



California Mental Health Planning Council

Transition of Mental Health Services for Students with Disabilities

January 2015

INTRODUCTION:

The federal Individuals with Disabilities Education Act (IDEA) of 1990, re-authorized in 2004, 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 Area (SELPA) is the service area covered by the local plan for providing special education services to individuals with disabilities. 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, which 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/LEAs are solely responsible for ensuring that students with disabilities receive the mental health services necessary, as outlined in their IEP, 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 the IDEA. The 2013-14 Budget Act has established a Local Control Funding Formula for school districts that replaces the old categorical funding system with a per-student base grant that allows districts more flexibility in spending, based on a Local Control Accountability Plan. However, funding for mental health services continues to be a separate “categorical” line item in the total allocation of funds from the State to school districts.

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/SELPA. 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 LEAs/SELPA, 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 school 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 who chose to develop their own school-based service delivery system did so by 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 had to hire licensed clinical staff, and building this capacity remains 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 who participated in the panels reported that at this time they have each hired a full team of mental health professionals (School 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 for mental health services.

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 reports they are reviewing current practices to determine next steps in developing a universal screening of social-emotional needs for all students at the elementary level. Many LEAs/SELPA 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 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 multiple 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. It was evident that mistaken assumptions continue to exist over the scope and intention of the AB 114 funding, on the part of both parents and school personnel, who still don't realize the restrictions of mental health services to students with educationally-related disability. 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."

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 MESA 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 – 3rd grade, using a specific curriculum for social/emotional development. This would not have been possible 2 – 3 years ago.

3. 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 of mental health services 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 many school-based systems.

The question of increased access is central to critics of the new school-based system. One panelist, a licensed psychologist, pointed out the deficiencies that students and families have experienced in her Northern California county. She stated that some SELPAs are determining eligibility for ERMHS without adequately defined or standardized assessment criteria, resulting in significant decreases in Special Education eligibility. Additional lack of coordination and communication among school departments and service providers have resulted in reduced numbers of referrals to both Special Education and outside mental health services. As a consequence, for some regions, child psychiatric crises and Emergency Room visits have increased substantially and continue to rise.

A few LEA/SELPA panelists mentioned that mental health referrals and services decreased after the transition, but most who reported 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/SELPAs 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/SELPAs 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.

4. Are you measuring outcomes, and if so, how?

Although some LEAs/SELPA's 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's could establish baseline data, and then it became possible to measure progress and outcomes. LEAs/SELPA's represented on our panels 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 SELPA's reported a dramatic drop in the number of students who were referred to and placed in Residential Treatment Centers (RTC). In some SELPA's, 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 SELPA's 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.

5. RTC Issues:

Shortly before the Sacramento area panel, the Sacramento Bee published an article¹ 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"². LEAs /SELPA's 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

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

² Ibid.

responsibility for providing RTC placements as mandated services, but lacked the funds in the budget to support a typical annual expense of over \$100,000.³ Funding to LEAs/SELPA 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 achieve 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 referrals. Butte County reports that currently an average of 3 students at any time is 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.

6. 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:

³ Ibid.

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 who are doing assessments. 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 about 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/SELPAs 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 local Family Resource Center where she got information 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. It is very important to have a parent partner liaison who has been through the grieving process. Parents think that teachers should know more about mental health issues. The school's system should include a component that will educate parents through the process of assessment and IEPs.

UCLA Mental Health Services Study:

In December, 2014, UCLA released a collective case study "Mental Health Services for Students with Disabilities: Implications of State Policy Changes on Mental Health Service Models for Students with Disabilities". Although this CMHPC report did not emphasize a literature search, this paper seemed relevant to many of the issues raised by panel participants regarding the transition of mental health services for students with disabilities. The UCLA researchers reported on three different models implemented by three school districts:

- a) total school based services provided by district staff;
- b) continuation of contracted services by outside agencies; and
- c) a hybrid model including both school-based and clinic-based services.

The pros and cons of each model were discussed, with similar observations as those expressed by participants in the CMHPC panel discussions: School districts gained more control over the mental health system, and residential placements decreased. However, rapid policy changes left little time to restructure the schools' mental health system so that students did not lose access to needed services. Uncertainties about which services were mandated under the new law, and who and when to assess for educationally-related mental health services, are prevalent across districts. Schools do not always have the resources to provide the same level of services available through the county mental health department by licensed clinicians. No matter which model was implemented, the district personnel who were interviewed by UCLA researchers expressed their preference for a system where a licensed therapist would be available at the district office to consult with students individually. They believed that this model would minimize transportation issues, would not affect confidentiality of student and families, and would provide a bridge between the district and outside service providers.

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 reports of Emergency Room mental health visits 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 emotionally-related mental health problems, but are not eligible to be treated under the AB 114-funded services, so it becomes necessary for schools to blend other 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