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**TAB SECTION      A**

  **X**   **ACTION REQUIRED:**  
Approve Minutes

**DATE OF MEETING**    1/15/15

**MATERIAL  
PREPARED BY:**      Leonelli

**DATE MATERIAL  
PREPARED**          12/12/14

<b>AGENDA ITEM:</b>	Approval of CSI Committee Meeting Minutes
<b>ENCLOSURES:</b>	<ul style="list-style-type: none"><li>• Minutes of CSI Meetings on October 15 and December 2, 2014</li></ul>
<b>OTHER MATERIAL RELATED TO ITEM:</b>	None

**ISSUE:**

CSI Committee review and approval of minutes from October Quarterly meeting and December In-between meeting.  
No meeting was held in November, 2014

# Continuous System Improvement Committee Meeting Highlights

Wednesday, October 15, 2014

Lake Natoma Inn  
702 Gold Lake Drive, Folsom CA 95630  
Boardroom - Natoma

## Committee Members Present:

Susan Wilson, Chair-Elect  
Renay Bradley, PhD  
Amy Eargle, PhD  
Lorraine Flores  
Karen Hart  
Walter Shwe  
Bill Wilson

## Staff Present:

Jane Adcock, EO  
Linda Dickerson, PhD  
Laura Leonelli

## Others Present:

Beryl Nielson, CALMHBC, Napa County                      Sheridan Merritt, MHSOAC

## Welcome and Introductions:

Chair-elect Susan Wilson welcomed those present, who all introduced themselves.

## Review and Approve June, July Minutes:

No changes or amendments were suggested; minutes were approved as written.

## Discussion: Update on Data Notebook progress

Linda Dickerson distributed a list of counties whose Data Notebooks are received or are in progress, showing a high compliance rate. Kings and Plumas counties are passing on the effort, due to insufficient resources. Fresno County is declining to participate. Persistent reminders have made this project successful, despite lack of contact information and email issues. Abundant useful and interesting information is being included in the reports. The combined Data Notebook report will be organized by topics, such as policies, programs, outreach, barriers to services, and unmet needs. The final report will be composed of several (at least 3) shorter issue cluster reports. The Data Notebook committee will resume conference calls later this year to discuss next year's report and what issues will be featured, such as residential care – how it is used, how is it connected to the wider system, etc. Future Data Notebooks will be more thematic, to better inform the overall mental health system. We hope to hear feedback from the CA Local Mental Health Boards/Commissions about the county MHB experience in preparing the reports.

- Glenn County was the first to submit their report, a letter of commendation will be drafted to recognize them.

**Presentation: MHSA Projects for Transition Age Youth**

Lorraine Flores is participating on an advisory committee to the MHSA Oversight and Accountability Commission (OAC) which is working with Dr. Todd Gilmore of UC San Diego to evaluate programs provided throughout the state for Transition Age Youth (TAY). UCSD has developed an excellent survey (short but comprehensive), which was reviewed and edited by the advisory committee, to assess each county's TAY programs funded by the Mental Health Services Act. Types of practices include wellness / recovery, housing, dual diagnosis. The purpose is to compile a listing of all programs and develop a training tool to help counties implement best practices for TAY consumers. Technical assistance to TAY programs will be provided by the Research Team if indicated. A report will be compiled from the information collected. Harder and Harder Company is conducting the survey. The emphasis on quality improvement and data collection would make this an appropriate collaboration between OAC and the Planning Council, specifically the CSI committee.

Renay Bradley mentioned that OAC will also conduct a survey for Older Adults using a similar model, and will issue an RFP soon. Another project is being conducted with Dr. Gilmore (who will be looking for advisors), to look at recovery orientation of programs funded through MHSA, for example Wellness Recovery Action Plans (WRAP) and other models. One question is how to measure and identify a recovery practice: does it predict positive outcomes for clients, and is it an example of promising practices? Recovery is an MHSA value, and the concept has transformed the process of providing mental health services by allowing consumers to define their own wellness plan. OAC is also conducting a survey on Data Strengthening, to assess what data is needed at Provider, County and State levels. DHCS is working with OAC to develop a statewide data collection system.

- Renay will send the link to the survey to be distributed to Planning Council members.

**Discussion: CSI Work Plan – Finalizing Data Notebook and AB 114 goals; Determine Goal for Trauma Report; CMHPC Collaboration with OAC Research projects; New topics and Goals for next year**

Possible new topic – Mental Health in jails: the problem is the lack of transition between jails and community for people with mental health needs. Parolees do not have a support system in the community. Inmates who are coming into the criminal justice system are more decompensated than before, crisis beds are always full - is it a sentencing problem, are mental health courts working effectively?

Trauma report from CSI committee – Include review of existing materials, and emphasize support for trauma informed approach, for both youth and adults. UCLA PTSD Reaction Index has been included in DSM-5. SAMHSA Strategic Plan includes the topic of Trauma and Justice. We will discuss this topic further in the next monthly teleconference call.

**Break**

**Panel Presentation: AB 114 Transition, Central Valley**

Introductions were made: Sacramento County Office of Education – Kathleen Larson, Mental Health Coordinator, Judy Holsinger, SELPA Director; Folsom Cordova Unified School District - Jeff Kramer, Mental Health Coordinator and Betty Jo Wessinger, Director of Student Support and SELPA; Butte County Office of Education – Rusty Gordon, SELPA Director; Placer County Mental Health Board – Sharon Behrens, parent and Theresa Thickens, PsyD; Yolo County SELPA – Camille Giametti-May, Director; San Juan Unified School District – Dana Parry-Erickson, PsyD, Supervisor of Educationally-Related Mental Health Team; Parent Advocates (United Advocates for Children and Families) - Michaele Beebe and Vicky Mendoza

Discussion was wide-ranging, and minutes content is arranged by Panelist responses. Questions included: What did you anticipate about this transition process? What about the level of intensity of services? Do SELPAs send more children to residential care, see more high end users, or implement less restrictive approaches? What is the continuum of care in your system? Are outcomes measured, and if so, how? General comments by panelists on the transition followed. Parent perspectives were included.

**Butte County SELPA:**

- We expected at least an 18 month time frame, but had only 3 months to complete the transition. We had a good relationship with County Mental Health so schools continued that partnership. New rules, but no one knew what they were; we are trying to figure it out as we go.
- In Yuba /Sutter County, the Department of Mental Health severed the relationship with the SELPA immediately, so the school districts were on their own to develop new systems.
- Butte: 50 – 70% increase in mental health caseload, from 23 to 75 to 135 students. All students have IEPs, are served at school sites; another 98 SED students participate in daily County run programs, eg intensive individual, group, family therapy. SELPA has licensed clinicians in classrooms, and licensed supervisors.
- Are increases due to better identification of IEP needs? Schools are being inundated with more children with serious behavioral issues. Children are identified at younger ages, and interventions are started earlier to prevent them re-entering the school system with more severe problems. SELPA wants to keep them in least restrictive home and school environments. Some children appear to be not socialized, perhaps not exposed to school before, eg pre-school; that could be an environmental factor. Trauma exposure is increasing. Services have to be educational related rather than medical necessity, so it is necessary to get other (non-educational) agencies involved, to collaborate in many areas.
- Continuum of services: Butte – Starts with a child pulled out of regular class for weekly services, to intensive on site isolated special day programs, to County regional programs that have classrooms outside the district, to non-public school, to residential treatment centers. SELPA is referring fewer students to RTC, no evidence that they have better outcomes. Some community partners want more referrals, parents are counselled to ask for residential placement, juvenile justice

wants referrals, also Emergency Room staff want placements. Currently 9 students are in and out of RTC, no more than 3 at a time, and duration of stay has been reduced to 6 months. SELPA went in with set expectation that student would be returned and then services were tailored to meet this requirement. Presenter provided an example of an out of state residential placement that had a successful outcome, with significant student input. Expect different outcomes, providers will respond. The community that the child returns to is the most important element. Don't send the student away and forget about them, parents get respite but then don't change behavior. District does family therapy to improve home environment.

- Progress on goals, objectives – prior to the transition they looked at students being rejected due to failure to participate – sometimes parents don't want the service but it's required in the IEP so they had to be educated about this. Now there is better coordination of services in the IEP, parents are better informed. Schools would rather offer the service and allow the parent to refuse and tell them why they don't need it rather than leave something out of the IEP. Weekly multi-agency meetings happen now to coordinate services for 20+ youth, with parent permission for release of information.
- Schools are becoming social service agencies from birth – 18, they are not equipped to do that but now are expected to be the experts when working with other systems. We would never have seen these kids before. Now Juvenile Justice is doing restorative justice and sending kids back to the community and into schools earlier, but their behavior hasn't been addressed. How do we address this as a society? Isolated groups are getting attention but we need to have a global conversation.
- There are always unintended consequences of these system changes; there are large roadblocks at the state level, we have to find solutions at the local level. Fiscal issues are not addressed here, that's another whole discussion that should be had.

#### **San Juan Unified School District:**

- The previous Director supervised the transition, and this is the third year of a good mental health services team. The district employs its own clinical staff. San Juan sees about 157 students – the district already had a clinical model in place, approved by County MH, so they had more children already being served at transition.
- Continuum - Positive Behavior Intervention System (PBIS) programs: Psychologists help teachers do first/second interventions in the classroom, provide resources for multiple types of referrals. When a student is eligible for special education then their behavioral support plan is in place. Mental health assessment determines whether students are eligible for services, then the district provides those services. Licensed therapists work on campus, day treatment special ed center is staffed by 4 therapists. If more intensive services are needed then the IEP team discusses non-public schools or residential treatment.
- Mental health team recognizes parent perspective. Feedback from program specialists is that the biggest benefit is the fostering of relationships between clinicians and family, and collaboration among staff. They are not fighting a battle, they are a team. It has been a great shift in attitude. Parent 'processing' group could

be helpful, district is surveying parents now to see if they would like to form a support group.

- We're really proud of our team. Monthly collaboration meetings are held at San Juan, they discuss case studies, work on communication, increase awareness. Small groups may be appealing to both parents and students as a therapeutic strategy.

### **Sacramento County Office of Education (SCOE):**

- 5 school districts/ SELPAs in the county, they had existing MOU with County Mental Health that was renewed for all SELPAs for convenience. Spent a good year working with County on IEPs, they met monthly to make sure all were on same page. Lots to keep track of: many students, lots of data. Did not want to drop any IEP services. Sacramento does not contract out, provides own services through district employees. Started with 127 – now 1000 students being served, all seen at school sites.
- Continuum: what are the roles of SCOE and districts? SCOE keeps all SELPAs involved and on track, holds monthly meetings, coordinates activities and trainings on best practices, builds collaboratives and maintains positive relationships. SCOE does not have direct responsibilities, the school districts implement their own programs. SELPAs benefit from the collaboration and coordination. SCOE meets with SELPA school psychologists, some MFTs to support them with presentations, trainings according to district needs. System is definitely growing, it requires more collaboration, and all discuss how best to respond to student needs. SCOE provides many more low-level intervention groups for students, basic skills development; the groups are social as well as therapeutic. Friendships built through the groups sustain the students over their years in school. Comment: Do they formalize peer support? Children who have experienced groups can serve as mentors. SCOE – Their Superintendent serves on the MHSA Oversight and Accountability Commission, has recommended a Task Force of School and County Mental Health leaders to look at barriers to providing mental health services to general education population. They will be issuing a report in December, to explore options to open up MHSA funding to serve all children with mental health needs.

### **Yolo County SELPA:**

- They did not have a good relationship with County Mental health; they had an MOU one year 2010-11, but then separated and started their own program and the transition process was seamless. The SELPA runs all the ERMHs services, they issued an RFP and County did not apply. So they moved forward – Yolo hired licensed clinical staff, not from County. Services increased by 50%: 80 – 120 students.
- Measuring outcomes – Yolo SELPA documents measurable IEP goals, records % met or not met for progress. The SELPA is a regional representative/trainer for Child and Adolescent Needs and Strengths (CANS) assessment, an evidence-based practice. Everyone in the region has been trained in this system of progress measures (it is not an eligibility measure). Ambiguity in mental health measurement is rampant, social progress can't be matched with measurable goals.

- Sacramento Bee article on RTC did not reflect all opinions. Schools should be able to show that they are serving more students by providing intensive services instead of referrals to residential placements.
- Any last thoughts: Parents need to be patient with schools too, there is a level of severity (of mental health needs) in students that hasn't been seen before. In the past kids may have committed a crime and would go into juvenile justice or county mental health, and now schools are having to deal with them. A recent crime committed by a juvenile was reported in the Sacramento Bee, the SELPA MH clinician had to testify at the student's trial. This is a whole new level of involvement that they (schools) haven't done before, and are not prepared for. Kids who have an IEP for reading disability may not be receiving MH services, but are assumed to be getting services at the schools. Before, those children would have gone to the County for services.
- The Director has both clinical and administrative perspective. Some places took a hard line on educationally- related mental health. Eligibility is narrow and restrictive, compared to the County open system, depending on who is in charge, and the philosophy within the SELPA of how it has been implemented.

**Folsom Cordova Unified School District –**

- What they didn't anticipate: there are different criteria for services in old Government Code 26.5 (AB 3632) and new Individuals with Disabilities Education Act (IDEA) systems, it would have been helpful to have considered this over the short time period in order to achieve transition. Each receiving group had to decide to take students from 26.5 programs. School districts had to make sure that anything counseling or guidance related had to be cited in IEPs. District needed training in assessments, goal writing, progress monitoring. No existing job descriptions for licensed staff. They had to consider all aspects of life that are mental health related, eg, stress, anger management.
- Regular meetings helped to share information, to all get on same page. There seem to be many different interpretations of IDEA requirements. SELPA tried to adopt the service model that was already in place through the County. Under IDEA the main thing was assessment – this identified needs, needs defined goals, goals directed services. Psychiatric staff works with teachers in classrooms, or student is pulled out and worked with individually, or students progress to work together in small groups on issues.
- Initial caseload 30 students, now serving 183 students. The district has added licensed MFTs and school psychologists, behavior analyst. Under the old system, students were terminated from services because of failure to participate; 15 – 20 students were referred from transition who hadn't been in services for 12- 18 mo. Staff went to PBIS.org site, it breaks down a systems approach to mental health development based on evidence based practice. Everything in their system is based on data. Capacity building had to happen first, then get baseline data, then measure progress and outcomes.
- Folsom – When the Hughes bill was repealed, (Assembly Bill 86 mandated the repeal of the regulations in Title 5, *California Code of Regulations*, also known as the

Hughes Bill, pertaining to behavior) it kept one component concerning behavioral crisis. When AB 3632 was repealed, it left a void for crisis services that used to be available, or complex situations that used to be supported, but that IDEA really doesn't give us guidelines about. There is collaboration between juvenile hall staff and child dependency staff, training in how to deliver extraordinary interventions, but school district staff don't get that kind of training for these kinds of situations, sometimes even MFTs don't.

- Success story – Folsom: schools have always used student teachers, and now because of behavioral health supports in the district, they are able to partner with universities and use MFT trainees at elementary schools to provide preventive services, following EBP at K – 3<sup>rd</sup> grade levels, using a specific curriculum for social/emotional development. This would not have been possible 2 – 3yrs ago.
- Kids who commit crimes don't go through the system. There are a large number of families that advocate for their kids to get them out of the justice system, but we don't have ways to support them otherwise.
- General education students want to access the special education mental health system, but the numbers have doubled, quadrupled, there are already large caseloads. Principals want to be able to access the clinical staff – what about 504 [Section 504 of the Rehabilitation Act of 1973: prohibits discrimination on the basis of disability in programs or activities receiving Federal financial assistance. Such eligibility may exist without concurrent eligibility for special education under the Individuals with Disabilities Education Act (IDEA)] can a child get access that way? District believes that students with anxiety are opting for alternative education models (eg, home schooling or independent study).

**Placer County:**

- The Mental Health/Alcohol and Drug Board is doing a report for their Board of Supervisors on ERMHS. There was County MH/SELPA collaboration through the transition process, but then they separated. Placer County Office of Education took over all mental health services; they hired no licensed clinicians – by philosophy. This is one of the concerns in the MHADB report. No known tracking of services, unknown number of students served. Data Quest (CDE) web site indicates significant decrease in services for Placer County. From licensed clinical perspective, it is unethical to continue clinical treatment if no progress is being made. Placer has significant concerns, long learning curve; incidents of suicide, etc due to lack of access to services.
- Placer County held a regional 18-county Trauma conference, training in trauma-informed assessments and care, collaborative relationships within communities to support schools. Programs are up and running now for children ages 3 - 6.

**Parent perspective:**

- Her daughter received services prior to transition. What worked was tight coordination of services with trained professionals who knew what to do. School counselors, doctors, all share information and worked for what was best for child – “healing teams” with parents and child at the center. Some families have never spoken to their counselor. It is important to respect each person's talents and roles,

if not then parents get angry and develop adversarial relationships with school districts. Coordination – have medical reports at IEP conference, psychiatrist evaluation, decide who is the best person to fill a gap – bring in the experts. Parents were advocates, part of the process. Schools were important partners in child’s recovery. Child can also provide good input.

- Parent - Families say that they won’t get services because the school doesn’t want to pay for them, it sets up an adversarial relationship. Most children receive good mental health services in the lower tiers of the system, the problem is the few kids in the top tier who have multiple problems that are expensive to treat. We don’t train principals and counselors on the parameters of the law. Site principals don’t get release time to get this training.
- Parent – more schools are getting parent/family advocates, provide parenting classes through SELPA funds. Teachers should know about mental health issues and system to educate parents through the process, train parents to be their own advocates. Parents need IEP information in advance to prepare for IEP. Systems make mistakes, but good systems self-correct and reassure parents that things can work well. Parents can participate and system can expand to best help this child.

**Parent perspective – Sacramento:**

- 3 of her children have severe mental health issues, have been in multiple systems with many agencies. She didn’t know how to navigate or coordinate services; a friend recommended a Family Resource Center that provided knowledge about the school mental health system. Parents don’t generally know that the AB 114 transition happened. She doesn’t feel that she lost any services, but she made sure her children got all the services she was aware of. The IEP process was adjusted for pre-existing service, which is ok because her children were already in programs, but other families may not know about or be offered them. There needs to be tighter coordination of services for success, that doesn’t always happen even though she is more knowledgeable now. Sometimes the specialists in the room for the IEP meeting are intimidating, they resist having the child return to the school, it’s really challenging and she would not get services without insisting.
- Parent – don’t send her to parenting class, schools need to do pre-interview before going to court to assess what the family’s issues are and then recommend classes and services. Parent really appreciates the schools, she could not deal with the children by herself, but goals have to fit the capacity of the child.
- Parent – received services under the AB 3632 system, her child was in and out of Residential Treatment. Parent lost her job due to frequent calls to deal with child at school. The San Juan case managers were very helpful, so she had a good experience with her own child. She was not able to do this (family advocacy work) until she came to acceptance, finished grieving that her child was “not normal”. Parents can be more angry during this stage. Teachers and principals have to recognize that. The process is ok as long as their children are making progress. It is very important to have a parent partner liaison who has been through the grieving process.

**Comments from the CSI Committee:**

- Sending a child home to a family that is not functioning is not helpful, can't result in a functional child. All parents should participate in a class. This is a struggle for schools, they have not been responsible before for fixing families and sometimes need to pay more attention to the families. Each child and family is individual and has own issues, culture, needs. That's why the need for coordination is so critical. Sitting down first with families to have an understanding of the family ensures you won't prescribe things that are unneeded or unwanted. Truancy records are a good indicator that things are going wrong, sharing that data is important.
- Providers should get more creative, they offer menus of services that are not individually tailored and need more creative approaches and interventions.

**Public Comment - None**

**Evaluate Meeting/Develop Agenda for Next Meeting**

Next In-between meetings coincide with Thanksgiving and Christmas, and will have to be rescheduled. LL will send out a Doodle poll to get the best time/date for most members.

**Meeting was adjourned** at 5:00 pm

**Continuous System Improvement Committee**  
**Meeting Highlights**  
**Tuesday, December 2, 2014**

**Committee Members Present:**

Susan Wilson, Chair  
Lorraine Flores, Chair-Elect  
Carmen Lee  
Monica Nepomuceno  
Noel O'Neill  
Bill Wilson

**Staff Present:**

Linda Dickerson, PhD  
Laura Leonelli

**Welcome and Introductions:**

The meeting was held by teleconference. Chair Susan Wilson called the meeting to order at 2:30 pm, and requested that callers identify themselves when making comments. Those attending introduced themselves.

**Discussion:** Data Notebook reports update – Linda gave an account of how many counties have submitted Data Notebook reports to date. A complete list will be mailed out to all members. Linda said she has completed a report outline and will include text from the actual documents. She will provide a data summary for each question. The preliminary report should be completed by December 15 to go into the meeting packets. She would like some input on what kind of supplemental reports would be useful. The Committee will discuss and develop new topics for next year's Data Notebook, so members can think of possible subjects and bring suggestions to the January meeting. Linda will prepare a PowerPoint summary of the Data Notebook report for the CSI Committee meeting.

**Discussion:** Request for updates on Priority Indicator Joint Task Force and other OAC projects for January meeting – The Joint Task Force is developing a Work Group charter, and a meeting is scheduled for Thursday, December 11<sup>th</sup>. The work will involve deciding a process of how to select and evaluate indicators. CMHPC's documents were sent to the OAC and will be shared after their review is completed. Lorraine will give an update on the OAC's Transition Age Youth Advisory Group and the UC San Diego study at the January CSI meeting. Members would also like an update on the Prevention/Early Intervention regulations which are in the last stages of public input and OAC approval. Laura will send documents on the PEI regs to members.

**Discussion:** Agenda Items for January CSI Meeting in San Diego – Besides the Data Notebook and OAC report items, the CSI Committee will discuss a plan for what we want to work on in 2015. Members asked about topics that the Committee had expressed interest in at past meetings. We can look up that information from meeting minutes. Most members would like to hear presenters on the topic of mental health and juvenile justice. It was suggested that the Committee invite members of the Juvenile Justice Commission, and staff from the Positive Youth Justice Initiative in San Diego. We will preface the discussion with a short introduction by CSI members who work in the juvenile justice field: Susan Wilson, Noel O'Neill, Lorraine Flores and Amy Eargle. There is also a new SAMHSA-funded

program at the California Department of Education called Project Aware, about increasing access to mental health services to youth at schools, and professional development for teachers about mental health issues in students.

New Business: CSI Committee survey – In November, Executive Officer Jane Adcock sent out the link to a SurveyMonkey questionnaire for Committee members; these should be completed before the January meeting. She also asked questions about member preferences for Committee assignments.

Public Comment - None

Adjourn – the meeting was adjourned at 3:20 pm.

X   INFORMATION

TAB SECTION        **B**

\_\_\_\_\_ ACTION REQUIRED

DATE OF MEETING    1/15/15

MATERIAL  
PREPARED BY:    Leonelli

DATE MATERIAL  
PREPARED        12/15/15

<b>AGENDA ITEM:</b>	Discussion: a) Preliminary Data Notebook report b) New topics for future reports
<b>ENCLOSURES:</b>	<ul style="list-style-type: none"><li>• Statewide Overview: Data Notebook 2014 for California Mental Health Boards and Commissions</li></ul>
<b>OTHER MATERIAL RELATED TO ITEM:</b>	

**ISSUE:**

- 1) Representing nearly two years of planning, research, compilation and writing, the Data Notebook 2014 draft overview report is presented here for your review. Authors Linda Dickerson and Susan Wilson will lead the discussion and will solicit feedback from members.
- 2) The Continuous System Improvement Committee will also develop the research topic for the next Data Notebook report.

\_\_\_\_\_ **INFORMATION**

**TAB SECTION C**

**X** **ACTION REQUIRED:** Approve  
2014 Reports and CSI 2015  
Work Plan

**DATE OF MEETING** 1/15/15

**MATERIAL  
PREPARED BY:** Leonelli

**DATE MATERIAL  
PREPARED** 12/15/14

<b>AGENDA ITEM:</b>	2014 reports and CSI Committee 2015 Work Plan
<b>ENCLOSURES:</b>	<ul style="list-style-type: none"><li>• AB114 Draft Report</li><li>• Community Forum draft report</li></ul>
<b>OTHER MATERIAL RELATED TO ITEM:</b>	CSI Work Plan (handout)  Trauma-Informed Care draft report (handout)

**ISSUE:**

- a) One of the work products of the 2014 Continuous System Improvement Work Plan is the report on the impact of AB114, the transition of responsibility for special education mental health services delivery from county mental health departments to schools. This draft has been reviewed by Jane Adcock, EO, and CSI member Monica Nepomuceno, Consultant, California Department of Education. The report needs to be reviewed and approved by the CSI Committee in order to be released by the CMHPC to state-wide stakeholders. The other CSI Committee goals were to complete a study of Trauma-Informed Care and to conduct Community Forums. These draft reports are also included for Committee review and approval. Staff would appreciate your constructive comments on all of these reports so they can accurately represent the Committee's work.
  
- b) The CSI Committee started a discussion about goals for 2015 at the October Quarterly meeting. The final work plan was not completed, and this meeting will provide an opportunity to decide on goals for research and action in the coming year.

# California Mental Health Planning Council

Assembly Bill 114 Assessment Report  
November 2014

## INTRODUCTION:

The federal Individuals with Disabilities Education Act of 1990 (IDEA) ensures that children with disabilities are entitled to a free and appropriate public education (FAPE) in the least restrictive environment. Special Education students may require mental health services in any of 13 defined disability categories. To be eligible to receive special education services, a student must be evaluated by a designated evaluator. If the evaluator determines the student has a disability which interferes with their education an Individualized Education Plan (IEP) must be drafted and kept on file. The special education services must align with the child's needs as identified in the IEP and are designed so that children will benefit from their educational programs. The services are free to all eligible students regardless of family income or resources.

In 1974, the California State Board of Education adopted the California Master Plan for Special Education in which all local educational agencies (school districts and county offices of education) were mandated to join together in geographical regions to develop a regional special education service delivery system. Each region developed a local plan describing how it would provide special education services. A Special Education Local Planning Areas (SELPA) is the service area covered by the local plan for providing special education services to individuals with disabilities in an area. Local Educational Agencies (LEA) can be members of either a multi-district SELPA or may be a single district. When the need for mental health services was identified through an IEP, the LEA and SELPA arranged referrals and services for students through an annual Memorandum of Understanding with their local county mental health department. However, these mental health services must be justified to support a student's academic instruction, rather than emotional or medical needs.

Since 1986, Assembly Bill (AB) 3632 (Chapter 26.5 of Division 7, Title 1, of the California Government Code) has mandated that local school districts be responsible for delivering only those services that could be provided by the school's counseling and guidance programs to meet a child's need for mental health care. The county mental health department was responsible for providing any augmented mental health services necessary for the student to benefit from special education that were beyond the capacity of the school's counseling and guidance services. In 2010, AB 3632-mandated services, that had been provided by counties, were suspended as a result of reduced funding in the State Budget. As a consequence, LEAs/ school districts had to assume the responsibility to provide directly - or pay for outside - mental health services for eligible students to comply with federal IDEA requirements. Once this responsibility shifted, and the LEAs in effect became service providers, a funding mechanism was necessary to complete the transition.

On June 30, 2011, AB 114 (a trailer bill to the 2011-12 Budget Act) was signed into law. Under AB 114, the state mandate requiring county mental health departments to provide

mental health services to students with disabilities was repealed. Instead, AB 114 requires that all California school districts are solely responsible for ensuring that students with disabilities, as designated by their IEP, receive the mental health services necessary to benefit from a special education program. The Budget Act of 2011-12 introduced the phrase “Educationally Related Mental Health Services” (ERMHS), and included funds from various sources to enable schools to provide these as required under IEPs. Funding for mental health services is currently a separate “categorical” line item in the total allocation of funds from the State to SELPAs.

### **ISSUE:**

This report derives from the Welfare and Institutions Code 5772 requirement that the California Mental Health Planning Council (CMHPC) review mental health system changes resulting from realignment: in this case, the 2011-12 realignment of budget allocations and responsibilities from county mental health departments to LEA/SELPAs. To accomplish this, the Continuous System Improvement (CSI) Committee of the CMHPC received a background briefing on the transition and implementation of AB 114 from the California Department of Education (CDE) Special Education Division. The CSI Committee also organized a series of panel presentations that involved San Diego, Riverside, Orange, Alameda, San Mateo, Sacramento, Yolo, Butte and Placer Counties. Panelists were representatives of school districts/SELPAs, county mental health departments, mental health providers, and parents of children with special education-related mental health needs. The CSI Committee asked the panelists a series of questions about their experiences with the transfer of mental health services and the implementation process at their local level, specifically asking them to share both manageable and challenging situations for stakeholders. Panelists reported that experiences and strategies have varied widely in each district depending on several factors, including the vision of administrative leaders, student demographic variables, relationships with county mental health departments, and the existing local mental health services delivery system. Each SELPA reported having an extensive transition planning process, a collective learning curve, a strong demand for staff training and/or acquisition of new clinical staff, and issues with placements for residential treatment.

This report provides a summary of findings on the above topics; presents some common themes relating to the transition process; and brings forward recommendations from those who are most closely involved with implementing the new systems of providing mental health services to special education students. It is hoped that this report also reflects the genuine commitment and care that was evident as the many SELPA administrators, mental health professionals, and parents provided their input and perspectives.

The following are questions posed to the panelists. The responses are indicative of the experiences of the individual panelists with their local level process.

- 1. What did your department / school district anticipate? What were surprises as this rolled out?**

Many stakeholders reported shock at the repeal of AB 3632, and that the termination of a long-standing relationship between school districts and county mental health departments

left them 'blindsided'. Add to this the short time frame to operationalize the changes, and school districts were galvanized into action. To assist with the adjustment, the CDE formed the AB 114 Transition Working Group in July, 2011 and held several planning workshops on financing, contracts, assessments and IEPs, service delivery models, and other topics of concern. CDE also started issuing guidance documents in September, 2011. These documents, and videos of the work group presentations, are available at <http://www.cde.ca.gov/sp/se/ac/ab114twg.asp>.

Despite all of these planning efforts, one very consistent report across LEAs/ SELPAs was that they would have felt more comfortable if there had been a unified operational strategy. However, the intention of the law was to give SELPAs more local control over their own transition process by providing a range of options to consider in meeting their service delivery needs. Each district represented on the panels had unique configurations of student populations, county relationships and service needs that required a very individualized response. For example, during the first year, part of the realignment included one-time Mental Health Services Act (MHSA) funds appropriated for this purpose, but those funds could only be distributed to county mental health departments. SELPAs had to develop an agreement with their county Mental Health Plan (MHP) to access these funds to provide ERMHS. A few SELPAs reported that after the first year they discontinued their relationship with the County MHP to develop their own service delivery system. Others stated that they built their new system with extensive technical assistance and support from their MHP.

All LEAs/SELPAs described an intensive planning process during the first year, with frequent stakeholder meetings to work out the system details. The goal was a seamless transition that would maintain continuity of services to their students. Some SELPAs chose to continue referring special education students to their county MHP, or to outside contracted providers. San Juan Unified School District in Sacramento County already had a clinical model in place, through a long-standing contract with their county MHP, while the Orange Unified School District gave parents a choice to continue services under the existing contract agency or switch services to the school district. The SELPAs that we heard from chose to develop their own school-based service delivery system, building on their existing special education services or adapting the County (AB 3632) service model that was already in place. The transition process to the school-based system involved matching services to IEP requirements, creating new positions and job descriptions, developing a continuum of services, revising contracts, and aligning eligibility criteria from the old to the new requirements. Several panelists mentioned that the IDEA regulations do not extensively define mental health services in the related services sections of the regulations. Other parts of the regulations provide no guidance, either. The result was differing interpretations of what kinds of services were required or had to be included in the school-based system. SELPAs had to consider all aspects of life that are mental health related, such as stress and anger management. They had to make sure that any service that was counseling or guidance related had to be cited in the IEP. As one SELPA expressed it, "there are new rules, but no one knew what they were; we're trying to figure it out as we go along."

San Mateo SELPA reported that they were surprised at how well the planning worked out. They expected that fewer services would be offered, that assessments would decrease, and that the allocated funds would be insufficient. Instead, they experienced an increase in assessments and services, more awareness of situations that should be referred sooner, a broader variety of services available, and that funds for implementation were sufficient.

## **2. From your perspective, what are the benefits of this change, and what have been the challenges?**

It was stated that one advantage of the AB 3632 system was the availability of professional, impartial clinical staff at the county MHP who could focus only on the counseling needs of the students and their families. In the counties we visited, the contracted agencies had flexible hours that were more accessible to families, and many were willing to provide services at convenient locations such as the school site or at the families' homes. The disadvantages, however, were that the services were disconnected from the school system and school personnel did not know what was happening, whether or not there was follow-up, and had little control over the process. According to some panelists, clinical staff did not always understand the educational system, and were less invested in the academic instructional outcome. After the transition, some districts hired experienced county clinicians to staff their programs, but initially there was limited clinical expertise on school staffs. LEAs/SELPA's had to hire licensed clinical staff, and building this capacity was challenging. School staff needed training in assessments, goal writing, and progress monitoring. All panelists reported a commitment to hiring bilingual and bicultural professional staff to meet the needs of racially/ethnically diverse student populations, but it is sometimes difficult to meet these workforce objectives. LEAs/SELPA's reported that at this time they have each hired a full team of mental health professionals (psychologists, Marriage/Family Therapists, behavioral specialists) who are district employees. Other school staff also requested and received more training: some districts provide Mental Health First Aid, Child and Adolescent Needs and Strengths (CANS) assessment, and behavioral training, to increase awareness of who should be referred.

A frequently-cited benefit of the new system is the fostering of relationships between clinicians and families, and increased collaboration and consultation among teachers and mental health staff. This enables them to refer and serve students quickly and individually. Schools have easy access to families, they can control linkages to staff, and it is easier to get feedback and follow-up on student participation. School staff are provided specific cross-training and are engaged as members of a mental health team, resulting in better assessment methods. The Orange Unified School District is developing a universal screening process for all students at the elementary level. Many LEAs/SELPA's also provide training to parents, and have engaged parents as part of the service planning process. Parents in the Riverside SELPA have been consulted about program design, so that school services were created in response to family needs. LEAs/SELPA's have had existing Community Advisory Committees (CAC) for special education, which provide a forum for parent education and training about the new mental health services system, as well as a means for addressing their questions and concerns. San Mateo SELPA maintains a Parent Resource Council, a subgroup of their CAC, which provides families extra training and

support. San Mateo also reported that mental health and behavioral health trainings are available to parents in various languages.

Several panelists pointed out that leadership decisions on the part of school districts and SELPAs determine the development of school based systems. Some districts embraced a different attitude that helped to educate staff and make their system more welcoming and effective. The result was a community-based service delivery system, focused on kids, schools, and families. The same leadership dynamics enabled funding decisions that emphasize service priorities. Some districts took a hard line on educationally- related mental health, restricting eligibility as compared to the more open County-run system. Because of funding limitations, if a district makes a direct referral for services they are concerned about their ability to pay. One panelist commented that “Schools want to know how to make mental health referrals without making the educational system responsible. This counters their desire to create programs and promote connectedness.”

### 3. **Has AB 114 enhanced partnerships with other agencies?**

The importance of collaboration was stressed by every panel participant. Whether LEAs/SELPAs continued to use services provided by their county MHP or through contracted vendors, or whether they established a self-contained system, all expressed the need to develop connections to community resources to which they could refer families of students receiving mental health services. Interagency partnerships were created with outside services that also worked with their students, such as child welfare agencies, juvenile justice, health clinics, and foster youth homes. Since the IDEA services are educationally related rather than medically necessary, it is important to get other agencies involved to meet the expanded needs of students and families. Monthly or even weekly multi-agency team meetings help to coordinate services. One parent related that what worked for her child was “tight coordination of services with trained professionals who knew what to do.” School counselors, doctors, and all stakeholders shared information and worked for what was best for child; they created “healing teams” with the parents and the child at the center.

Partnerships provide essential services support to LEAs/SELPAs who report that they are being overwhelmed with more children with serious behavioral problems. Under the AB 3632 system, these children would be treated through county MHP programs, since school mental health capacity was so limited. Northern California SELPAs (Butte and Yolo Counties, Folsom Cordova USD) emphasized this issue. One administrator stated that “Schools are becoming social service agencies from birth – 18; they are not equipped to do that but now are expected to be the experts when working with other systems.” Students are being identified at younger ages for mental health services, and interventions are started earlier to prevent them from re-entering the school system with more severe problems. Another administrator noted that “When AB 3632 was repealed it left a void for crisis services that used to be available, or complex situations that used to be supported, but IDEA really doesn’t give guidance on what alternatives are allowable. School district staff, even the mental health professionals, don’t get the training needed for these kinds of situations.”

The Orange County Office of Education has leveraged MHSA funds to develop a new program that brings together constituents from various sectors that have been isolated in 'silos' into one continuum of care. They have been able to make the connection from Educationally Related Mental Health Services to clinical services and resources that would not happen otherwise. To be effective, every aspect of the system has to be in continual communication. Logistical issues common to working with different systems include obtaining parent permission to share information, and defining confidentiality policies concerning medical records and other sensitive data. For example, the easiest way to determine whether students are having trouble is to obtain data on the number of absences, but getting this information is an ongoing process that depends on a good working relationship with principals to enable access to internal school resources.

Several LEAs/SELPA that we heard from mentioned that the new system presents opportunities for improvement in service delivery based on creative approaches to their students' unique needs. The Folsom Cordova Unified School District in Sacramento County shared a collaboration success story: All along, schools have had access to student teachers. Now, because of behavioral health supports available in their district, they are partnering with local universities and using Marriage and Family Therapist (MFT) interns at elementary schools. The MFT interns provide preventive services following evidence-based practices in Kindergarten – 3<sup>rd</sup> grade, using a specific curriculum for social/emotional development. This would not have been possible 2 – 3 years ago.

#### **4. Has access to mental health services for special education students increased?**

Every LEA/SELPA is required to have a Child Find system to identify, locate and evaluate students in need of special education services. Some LEAs/SELPA mentioned that they start by identifying students who are truant, and refer them for assessment. Other schools have received training on the effects of trauma on children's social and mental development; a student with excessive suspensions is referred for a Special Education assessment and parents are also contacted and engaged in the process. Under IDEA the assessment is key – it identifies needs, needs define the goals, and goals direct the services. The emphasis is on proactive intervention and short term stabilization.

LEA/SELPA panelists reported offering a multi-tiered system of support in delivering mental health programs and services. Psychiatric and/or counseling staff work with teachers in classrooms on the first and second tier interventions, using Positive Behavior Interventions and Supports (PBIS) programs. Several LEAs/SELPA mentioned that these services are available to all students (ie, even those without an IEP). At the Sacramento County Office of Education, for example, first tier services include intervention groups that allow students to work on basic skills development. The intervention groups are social as well as therapeutic; friendships built through groups sustain the students over their years in school. If students are assessed and determined eligible for services under AB 114/IDEA, then the school team is available to provide those services. The Poway School District in San Diego County explained that if a student is new to the special education system or never before identified with a disability, the school is mandated to start with less-restrictive supports and services. Further assessment for IDEA can take up to 60 days. During that time, meetings with parents and IEP team, and interim services, can be

provided by the school. The Oakland SELPA reports that there is an on-site clinic at every school, where both contractors and qualified school district staff can provide mental health services.

The third tier of services in school-based systems involves students being pulled out of regular class for weekly individual counseling. Some students progress to work on issues together in small groups. Third tier services include on-site isolated Counseling Enriched Special Day Classes, often operated by the county MHP, and county regional programs that have classrooms outside the district. Severe behavior problems and mental health needs that are beyond the capacity of the school-based system require referral to non-public schools (specialized private schools that provide services to public school students with disabilities), or to residential treatment facilities. Parent training and family counseling are also offered at every tier of services in the school-based system.

A few LEAs/SELPA mentioned that mental health referrals and services decreased after the transition, but most experienced an increase in demand for services as they developed in scope and capacity. Children receiving services under the AB 3632 system had to be transitioned into the new IDEA systems under AB114, and one challenge that was mentioned is the numbers of children and families who had discontinued services or were resistant to participating in the new school-based service plan. Children who had been terminated from AB 3632 services were brought into the new systems where school staff were able to work with parents and educate them about what was required in the student's IEP. LEA/SELPA panelists reported increases over the past two years in student mental health caseloads of 50, 70 or 100% over those in the previous system. Larger caseloads have stretched capacity and resources, as LEAs/SELPA are growing their programs to meet increased needs.

As comprehensive as the new school based system is becoming, it still lacks the component of medication management. This service must still be implemented by psychiatrists at the county mental health departments, because the IDEA defines any services administered by a physician to be medical and not educationally related. LEAs/SELPA report that sometimes processing referrals for medication can be difficult. If a child has good medical insurance there's less of a problem. Students who don't have adequate health coverage have problems obtaining the medical services they need, including medication management.

#### 5. Are you measuring outcomes, and if so, how?

Although some LEAs/SELPA expressed that it is difficult to match social progress with measurable goals, quantifiable outcomes tracked through data collection have included improved school attendance and social skills, and reduction in behavioral problems. Capacity building for evaluation had to happen through professional development first, then SELPA could establish baseline data, and then it became possible to measure progress and outcomes. LEAs/SELPA reported that evaluations of service effectiveness occur at every tier or level of service. Progress outcomes are measured against the IEP goals: how many are met or not met. If students continue to exhibit behavioral difficulty and it is interfering with their ability to learn, they are re-assessed and they and their families are referred to more intensive interventions.

Under AB 114, the funding structures available to school districts have supported shifts in services that maintain the principle of least restrictive environment and have moved from acute care to the least restricted levels of care. There was a definite consensus among panelists that children should receive services and interventions that will allow them to remain at home and within the public school environment. Most SELPAs reported a dramatic drop in the number of students who were referred to and placed in Residential Treatment Centers (RTC). In some SELPAs, the county MHP still provides case management for children in RTC. In the Irvine Unified School District, residential treatment referrals were transitioned to the SELPA Program Specialist for evaluation and case management. Their SELPA's RTC placements are followed internally from start to finish, providing continuity with school staff who know the student and family. Panelists reported that both in and out of state RTC providers are used, and facilities which receive school referrals are certified by the CDE. Out of state RTC facilities are reported by a few SELPAs to cost less and to provide better quality services. However, this requires a long term separation from family members who may not be able to afford visits.

## 6. RTC Issues:

Shortly before the Sacramento area panel, the Sacramento Bee published an article<sup>1</sup> that claimed a connection between reduced RTC referrals by school districts and an increase in teen mental health hospitalization. Actually, the article's chart documents that mental health hospitalizations of children increased beginning in 2008, before the AB 114 transition took place. However, the article's claim does reflect a tension between the expense and the necessity of providing the most intensive levels of mental health treatment to youth. "Counties [Mental Health Departments] used to take an expansive view of the services they could provide to emotionally disturbed children, considering the risks and challenges students and their families faced at home as well as on campus. School districts now make their treatment decisions based primarily on whether children's mental health needs affect their educational performance"<sup>2</sup>. LEAs /SELPAs that participated in the panels have responded that this is exactly what was required by the new law that returns mental health services to the IDEA system. Under the old (AB 3632) system, County MHPs had responsibility for providing RTC placements as mandated services, but lacked the funds in the budget to support a typical annual expense of over \$100,000.<sup>3</sup> Funding to LEAs/SELPAs for mental health services is also limited. Some additional funds for mental health treatment are available through Medi-Cal for those students whose families meet income qualifications, but private health insurers can exclude coverage for services that are determined by an IEP team as a necessary component for a Free and Public Education (FAPE) and therefore designated to be provided by SELPAs.

The Butte County SELPA reported that they are referring fewer students to RTCs since they see little evidence that they have better outcomes. The SELPA is under some pressure from community partners that want more referrals: parents are counselled by advocates to ask for RTC placements, and the juvenile justice system and Emergency Room staff want RTC

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<sup>1</sup> Wiener, J. "Crisis seen in Teen Mental Health Care". The Sacramento Bee, August 26, 2014.

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

referrals. Butte County reports that currently no more than 3 students at a time are in RTC, and the duration of stay has been reduced to 6 months. The SELPA went in with set expectations that students would be returned to public school and therefore residential treatment services were tailored to meet this requirement. They emphasize that the community that the child returns to is the most important element in their recovery. The SELPA provides family therapy to improve the home environment for students in RTC. The Riverside County SELPA has made no new RTC referrals over the last 1.5 years nor have they experienced any recidivism to residential placements. They recognized that parents do need respite, though, and have addressed this need with a 24-hour crisis phone line. Feedback from parents indicates that this is probably the most crucial support in keeping kids out of residential treatment.

How have parents been involved in the paradigm shift in service delivery? In Alameda County, parent partner liaisons are connected to the districts, involved in Administration meetings, and they influence program design. San Mateo SELPA reports that the new system has resulted in fewer parent complaints. Riverside SELPA has a Community Advisory Committee that helps parents navigate the system; they have a strong voice – there is one overall organization and one for each school district. A parent shared that any system can make mistakes, but good systems can self-correct and this reassures parents that things can work well.

## 7. Parent Perspectives:

The Continuous System Improvement Committee was fortunate to hear from parents of children with special education-related mental health needs who contributed their time and perspective to all of the panels. Ten parents from San Diego, Orange, Alameda and Sacramento Counties participated, including members of the Family Youth Roundtable, United Advocates for Children and Families, and the National Alliance for the Mentally Ill. All of them attested to the great difficulty in raising a child with mental health needs. One parent shared that she had experienced grieving that her child was “not normal” and that parents can be more upset during this stage until they come to acceptance. She said that “Teachers and principals have to recognize that, for parents, the process is working as long as they know their child is making progress.” Several themes emerged from parent comments:

*Access to needed services is challenging* - Parents have to go through a lot. IEP meetings are emotionally stressful; obtaining services is not easy; one parent shared that her family had to exercise their due process and hire lawyers, etc. Her child was not attending school due to depression, but did not receive an assessment until after a private psychiatric evaluation. Another parent shared that sometimes the specialists in the room for the IEP are intimidating, and they resist having the child return to the school. She did not obtain services without insisting and found it to be a very challenging process. Another parent claimed that school personnel imposed their own ideas on service needs. She had questions about the clinical expertise and training of district personnel. There appeared to be no mental health professional at IEP meetings. Often, the parents experienced long waits for the results of their child’s assessment, and did not receive a written report. One parent believes the IEP team made decisions despite input from the child and therapist. Families say that they won’t get services because the school doesn’t want to pay for them,

and that sets up an adversarial relationship. Another parent expressed that most children receive good mental health services in the lower tiers of the system; the problem is the few kids in the top tier who have multiple problems that are expensive to treat. She said, "We don't train principals and counselors on the parameters of the law. Parents would be less angry if they knew the restrictions of the new law, their rights, and had reasonable access to advocates." She stated that she also had to request the IEP information in advance to prepare for the IEP meeting.

*Services are not always received as expected* – A parent stated that the programs look good on paper, but her child did not get the services that were promised: the required specialists were not available and the parents were not informed. One parent understands that emotional health is important, but her child is not prepared for his grade level. He is not getting standard tests and she doesn't know how her son is measuring up academically. She did feel that her family gets support from school programs and from school mental health staff, but if she doesn't call and insist that her child is put in a regular classroom it won't happen. Sometimes she calls and finds out the IEP protocol is not being followed. "If parents don't advocate for their child then they will fall through the cracks. The psychologists and everyone involved with special education should realize that it's not just the mental health but the academics that the children need."

*Parent advocacy is critical in meeting their child's needs* – "We are our children's voice". Schools/SELPA's should provide training for parents to become family advocates. One parent stated that having a Family Partner assigned to her for her child's IEP process was crucial. More Family Partners should be available for children in Special Education, especially those with mental health needs. If parents can participate, then the system can respond to best help their child. It is necessary to respect each person's talents and roles. One parent stated that Residential Treatment is a great help for some children; many need it and are not receiving it without families advocating for it.

*Parents need help to navigate special education systems, especially for children with mental health needs* – Parents often don't understand the process. Some parents think that if their kids are getting special education then they're automatically getting what they need. One panelist has 3 adopted children who have severe mental health issues, and who have been in multiple systems with many agencies. She didn't know how to navigate or coordinate services. A friend recommended the Family Resource Center where she got knowledge about the mental health system. Services in a complex system need to have tighter coordination for success, and that doesn't always happen even though she is more knowledgeable now. This mother doesn't feel that she lost any services in the transition, but she made sure her children got all the services she was aware of. Another parent acknowledges that more schools are getting parent/family advocates, and thinks that teachers should know about mental health issues and the school's system to educate parents through the process. It is very important to have a parent partner liaison who has been through the grieving process.

**Following are recommendations suggested by panel participants throughout the state:**

**For Schools -**

1. Schools should work to get Seriously Emotionally Disturbed students actively ready to learn, and make more effort to actively engage parents from the very beginning of the special education process.
2. Use truancy incidents and hospitalizations to engage students and to assess needs for mental health services.
3. Review school disciplinary data regularly. Determine how many children are suspended and expelled and investigate the relationship of these incidents to their mental health status.
4. There is a need for schools to fund more mental health personnel and implement more programs at the Tier 1 – 2 levels, including more counseling time for all students to resolve emotional/behavioral problems earlier. Some general education students have family-related mental health problems, but are not eligible to be treated under the AB 114-funded services, so schools have to blend funding sources to meet this need.
5. Each child and family is individual and has their own issues, culture, and needs. School personnel should take the time to understand the unique details of the situation and obtain the students' and families' input to avoid prescribing services that are unneeded or unwanted. When the IEP requires services that are delivered both at the school and through outside agencies, the need for coordination is critical.

**For Parents:**

1. Families need to be patient with schools, too. Districts are dealing with a level of severity of needs in students' mental health that hasn't been seen before, as an unintended consequence of the mental health services transfer.

**For the State:**

1. There is a lack of consistency in data collection and reporting. It would be helpful for the CDE to determine a set of measureable outcomes for LEAs/ SELPAs to report. The collection of similar data would allow for comparisons and the identification of any gaps in services.
2. It is imperative that mental health funding remain a separate line item in the Local Control Funding Formula. Otherwise these funds would effectively "disappear" into the larger Special Education allocation.

## AB114 Panel Participants:

San Diego: January 15, 2014

Mental Health Case Manager, Riverside County Special Education Local Planning Agency  
Special Education Director and SELPA Director, Poway Unified School District  
Chief, Juvenile Forensic Services, San Diego County  
Senior Clinical Director, San Diego Center for Children  
Community Engagement Specialist, Family and Youth Roundtable

Irvine: April 16, 2014

Program Specialist - Irvine Unified School District  
Coordinator for Mental Health, Orange Unified School District  
Manager, Children and Youth Services, Orange County Behavioral Health Services  
Coordinator of Student Services, Orange County Office of Education  
Anaheim Unified School District  
Project Together Mentor Program, Mental Health America Orange County  
(2) Parents, Santa Ana Unified School District

Oakland: June 19, 2014

Senior Administrator, SELPA - San Mateo County Office of Education  
Coordinator, Mental Health Programs, Oakland Unified School District  
Chief of Children's Specialized Services, Alameda County Behavioral Health Care Services  
(3) Parent Partners, United Advocates for Children and Families, Oakland

Sacramento: October 15, 2014

Mental Health Coordinator, Sacramento County Office of Education  
SELPA Director, Sacramento County Office of Education  
Director of Student Support Services and SELPA, Folsom Cordova Unified School District  
Supervisor of Educationally-Related Mental Health Team, San Juan Unified School District,  
Special Education Department  
SELPA Director, Butte County Office of Education  
Psychologist, in private practice as a school-based mental health specialist  
Parent, member of Placer County Mental Health Alcohol and Drug Board  
(2) Parent Partners, United Advocates for Children and Families, Sacramento

X   INFORMATION

TAB SECTION        D

\_\_\_\_\_ ACTION REQUIRED

DATE OF MEETING    1/15/15

MATERIAL  
PREPARED BY:    Leonelli

DATE MATERIAL  
PREPARED        12/15/14

<b>AGENDA ITEM:</b>	Panel Presentation: Juvenile Justice and Mental Health in San Diego
<b>ENCLOSURES:</b>	None
<b>OTHER MATERIAL RELATED TO ITEM:</b>	

**ISSUE:**

The Continuous System Improvement Committee decided that the delivery of mental health services within the Juvenile Justice system was the most timely and relevant topic for this quarterly meeting discussion. Several CSI Committee members have experience working with youth in the juvenile justice system, and will be introducing this subject through their own experiences. Nancy Gannon Hornberger, CEO of Social Advocates for Youth San Diego, is a confirmed presenter and will report on their Juvenile Diversion and Prevention and/or Teen Court programs. The San Diego Probation Department and the Juvenile Justice Commission have also been invited to present. San Diego County is implementing a Positive Youth Justice Initiative funded by the Sierra Health Foundation.