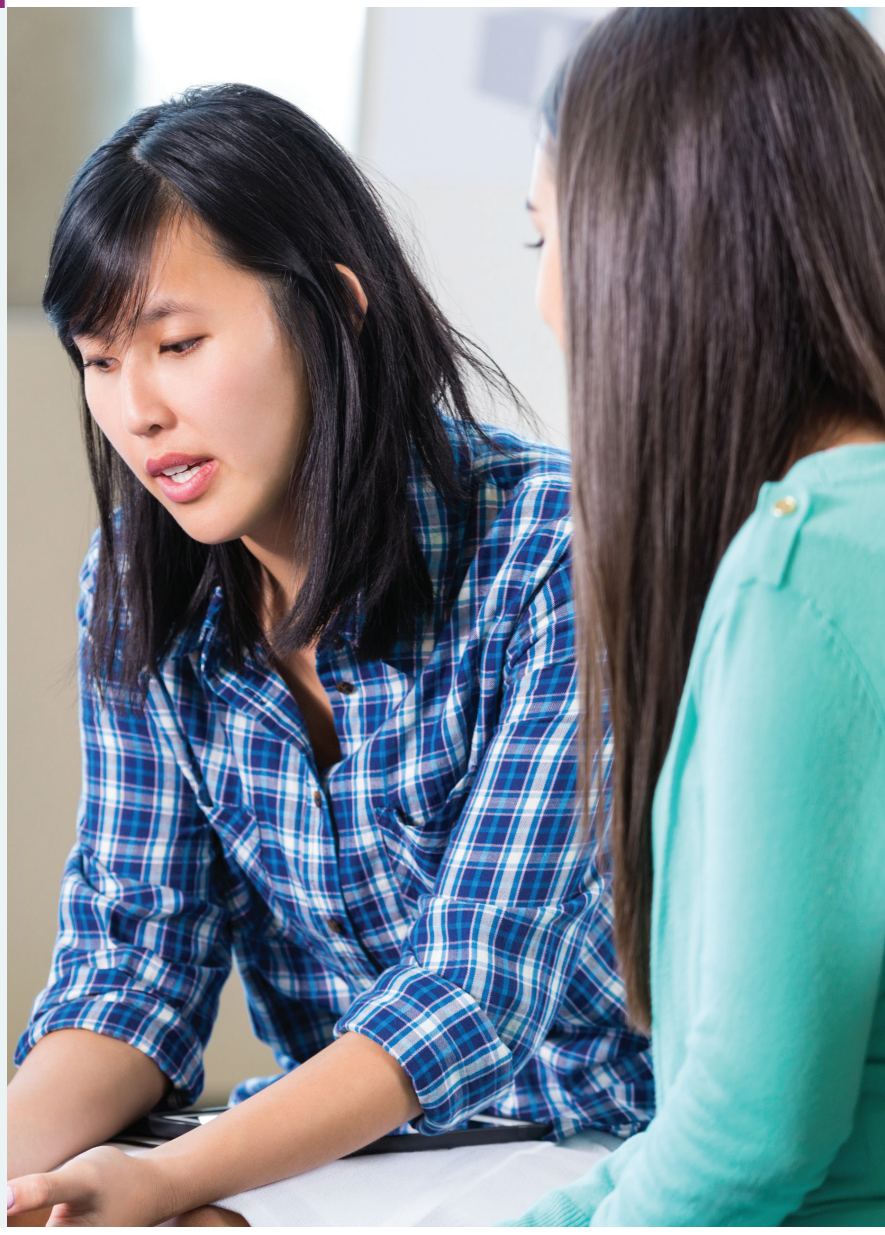
Desert/Mountain SELPA 17

Monterey County 22

Breaking Barriers: Progress in Coordinating Systems 26

The Finances of Behavioral, Social-Emotional, and Mental Health 30

This issue of The EDge *examines the importance of social, emotional, behavioral, and mental health for students—how these forms of health are critical to school success; how local educational agencies and counties are working together to provide services; how school systems can better promote services; and what California is doing to make these services more equitable and effective across the state.*



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Letter from the State Director

This issue of *The EDge* was conceptualized before our world was turned upside down by the COVID-19 pandemic. In such a short time, we were thrust into a new normal, new routines, and new ways of engagement and learning. The impact on all of our students has been profound, and the need for innovation in supporting students with disabilities has never been more critical. The articles in this issue highlight strategies and systems for supporting social-emotional, behavioral, and mental wellness for our students. We are going to need these supports more than ever as ensuring wellness has newfound significance today.

Navigating the pandemic and the vast changes to our educational system has depended on humanity, kindness, empathy, and resolve. Students have been abruptly disconnected from their classrooms, schedules, graduations, services, teachers, and friends. Educators have pressed on, without a roadmap for practice, to provide instruction in a completely different way. Parents have had to pivot between the demands of working remotely and simultaneously supporting their children as they learn from home. The way each student and family has experienced the shift is personal and unique.

The California Department of Education has mobilized in many ways to create the resources and guidance urgently needed by educators, service providers, and families. These resources can be found on the CDE webpage: *https://www.cde.ca.gov/ls/he/hn/coronavirus.asp*.

Much remains unknown as we head into summer and look toward the fall. What we do know is that the social-emotional, behavioral, and mental wellness of our students—now and when they return to school—deserves thoughtful and deliberate consideration. We have an opportunity to rethink the systems that serve our children and families. The articles in this issue highlight creative cross-agency partnerships and initiatives aimed at supporting the whole child, all in the name of wellness. Building the relationships and structures necessary to be collectively nimble in addressing the ever-changing needs of a child is exactly what we need in order to overcome the challenges ahead.

It has been a great honor to serve as California's State Director of Special Education for the past four years. I've had the privilege of meeting hundreds of amazing teachers, students, and families who are trailblazing in their own local communities. Like many, I have spent time during this pandemic reflecting on my own path and have decided to embark on a new professional journey. While I will continue to pursue my passion for improving our system of education for all students, I will be working from a more local vantage point. Rest assured, students with disabilities across the state remain supported by the champions at the California Department of Education as well as by teachers and leaders throughout local educational agencies across the state. It is my greatest hope that we use the opportunity the pandemic affords us to pause, reflect, rethink, and rebuild our system with an eye on equity and accessibility and a re-energized commitment to honoring the incredible diversity and gifts of each of our students. The commitment and grit I've witnessed from so many educators and professionals during my tenure as director will persevere as we continue to navigate the unknown, innovate, adapt, and ultimately thrive.

Take care and be well. — *Kristin*

Effective and Equitable Education: The Critical Role of Behavioral Health in Schools

Robert H. Horner, University of Oregon

Readers of *The EDge* are well aware of the ongoing efforts to improve education in California. Two important themes unite many of these efforts. The first is that effective and equitable education requires attention to the social, emotional, and behavioral development of students as much as to their academic and physical development. The second is that while we can celebrate the development of many effective interventions, strategies, or programs for improving student behavior, few of these are used well unless they are implemented in combination with effective organizational "systems" (e.g., policies, funding, teaming structure, data). Successful and equitable learning environments invest both in evidence-based behavior support within a multi-tiered approach, and in the schoolwide/districtwide "systems" that allow these supports to be implemented with efficiency, precision, and sustainability.

The Critical Role of Behavior Support

Achieving the core academic outcomes that are the foundation for all schools will occur only if schools become more effective at delivering the companion behavior supports needed to keep students coming to school, socially successful, and academically engaged. There is strong agreement that problem behaviors, such as noncompliance, aggression, disruption, withdrawal, and bullying, damage the ability of schools to be effective learning environments. Too often a small number of students with significant problem behavior can destabilize and limit the learning opportunities of all. There is agreement that an effective response should both provide support to the student(s) with problem behavior, and allow effective education to continue for all others.

Traditional approaches to addressing problem behavior have too often been limited to identifying, punishing, and/or removing the offending student. These approaches have been repeatedly demonstrated to be ineffective, inefficient, and inequitable. The constructive alternative is to focus on a

multi-tiered approach to behavior support that emphasizes prevention strategies applied throughout the whole school, combined with more targeted and intensive supports for students with greater behavior support needs. The over-riding theme is to treat "behavior" like any other educational skill. Start by overtly teaching appropriate behavior to all students in a school.

There are many ways of building schoolwide, multi-tiered behavior support. But it is clear that effective behavior support is much more than individual student intervention. Effective behavior support is a schoolwide commitment. Every school needs to start by identifying how it will create a predictable, consistent, positive, and safe school culture. This overall "school culture" is the set of common agreements among students, families, and staff about what behavior is acceptable and what behavior is unacceptable. Investing in the development of a positive, schoolwide social culture benefits staff as well as students. Recent research reports that teachers in schools adopting PBIS perceived themselves to have lower levels of stress, and to be more effective educating their students, compared to matched school staff not implementing multi-tiered behavior support. Establishing a clear understanding of social interaction standards (i.e., how we treat each other) builds the foundation for all of the more intensive behavior support.

Schools that are most successful and equitable in their academic efforts also invest in schoolwide, multi-tiered behavior support. Successful investment in schoolwide behavior support involves the following:

(a) Establish a schoolwide approach to social, emotional, and behavioral support.

(b) Define three to five social expectations for all students that capture the values and vision of the school community (e.g., be respectful, be responsible, try your best).

(c) Teach and acknowledge these schoolwide expectations so students understand that they are a durable, defining, and nonnegotiable part of the school.

(d) Establish "instructional" consequences for problem behavior that teach constructive behavioral alternatives, and prevent problem behavior from being rewarded by peers or inadvertent school outcomes. (Note that instructional consequences build on the initial teaching of schoolwide expectations.) When a student behaves inappropriately the teacher [1] interrupts the behavior, [2] labels the inappropriate behavior as NOT an example of the schoolwide expectations, [3] prompts the student to repair the situation by engaging in schoolwide expectations, and [4] provides the opportunity for the student to respond and re-engage. This simple, "instructional" process is effective much of the time, but if the student continues to be disruptive then the teacher sends the student to the office, and is allowed to continue instruction for the remainder of the class.)

(e) Build targeted and intensive supports for those students with more significant support needs, and braid mental health and academic supports with more individualized behavioral interventions. (Note that a major development within PBIS, and multi-tiered behavior support in general, has been the combination of behavioral interventions with innovative mental health support strategies. Students who need high-intensity [Tier 3] behavior supports typically benefit best when that support is comprehensive: e.g., includes academic, behavioral, mental health, and related assistance.) Improving the stability in a child's life through family assistance,

medical services, and housing is becoming a regular part of high-intensity behavior support in schools today. This reality is defining the growing collaboration between those providing direct, educational supports and those providing school and community mental health support.

(f) Use information (data) from academic and behavior support to reflect [1] fidelity (did we implement the strategies) and [2] student outcomes to guide, adapt, and improve behavior support over time.

Effective Practices with Sustainable Systems

The second major theme guiding behavior support advances today is recognition that we must combine effective practices with effective organizational systems. We should celebrate the impressive gains in strategies for supporting students with problem behavior, especially recent recognition of the impact of early trauma, the role of disabilities, and the role of physical, social, chemical (i.e., environmental toxins), and economic hardship on student behavior. As a result, our approaches to building social, emotional, and behavioral support have become more detailed and effective. Specific strategies now exist for use at the schoolwide level (for all students), at the targeted level (for some students with more complex support needs), and the intensive level (for those students with the most challenging needs).

We have the constellation of prevention and intervention tools needed to address problem behavior in schools. The challenge now is one of social, organizational, and economic commitment. Are we willing to invest in what it takes to make schools effective for all students?

The emerging data suggest that the key to this challenge is combining effective practices with strong organizational systems. It is not enough to demonstrate the effectiveness of a particular program or package for managing classrooms, or reducing bullying behavior. Too often school districts have invested large sums in training personnel to implement these practices only to find that within two years, most of the trained staff have changed roles, and the program has been abandoned.

The over-riding message of recent research is clear: adopting evidence-based practices must accompany the adoption of the organizational systems that support adoption, adaptation, and sustained use of these practices. Key features of successful organizational systems emphasize that while effective interventions need to be schoolwide, the sustaining organizational systems are typically districtwide. In general, decisions at the district level determine if effective schoolwide and classroom-wide supports endure. This requires a district or group of schools to invest in the following:

(a) District commitment to the schoolwide social culture and social/emotional/behavioral success of students.

(b) A district leadership team with the responsibility and authority to promote positive social behavior.

(c) A multi-tiered approach to behavior support that emphasizes prevention, with graduated levels of support intensity.

(d) District policy to recruit, hire, train, and support individuals with documented experience and success in applying multi-tiered academic and behavior supports.

(e) District investment in building capacity: ongoing professional development both to train new and current personnel in the core elements of multi-tiered behavior support and to ensure that staff have the skills to match behavior support strategies to the ever-changing needs of students and families.

(f) District investment in allocating personnel (school psychologists, social workers, counselors, special educators, administrators) to provide on-site coaching of newly acquired behavior support skills.
(g) School-level investment in intervention teams (at all three tiers) who have access to useful information and have the decision-making authority to implement schoolwide behavior support.
(h) District investment in decision systems (data and information technology tools) that provide school teams, teachers, and specialists with the information they need to identify students needing support, assess the extent to which support efforts (at all three tiers) are being implemented as intended, and determine if behavior support efforts are being effective.

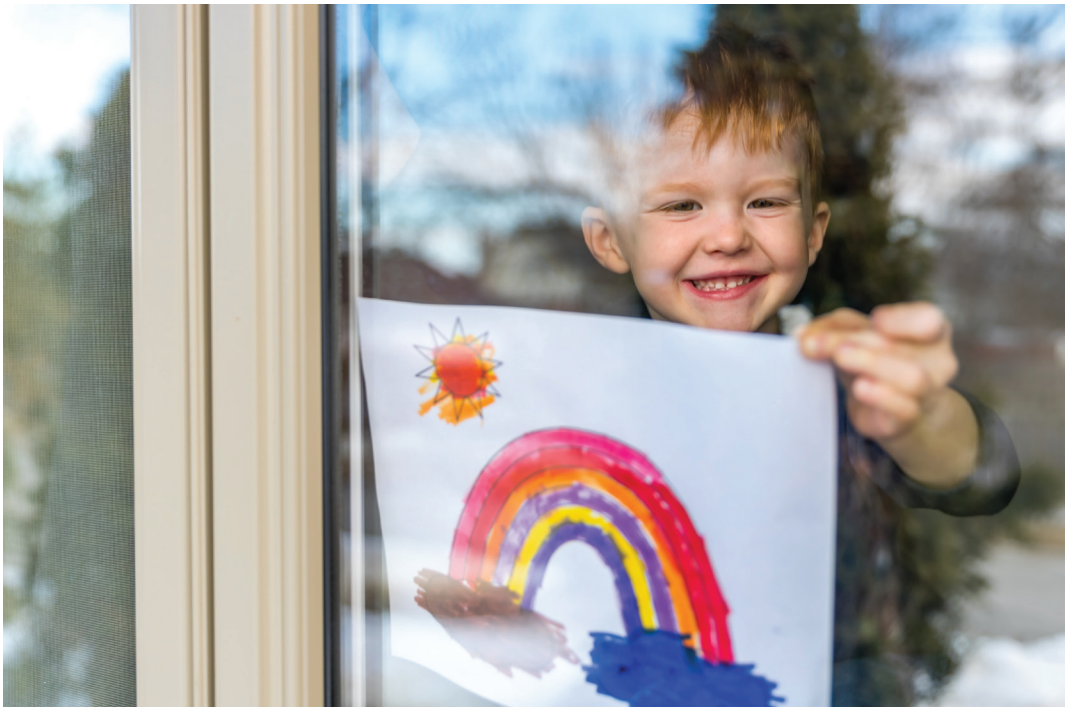
Summary

We are united in our commitment to all students in California schools. Too often we are faced today with disheartening choices of supporting some at the expense of others. This unsatisfactory choice is not necessary. There are strategies, practices, and programs that are effective at identifying and addressing problem behaviors that are a barrier to positive educational outcomes for all students. These advances will achieve their promise, however, only if they are implemented with the organizational systems needed for high-quality, sustained use. This requires whole-school systems of behavior support matched with districtwide adoption of effective organizational systems.

Large-scale adoption of effective social-emotional and behavior support will depend on district leaders who (a) define schoolwide policies and vision; (b) select practices with a proven evidence base; (c) recruit, hire, train, and support school personnel skilled at using multi-tiered systems of academic and behavior support; (d) establish schoolwide teams with decision-making authority; (e) implement data systems that facilitate effective decision-making; and (f) provide the ongoing training and coaching needed to make effective practices match the social and cultural context of each school community. ◄

Resources

- Learn more about Positive Behavioral Interventions and Supports at *https://www.pbis.org/topics/schoolwide* .
- *School-based Intervention Teams—Finding the Keys to School Success: A Quick Guide* is available at *https://flpbis.cbcs.usf.edu/docs/Pasco%20County%20SBIT.pdf*



The California PBIS Coalition

When California schools began implementing Positive Behavior Interventions and Supports (PBIS) in the 1990s, there was no statewide model or framework to follow and little coordination among schools. So counties, districts, and schools developed their own models.

As research continued to show the relationship between the implementation of schoolwide PBIS and improved school climate, PBIS became more prevalent in the state—but still only school by school, district by district.

A grassroots movement to scale up PBIS began in 1998 in Orange County when 15 schools from five districts began sharing resources and expertise. But it wasn't until 2011 that a group of statewide implementers came together to coordinate PBIS practice throughout California.

"The advantage of starting the way we did is that the stakeholders had to be willing to make the investment. We had to bring our resources together; we weren't dependent on large grant funding," says Michael Lombardo, co-coordinator of the California PBIS Coalition (CPC), which grew out of that first convening of PBIS leaders, and executive director of Prevention Supports and Services for the Placer County Office of Education. "There were multiple methods of implementation. The question was how do we support a state as diverse as California to scale up PBIS? We provided a framework."

The CPC goal: to use evidence-based, culturally relevant practices to build the capacity of schools to successfully incorporate PBIS throughout their sites. This begins with a core state leadership team made up of members from each of the state's 11 California County Superintendent Educational Services Association (CCSESA) regions with advisory support from universities and nonprofits. Regional and county/Special Education Local Plan Area (SELPA) implementation teams provide training in PBIS and technical support to district and school implementation teams that deploy PBIS in a multi-tiered system of support (MTSS) model.

Teams

To be successful with PBIS, "Each school needs a site team that is reflective of the school community," says Lombardo. "The team should include at least a teacher, an administrator, a parent, and someone with a behavioral background." The goal of the team, he says, is "keeping students at school all day every day." The teams "use data, look at issues of behavior, equity, and disproportionality in the data, and develop, implement, and evaluate interventions to address those issues."

The coalition has grown steadily since its founding and today supports 3,120 participating PBIS schools throughout the state, with 668 signing on in the last full school year.

Because of the importance of early screening and intervention for issues of behavior, the majority of participants are elementary schools. "Starting in elementary—or even pre-K—sets up the foundations for learning social expectations and strategies for coping," says Lombardo. "Internalization of these skills as early as possible is as important as English language and other subjects."

Training

The regional CPC Technical Assistance Centers provide PBIS training for teachers and school staff who then return to their respective schools and train the rest of the staff. "We've created a system of support for teachers. They learn strategies for teaching social expectations," says Lombardo. "They learn to teach what's expected in a positive way, to create routines and norms in the classroom." They also learn to recognize and acknowledge good behavior far more often than they correct unwanted behavior, thereby increasing the number of positive interactions between student and teacher.

During training, each school team develops its own three-to-five behavior expectations. Then the team works with stakeholders to define specific expectations for the important routines and locations at a school site. An elementary school, for example, might include expectations like "play fair and include all" for time on the playground while a high school might encourage students to report to class promptly.

The regional CPC teams also typically teach Tier 2 interventions such as "Check In-Check Out" or "Strong Kids." But because PBIS is a framework and not a specific program, when a student needs additional support "schools will select Tier 2 and Tier 3 practices that work best with that student," Lombardo says.

The training also focuses on the importance of screening all students and monitoring student performance and progress continually. But, Lombardo cautions, when schools screen students, "they need to have a strong system of supports in place already and an established decision-making system based on data."

Data

Lombardo was one of the authors of a 2019 research report that compared 544 California schools implementing Tier 1 schoolwide PBIS with fidelity and 544 schools that had not been trained in the use of PBIS. While other studies had shown the value of PBIS for schools in the aggregate, the researchers wanted to examine the effect on specific student groups, noting that students of color and students with disabilities receive a disproportionate share of exclusions from classrooms.

Confirming earlier research, the study found a statistically significant decrease in out-of-school suspensions and days missed because of suspensions for all students at PBIS schools. The study then demonstrated the positive effect of PBIS on a number of groups, including black and Hispanic students. But, the authors reported, the largest effect was for students with disabilities who were "significantly less likely to be sent to alternative settings due to behavior in schools implementing [schoolwide] PBIS with fidelity" (Grasley-Boy, Gage, & Lombardo, 2019).

Schools use the Tiered Fidelity Inventory to assess the degree to which they have successfully implemented PBIS with fidelity.[1] A rating of at least 70 percent indicates that a school has the systems in place to achieve and sustain positive outcomes. Based on these fidelity scores and other measures, each year the CPC acknowledges successful schools with designations ranging from bronze to platinum, and each year the number of platinum schools has grown. In the 2018–19 school year, 117 California schools received the highest award.

CPC schools' use of MTSS to implement PBIS is in line with California's plan to expand MTSS statewide. The CPC has been a partner in the state's Scale Up MTSS (SUMS) Initiative. "We're very conscious of collaboration. We were there at the beginning of SUMS," says Lombardo, who serves on the SUMS advisory group.

He notes another impetus for promoting the use of PBIS: changes in the Teacher Performance Expectations (TPEs) recently approved by the California Commission on Teacher Credentialing. The new TPEs include the directive to establish and maintain clear expectations for positive classroom behavior and to have knowledge of the range of positive behavioral supports for students.

The goal of all of these efforts, Lombardo says, "is for all kids to have the opportunity to succeed in school. We want a safe, equitable environment for them to learn, but sometimes they have behavior needs." Teaching students behavioral expectations "supports them so they can learn and succeed."

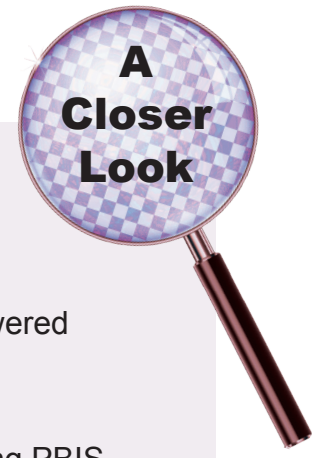
For more information about CPC and PBIS in California visit *http://www.pbisca.org/* ◄

Reference

Grasley-Boy, N., Gage, N., & Lombardo, M. (2019). Effect of SWPBIS on Disciplinary Exclusions for Students With and Without Disabilities. *Exceptional Children, 86*(1). *https://journals.sagepub.com/doi/10.1177/0014402919854196*

Resources

- For more about the Check-In/Check-Out Behavior Intervention, go to *https://www.pbisrewards.com/blog/check-in-check-out-behavior-intervention/*
- To read more about the Strong Kids Program, go to *https://strongkidsresources.com/research/strong-kids*
- Find the Tiered Fidelity Inventory for PBIS at *https://www.pbis.org/resource/tfi*



Inside PBIS

Jerry Lewis Elementary School, located in the high desert of Southern California, received a Platinum-level award from the California PBIS Coalition in 2019 for its successful implementation of PBIS. Taryn Lamoreaux, principal of the school, answered questions about the process of putting PBIS in place.

When did your school start incorporating PBIS?

Most of the schools in the Silver Valley Unified School District started implementing PBIS in 2012. Shortly after, the remaining sites joined in. We had heard such great things about how PBIS was changing the culture of schools, reducing the number of challenging student behaviors, and helping to improve attendance.

How long did it take to fully implement PBIS?

After only one year of implementation, our district knew that we were committed to continuing PBIS and to implementing it at all school sites. It took three years, however, for full implementation. We started implementing Tier 1 supports the first year, then added Tier 2 supports the second year, and then Tier 3 supports the following year.

What was your biggest challenge?

The biggest challenge was with staff buy-in. Ensuring the success of the effort required changing mindsets. When we saw student behavior change, and staff started to see the difference that PBIS made, then we had more staff buy-in.

Staff turnover was another challenge—and remains one. We have a high turnover rate of staff due to our remote location and also because of PCS (permanent change of station) moves with our teachers who are military spouses. We overcome these challenges by putting in place written procedures, conducting regular staff training, and providing grade-level leads and a PBIS coach to support staff.

What have been the benefits of PBIS? How are those benefits reflected in your data?

The number of behavior incidents has declined significantly, and attendance has improved. The number of suspensions also has declined, especially in the upper grades.

What advice do you have for other districts that are just beginning to introduce PBIS?

- Implement with fidelity.
- Take the time to fully train your staff.
- Include your parents. Get parent buy-in by providing them with information on how they can help support students at home (through parent nights, training, etc.)
- Be patient with staff and students. You will start to see results.
- Be enthusiastic when talking about it to staff and students.
- Implement an incentive system for staff as well as for students. Staff work so hard and they deserve to be recognized.
- Don't take on too much at once. Start with Tier 1 and have it fully running before moving on to Tier 2 and then Tier 3.

Ensuring Broader Access and Equity for All: UDL and PBIS

By Patricia Schetter, Coordinator of Autism Education Initiatives at the Center for Excellence in Developmental Disabilities at the MIND Institute, UC Davis

Students with disabilities and students of color are at higher risk for suspension and expulsion than their peers (Skiba, Arredondo, & Rausch, 2014). Positive Behavior Interventions and Support and Universal Design for Learning (UDL) can change this and other discipline-related inequities. When used together, these two approaches can transform the classroom into a place of success for all students.

Years of research show that PBIS helps to reduce many of the disparities associated with behavior problems and may also reduce the need for more restrictive placements, exclusionary discipline practices, and potentially even the use of emergency interventions (such as restraint or seclusion). In a study of 544 schools implementing PBIS, students with disabilities were removed significantly less often from their home schools (to more restrictive alternative settings) for disciplinary reasons than students in comparable schools not implementing PBIS (Grasley-Boy, Gage, & Lombardo, (2019). With this and other solid evidence of its effectiveness, it is no wonder that PBIS is gaining steam in many schools in California.

Frank Otis Elementary School in Alameda is one of those schools. Principal Tanya Harris and her team adopted PBIS in 2016 as a result of a districtwide initiative. In just three short years, the school has implemented Tier 1 supports at 100 percent fidelity (as indicated by the Tiered Fidelity Inventory) and has been recognized as a Gold Level PBIS school by the California PBIS Coalition. Since Tier 1 supports are provided to all students, and since the majority of students need only Tier 1 supports to realize behavioral success in school, this level of fidelity represents a significant achievement.

Core features of Tier 1 PBIS include teaching children behavioral expectations and acknowledging appropriate behavior. For its expectations, Otis Elementary uses the three B's—Be Safe, Be Kind, and Be Your Best—and teaches these expectations to all students each year, with reminders posted throughout the school campus. These reminders state explicit expectations that support positive behavior in different areas: restrooms, for examples, and playgrounds. Staff then recognize students for following these expectations by giving them "Hoot Hooray Tickets." When a student is awarded a ticket, staff praise him or her for the expected behavior observed. The student then takes these tickets to class where they are collected in a "Hoot box." Each Friday during lunch, a ticket is drawn from each class box, and the selected student gets a reward, such as a tub of slime or a deck of playing cards.

"The students really take pride in being recognized, and it has resulted in a huge shift in our school culture," says Harris. "We are all so much more focused on positive and appropriate behaviors."

As an approach to reducing disparities in schools, Universal Design for Learning (UDL) is also rapidly gaining momentum. Its research-based framework is designed to fully engage the wide variety of learners present in any given classroom. Research has long demonstrated that when

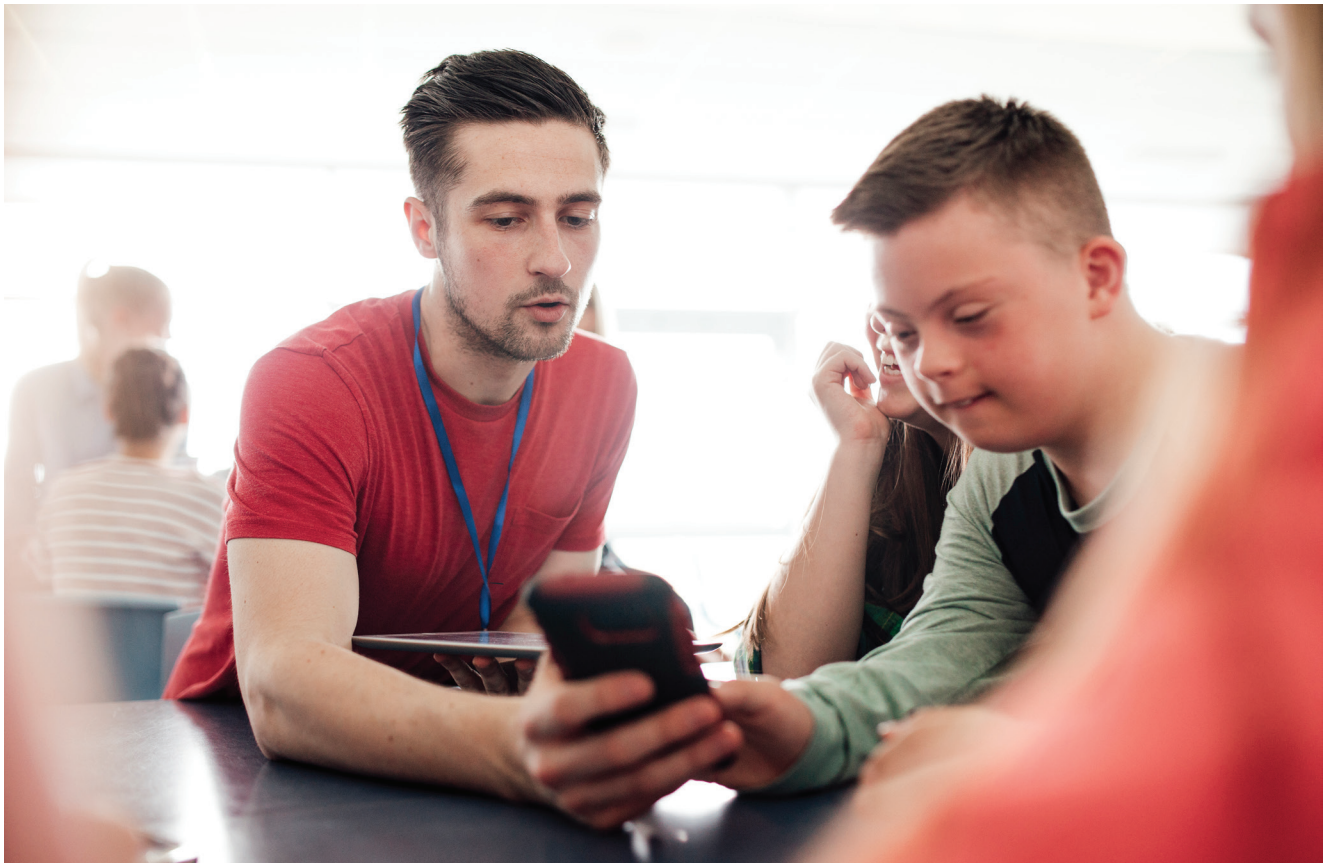
students are engaged in classroom learning, behavioral challenges dissolve (Tomlinson, 2012).

UDL guides teachers to develop instruction that is presented in multiple ways, and to allow students to respond to instruction and demonstrate their knowledge and skills through multiple pathways—which lead to greater student engagement.

The key to UDL is its focus. The idea is that there is no "average" learner, and all students are learners. So as teachers plan for and instruct the full range of learners who make up their classrooms, they identify any instructional barriers that may limit a student's access. Whatever the barriers are, the teacher considers ways of eliminating them so that students can more fully understand the instructional content, more fully engage in learning, and more fully demonstrate what they have learned.

While reducing barriers to instruction, UDL maintains high achievement expectations for all students, including students with disabilities and students with limited English proficiency.

For example, if there are students in a classroom who are English language learners, certain vocabulary and/or lengthy verbal instructions given in English may limit their ability to understand what the teacher is asking them to do. A UDL teacher recognizes this as a potential barrier and builds in alternative or additional mechanisms for access, which might include providing visual supports to clarify vocabulary, or providing instructions in both English and Spanish, or allowing the students to use a translation app.



Often the UDL methods that break down barriers for specific student groups also benefit and enhance learning and access for all students. "At Otis Elementary, we began adopting a UDL approach by accident in 2018 when we became a full inclusion site for students with disabilities. This was the year we made a conscious shift to more fully include students with autism and other disabilities rather than having them go to a more restrictive placement," Harris says. As part of this inclusion initiative, Otis Elementary staff began receiving support from their district's CAPTAIN Cadre. CAPTAIN is the California Autism Professional Training and Information Network. As a part of California's System of Support, CAPTAIN trains and supports autism coaches within each of the Special Education Local Plan Areas (SELPAs) across the state. These Cadre members are experts in autism and evidence-based practices for supporting students with this disability. Under the instruction and with support from their CAPTAIN Cadre, Otis staff began incorporating the evidence-based practice of visual supports as a proactive strategy to support positive behavior for students with autism within their general education classrooms. Teachers soon noticed that these visual supports were effective not only for their students with autism, but for all students, who were paying better attention and improving their behavior when these visual supports were used.

"It was a 'no-duh' and an 'aha!' moment for us when we realized that providing information both auditorily and visually could actually support ALL of our students better," says Harris. Since then, Otis has redesigned its Tier 1 PBIS supports by adding many visual supports and incorporating a UDL mindset into every aspect of its PBIS implementation.

Both UDL and PBIS can address some of the challenges that California's public schools face. The California Schools Dashboard has illuminated the challenges. For example, of the 333 districts identified in 2019 for Differentiated Assistance, 187 were eligible in part because of the performance of students with disabilities in the indicators of "academic achievement" and "student engagement."

As schools review their data and make their strategic plans for improvement, many are considering the implementation of UDL or PBIS. But why not consider using both together? An integrated implementation offers the potential for the broadest impact and best outcome, given how complementary they are.

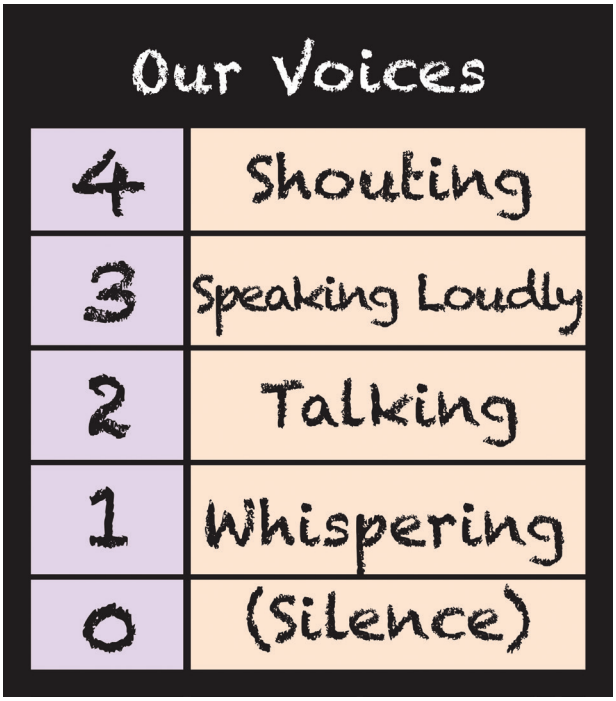
Specifically, district and school teams could take advantage of the implementation frameworks offered by PBIS to build the needed infrastructure, while applying UDL to the development and instruction of PBIS Tier 1 practices. The combined effect can support the best outcomes for all students and staff—and create a sustainable infrastructure for scaling up both PBIS and UDL.

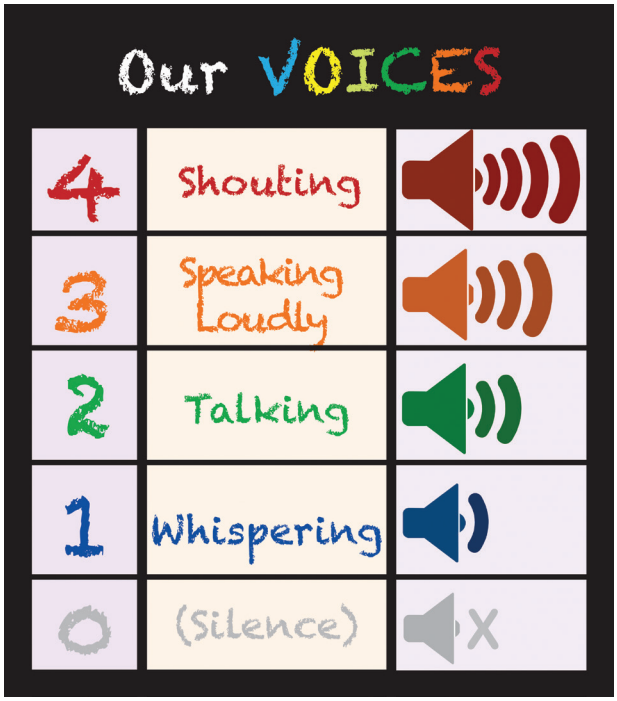
The data at Otis Elementary certainly reflect the benefits of combining these frameworks. Office referrals and "Uh-oh" referrals (low-level behavior) have been reduced significantly. Principal Harris indicated that this year, when behavioral incidents happen or when children act out, their PBIS team members automatically think about how to use UDL to improve the school's structures so that students can better understand and demonstrate the expectations.

In addition to seeing improvements with their Tier 1 PBIS implementation and office referral data as a result of adopting UDL, Otis Elementary has also been on a fast track to implement Tiers 2 and 3 with full fidelity. Harris credits this effort to how school staff now think about student behavior and

needs. “We automatically use any [mis]behavior as a clue that we need to do something different to support the student,” says Harris .

What do some of these Tier 1 behavioral supports look like when they’re shaped by UDL? Here is an example:





The chart on the left illustrates typical classroom expectations that are not universally designed. The one on the right is universally designed, incorporating multiple means of representation and using a variety of visual images that are inclusive of a variety of learners.

In addition to creating standard English language versions of these charted expectations, staff can develop a version in Spanish and add culturally appropriate photos to broaden the accessibility of the poster to include more of their student population.

Implementation

Full-scale implementation of any new initiative requires the use of systematic strategies that provide for the needed infrastructure and teacher supports to use the new innovation with fidelity. Applied Implementation Science (Fixsen, Blasé, Metz, & Van Dyke, 2014).) can help to roll out new initiatives in a relatively short period of time. Methods from implementation science are fundamental to establishing PBIS in schools—and are part of what makes PBIS so successful. These methods include

- district and site leadership teams that work through stages of implementation, from exploration to full implementation;
- specific and ongoing training and coaching at all levels;
- the use of data to inform and support decision making; and
- fidelity measures to ensure that PBIS components are being implemented as they are intended.

PBIS in a Universally Designed classroom offers a proven way to reduce discipline and behavioral problems, improve student engagement and achievement, and contribute to a healthy school climate overall. And it's more fun for both teachers and students!

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Resources

- For more about CAPTAIN, go to *http://www.captain.ca.gov*
- The Tiered Fidelity Inventory for PBIS is at *https://www.pbis.org/resource/tfi*
- The Open Access Project, part of California's Statewide System of Support, offers professional development and resources for educators, administrators, and organizations to enhance their understanding of Universal Design for Learning, Assistive Technology, and Augmentative and Alternative Communication. Go to *https://www.openaccess-ca.org*

Coordinated Services in Schools: Desert/Mountain SELPA

What does a comprehensive school-based system of mental health care look like in California? For years, interested stakeholders didn't have to look any farther than Desert/Mountain SELPA's Children's Center. One of the first programs of its kind in the state, the Children's Center quickly became the standard for coordinated mental and behavioral health services—and coordinated financing. The SELPA's motto—"The relentless pursuit of whatever works in the life of a child"—seems to have played a part in how the Center was established and grew.

Similar to many SELPAs, Desert/Mountain had been providing mental health services to students with disabilities since the 1990s. SELPAs (Special Education Local Plan Areas) in fact were created to ensure that California's students with disabilities receive the services they need to benefit from their education. These services have always included mental health.

Over the years, Desert/Mountain's vision became broader.

In 2003, under the guidance of then-director Ron Powell, Desert/Mountain applied for a contract with the San Bernardino County Department of Behavioral Health "to provide school-age mental health treatment services to students with and without disabilities who were eligible for Medi-Cal," says Jenae Holtz, who worked at Desert/Mountain SELPA with Powell at the time. "We were pretty surprised when we received the contract."

Holtz's surprise was understandable. The vision of this broadened service lens included serving both general and special education students—an effort that was groundbreaking for SELPAs at the time.

One of the first things the SELPA did after receiving the grant was to create the Desert/Mountain Children's Center, with Holtz as director. The Center became "our mental health component that coordinates all mental health services in the area," says Holtz. Together with Desert/Mountain SELPA and Desert/Mountain Charter SELPA, the Center became part of the California Association of Health and Education Linked Professionals, or CA-HELP, a Joint Powers Authority (JPA).

The Finances

The next task was to begin providing services. A lack of program funding is typically cited as one of the primary reasons children who need services don't get them (California Behavioral Health Planning Council, 2018). Desert/Mountain's contract with Behavioral Health helped to address that problem by allowing the Center to bill Medi-Cal for what are called EPSDT dollars: Early and Periodic Screening, Diagnosis, and Treatment. In terms of mental health, this meant that the Center could provide screening and assessments for mental health concerns and challenges, early intervention services, regular check-ups, screening for developmental delays, diagnosis, and treatment to children who needed them.

The Medi-Cal funding for these services represented a significant boon. "We have such a high poverty rate here," says Holtz. "The majority of our kids are on Medi-Cal."

Funding Challenges

Pinpointing sources of money is one challenge. Securing it is another. Using funds from disparate sources in a way that is efficient, coordinated, and effective becomes a third hurdle altogether. And there is no primer on how to blend and braid the many existing, concurrent entitlement funds that cover mental health services for children.

In California, these funding sources include EPSDT Medi-Cal; the Mental Health Services Act, which includes Prevention and Early Intervention and Community Services and Support; standard SELPA allocations (AB 602 Special Education Apportionment); Educationally Related Mental Health Services (ERMHS, as established by AB 114 in 2011 after the repeal of AB 3632); and Local Control Funding Formula money. With different directives, limitations for use, and varying eligibility requirements, financing mental health services for students quickly becomes complicated, and the processes for "drawing down" and "providing the match" confusing.

Desert/Mountain was visionary—and intrepid—in figuring out how to make the best use of its money.

With the Behavioral Health contract in place and the JPA established, the Children's Center began serving the mental health needs of general education students, providing school-based services billable through Medi-Cal EPSDT. At the same time, Desert/Mountain SELPA contracted with the Children's Center to use ERMHS funds for mental health services for students with disabilities.

With the federal government matching every dollar spent on allowable Medi-Cal costs—essentially, on the services that children with and without disabilities needed to stay or get healthy (Tatar, M., & Chapman, A. (2019, February).—the Children's Center put Medi-Cal dollars to best use by using California ERMHS dollars "as the match for their Medi-Cal EPSDT contract. This has allowed DMCC [the Children's Center] to increase their EPSDT budget [again, for students with and without disabilities] without further burdening the local government general funds, while also providing financial relief to partner school districts that were previously paying a 'fee for service' out of their own budgets for mental health services" (The California School-Based Health Alliance & Fight Crime: Invest in Kids California. (2014, September).

Using Medi-Cal dollars in this way made it possible for the Children's Center to serve many more students. From there, things quickly evolved. "We went overnight from five to twenty-five therapists," says Holtz. "And then we started just growing and growing."

The Children's Center now holds several Behavioral Health contracts for mental health services and has become the largest children's mental health provider in San Bernardino County. In this growth, the Center has added three clinics in different locations, making it possible for clinicians to serve students in all 22,000 square miles of this SELPA's daunting catchment area.

MTSS/PBIS

"The majority of our mental health services are provided in schools," says Holtz. "And the majority of our schools are in some level of PBIS. So schools work with the Children's Center to coordinate efforts to provide services through a multi-tiered system of supports (MTSS), which addresses behavior and the social-emotional health of students, as well as academics." True to the key

principles of MTSS, the focus is on prevention through the first tier of services, with consecutive tiers providing increasingly more intense services in response to a student's need.

"The Student Assistance Program," says Holtz, "the contract we hold with the Department of Behavioral Health through the Children's Center, is a Tier 1 intervention for general ed students. That contract blends nicely with PBIS." Through that contract, Center staff "work closely with schools, teaching social-emotional learning in large and small-group settings. In Tier 2, we run groups of kids who don't qualify for special education but have a little more conflict or inability to regulate.

"We also have a Triage Grant from the state," says Holtz, which "fits in nicely with PBIS and the Children's Center, where we are working hand-in-hand to make sure that we're doing the earliest intervention with kids—so we don't have to go to a higher level of services."

While MTSS is the primary vehicle for service delivery, the Center also provides individual, group, and family therapies at its three clinics as well as in the homes of students.

"What I think is unique about the Center," says Holtz, "is its child focus." This focus, she says, "creates true experts [among the therapists who work] with those children. You truly do learn a different way of dealing with children at every level—infant care, toddler care, young elementary, middle school, high school. It's very different from just going to a therapist in private practice."

Collaboration

Linda Llamas is the current director of the Children's Center. She values the collaboration that's required within a MTSS/PBIS structure. Therapists who work in schools are on PBIS teams, as well

as in the classroom working "with kids, talking to teachers, working together on a treatment plan for a child," says Llamas "The expectation is that we work closely together. This is unique to us. When I talk to other mental health providers, they don't have the 'in' with the schools that we do. They don't have the names of the folks from the SELPA or the school districts who are providing PBIS."

The Center's "in" clearly makes a difference. "Our mission and our philosophy is to collaborate with everybody who can benefit the child's success," says Llamas. This collaboration goes well beyond the schools to include any "other mental health providers or community-based organizations in the area. We lean on them highly." Llamas attributes this cross-agency collective identity to "our Department of Behavioral Health. They view us all as one mental health provider. It's not 'this agency versus that agency.' We are expected to function as one. And we do."

Both Holtz and Llamas are grateful to Behavioral Health for building those relationships "into our contract—with public health, with child and family services, with First Five. [Behavioral Health staff] are the ones who are setting up the larger scale meetings for the community-based partners to all meet to discuss processes for transitions for children, to discuss what we are really needing as a community for our children."

Challenges

Holtz is candid about the challenges Desert/Mountain faced in developing collaborative relationships. "There are always stumbling blocks," she says. "And there are always egos involved. People can be territorial. But once we build relationships and trust, then those walls start coming down."

Holtz tells about wanting to apply for a grant, and then learning that one of her community partners was applying for the same grant. "We wrote in our response to the RFP that, 'if this organization does not apply for this contact, we are interested. But if they apply, we will support them' and not go forward with a proposal.

"That started to thaw the ice. I keep saying, 'there are so many kids. There's plenty to share.'"

Holtz's final advice: "It's not about me. It's not about you. We have to keep the kids at the center of the conversation.

"And it's about just not giving up." ◄

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Notes

- "ERMHS funds are not restricted to students who have 'emotional disturbance' as their identified disability. Students with IEPs who demonstrate behavioral health issues that impact their ability to learn and access the school curriculum are eligible for AB 114 funds. Services must be included in the IEP and can include: individual counseling, parent counseling, social work services, psychological services, and residential treatment. Any service agreed upon by the student's IEP team as necessary for the student to receive a free and appropriate public education may be considered a related service and covered by AB 114 funds." For more, see *https://www.schoolhealthcenters.org/start-up-and-operations/funding/mental-health/ermhs/*
- AB 3632 required all mental health services for students with disabilities to be provided by county mental health agencies. With the repeal of this law, and the passage of AB 114, the local educational agency, or LEA, became responsible for providing mental health services.

Resources

- For more information about School-County Collaborative Triage Grants, go to *https://mhsoac.ca.gov/what-we-do/triage/triage-program-overview*
- To learn more about Special Education Apportionment, see *https://www.cde.ca.gov/fg/aa/se/*
- *The Role of System of Care Communities in Developing and Sustaining School Mental Health Services*, from the American Institutes for Research. (2019), explains the importance of creating a System of Care to address the mental health needs of students: *https://www.air.org/sites/default/files/downloads/report/Systems%20of%20Care%20Communities%20in%20School%20Mental%20Health%20Systems.pdf*
- The *Schools Mental Health Referral Pathways Toolkit*, from Substance Abuse and Mental Health Administration. (2015), provides best-practice guidance, practical tools, and strategies to improve coordination and collaboration both within schools and between schools and other youth-serving agencies: *http://www.esc-cc.org/Downloads/NITT%20SMHRP%20Toolkit_11%2019%2015%20FINAL.PDF*

Coordinated Services in Schools: Monterey County

"There's applause," says Kacey Rodenbush as she describes her community's response to school-based mental health services.

Rodenbush is the behavioral health services manager for School Based Mental Health Programs within Monterey County Behavioral Health. She started working for the county in 2012 and now leads a large team of clinicians, supervisors, and support staff who deliver a full range of school-based mental health services to all students, those with disabilities and those without. How this system of coordinated care came about is a complicated story. The simplified version starts with a longstanding relationship with Monterey's Special Education Local Plan Area (SELPA).

As the organization that coordinates special education funding for all of the county's students with disabilities, "SELPA was the foundation for our current mental health efforts," says Rodenbush. "We serve 25 school districts, and it's one SELPA." So the SELPA was the connecting hub, paving important inroads for Behavioral Health to also connect with the general education student population.

This broader coordinated reach got its first toehold in 2012 when Behavioral Health gave the Monterey County Office of Education (MCOE) $35,000 to begin implementing Positive Behavioral Interventions and Supports (PBIS), followed in 2015 with another $100,000. This money formally brought general education into the mix. Later in 2016, "right around the time I became manager," says Rodenbush, MCOE, was granted a School Climate Transformation Grant to implement PBIS countywide. This $2.7 million from the federal government created an inflection point.

With her understanding of PBIS and of the interconnection between behavior and mental health, Rodenbush "took our services continuum—all the things related to behavioral health that we do for kids, depending on their needs and severity—and I basically aligned those services with the PBIS pyramid. In Tier 1, we came up with a whole menu of training that my supervisors and I provided: suicide prevention and response, youth mental health first aid, mindfulness training," and other trainings that addressed topics that were requested or determined to be significant. She and her staff wanted to give "as much information on mental health to the entire learning community as possible," information that prepared adults to recognize mental health problems in students "and know what procedures to follow to connect students with help." This kind of community-wide knowledge is critical for adults to understand that behavior is a message—and sometimes a cry for help.

There was strong evidence that the county's students would benefit from more, and more readily available, mental health services. Levels of anxiety and depression among students have been steadily increasing throughout the past decade, the result of immigration worries, financial burdens, social media stressors, intimidating academic expectations, and concerns about school safety, among others. At the time of the grant, says Rodenbush, "Salinas had one of the highest homicide rates in the country. There was also a lot of gang activity. It was a high-needs area without a lot of resources."

Coordinating Funding and Services

With the grant, MCOE now had resources—and a vehicle through PBIS—for delivering mental health services in schools. To train as many adults and help as many students as possible, Rodenbush knew she needed to be strategic. “As Behavioral Health and MCOE deepened our partnership, we began blending our funding to maximize our impact and strengthen our efforts to integrate mental health services in schools using the Interconnected Systems Framework, a model that weaves mental health services and supports into PBIS.”

“My work is about connections,” says Rodenbush. And she knew she needed to make many of them. “Children enter our Behavioral Health system through different doors,” she says. “For example, if they get arrested and are placed on probation, they go through our juvenile justice door. Given that we have a team of clinicians who work in our juvenile justice program, we can provide bridges to care internally without duplicating services.”

Behavioral Health has teams working with many child-serving programs in the county. But these services are all connected with the schools. “The thing is, all kids go to school, and coordinating mental health services across systems and through schools just made good sense.”

This growing, interconnected system was also helped by “the system of Medi-Cal billing for eligible students’ services” that Behavioral Health had been working with the SELPA to refine. In this world, however, the word “system” is not an impersonal abstraction. An effective system for accessing Medi-Cal money makes it possible for clinicians and educators to work together to help students. “We’re a System of Care,” says Rodenbush. “This is why I love it so much.”

With the goal of embedding Behavioral Health staff into the everyday fabric of the school, “I started assigning clinicians to work with specific school sites,” says Rodenbush. These professionals work alongside teachers within an Interconnected Systems Framework that allows the clinician to do more than provide an individual service. “They are in the classrooms,” says Rodenbush, “pushing [services] in and providing Tier 1 training to the students, in addition to training parents and

classified staff through both the SELPA contract and the general education contract. And any time I have a clinician in a district where we have both types of service contracts, then that clinician serves both populations. We are no longer separating students into piles because one has an IEP and another doesn't."

Blending funds and coordinating providers allows Behavioral Health to deliver an extensive range of school-based services: individual, family, and group therapy, case management, training for both students and teachers, classroom presentations, psycho-educational groups for students, and enhanced behavioral health services to students with severe emotional disturbances. Behavioral Health also delivers mental health services through its HART program (Home Alternative to Residential Treatment), which provides in-home therapeutic services designed to keep students, who otherwise would be sent to residential treatment centers, in their own homes and attending their local schools.

Working Collaboratively

Rodenbush capitalized on the emphasis PBIS places on teamwork. She works closely with her partners from the SELPA, MCOE, and school districts to integrate mental health services into PBIS and MTSS frameworks. When Behavioral Health "started joining forces with our county office of education, I became a member of the School Climate Leadership team. SELPA was part of that team." And all community mental health providers who are involved with students with disabilities are included on the IEP team. "They provide input and offer their expertise on mental health. So when the team is trying to figure out what intervention is going to be the most appropriate, you have a behavioral health clinician at the table helping determine supports."

Surviving the Difficult Parts

While the results of her efforts are remarkable, Rodenbush does not pretend that developing an integrated system of care has been easy. "It took time to shift some of the attitudes" about the importance of collaborating and the best approach to providing mental health services. "So it certainly wasn't all fabulous when I started. I had to work on the relationships and build trust with everybody." But she has advice on how to do it.

"At first I removed barriers and made things more efficient and streamlined" for referring students to special education. "The directors are concerned about those students. When we're talking about mental health, people are very emotional and worried." For good reason. "We have kids who have suicidal ideation, they're cutting themselves, they're doing all kinds of things that are very concerning. And the districts look to us for help. But who wants to fill out a four-page referral form when the student needs help right away? So I just made a simple form that would give us enough information to start moving on an assessment and make immediate contact with that student."

Rodenbush places a high value on good customer service. "Any time a concern comes up, we're there. We're as responsive and proactive as we can be so the students and the districts get what they need."

Then she talks about the importance of creating and maintaining relationships. "Go into the schools," she advises. "Have face time with people. This took us time to figure out." It was

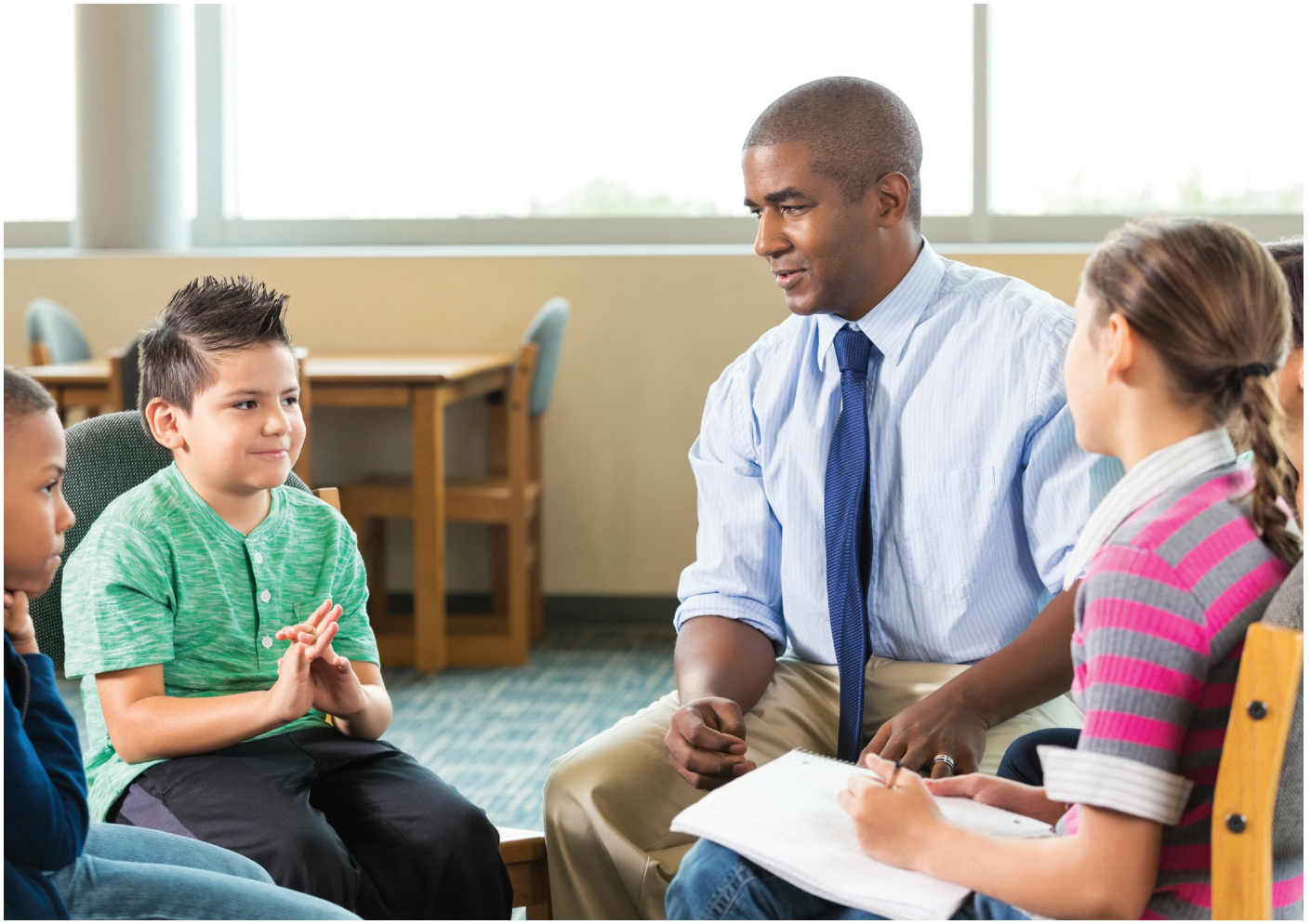
Rodenbush's idea for her Unit Supervisors to move district-level meetings to the school sites. "Now we know what's going on with the principals and the vice principals." As a result, Behavioral Health has relationships in place so that supervisors can respond in real time when there is a crisis.

One of the best ways to create trusting relationships, she says, is to "be reliable. Do what you say you're going to do."

Rodenbush also strongly advises educators, parents, and service providers to take care of themselves. She sees many adults as "stressed, tired, and burned out. They care so much for kids. But if we're not getting enough sleep, not eating well, how in the world can we tend to other's needs and respond in a way that is going to be helpful?"

Lastly, "We all want the same thing. We want to help kids and see good things for them and their families. It's our main mission. But things can get very contentious" in the world of special education and behavioral health. "So we have to see whatever happens as an opportunity. How do we find peace and opportunity in conflict?"

Good question. Clinicians and educators in Monterey are finding some answers. ◄



Coordinating a Fragmented System of Health Care

Elizabeth Estes, JD, Founder of Breaking Barriers, and Ron Powell, Ph.D., Former CEO of Desert/Mountain SELPA and CAHELP

Like so many movements for change, Breaking Barriers was founded from trauma—the direct result of a hostage crisis and mass shooting in 1990 that its founder Elizabeth Estes experienced. In the aftermath of this experience, Estes realized that while she was able to access the care and support she needed to address her resulting trauma, so many children and families in California with similar needs could not. As Estes publicly shared her story, her passion and concern resonated with aligned experts from across California's child-serving systems who agreed to join in a positive reform effort to overcome the barriers that hinder equitable access to the services our children desperately need. Breaking Barriers was born.

Since its inception in 2014, Breaking Barriers has worked with local and state leaders to overcome inequities in the delivery of services and to support the creation of a coordinated, comprehensive system of care that serves the social, emotional, and behavioral health needs of California's children and families. The need could not be more stark.

There is a mental health crisis among our nation's children. Studies show that over the course of their school-aged years, 46 percent of children will experience a significant mental health disorder (Merikangas et al., 2010a). While many of these disorders will resolve with appropriate supports, the number of unresolved, chronic mental health disorders is increasing at an alarming rate and is now estimated to impact 20 to 25 percent of children between the ages of 5 to 17 (Merikangas, et al., 2010b). And even though there is strong evidence for the effectiveness of interventions to treat mental health disorders (Kutash, Duchnowski, & Lynn, 2006), studies show that effective mental health services are not readily available or accessible. As a result, only two out of every ten children with the most significant mental health disorders receive the treatment or services they need (Katoaka, Zhang, Wells, 2002). This finding suggests that only 360,000 of the nearly 1.9 million children in California with chronic mental health disorders receive appropriate treatment.

The impact of untreated mental health disorders is significant. Compared with the general population, children identified with emotional disturbance are more likely to use alcohol (54 percent), illegal drugs (36 percent), marijuana (33 percent), and cigarettes (53 percent) (Yu, Huang, & Newman, 2008). They are also more likely to experience a cascade of poor educational outcomes and disruptive school experiences marked by poor school attendance, academic difficulties, and behavior problems (Repie, 2005). Nearly half will drop out of school prior to graduation, resulting in a 75 percent greater likelihood of incarceration than their academically high-performing peers (Read, & O'Cummings, 2011). Within four years of leaving high school, 60 percent of children with emotional and behavioral health disorders report being arrested at least once (Newman, Wagner, Cameto, & Knokey, 2009). Studies show that nearly 70 percent of children in the juvenile justice system have a diagnosable mental health disorder (Skowyra & Cocozza, 2006). In short, children with untreated social, emotional, and behavioral health disorders are too-frequently destined for

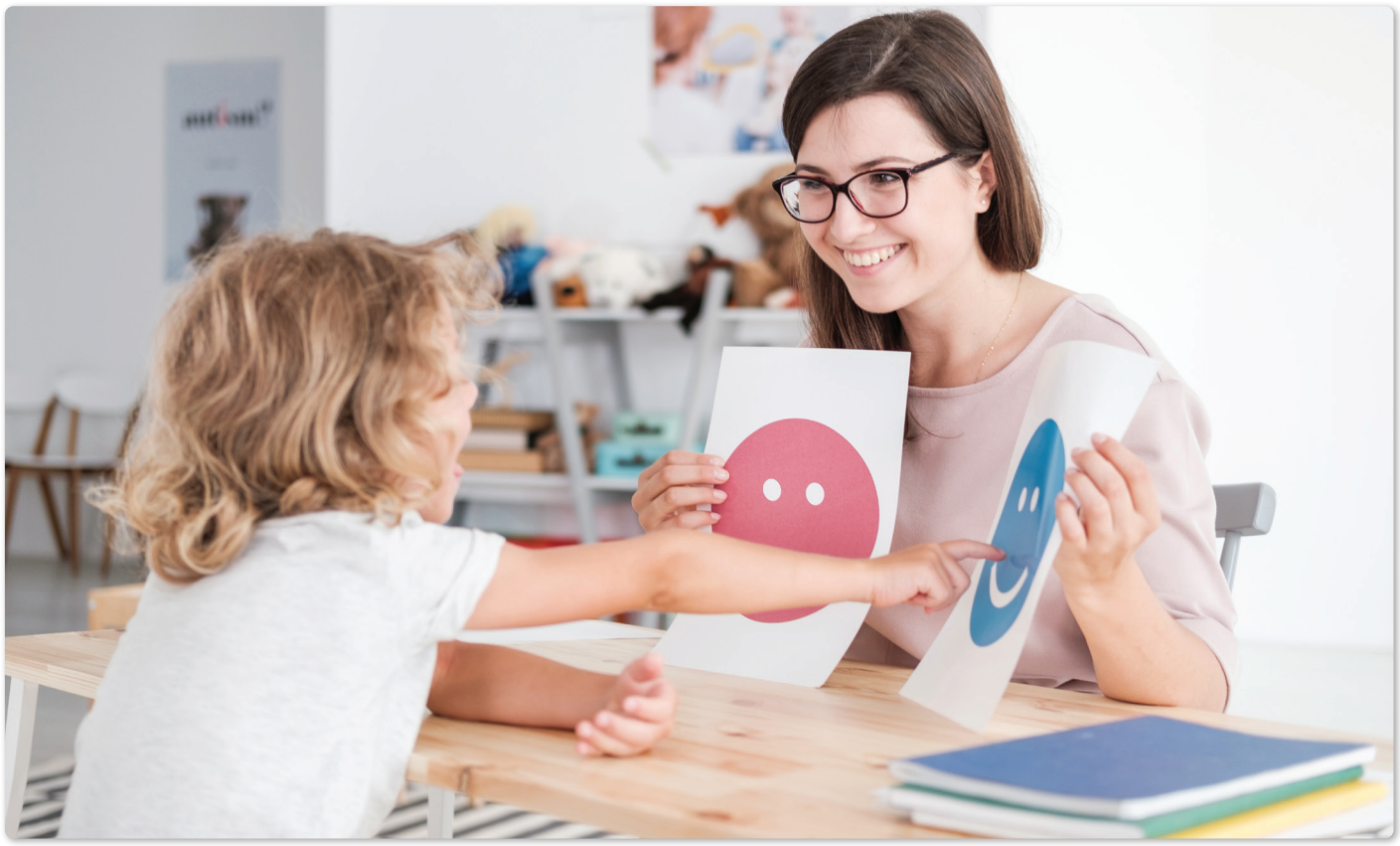
a life of unemployment, crime, addiction, homelessness, and chronic mental health disorders. Coordinating services among the multiple agencies that are designed to support the child is essential to averting this course.

During and following the COVID-19 pandemic, this effort becomes more important than ever, as we attempt to address the added stressors on children and families. We must become as effective and cost efficient as possible with California's child-serving resources.

Breaking Barriers is committed to helping develop and sustain these kinds of coordinated efforts. The initiative has already facilitated numerous integrated care partnerships and pilot programs in California, at both the state and county levels, that expand services to children and families, particularly in the area of education and health services. Breaking Barriers also convenes an annual statewide Interagency Symposium that is designed to support the success of those state and local child-serving collaborative efforts, and to highlight those efforts in a Community of Learning and Practice. Each year, nearly 250 stakeholders from county and state agencies, service providers, youth, and families attend the Symposium in Sacramento, with 20 to 25 county and/or school teams represented. The agenda of the past four years has included the innovative work of numerous counties to wrap their service delivery systems around children and their families.

The Need

While California's legislative history has for more than 40 years reflected a recognition of the need for effective interagency collaboration, the work of Breaking Barriers has shown light on the gaps that remain in those efforts. Across the state, services are still inconsistently provided and



coordinated, which challenges parents and families who must apply separately to the various agencies for help. Each agency then has its own eligibility criteria and limitations for service delivery, complicating further the application process. And services available in one region may not be available in another, resulting in geography rather than need determining access. In addition, many agencies face scarce resources. So they allocate their services to those with the most critical needs—a policy that does little to curtail the growing number of children who require prevention and early intervention services.

No single agency can provide the depth of expertise and the breadth of services necessary to meet the diversity of needs that children have. To be comprehensive, services often require experts in multiple disciplines, which makes collaboration and coordination essential. Partnerships among multiple agencies can ensure that more children and families are served, and that they are able to access the services they are entitled to and need. And when working together, agencies can blend and braid their various funding streams to expand not only services but early intervention and prevention efforts—which identify and address the social, emotional, and behavioral health needs of children before they reach the level of a chronic disorder.

The Benefits

A coordinated system benefits every agency involved by allowing it to (1) avoid the constraints that are inherent within single-agency job descriptions; (2) improve access to prevention, early identification, and intervention services; (3) improve efficiency; and (4) increase access to more intensive services that extend into the home as well as the community.

Breaking Barriers has long recognized that in order to begin to realize the long-term outcomes we seek for California's children—and the outcomes they seek for themselves—the state must unite its child-serving agencies and resources into one system, with every member holding shared goals and responsibility for the outcomes of children and families. To embody that vision, Breaking Barriers is working to develop and implement comprehensive solutions that are possible only if processes, policies, regulations, and systems are transformed—and then realigned around policy and programs that share both goals and financial support (see the insert to this newsletter).

Evolving and Future Goals

The current goals and projected outcomes of Breaking Barriers include the following:

- Create incentives for integrating the systems that serve California's children and their families in order to improve their access to care and improve outcomes. This integration includes shared goals, governance, accountability, and financing.
- Document and disseminate state and local strategies and best practices for integrating child-serving agencies around improved shared goals for California's children and their families.
- Expand, develop, and strengthen local and statewide partnerships to support local planning and problem solving that improves access to a comprehensive continuum of accessible care across child- and family-serving agencies; and ensure responsive state administration and policy.

- Create a California Community of Learning and Practice for integrating child-serving systems that synthesizes data about current cross-systems performance, showcases emerging models, builds common language, and provides interagency technical assistance and training for the work.
- Continue to provide an opportunity for stakeholders in child-serving systems to convene annually at a symposium to learn from each other and unite around improved goals and outcomes for California's children.
- Partner with existing aligned efforts and organizations to realize these shared goals—for example, with the San Diego Social Policy Institute, Integrated Human Services Group, the California School-Based Health Alliance, the California Children's Trust, and the UCSF Dyslexia Center.

To learn more about Breaking Barriers, go to *http://www.breaking barriersca.org* ◄

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The Finances of Behavioral, Social-Emotional, and Mental Health

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Integrating child-serving agencies not only increases the effectiveness of service delivery, it also creates greater efficiency in the use of public dollars. Considering the cost of health care, special education services, juvenile justice, and lost productivity, it has been estimated that the annual cost of mental health disorders among individuals under the age of 24 in the United States is $302 billion (all figures in 2020 dollars). This amount is equivalent to 40 percent of the total annual expenditures for public elementary and secondary education in the United States in 2019. And yet, in spite of the substantial role untreated mental health disorders play in the growing costs of health care in America, few studies have examined the potential cost savings that would accrue if necessary services were available to all children with emotional and behavioral health needs. Researchers have examined the costs associated with high-risk youth (crime, school drop-out, and drug abuse) and calculated the monetary value of preventing a child from following this life course. Considering the duplication and overlap that often occurs between school drop-out, drug use, and criminal behavior, the lifetime value of saving one high-risk youth is estimated to be between $2.7 and $3.7 million.

The critical question then becomes, how many children must be diverted from this path in order to justify the expense of comprehensive social, emotional, and behavioral health services? Using data from the National Health Expenditure Accounts for 2009–2011, research calculates that the annual average expenditure for mental health treatment for school-age children is $2,572. Of that amount, prescription medications account for 44 percent, and nearly half of those expenditures were paid by Medicaid. Given this calculation, it is evident that the cost of treatment ($2,572) is dwarfed by the lifetime savings that could be realized as a result of successfully mitigating a child's mental health disorder ($2.7 million). Given this rate of return, the expansion of social, emotional, and behavioral health services would pay for itself if it were successful for even one child out of every 1,050 children served.

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